Understanding experiences of people with mental health in employment: research findings and positive steps towards managing mental health in the workplace

office manager limousine driver lorry driver joiner care assistant civil servant hairdresser personal assistant school teacher hospital domestic bank associate caretaker teaching assistant developmental officer art centre manager public relations manager

Understanding experiences of people with mental health in employment: research findings and positive steps towards managing mental health in the workplace

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FOREWORD

In 2011, SAMH published *What's It Worth Now?*, a research report investigating the costs of mental health problems to Scotland's employers. The findings were staggering: mental health problems cost Scotland's employers £2.15 billion per year, through sickness absence, lower productivity and staff turnover[1].

Such figures would be worthy of the public's attention in any economic climate. In the current financial crisis, with both the private and public sectors seeking to cut costs, higher levels of unemployment and far-reaching reforms of the welfare system, the importance of workplace mental health cannot be ignored.

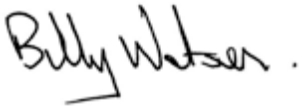
In recognition of these challenges, Dismissed?, SAMH's campaign for fairness in mental health and employability, has been working to raise awareness of mental health at work and to help employers in Scotland find practical ways to support the mental health of their staff.

While *What's It Worth Now?* revealed the financial costs of poor mental health, little research has been done to understand individual's lived experiences of mental health problems in the workplace.

People with mental health problems face numerous challenges to managing their condition as well as their workload. To understand workplace mental health and to devise effective, practical measures by which employers can support the mental health of their staff, we must understand the experiences of the one in six employees who experience a mental health problem at work[2].

To do this, we have worked with the Centre for Research on Work & Wellbeing at Heriot-Watt University and the Business School at the University of Edinburgh. Together, we surveyed hundreds of employees in Scotland and conducted in-depth interviews with dozens of working people with experience of mental health problems.

The result is this report. *What Works?* reveals the facts about mental health in the workplace and provides employers of all sizes and sectors with practical ways to tackle both the human and financial costs of poor workplace mental health.



BILLY WATSON
CHIEF EXECUTIVE, SAMH

DISMISSED? SAMH

SAMH's **Dismissed?** campaign focuses on the employability journey of people with mental health problems. From claiming benefits to which people are entitled when they are sick or disabled, to applying for, getting and keeping a job, people with mental health problems are currently disadvantaged in employability.

The Dismissed? campaign works with employers to help them support staff and save money by managing mental health in their workplace, and seeks to influence the benefits system to make it fairer and easier to navigate.

There are many ways to get involved in the Dismissed? campaign. Visit **www.samh.org.uk** to find out more.

EXECUTIVE SUMMARY

AIM OF THE REPORT

The main aim of this report is to better understand the experiences of people with mental health problems in employment.

OBJECTIVES OF THE REPORT

The main objectives of the report are to: identify positive steps that employers and employees can take to help maintain a mentally healthy workplace; identify positive steps that employers and employees can take to avoid losing staff when they develop mental health problems; and identify common experiences that are unhelpful in maintaining a mentally healthy workplace, so that employers and employees can avoid these in the future.

RESEARCH DESIGN

A mixed-methods research approach, encompassing both quantitative and qualitative elements, was identified as the most appropriate way to address these objectives. An electronic questionnaire (Phase One) was used to collect data from a range of employees (n=312) in Scottish workplaces to ascertain the prevalence and nature of mental health problems and to gather information about a range of workplace experiences in the management of mental health. Qualitative interviews (Phase Two) with a selection of employees (n=38) who had experienced mental health problems were designed to provide a more holistic insight into the lived experiences of working while at the same time experiencing or developing a mental health problem.

KEY FINDINGS

These include the following:

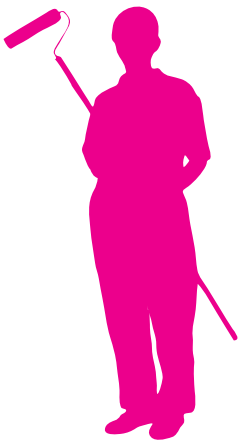
- The report findings highlight how crucial disclosure is in the successful management of mental health in the workplace. Although a majority of respondents with mental health problems had disclosed their condition to their employer, experiences were mixed. Satisfaction was higher when employers provided a prompt, appropriate response.
- Line managers and colleagues appeared to be the main sources of support within the workplace, providing key practical and emotional support. Employees reported higher levels of satisfaction where they were actively involved in discussions and decisions about the support they received from their employer
- In many cases, employers were not the first or only source of support for a person experiencing mental health problems. Many survey respondents sought support from their family and friends, a GP or a mental health professional, often in combination.
- Employees reported higher levels of satisfaction with an employer's response where they were offered a combination of formal and informal support and receive support from their line manager and colleagues.

- Formal interventions to limit or manage stress were relatively rare (although the research was not designed to undertake a systematic audit), and restricted in the main to large organisations. Stress awareness initiatives were somewhat effective, with those reporting higher levels of awareness of such initiatives less likely to report feeling stressed at work. However, to be effective such initiatives require concerted promotion.

MAIN RECOMMENDATIONS

The main recommendations from the study include the following:

- Actively raise awareness of organisation's approach to stress management, especially to support members who may be experiencing mental health problems.
- Recognise and support pivotal roles played by colleagues and line managers.
- Pay more attention to disclosure of mental health problems.
- Involve people with mental health problems in discussions.
- Assess the contributions of formal and informal approaches.
- Understand and recognise that successful management of mental health conditions is a shared responsibility.



1. AIM AND OBJECTIVES

This research was commissioned by SAMH in order to provide information to support its 'Dismissed' campaign, which seeks to improve the employment experience of people with mental health problems, focusing on both employers' and employees' needs.

The overall aim of the research was to better understand the experiences of people with mental health problems in employment by focusing on three specific objectives:

- To identify positive steps that employers and employees can take to help maintain a mentally healthy workplace;
- To identify positive steps that employers and employees can take to avoid losing staff when they develop mental health problems;
- To identify common experiences that are unhelpful in maintaining a mentally healthy workplace, so that employers and employees can avoid these in future.

2. RESEARCH DESIGN AND METHODS

2.1 OVERVIEW

A mixed-methods research design encompassing both quantitative and qualitative elements was identified as the most appropriate way to address these objectives. The survey (Phase One) was used to gather data from a range of employees in Scotland to ascertain the prevalence and nature of mental health problems and to gather information about a range of workplace experiences in the management of mental health. This complemented recent quantitative descriptive research in this field (e.g. CIPD, 2011). Qualitative interviews (Phase Two) with a selection of employees who had experienced mental health problems was designed to provide a more holistic insight into the lived experiences of working while at the same time experiencing or developing a mental health problem. The research was carried out in autumn 2011 and winter 2011/12.

2.2 PHASE ONE: THE SURVEY

The online survey was designed to capture a range of experiences of managing mental health problems in the workplace. It was thus decided to distribute it to all employees in the sample organisations to include opinions of those with and without mental health problems. For ease of completion it comprised mainly closed questions, supplemented by some open questions to allow participants to provide further details and information where appropriate. The questions asked about experience and nature of mental health problems[1], before probing more deeply about issues of disclosure, employer responses, and eliciting information on the various formal and formal mechanisms

1 In both research phases, nature and prevalence of mental health problems were based on self-reported data. We acknowledge the limitations of this and the debates between self-report and confirmed medical diagnosis in influencing employee behaviour (see e.g. Loretto and Taylor, 2007). However, medical diagnoses would have been outwith the scope of this project.

used to manage mental health problems at work. The survey was constructed in 'Survey Monkey', with respondents completing the survey via a secure link from the email circulated. The usual assurances of anonymity (unless the respondent wished to volunteer to be interviewed in Phase Two) and confidentiality were applied.

The initial circulation of the survey was through the SAMH Dismissed campaign's supporters, and this approach yielded about 80 respondents. The survey was then distributed more widely through, for example, the Scottish branches of the Chartered Institute of Personnel and Development (CIPD). By the middle of February 2012 there were 312 respondents to the survey (this figure is based on 286 fully completed questionnaires and a further 26 partially completed questionnaires).

2.3 PHASE TWO: THE INTERVIEWS

The purpose of the interviews was to explore, in more depth than is offered by a questionnaire, the experience of combining paid work with a mental health problem. The semi-structured schedule covered: the nature of the individual's work, stress at work, workplace support for individuals with mental health problems, management of absence and the impact of mental health problems on workplace relationships.

In total, we interviewed 38 individuals. Four interviewees had volunteered when completing the survey. The remaining 34 were recruited via a professional company with experience in policy-related research. The recruitment company was instructed to recruit participants with a greater diversity of socio-economic backgrounds in order to extend the relevance of the findings to a broader spectrum of people and work contexts (see Appendix One[2]). The interviewees were drawn mainly from the Central Belt of Scotland. The original intention was to conduct these interviews via telephone, but some were conducted face-face to accommodate the preferences and needs of research participants. The interviews ranged from 45 minutes to two hours in length, and were fully transcribed.

2.4 APPROACH TO ANALYSIS

The survey data were exported into SPSS to enable appropriate univariate and bivariate analysis. The qualitative (interview) data were coded both deductively (recording evidence under each of the research themes) and interpretatively (scanning the interviews for additional and relevant information). The Results presented in Section 4 draw upon the quantitative and qualitative data together in order to address the research objectives. The richness of the interviews also enabled the construction of a series of case examples (contained in Appendices Two to Seven) which provide an indication of the variety in experiences and also act as a means to guide positive steps that employers and employees can take to help maintain good mental health in the workplace.

2 The names of the interviewees have been changed in the report and only non-identifiable details of the interviewees are noted in Appendix One.

3. DETAILS OF SAMPLES

3.1 SURVEY RESPONDENTS

Three hundred and twelve responses were received to the survey. Three-quarters (n = 226) of respondents worked either in the public sector or third sector. Eighty-two per cent of survey respondents (n= 212) were female which may reflect both the sectors of employment, the propensity of women to respond to surveys as well as the higher prevalence of some mental health problems in women (NHS, 2009; see also section 4.1). In terms of age, the majority were aged 40 or older. Forty-five per cent of survey participants described themselves as working class and 50.2 per cent as middle class, while 61.2 per cent of survey participants had an undergraduate degree or higher qualification.

Full demographic details of the survey participants are shown in Table 1.

3.2 INTERVIEW SAMPLE

The skewing of the survey sample to highly educated white collar workers (typical for this type of survey) meant that we felt the need to broaden the demographic profiles of the interview participants to capture a broader spectrum of work experiences and contexts. In total, 38 respondents were interviewed. Just over three-quarters of the interview participants were female and the average age of the interviewees was 45 years. The interview sample also included a wider range of jobs and professions than did the survey sample. (The full profile of the interviewees can be found in Appendix One).

TABLE 1: PROFILE OF SURVEY RESPONDENTS

SOCIO-DEMOGRAPHIC CHARACTERISTIC	PER CENT	N OF RESPONDENTS
Men	18.4	50
Women	81.6	212
		Base = 272
Self-defined as working class	45.2	118
Self-defined as middle class	50.2	131
Don't know/prefer not to say	4.6	12
		Base = 261
No formal school qualifications	1.5	4
O levels/Standard grades	6.0	16
A levels/Highers	8.3	22
HNC/HND/BTEC	15.8	42
Undergraduate degree	33.8	90
Higher degree	27.4	73
Other	7.1	19
		Base = 266
Under 30	20.5	54
31-30	24.2	64
41-40	34.1	90
51-60	16.7	44
60+	4.5	12
		Base = 264

Bases vary because of different numbers of missing responses. The only links between the demographic variables was an expected positive association between age and length of service. Nevertheless, this association (Pearson's r = 0.51; p<0.001) was only moderate.

4. RESULTS

4.1 EXPERIENCE OF MENTAL HEALTH PROBLEMS AT WORK

4.1.1 NATURE AND PREVALENCE OF PROBLEMS

Sixty-nine per cent of the survey respondents (n = 210) had experienced or were currently experiencing mental health problems, the vast majority of these (83 per cent; n=185) within the past five years. These levels of prevalence far exceed those found in national surveys (e.g. SAMH, 2011) and therefore suggest response bias - i.e. those with mental health problems were more interested in participating in the research. Nevertheless, they provide a useful and valid platform for assessing employer responses to managing mental health in the workplace.

39 per cent of respondents reported one condition; 44 per cent reported two; 28 reported three; 2 per cent four and 1 per cent (3 individuals) reported experiencing 5 out of the list of 9 conditions.

There were no statistically significant differences between the proportion of men and women reporting experience of mental health problems. This is interesting given that national surveys regularly report higher prevalence (or reporting) of mental health issues among women (see e.g. National Statistics 2010). In the current survey, men were more likely than women to say that they 'didn't know' whether or not they had experienced mental health problems. Neither age of respondent nor length of service with current employer had any association with the likelihood of experiencing mental health problems.

TABLE 2: PROFILE OF MENTAL HEALTH PROBLEMS EXPERIENCED (MULTIPLE RESPONSES ALLOWED)

MENTAL ILLNESS	PER CENT	N OF RESPONDENTS
Depression	75.2	162
Anxiety	63.6	137
Eating Disorders	11.7	25
Other[3]	10.5	22
Postnatal Depression	9.7	21
Phobias	8.7	18
Bipolar Disorder	8.3	18
Obsessive Compulsive Disorder	4.4	9
Personality Disorders	1.9	4
Schizophrenia	0.5	1

By far the most commonly experienced problems were depression (75 per cent) and anxiety disorder (64 per cent). A substantial number of respondents (n=97) experienced both of these conditions together. Between 8 and 12 per cent of respondents with mental health problems reported experiencing other conditions such as bipolar disorders, phobias, eating disorders or post-natal depression. The full profile of problems experienced is provided in Table 2. It is also worth noting the total number of conditions experienced:

All interview participants had ongoing mental health problems as per the selection criteria. The profile of problems experienced was very similar to that of the survey respondents: the majority of the interviewees also reported some form of depression or anxiety-related problem (see Appendix One).

Nearly half of the survey respondents (49 per cent; n=90) described the severity of their problems as 'moderate'; 19 per cent (n=35) categorised their problems as 'mild';

3 These included: sleep problems, Seasonal Affective Disorder, self-harming, Post-traumatic Stress Disorder.

and 27 per cent (n=50) felt their problems to be 'severe' (nine people could not provide a categorisation). One-way Anova showed that a higher number of reported conditions was associated with a higher perception of severity ($F=4.35$; $p<0.05$).

4.1.2 TIMING AND DURATION OF PROBLEMS

Respondents to the survey were asked how long their problems had lasted for. A number of respondents could not give a definite answer to this question because of the sporadic nature of their conditions or symptoms. However, out of the 162 who provided answers, problems had lasted between a few months to 40 years, with an arithmetic average of 5.6 years. The distribution was rather skewed as 73 per cent of respondents had experienced their problems for up to 5 years. Length and perception of severity were strongly linked ($F=5.16$; $p<0.01$): the mean length of time for those reporting mild problems was 1.8 years. This compares to 5.6 years for those reporting moderate severity and 8.3 years for those whose problems were severe.

As regards timing of their problems in relation to their current job, nearly half (44 per cent; n = 95) reported that their problems had occurred while working for their current employment. A further fifth (n = 43) said that the problems had occurred when working for a previous employer only, while 23 per cent (n = 49) had experienced mental health problems covering two or more periods of employment with different employers. The remaining 13 per cent (n = 28 of respondents reported that their problems pre-dated employment. There was no significant association between this timing variable and reported severity.

4.2 RELATIONSHIPS BETWEEN WORK AND EXPERIENCES OF MENTAL HEALTH PROBLEMS

4.2.1 EFFECTS ON WORK ACTIVITIES

The reported effect on day-to-day activities or the type of work a respondent could do varied. Full details can be seen in Figure 1.

FIGURE 1: EXTENT TO WHICH MENTAL HEALTH CONDITION(S) AFFECT DAY-TO-DAY ACTIVITIES OR TYPE OF WORK

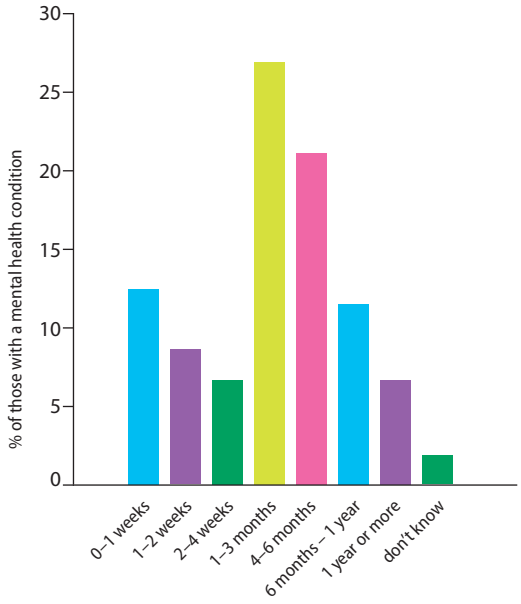
Not at all	17%
A little	35%
Moderately	29%
Severely	19%
	100%

There was a moderate association ($R=0.47$; $p<0.001$) between reported severity of problems and the effect they had on day-to-day activities or the type of work the respondent could do. This indicated that reported severity and affect on work tended to increase together. However, it is important to note that this was by no means a perfect relationship (that would have been a correlation of 1.00). Instead there was heterogeneity. For example, over half (54 per cent) of respondents in the group who said their mental health had no effect at all on their work reported moderate or severe problems in general.

4.2.2 ABSENCE

The response rate to this question and quality of answers received were rather poor, indicating potentially sensitive nature of the topic of absence from work. Eighty-four respondents (40 per cent of those with a mental health condition) said that their condition had not lead them to being absent from work for any length of time. Of the 93 respondents who gave answers, several provided non-committal comments such as, 'it varies'. As Figure 2 below shows, the length of absence varied greatly, with an average time off of between 1 and 3 months

FIGURE 2: ABSENCE ARISING FROM MENTAL HEALTH PROBLEMS



4.2.3 ATTITUDES TO WORK

Respondents who reported mental health problems were less likely to feel happy 'in general' (e.g. 16 percent of those with current mental health problems said they were 'very happy' as compared to 36 per cent of those with no problems), but there were no differences in happiness levels according to reported severity of the problem(s).

Experience of mental health problems also affected attitudes towards work and motivation levels. Respondents with experience of mental health problems were significantly more likely to report that their opinion of themselves decreases if they do a job badly ($F=7.96$; $p<0.001$) and to feel unhappy if their work is not up to their usual standard ($F=3.5$; $p<0.05$). However, they were also less likely to say that they took pride in doing their job as well as they could ($F=3.6$; $p<0.05$) or that they tried to think of ways of doing their jobs effectively ($F= 3.2$; $p<0.05$). As with general happiness, there was no clear relationship between reported severity and attitudes towards work.

4.2.4 ROLE OF WORK IN CONTRIBUTING TO MENTAL HEALTH PROBLEMS

Sixty per cent (n = 171) of survey respondents agreed or strongly agreed that they often felt stressed at work. A further 21 per cent (n = 59) were neutral on the issue, with 15 per cent (n = 43) disagreeing and only 4.5 per cent (n = 13) saying that they strongly disagreed. Those who had no experience of mental health problems were less likely to report feeling stressed at work ($F=6.32$; $p<0.01$). Within the group who had experienced mental health problems, the likelihood of reporting feeling stressed at work was increased with reported severity of their condition(s).

While the survey can only demonstrate association and not causality, the nature of the relationship between work and stress could be investigated further in the interviews. Fifteen interviewees (40 per cent of those interviewed) reported developing their mental health problem(s) as a result of a range of work-related pressures. The following quotes illustrate how a build up of extra work, often concerning excessive

workloads related to performance targets, can have an unhelpful effect on the mental health of employees:

> ...but what had actually happened was out of a team of eight workers and two Seniors there's only myself and another worker and another Senior, so we were doing the work, two of us doing the work of eight and I was just knackered and I took a chest infection and my body and my brain just went "oh let's stop"... (Social Worker).
>
> ...I was deputising [as a line manager], I actually deputised for a year and a half constantly, that's why I put in for the job and it was just a nightmare, it was an absolute nightmare. What do you call it… I was in late nearly every single night and it was just a nightmare, just an absolute… just to try and get things cleared and then the audit failed and everything else and things were in a bit of a mess with inspections and things like that, just a lot of things, you felt as if you were going home and thinking about the place too much... (Civil Servant).

4.3 MANAGING MENTAL HEALTH PROBLEMS IN THE WORKPLACE - DISCLOSURE

4.3.1 DISCLOSURE OF MENTAL HEALTH PROBLEMS TO EMPLOYERS

Sixty-three per cent of the respondents (n=115) who had a history of mental illness had disclosed their condition to their current employer, but the outcome of this disclosure was extremely mixed, as evidenced by comments from an open question. The main theme to emerge in relation to disclosure was hostility and scepticism on the part of the employing organisation.

> I was] told to go home. Line manager ignored the specific problems I was having with him. Director said he didn't know whether to believe me or not. (HR manager)
>
> 10 days after I disclosed my diagnosis I was sent a dismissal letter in the post with no opportunity to discuss. I wish I had some one to help me retain my post when I went off sick and then someone to negotiate my return to work. Instead I went through the tribunal process. (Project co-ordinator)

From the comments, most respondents had disclosed their conditions to their line managers, and encountered problems because the line manager was not experienced in issues associated with mental health, or because of structural issues (line manager had no power to act on the disclosure), or in some cases the line manager was a contributory factor to the problem(s).

Each of these situations is illustrated in the following series of quotes:

> Occupational Health were fantastic and understanding. Line Manager failed to acknowledge the seriousness of the illness and presented a "well you don't look unwell" stance (Credit Controller).
>
> Line manager knew of the difficulties I experienced, and degree of bullying I experienced - however due to the hierarchical structure of the management, he did not do anything therefore I felt unsupported. This could have been improved through awareness and proper training for senior managers re managing staff and appropriate codes of conduct. (HR manager)
>
> My manager was a major cause in the triggering the condition and was very dismissive when I raised my concerns. (Business Partner)

Another theme was an initially positive, or at least non-negative, response but then inertia of inadequate follow-up:

> After informing, there was no meeting to see if anything could be done in my job to help. I was happy to at least be able to explain how I was feeling so my boss could perhaps understand if I acted out of character. (Development Team Leader)
>
> I got told not to hide it, talk about it, and got told that they would send a form to me as I am on anti depressants. (Security guard)

It is also important to note that disclosure may not have been an active decision:

> I was sectioned following a manic episode, my line manager was annoyed that I did not "give them any notice" to get my workload covered! I was in hospital for 3 months and when I went back to work it was clear that everyone in the office knew where I had been and why. I resigned 2 months later. (Recruitment consultant)

Although we do not have the data to know how many disclosures were not the choice of the employee, we can see from the survey that the likelihood of disclosure increased with the severity of the conditions: 37 per cent of those who said their problems were mild had informed their employer, as compared to 58 per cent of those with moderate severity and 86 per cent of those with severe conditions.

The minority of reports of positive reactions to disclosure focused on the difference that simply listening to the employee makes:

> They listened and gave my the phone number of the counselling the bank uses, I have called them (Cash supervisor)

4.3.2 DISCLOSURE TO PROSPECTIVE EMPLOYERS

While (61 per cent; n=158) believed employees should inform a prospective employer of such past or present problems, there was not a perfect relationship between what people had done in their own cases and what they thought *should* be done. Relationships can be seen in Figure 3 below.

FIGURE 3: RELATIONSHIPS BETWEEN ACTUAL DISCLOSURE BEHAVIOUR AND WHAT SHOULD BE DONE

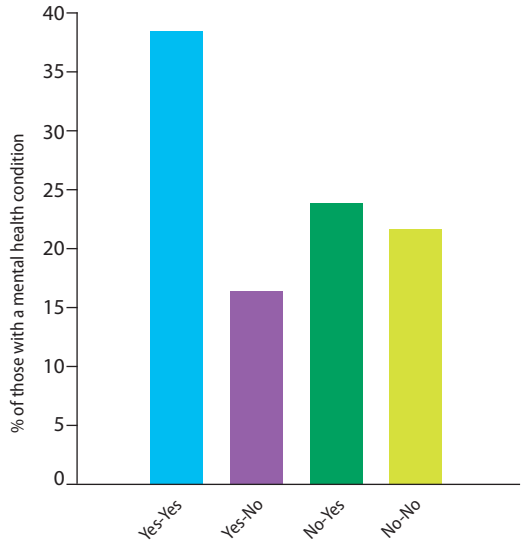


Figure 3 shows that 38 per cent of respondents with mental health problems had informed their employer and would advocate informing a prospective employer (Yes-Yes column). This can be interpreted as an indication that they had a positive experience of their own disclosure. A relatively smaller proportion (16 per cent) had disclosed their condition but would not recommend it (Yes-No column). Nearly one quarter (24 per cent) had not disclosed their own condition but would recommend disclosure (No-Yes column), while 21 per cent had neither disclosed their condition nor would recommend disclosure (No-No). The interviews picked up on some of these tensions between attitudes and intentions and actual behaviour:

> I didn't tell my current employer until it became an issue and I had to be off work with it. I hadn't had to own up to it on the application form because in the job I'd had previously I'd had a really good spell and I'd never been off long-term sick... Rightly or wrongly I believe that if you have to put something like that down on an application form you're probably slashing your chances of being invited to interview (Personal Assistant).
>
> No. I mean there is no legal obligation to disclose it so I don't. And I do understand the employer's side that if we knew that you were mentally ill we could make better adjustments, real adjustments and whatever for your mental illness to become, you know, not a problem but who believes that? (Public Relations Manager).

4.3.3 DISCLOSURE TO COLLEAGUES

Fifty-three per cent (n=107) of those with mental health problems had disclosed their condition to their work colleagues.

In the main, the reactions reported were more positive compared to disclosure to employers, with many accounts in the open comments praising their colleagues, and some noting that their own disclosure had prompted others to reveal their mental health problems, thereby promoting discussion and a more open climate.

However accounts were not unanimously positive. Several respondents reported mixed support from colleagues: 'some were; others not' (Staff nurse) while others noted that their colleagues did not know how to act after being told. This ignorance on the part of colleagues also manifested itself in assumptions being made or in impatience with the employee when their symptoms were bad.

> Mostly supportive, one or two people make assumptions about me and my work capacity being less which I try hard to challenge. (Development worker)

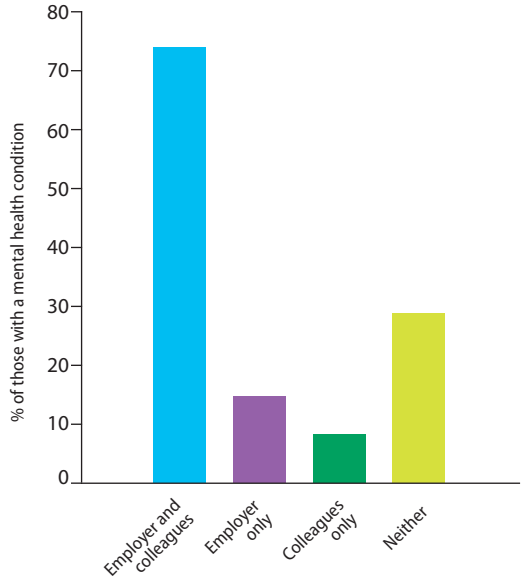
Other respondents reported ambivalence on the part of colleagues, whose support was conditional – they were sympathetic as long as it did not affect anyone's work performance. This was linked with another commonly reported response whereby the initial reaction of colleagues was sympathetic but this did not last long.

> At first they were, then it was questioned as to what I have to be depressed about (Receptionist)

A few respondents had encountered straightforward hostility, with quite distressing consequences:

> Felt segregated...different, acutely lonely. Suicidal... (Administrative assistant)

FIGURE 4: RELATIONSHIPS BETWEEN DISCLOSURE TO EMPLOYER AND TO COLLEAGUES



Before leaving this section, it is worth noting the relationships between disclosure to employers and to colleagues. As Figure 4 below shows, just under half of those with mental health conditions had informed their employer *and* their colleagues, but a substantial minority (n=52, 30 per cent) had informed neither.

From interviewees' accounts, it was apparent that distrust and fear for negative consequences were the main motivating factors behind the decision not to tell anyone at work.

> No, no. Obviously… when you're asked that [disclosure] when you go for your interview and stuff like that but again I didn't really put it down, I didn't really see it as any of their business...Realistically I think if you're going for any job at all and they say that you're… I mean I know they're no allowed to discriminate against you but I think they would. So a lot of things are best kept sort of private...I think if you're going for a job I dinnae think telling them [colleagues] that you've got depression is the best thing in the world... (Hairdresser).
>
> Or if you go to your bosses and say "listen I need you to sort something out", it's always in the back of your mind where you think, are they going to put that on the record, but you hope not (Police Officer).

4.4 MANAGEMENT OF MENTAL HEALTH PROBLEMS IN THE WORKPLACE: SUPPORT PROVIDED

4.4.1 OVERVIEW

As Table 3 shows, non-work sources of support vastly outweighed support in the workplace. By far the most common sources of support were the respondent's family and friends (63 per cent)[4], followed by GP (53 per cent) or specialist medical or counselling support (91 per cent). Within work, support from colleagues (28 per cent) and line managers (23 per cent) were the most commonly experienced.

4.4.2 TYPES OF SUPPORT

The responses to the open questions revealed a range of formal and informal support practices[5]. The more formal practices included: facilitating access to workplace counselling or to similar services offsite; providing time off for treatment and/or convalescence; offering flexible work options, most often part-time working or working from home. Structural solutions were also offered, most frequently moving the employee to a different department or unit, and easing their workload. While respondents appreciated such formal interventions, their satisfaction was often tempered. For example, timing was seen to be a key issue:

> It took my employer 4 months to offer reasonable adjustments in my work environment to address my work based anxiety. I feel that I suffered unnecessarily during this time and this has seriously affected my recovery. Prompt implementation of minor adjustments would have made all the difference. (Executive officer)

It was clear that the most successful support from the employee's point of view often prioritised informal support:

> A bit of flexibility in working times. I did not want time off, but it helped to be able to do slightly shorter days to avoid the busiest times on public transport when I was at my worst. (IT support)

4 A subsidiary question indicated that spouse/partner was the favoured source of support in this sub-category.

5 Given the relatively low numbers of respondents who reported receiving support from organisational sources, further exploration of the detail and types of support has drawn upon qualitative responses within the survey and interview data

TABLE 3: SOURCES OF SUPPORT FOR THOSE EXPERIENCING MENTAL HEALTH PROBLEMS AT WORK (MULTIPLE RESPONSES ALLOWED)

SOURCE OF SUPPORT	PER CENT	N OF RESPONDENTS
Family and friends	62.9	132
GP	52.9	111
Counsellor/psychologist/psychiatrist	43.3	91
Colleagues	27.6	58
Line manager/supervisor	22.9	48
Occupational health (work)	8.6	18
HR/Personnel	8.1	17
Trade union representative	5.7	12
Occupational Health (outside work)	3.3	7
Citizens Advice Bureau	1.0	2
Health and safety representative	0	0
Base		210

> Help form of informal support from immediate line manager in current employment, rather than any formal response: I was a) allowed quiet space to work or allowed to work from home when anxiety levels made it difficult for me to be around other people or to leave house; b) allowed to present work in written rather than oral form at times of high anxiety c) (most importantly) treated as the 'expert' on my own mental health i.e. allowed to decide when I needed to change my work patterns or location, and what I needed to do to mitigate the effects of my mental ill-health, rather than having to provide evidence from an external authority (e.g. GP). d) allowed to sit at my desk and cry quietly whilst working when very depressed without anyone approaching me - sometimes all I need to do to is this for a few moments in order to cope with the rest of the day. Importantly, I've been given a safe space in which to discuss my mental ill-health openly without fear of reprisal, which in itself has gone a long way to reducing my anxiety and depression levels - fear of being judged for being depressed has, in other employment circumstances, fed the depression and triggered a breakdown. (Information analyst)

This quote also illustrates another key point raised by several respondents – that of being actively involved in deciding the types and levels of support that would best help them. Further, the language used by this respondent resonates with wider themes – feeling 'safe' and 'trusted' were viewed as extremely valuable aspects of support received.

Nevertheless, limitations to informal support are highlighted by the following account which illustrates the vulnerability of arrangements if there is some change within the organisation.

> Whilst having gone through a difficult 12 months I was supported well by my previous line manager however having transferred line management in the last 6 weeks in one phone call with my new line manager this has all been swept away. (HR Manager)

At the other end of the spectrum, several respondents spoke of the negative 'support' from their employers. The common theme to these accounts was that the employee had been dealt with via the formal performance management or disciplinary schemes, and without exception, these had negative consequences.

> I strongly believe that taking a member of staff through a formal attendance management process (which is just a nicer word for a disciplinary) is not in the best interest of the employee. If you are already in a state of depression, with suicidal thoughts this is NOT in anyway supportive! (Recruitment Team Member)
>
> I received CBT through my organisation but as soon as the course was finished I was taken to an incapability hearing where I had to give a return to work date or my contract would be terminated. (Veterinary Surgeon)

It is important to emphasise here that these were employee accounts only – the research did not gather employers' perspectives and experiences, and we realise that we are portraying only one side of the employment relationship. It is not the place of this

research to make judgements about the veracity of different perspectives. However, what is of very real significance is how much people's perceptions actually matter – once an employee with a mental health condition perceives they are being ignored, marginalised or discriminated against, then as far as they are concerned the opportunity to engage constructively with their employer about how they may best continue in work is irrevocably damaged.

4.4.3 LINE MANAGER AND COLLEAGUE SUPPORT

Comments from the open questions in the survey and from interviewees revealed that often line managers were crucial in the success of more formal initiatives, such as counselling, work (re)scheduling or flexible working patterns:

> Time off for weekly counselling appointments (often almost half days), flexibility with leave at short notice, reduced workload, sensitivity with workload/type, regular contact with Line and Section Managers, reassuring emails/ support from Line and Section managers, confidentiality, awareness, trust, encouragement. I wouldn't have survived if it hadn't of been for the support from my Line and Section Managers (Educational Advisor).
>
> ...my line manager was very good and when under treatment agreed how I could contact a colleague rather than him if that was easier for me to do. My line manager did not try to be a substitute counsellor, was available if required and allowed me to be involved in decisions around my work. I felt that confidentiality was maintained by those that knew and I never felt that it anyway this hindered or impacted on my subsequent succession within the company (HR Officer).

These quotes also illustrate the types of support given by line managers: both instrumental (practical) and emotional (Barrera, 1986). The support provided by colleagues was almost entirely emotional:

> Well I can text [my colleague] during the week sometimes or I see her about but she's more just like a colleague and we sort of share things when we're working like "what are you up to" and "how's your week been this week" or whatever but I don't visit or go out of my way to see her or anything when we're not at work (Hospital Domestic).
>
> You know sometimes there's [fellow colleagues] who burst out crying when it gets too much for them and we're all sort of around and supporting them. It's just – we're there (Social Worker).

Further positive accounts of the interactions between good provision for employees in terms of time off, counselling and broader support from colleagues and line managers can be seen in the Case Studies in Appendices Two, Four, Five and Six.

The interviews also allowed for interrogation of the limitations of line manager and colleague support. It was clear that in some cases, line managers were not only unsupportive of employees but used an individual's mental health problems to discriminate against the employee (see in particular the Case Study in Appendix Three). Further, in a number of instances, participants believed that they had been unfairly dismissed based on their health problem. As two interview participants described their individual situations:

They [the employer] did not follow GP's advice on my return to work conditions (agreed prior to my return) which lead to a relapse. Subsequently they discriminated against me on my second return and made it as difficult as possible for me to return to work by isolating me from everyone except the Admin Director/HR person who was bullying me. In the end, the GP signed me off permanently and I tried to go through grievance procedures, until eventually I had to put in a claim to tribunal. The company settled out of court at this stage. However, my relatively mild condition had by then turned into a serious Anxiety Disorder. I have only just started a new job over three years after my initial two week absence for work stress. All of which could have been dealt with following standard procedures and I could have been back at work within a couple of months fully recovered (Business Development Executive).

My previous employer took the line that as depression was under the Disability Discrimination Act, I could not be dismissed due to my sickness record, but I could be deemed unfit to do the job so be dismissed. It was be at work and well, or don't be at all... (Project Worker).

Limitations to support received from colleagues most frequently centred around a disconnect between the attitudes of a respondent's colleagues and the wider organisational response:

My colleagues in my office were very supportive, but the organisation refused to recognise what I was telling them (Assistant Service Delivery Officer).

Some interviewees commented on the lack of opportunities to interact with supportive colleagues:

Yes, I confided in a few colleagues, you know, but you didn't often meet up with the other managers because you had a job to do and so had they. But I had confided in them... (Office Manager).

Further, it was also evident from several accounts received that colleagues could make the situation worse by breaching the confidence of the employee:

No I don't think I ever have discussed [my mental health problems] with my colleagues... No, no, if I would it would be a very, very select few who I know wouldn't say anything... Because I just don't want it to get out. I don't want it to be passed in a conversation between anyone else (Police Officer).

Colleagues I hadn't personally told and hardly knew were making jokes about me being a "loose cannon" and "window licker". (Recruitment Consultant)

As noted in Section 3, the majority of the survey sample worked for public sector or third sector organisations. Because of this, membership of trade unions was relatively high (Forty per cent of participants were members of a trade union[4].) Nevertheless as can be seen from Table 3 above, relatively few respondents had used their union as a source of support. Those that had recounted a positive experience of mainly instrumental support:

The Union support is good. I mean obviously they will take your side. They will look at the facts and tell you what they can and can't say to you, what they can and what they can't do. .. (Bank Associate).

4 The latest figure on trade union membership density for Scotland is 32.3 percent (Achur, 2011).

However, it also became evident, from the interviews, that this form of support was not always easy to access or that seeking support from a union might lead to employer disapproval.

> Yes, I had a union rep but sometimes I think … I got one on the phone but they're quite hard to get appointments with and stuff for certain days. I think I did try but I didn't even go that far. I think I was actually just that unwell that I didn't have fight in me, spirit in me or anything, because I really was very, very ill (Telephone Advisor).
>
> I did consider speaking to the union, but I didn't go ahead with it I'm not wanting to be a bit of a stirrer (Social Worker).

4.4.4 SUPPORT FOR RETURN TO WORK

The distinction between instrumental and emotional support was even more apparent in the responses to the question asking people if they had a week or more's absence because of their mental health condition, who would they speak to about returning to work. In this case, the role of GPs again was strong, but that of friends and family less so. Within the workplace, it can be seen from Table 4 that line managers were by far the most commonly cited source, while the role of colleagues was much lower than that for general support.

TABLE 4: SOURCES OF ADVICE FOR RETURN TO WORK AFTER ABSENCE (MULTIPLE RESPONSES ALLOWED)

SOURCE OF ADVICE RE RETURN TO WORK	PER CENT	N OF RESPONDENTS
GP	54.8	115
Line manager/supervisor	38.1	80
Family and friends	28.1	59
Counsellor/psychologist/ psychiatrist	18.6	39
HR/Personnel	14.8	31
Occupational health (work)	11.9	25
Colleagues	8.6	18
Trade union representative	7.1	15
Occupational Health (outside work)	1.9	4
Health and safety representative	1.4	3
Citizens Advice Bureau	1	2
Base		210

As with support in general, the qualitative comments revealed how crucial line manager support was in facilitating a successful return to work. The following quotes are indicative of two contrasting experiences:

> Yeah I feel [my line manager] was fine. I mean she asked me if I was ready to come back and I said "yeah" and she was like "are you sure, it's maybe a bit quick for you?" and she was no wanting me to relapse and be off again, but no I says to her "I don't know how other people would be but in my way I need to get out of here" (Hairdresser).

No support from managers at all. Had indicated that I was unable to do all that was being asked of me at work but there was just continued pressure to carry out more and more tasks. Treated poorly on return to work. I was put in a room on my own on my return to work. I was not told what job I would return to although that had been a stipulation of my GP that I needed to be aware of what I was going to be doing on my return to work (Monitoring Officer).

4.5 SATISFACTION WITH EMPLOYER'S RESPONSE

The responses to the survey reflected the very mixed experiences of support received. The variation is shown by Table 5.

TABLE 5: SATISFACTION AMONG THOSE WHO HAD INFORMED THEIR EMPLOYER OF THEIR CONDITION

LEVEL OF SATISFACTION	PER CENT	N OF RESPONDENTS
Very Dissatisfied	20.0	22
Dissatisfied	20.0	22
Neither Satisfied nor Dissatisfied	20.9	23
Satisfied	23.6	26
Very Satisfied	15.5	17
Missing – no response		5
Total who had informed employer	100	115

There were no differences in satisfaction levels according to reported severity of mental health problems. As indicated in Section 4.4.2 above, satisfaction was much higher amongst those respondents who had received either informal support or a mixture of formal and informal support, and who were actively involved in deciding the best regime of ongoing support that would deliver mutual benefits to the employee and to the organisation.

Levels of satisfaction did have a bearing on how happy the respondent said they currently felt ($F=4.17$; $p<0.05$). Those respondents who reported higher levels of satisfaction with the way their employer had responded to their problems were also those who felt happiest.

4.5 INITIATIVES TO REDUCE STRESS/PROMOTE POSITIVE MENTAL HEALTH

In terms of promoting a mentally healthy workplace, 55 per cent of survey respondents (n = 157) were aware of organisational initiatives to reduce stress, although 28 per cent (n=81) said there were no such initiatives where they were employed, with 17 per cent (n=48) reporting that they did not know whether or not any initiatives existed. There were no significant differences according to whether or not the respondent had personal experience of mental health problems. This is slightly surprising, as one might have expected those who had experience of mental health problems to be more aware of workplace initiatives that may be there to help them. On the other hand, the finding also reflects the relatively low proportion of respondents with mental health problems who had received support from an organisational source.

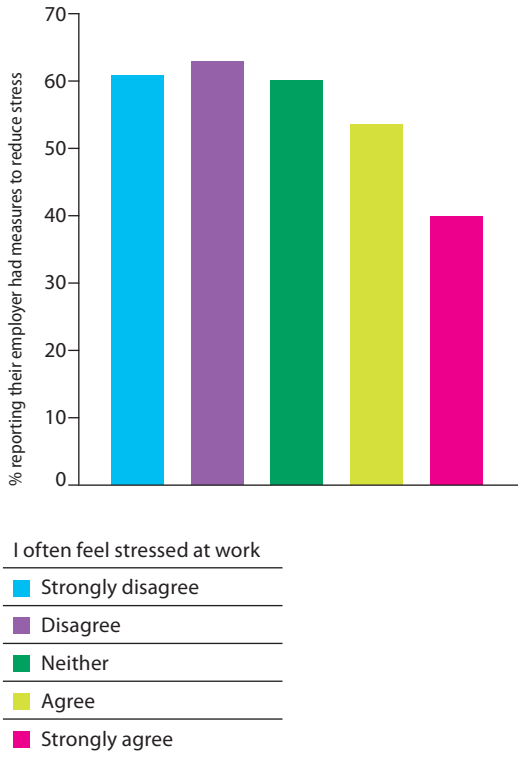
Details of the types of stress reduction initiatives emerged from interviews. Around half of the interviews reported knowledge of initiatives in their place of employment. The most common examples were face-to-face counselling and access to an Employee Assistance Programme via a telephone. Less common examples included a gym and with a resident masseuse, access to training and the provision of a mentor, a "Roadshow" campaign, as well as stress-based Risk Assessments. All of these were offered mainly by larger employers.

However, the interviews also showed that provision does not necessarily translate into uptake. It became apparent that a sizeable minority of interviewees chose not to pursue the employer initiatives.

> I know there is, [omitted] Council do have things in place for their workers, not that I've ever taken anything up but they do have things in place (Teaching Assistant).
>
> ...there was a Counsellor thing that you could get or something but that's about it. I never ever found out the details or that, it was just mentioned to me that you could get something like that, but I've never sort of looked into it or went any further with it or that. I never even went back to see the Manager again or anything for to follow it up (Hospital Domestic).
>
> There probably is but see to be honest, see if I was to… I stopped and looked at them I probably wouldn't. When I go in there it's a case of get ready for your work and just go in (Fitter).

What was clear from the survey was that there was an inverse relationship between feeling stressed at work and awareness of employer initiatives to reduce stress (chi-square= 18.39; d.f.=8; $p<0.05$). This relationship is portrayed in Figure 5, and could indicate a potential mismatch between need and availability. Alternatively, it could also support a more positive scenario, in that higher awareness of employer initiatives was associated with feeling less stressed at work.

FIGURE 5: RELATIONSHIP BETWEEN EMPLOYEE'S PERCEPTION OF STRESS AT WORK AND AWARENESS OF AVAILABILITY OF INITIATIVES TO MANAGE STRESS



5. CONCLUSIONS

The central aim of this report was to provide a better understanding of the experiences of people with mental health problems in employment in Scotland. The conclusions will summarise the main findings keeping in mind the three key objectives of the research:

- To identify positive steps that employers and employees can take to help maintain a mentally healthy workplace;
- To identify positive steps that employers and employees can take to avoid losing staff when they develop mental health problems;
- To identify common experiences that are unhelpful in maintaining a mentally healthy workplace, so that employers and employees can avoid these in future.

The survey findings, supported by the interview accounts, confirm existing knowledge of the wide range of circumstances surrounding: the types and combinations of mental health problems experienced by people; the variation in timing and duration of these problems; and the variety of interactions between mental health problems and their effects on an individual's ability to work and their experience of work. This underlying information serves to support the complexity of the subject area and to highlight the need for a more nuanced understanding of the ways in which mental health problems and work interact. Despite this complexity and heterogeneity of experiences, our research has allowed us to draw out some common themes which appear to promote or hinder successful management of mental health problems in the workplace.

5.1 DISCLOSURE

For many survey respondents, the experience of disclosure was a negative one, either because of the reaction they had received or because they had not actively chosen to disclose their condition. Negative reactions included hostility and inertia, often on the part of an individual's line manager. Disclosure to colleagues tended to receive a more positive reaction, but as with line managers, their reactions often appeared to be based on ignorance of mental health issues – people often do not know what to say or how to react so they say nothing or act, in the eyes of the individual with the condition, inappropriately. This sort of situation can quickly descend into a vicious circle as the employee with the mental health condition feels it is easier not to tell people. Our findings showed that a sizeable proportion of people had not disclosed their condition, nor felt they should do so. We know from research in other areas (e.g. sex orientation) that keeping such 'secrets' at work, far from being easier, places a considerable burden on the employee, often with a concomitant effect on their work performance (Guasp and Balfour, 2008).

5.2 SUPPORT FOR EMPLOYEES WITH MENTAL HEALTH PROBLEMS

Overall, non-work sources of support were utilised more than work-based support. Employees with mental health problems were more likely to seek support from their family and friends (especially their partner or spouse) and their GP than they were to turn to their organisation. This could

be interpreted as a lack of provision of organisational support or a lack of awareness of such support, and certainly our research produced indications of both of these. In particular, it appeared that formal support (e.g. workplace counselling or formal flexible working schemes) were more often found in larger organisations and would therefore be unavailable to many of Scotland's working population. However, qualitative accounts from survey respondents and interviewees revealed that while some formal interventions could be of help, the support they valued most was more likely to be informal, or a combination of formal and informal. Line managers and colleagues were identified as crucial in providing support: line managers in providing both practical and emotional support; colleagues in providing mainly emotional support. Two other key points emerged – that of timing of interventions and active involvement of the employee in their own support agenda. In terms of timing, timeliness of interventions and ongoing support were viewed as crucial, again recognising the complex nature of many mental health conditions and the myriad of ways they can affect people and how these affects may change over time. As regards involvement, it is well established that control is key to helping prevent the negative effects of workplace stress (Karasek, 1979). In fact Karasek's full control-demand-support model (Karasek and Theorell, 1990) suggests that the most healthy combination of circumstances is where the employee has high control over their work, low (or manageable demands) and high instrumental and emotional support. Our results clearly showed that these combination of circumstances led to better outcomes for the employee and their work.

5.3 PROMOTING A MENTALLY HEALTHY WORKPLACE

Many of the findings and implications discussed in Section 5.2 are also relevant here. Formal interventions to limit or manage stress were relatively rare (although it should be noted that the research was not designed to undertake a systematic audit), and restricted in the main to larger organisations. A finding of concern was that availability or awareness of availability appeared to be lower amongst those who said they were experiencing most stress at work. Previous research into managing aspects of mental health at work has revealed the importance of timely and relevant communication in promoting positive mental health at work (see e.g. Loretto, Platt and Popham, 2009).

6 RECOMMENDATIONS

Based on the evidence presented, we suggest the following as positive steps towards maintaining a mentally healthy workplace and avoiding the loss of staff when they have developed a mental health problem:

6.1 RAISE AWARENESS

This is by no means a novel recommendation, but the current research has added to the existing evidence base showing that low awareness of mental health issues in general and organisational policies and practices designed to promote better mental health or help those who develop problems act as barriers. It is not sufficient to have initiatives in place 'just in case'. Organisations need to actively promote their approach to stress management and support for members who may be experiencing mental heath problems and communicate these to all staff.

6.2 RECOGNISE AND SUPPORT PIVOTAL ROLES PLAYED BY COLLEAGUES AND LINE MANAGERS

As shown in this study, colleagues can provide valuable emotional support to people with mental health problems. Raising general levels of awareness and knowledge about mental health issues would help them to provide this support.

As also shown, line managers play a vital role in supporting employees with mental health problems, both in terms of emotional support, but also delivering practical help, e.g. facilitating flexible working or adjusting workloads. Recognition of the dual roles that line managers play, and providing training and support for them, is crucial. Many line managers have reached their positions because of technical ability – they are not automatically good people managers and are certainly not automatically mental health experts.

6.3 PAY SPECIAL ATTENTION TO DISCLOSURE OF MENTAL HEALTH CONDITIONS

It was clear from this study that decisions whether or not to disclose a mental health condition and how any disclosure was handled was a crucial point. It was quite clear that a negative experience at this stage would set in motion a negative trajectory, while a positive response facilitated a much more constructive approach. Employees with mental health problems should be encouraged to disclose their condition(s) safe in the knowledge that they will not be ignored, stigmatised or disciplined.

Again, this points to the role of line managers and may require training especially focused on disclosure.

6.4 INVOLVE PEOPLE WITH MENTAL HEALTH PROBLEMS IN DISCUSSIONS

A clear finding from the current study was that active involvement and dialogue between employees who have mental health problems and their line manager and other relevant staff yields the most positive and mutually beneficial results. As well as promoting control for those experiencing the problem, this also serves to take some of the burden away from the line managers. We fully acknowledge that, in some cases such as with excessive absence, an employee may need to be managed out of work. Keeping them appraised of what is happening and why could help ameliorate the bitterness and knocks to self-esteem reported by some respondents to the survey and interviews.

6.5 ASSESS THE CONTRIBUTIONS OF FORMAL AND INFORMAL APPROACHES

While formal policies and initiatives have an important place in managing mental health at work, the study showed that they work best when coupled with informal interventions. Organisations with formal practices may wish to assess the extent to which they have contributed to helping people with mental health issues, and not reply on usage statistics as a proxy for success. Organisations which do not have the resources for a suite of formal practices can instead focus on improving their informal support (via line managers and other staff – see 6.2).

6.6 UNDERSTANDING AND RECOGNISING THAT SUCCESSFUL MANAGEMENT OF EMPLOYEES WITH MENTAL HEALTH CONDITIONS IS SHARED RESPONSIBILITY

Building on 6.4, it is important to fully appreciate that managing mental health in the workplace is not the responsibility of one person or one function of the organisation - it is the responsibility of all members and functions of the organisation.

Furthermore, organisations are not in isolation. The research has shown the significance of medical and specialist support (notably GPs) and the salience of family and friends in helping to support employees with mental health problems. Guidance on how managers can build links to sources of support outside work would be helpful.

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APPENDIX 1: PROFILE OF INTERVIEW PARTICIPANTS

NO	GENDER	AGE	JOB	MENTAL HEALTH	DATE OF INTERVIEW
1	Female	40s	Office Manager	Work-related Stress	12/12/11
2	Male	40s	Limousine Driver	Depression	8/12/11
3	Male	50s	Lorry Driver	Depression/Eating Disorder/Anxiety	7/12/11
4	Male	40s	Joiner	Work-related stress/Depression	8/12/11
5	Female	50s	Care Assistant	Depression/Anxiety	6/12/11
6	Female	40s	Civil Servant	Work-related Stress/ Depression/Anxiety	7/12/11
7	Female	20s	Hairdresser	Stress/Anxiety/Depression	14/12/11
8	Female	30s	Personal Assistant	Bipolar Disorder	12/12/11
9	Female	30s	School Teacher	Bipolar Disorder	13/12/11
10	Female	20s	Hospital Domestic	Post-natal Depression	13/12/11
11	Female	40s	Bank Associate	Bereavement/Depression	14/12/11
12	Female	50s	Caretaker	Depression	16/12/11
13	Female	40s	Teaching Assistant	Post-natal Depression/Anxiety	12/12/11
14	Female	40s	Developmental Officer	Bipolar Disorder	8/12/11
15	Female	50s	Art Centre Manager	Depression	13/12/11
16	Male	40s	Public Relations Manager	Bipolar Disorder	15/10/11
17	Female	30s	Bank Associate	Work-related Stress/Depression	17/10/11
18	Female	50s	Telephone Advisor	Work-related Stress/Anxiety	18/10/11
19	Male	20s	Security Guard	Work-related Stress/Depression	26/10/11
20	Female	40s	Transport Manager	Work-related Stress/Bipolar Disorder/Depression	5/12/11
21	Female	40s	Civil Servant	Work-related stress/Anxiety	21/12/11
22	Female	40s	Civil Servant	Work-related stress/Depression	19/12/11
23	Female	50s	Administrator	Bipolar Disorder	6/1/12/11
24	Female	40s	Release Support Assistant	Bipolar Disorder	13/1/12
25	Male	50s	Fitter	Bereavement/Depression	6/1/12
26	Female	50s	Social Worker	Work-related Stress/Anxiety	30/1/12
27	Female	20s	Bartender	Post-natal Depression/Anxiety	30/1/12
28	Female	40s	Care Assistant	Post-natal Depression	31/1/12
29	Female	60s	School Transport Assistant	Bereavement/Depression	6/2/12
30	Male	30s	Team Leader	Depression	8/2/12
31	Female	40s	Civil Servant	Work-related Stress/Depression	8/12/12
32	Female	20s	Administrator	Post-natal Depression/Anxiety	10/2/12
33	Female	50s	Social Worker	Work-related Stress/Anxiety	5/2/12
34	Female	40s	Retail Manager	Work-relates Stress/Depression	5/2/12
35	Male	40s	Police Officer	Work-related Stress/depression	4/2/12
36	Female	40s	Call Centre Operator	Work-related Stress/Anxiety	8/12/12
37	Female	40s	Store Worker	Depression	7/2/12
38	Male	50s	Painter and Decorator	Depression and Anxiety	9/2/12

APPENDIX 2: FORMAL GOOD PRACTICE OF MANAGING MENTAL HEALTH PROBLEMS IN THE WORKPLACE

Paula has worked in the banking industry since leaving school more than twenty years ago.

She works as a bank associate and has been in her current job for approximately 10 years.

The work involves having a "good head for figures", working with a small team and is "very hands on", with "lots of deadlines to meet".

However, seven years ago Paula's life changed dramatically with the loss of her baby in the advanced stages of pregnancy and a while later her father died from a relatively short illness.

During time off to recover from the first bereavement Paula was diagnosed with depression by her GP and prescribed anti-depressants.

Paula felt uncomfortable with the idea of taking anti-depressants and instead began to plan a return to work after approximately two months of being absent from work.

The return to work process began informally with such discussions between Paula's managers and Paula being held in a city centre cafe.

Over the coming months Paula's employer organised regular visits for her to the company nurse, in company time, and also arranged for private bereavement counselling close to where she lived.

Paula also points out how kind and thoughtful comments and gestures by colleagues played a part in the recovery process too.

Since then Paula has taken no time off due to her depression and reports high levels of job satisfaction and an employer more than satisfied with her efforts and commitment.

Paula says she is now over the worst and making good progress.

APPENDIX 3: AN UNHELPFUL WAY TO MANAGE MENTAL HEALTH PROBLEMS IN THE WORKPLACE

A year or so ago Anna was working as a line manager for a voluntary organisation. Anna began working for her employer around the year 2005.

While Anna's role mainly involved co-ordinating activities and managing a small number of staff, rather being hands on with the people her employer ultimately served, she enjoyed the job and got on well with the people she worked with and managed.

However, in more recent times Anna began to increasingly sense she was being bullied by her manager.

What is more, Anna strongly believed the bullying to be racially motivated.

At the same time Anna began to get heart pains, not sleeping well, not eating as much as she used to do, constantly crying, not wanting to do things with family and friends, having morbid thoughts, and just did not want to go to work.

Anna tried to resolve the matter through filing a grievance against her manager but her deteriorating emotional and mental health and a reluctant human resources department led to several periods of absence, although the problem was still there every time she returned to work.

Anna reports how she found the human resources department to be a "brick wall" between herself and her quest for some level of justice.

Anna knew her employer clearly had the policies in place to deal with such matters, yet sensed her case was like "opening a can of worms" and human resources just "didn't want to go there".

After a further period of absence Anna gave notice of her intention to leave, yet received no specific correspondence from her employer on her decision, nor was she invited to an exit interview that she herself routinely carried out as a manager.

After a short period of unemployment Anna found a job that both suited her and allowed her a chance to champion the causes of people who have been badly treated at work.

Her current job is not as well paid and more precarious than her previous job, but Anna is now on the road to recovery.

Anna believes her recovery has only been possible with high levels of personal resolve and a personal understanding of mental health problems, a supportive GP, as well as a supportive and very understanding husband.

APPENDIX 4: EMPLOYMENT AS A PROVIDER OF POSITIVE EXPERIENCES FOR AN EMPLOYEE WITH A MENTAL HEALTH PROBLEM

Billy has worked for many years as a fitter with a large private engineering company.

Billy enjoys the job because it involves using high levels of skill acquired from a traditional apprenticeship and many years of hands on and varied experience.

A further enjoyable aspect of the job is the camaraderie and banter of the shopfloor.

However, around ten years ago Billy's wife was diagnosed with cancer and died soon afterwards.

Billy was devastated and is still struggling to get over the shock of his wife's death.

Billy returned to work a few months after the death of his wife, yet it was over one year before Billy summoned up the courage to see his GP about how we was feeling.

Billy reported how he could not get out of bed in the morning, felt tired all the time, drank more than was good for him, and that "everything seemed to be on top of me".

Added to this, Billy received little support from family, and friends seemed more interested in getting Billy to start dating again, rather than considering this was one of the last things on his mind.

Instead, Billy's approach to coping with life was to "put everything into work" and with his job requiring high levels of concentration and being able to work in a way that suited him, it "kept my mind off everything".

An important point to note was how Billy spoke purposely and frankly to his supervisor about just wanting be left alone and how his supervisor and colleagues mindfully respected Billy's choice.

Billy has not had any periods of absence since and believes his work ethic and chance to work in a manner that suited his state of mind, kept him from drinking to excess, and most of all got him through a very difficult part of his life.

APPENDIX 5: INFORMAL GOOD PRACTICE AND THE USE OF THIRD PARTY INTERVENTION IN MANAGING MENTAL HEALTH PROBLEMS IN THE WORKPLACE

Aileen has had problems with her mental health since she was a teenager, although she was in her late 20s when she had her first extreme experience of Bipolar Disorder.

Since then Aileen has had three further major experiences of Bipolar Disorder, although she has not been hospitalised for more than ten years.

During this time Aileen has had a small range of jobs, yet these jobs have been largely disappointing due to less than understanding treatment by her employers.

Around ten years ago she managed to gain employment, with the long-term support and help from a mental health support organisation, as an administrator for a small to medium sized business.

Aileen performs many tasks across the working week and across many company functions, from organising work schedules, to inputting purchase invoices into a database, to collating data about the performance of the company.

An important part of the job is to work closely with a range of managers and as a consequence of such relationships she is well known and respected by the Managing Director of the company.

Despite continuing to have quite serious mental health problems, Aileen believes the main reason why she has settled and steady experiences of employment with her current employer is because her employer has "always been very, very willing to accommodate my problems and if you like difficulties that I've had over those years".

As a company unable to afford to employ specialised staff or being unable to pay for external support, Aileen believes the key to success in her case has been a Managing Director who "actually cares about his employees".

What this has meant for Aileen is the sanctioning of a range of informal practices that allows her to cope with the many and varying demands of the job in hand.

Over the years some managers have come and gone, yet it has been the consistency from the top in terms of listening to concerns no matter how trivial they may be and putting in place "any kind of extra bits" where necessary.

This includes working in small ways with the expertise of both a specialist third party and that of the individual employee.

Aileen also plays her part, as despite having difficulties with concentration, she has also managed to devise a list-making strategy to more than cope with the many facets and demands of her job.

APPENDIX 6: FORMAL GOOD PRACTICE OF MANAGING MENTAL HEALTH PROBLEMS BY A VERY SMALL EMPLOYER

Sandra is a bartender and is employed by a pub that has just a handful of mainly part-time employees.

Sandra is employed part-time, works mainly at the weekend, and been with her current employer for approximately four years.

The job is not paid very well and employee benefits, such as paid sick leave, are simply not affordable or expected.

Around three years ago Sandra gave birth to a baby girl and about one year later began to feel increasingly down and lethargic.

Sandra reported how she increasingly "didn't want to do anything", "couldn't be bothered" with many things she previously enjoyed or did not mind doing, and how it got "worse and worse", resulting in a visit to her GP.

Worst still, her GP was not very helpful and to her took a "yep, here's what it is, here's the tablets, away you go" kind of attitude.

At the same time Sandra was regularly calling in sick at work, using a range of common ailments to explain her absence, yet after a while, mainly because she feared losing her job, decided to come clean and tell her employer that she had depression.

In response Sandra's employer offered to excuse her absences and to change the days that she worked so as to avoid the typically much busier, rowdier and demanding weekend trade.

A further concession by Sandra's employer was to ease up in terms of expecting her to be "chatty" to customers at the usual amount and level of intensity.

Sandra only partly took up such offers from her employer mainly because she wanted to carry on as usual and not unnecessarily withdraw from an important part of her life.

Sandra is now over the worst of her depression and ultimately believes that having something structured, purposeful and certain in her life played a big part in this recovery process.

What is more, Sandra's employers may not have been able to provide her with the formal support that much larger employers can, yet they managed to make enough of a difference and that difference was affordable and allowed them the continued services of a reliable and loyal member of staff.

APPENDIX 7: THE ROLE OF STAFF REPRESENTATION IN POSITIVE EMPLOYMENT EXPERIENCES FOR EMPLOYEES WITH A MENTAL HEALTH PROBLEM

Carol is an administration officer with the Civil Service and has worked in this role for more than twenty years.

During this time Carol's part of the Civil Service has undergone many organisational changes.

In more recent times it has been announced that the unit where Carol is employed may close in the next year or two.

A consequence of possible closure has been a gradual, yet long term decline in headcounts, with many staff leaving or retiring and not being fully replaced, resulting in a palpable rise in the amount of work done by all employees where Carol is employed.

The workplace in question is highly unionised and the trade union has run a series of campaigns on bullying and harassment, as well as doing its best to deal with individual cases of the same kind.

Over recent times bullying and harassment has led to ongoing involvement of trade union and health and safety representatives, as well as campaigning for the introduction of Harassment Officers.

Despite such initiatives, several members of staff, including Carol, have taken time off due to work-related stress.

In this instance, Carol, for the first time in her working life, did not want to get up in the morning and go to work.

More specifically, Carol was off work for three weeks and also reported feelings of anxiety, panic attacks, crying all the time, sleepless nights, stomach problems and an irritable bowel.

A standard procedure is that employees returning from more than two weeks of absence are expected to report to the Civil Service's occupational health service, Serco.

This happened and Serco informed key personnel about how things needed to change because of what had happened previously.

However, it was not long before Carol was expected to work in a way that had led to her recent mental health problems.

Instead of accepting the bullying attitude of one of her managers, Carol took a stand and was quite firm with her manager about what she was going to do and for how long.

Carol believes this was only possible because the trade union was known to be active on the problem of bullying and harassment and was there as a fall back if personal interventions failed.

Carol has since settled down well in her job, but is aware that bullying continues to be a very real feature of where she is employed.

SAMH can provide further information, guidance and training on workplace mental health. To find out more, visit **www.samh.org.uk** or contact us on 0141 530 1000.

bank associate telephone advisor security guard transport manager civil servant administrator release support assistant fitter social worker bartender care assistant school transport assistant team leader administrator retail manager police officer call centre operator store worker painter and decorator

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SAMH is the Scottish Association for Mental Health, a charity working across Scotland. Every year, we provide over a million hours of support to people who need our help. Every week, we work with around 3,000 individuals in over 80 services. Every day, we campaign for better mental health for the people of Scotland.

To find out about making a donation, volunteering or training your staff in managing mental health at work, visit www.samh.org.uk or call 0800 917 34 66.

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