Welfare or Farewell? Mental health and stress in the workplace

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Abstract

Mental health problems, including stress, account for a high proportion of sickness absence and result in loss of employment. The paper presents findings from a recent qualitative research study into employers' policies and practices in relation to mental health and stress. A number of problems are identified in how employers perceive mental health, particularly in the distinction between 'home' and 'work-based' problems and in how it is dealt with. These include managers' skills in dealing with mental health issues and in the availability of help, such as counselling. The paper identifies a range of measures which would improve current practice. These are seen to have wider benefits in improving employee well-being more generally.

Key words: employment, mental health, stress

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Introduction

It has been estimated that between 20 and 30 per cent of employees will experience mental health problems in one year and that anxiety and stress conditions account for half of all days lost though mental health (Gray, 1999). The policies and practices of employers have serious implications for people with mental health problems: analysis of Labour Force Survey data has found that people with mental health problems are more than twice as likely to leave employment than others following on-set of a disability (see Burchadt, 2003); and thirty-four percent of respondents to a survey conducted for MIND said they had been dismissed or forced to resign because of a mental health problem (Read and Baker, 1996). There is evidence that loss of a job because of mental health problems can result in long-term unemployment (see Grove, 1999) and may therefore be the beginning of a downward economic and social spiral for some people and their families.

Research on employers' practices has tended to focus on recruitment of people with mental health problems rather than retention (see Fenton et al, 2003; Gilbride 2000). As the review on workplace interventions by the Sainsbury Centre for Mental Health observes, it has also tended to focus on the more serious mental health problems (see Seymour and Grove, 2005). Research on employers has also tended to focus on policies and understanding of mental health problems rather than practice (see DoH/MORI, 1996). Although it is known that common mental health problems are higher in some industries and occupations than others, there has been little empirical research with an industry focus. The Sainsbury review found no studies that looked at mental health in small or medium sized enterprises where there is limited access to specialist support. The research on which this paper is based was carried out to help fill these gaps through qualitative research, across a range of industries, on how employers address stress and mental health, at what they do when their employees experience various types of mental health problems at work. The research was funded by the Nuffield Foundation following pilot research funded by the Institute for Social Psychiatry.

The relationship between work-related stress and mental health

The principal interest of the research was with how employers treat employees with mental health problems which would be diagnosed as such by a medical practitioner. These would include, for example milder forms of depression and anxiety as well as more serious conditions, such as bi-polar (manic-depressive) disorder. Most such conditions involve loss of function, which can affect an individual's ability to work. 'Stress', including work-related stress, in comparison, is widely considered to be a 'layman's' term, referring to mild to moderate depression and anxiety.

As a report by the Mental Health Foundation states, the association between work-related stress and mental health is complex (Ryrie, 2003:8). Stress may be regarded as different to other mental health conditions in that it may not pervade all aspects of an individual's life. However, this may not be a clear distinction since, other than in its very mild forms, it is likely to affect an individual's mental health more widely, including relationships with family and friends. The distinction between stress and mental health then becomes blurred, as a person's general ability to function is affected. It is also possible that some people experiencing workplace stress have a

diagnosable psychiatric disorder, particularly given that many people with such disorders remain undiagnosed and untreated (see Ettner *et al*, 1997). At the same time, stress is not necessarily a feature of some mental health problems.

Aside from the difficulty in drawing a clear boundary between stress and mental health, one reason for including workplace stress in research on mental health is its sheer prevalence. A recent report for Mind states that 'stress at work is now one of the most common forms of mental distress.'(Robertson, 2005). Stress accounts for a high proportion of sickness absence, and may lead to dismissal in the same way as absence for mental health problems. It is also likely that workplace stress can exacerbate the problems of people with diagnosed mental health problems (see Warner, 2002). Existing research suggests that the relationship between stress and mental health at workplace level is both poorly understood and under-researched. A small number of studies have looked at the relationship between work-related stress and mental health among groups of employees (see Sutherland and Cooper, 1992: Shigemi *et a*l, 2000). However, employers' perceptions of this relationship appear to be unexplored. The research aimed to help to address this deficiency by exploring employers' perceptions of stress and mental health and whether these have implications for how employees with such problems are treated.

Research Design and methods

The research was conducted in five industry sectors: local authorities, health, rail transport, food manufacturing and entertainment. These sectors were chosen in order to include a range of industries and occupations, small and large organisations in the public and private sector. Initial visits were also made to employers' organisations covering four of the selected industries and sectors[2]. In addition to providing background information on the industry and issues relating to stress and mental health, a number of these assisted in the selection of employers. Other employers were selected largely through internet searches. The selection of employers was guided by the need to include both employers with well-developed policies and those without, in order to include some who had addressed the issue of mental health and stress as well as those who had not. All employers were contacted initially by letter, followed by telephone call to arrange a visit for a face to face interview.

The 50 employers who took part in the research are presented in Table 1. As intended, they included a range by size and include public and private sector organisations. In addition, they were geographically diverse, located throughout England and Wales. In each of the sectors, except entertainment[3], between 14 and 18 employers had to be approached to achieve the target of 10 participants. Of the 26 employers who were contacted but did not take part, 13 declined to take part stating reasons of time or resources; 3 expressed willingness but did not proceed; and repeated efforts to contact the remaining 10 were unsuccessful. Employers in the health sector were, perhaps not surprisingly, more willing than others to take part in the research, with only 4 refusing

[2] The organisation for the food industry did not take part in this stage, but provided contact details of 3 companies who agreed to take part in the research.

[3] In the entertainment sector, employers were selected from lists provided by the employers organisations. It was not thought that these differed significantly from other employers in the sector of similar size.

to take part or to respond to repeated contact. It is not thought that the selection methods resulted in bias: employers proving impossible to contact, or who declined to take part included those with awards for good practice in stress prevention and some who were keen to participate had carried out little work in the area. What cannot be judged from using qualitative methods is whether the participating organisations or interviewees were representative. However, there is no reason to believe that they are not and that their treatment of mental health was in any way unusual.

Letters were usually addressed to the Head of Human Resources (HR), but in some organisations were forwarded to another manager, usually with an occupational health responsibility. In the entertainment sector interviews took place with the director or chief executive who usually has responsibility for all personnel matters. Therefore, as Table 1 shows, interviewees included managers with responsibility for occupational health, for human resources or the business as a whole. This allowed the research to draw on a range of perspectives and experience.

Interviews were conducted using a semi-structured topic guide which included sections on policies and practices in relation to mental health and stress. To facilitate discussion of practice, part of the interview involved discussion of hypothetical cases, or 'pen portraits'. The generic portraits, which were adapted for each of the sectors, are shown in Figure 1. They were designed to include what Seymour and Grove (2005) term 'common mental health problems', such as depression and anxiety, and more serious mental health problems which have more severe symptoms and are longer-lasting. This second group includes, for example, schizophrenia and bi-polar (manic depressive) disorder. Interviews, which were carried out between April and August 2005, took between just under an hour to 1 ¾ hours, with most taking around 1 ¼ hours. Qualitative methods, aimed at drawing out themes, issues, similarities and divergence, were used to analyse the data first within sectors and then between them. The paper includes statements from many of the employers interviewed. To protect the identity of individuals while retaining important contextual information, such as role and sector, only a broad indication of organisation size is given rather than the precise number of employees.

Table 1 Employers interviewed for the research

Sector	Number	Organisations	Employee numbers (range)	Interviewees	Selection method
Local Authorities	10	2 Shire District, 5 Metropolitan, 1 County, 1 Unitary and 1 London Borough	500-25,000	7 Human Resource managers, 2 Occupational Health and Safety managers, 2 Occupational Health officers, 1 Welfare Officer	Employers Organisation web-site and internet search
Health	10	9 healthcare trusts and 1 ambulance trust	1000-13,000	8 Occupational Health managers, 1 Human Resource manager, 1 Medical Director	Internet search
Rail Transport	10	National and regional train operating companies	300-16,000	4 Human Resource managers, 2 Health Safety or Welfare managers, 3 Occupational Health managers, 3 Employee Relations managers	Employers Organisation membership directory
Food Manufacturing	10	Food manufacture and packaging (1 food and health products)	300-11,000	5 Human resource managers, 4 Health and Safety managers, 2 Occupational Health managers 1 Operations Manager	Employers Organisation and internet search
Entertainment	10	6 theatres (3 employing actors) and 4 orchestras (mixture of contract and freelance)	8-120 core employees	7 Directors/Executives 2 Theatre Managers 1 Human Resource manager 1 Occupational Health nurse	Employers Organisations

Employers' perspectives on stress and mental health problems

The research explored employers' perspectives on mental health and stress. Almost all employers responding to a CBI survey said that they thought the mental health of employees should be a company concern (see Gray, 1999). This view was found among most of the 50 employers interviewed who regarded stress and mental health as an issue of some importance. Concern among employers about stress and mental health was higher in local authorities and the health sector than in food manufacturing, rail transport and entertainment. All of the Health Trust interviewees believed that stress and mental health is a significant problem for the NHS, a view which was shared by most local authority employers. This is perhaps not surprising given that these are large employers where the issue of stress and mental health has been the subject of various investigations and initiatives. For example the Employers Organisation for local authorities has led a number of initiatives linked to stress and mental health and has been involved in national campaigns such as 'Mind out for Mental Health'[4]. A further factor relevant to the health sector is that mental and occupational health is part of their core business. Moreover, levels of mental health and stress may be objectively high in these two sectors: both were highlighted by a survey into employee attitudes as having particularly high levels of work-related stress (CIPD, 2002).

Employers in the rail sector saw stress and mental health as a key issue for the industry and particularly for drivers and train crew. Employers in theatres and orchestras also identified stress and mental health problems as a particular issue for managers and to a lesser extent for performers. The food industry was the only sector where stress and mental health problems were not believed to be particularly high and it was not seen as a major issue.

Perceptions on the scale of stress and mental health problems

Employers' principal concern with mental health and stress was with levels of sickness absence. Other factors such as poor work performance, demands on occupational health departments, health and safety, and the possibility of legal action were also viewed as important but less pressing and serious. Many employers said that sickness absence resulting from stress and mental health was high, and increasing. Research conducted almost 10 years ago found that many employers do not know the extent of sickness absence due to stress and mental health (DOH/MORI, 1996). The extent to which employers examined their sickness absence figures varied greatly between and within sectors: many local authorities and health trusts analysed their sickness absence records, producing estimates of main causes of sickness absence. As small employers, theatres and orchestras did not analyse their sickness absence figures. Food and rail companies produced headline figures on sickness absence and its costs but only estimated the proportion accounted for by stress and mental health. Lack of resources for such work was given as the main reason for this: the data was available but no-one had time to analyse it.

[4] A national campaign run by the Department of Health to stop the stigma and discrimination surrounding mental health.

The HSE reports that work-related stress is now the biggest cause of working days lost through occupational injury and ill health (see HSE, 2003). This was confirmed by employers who had such figures to hand. Most health trusts said that around 30 per cent of sickness absence was accounted for by stress and mental health. A similar figure was cited by local authority employers. In these sectors it was widely agreed that work-related stress was on the increase relative to musculoskeletal problems, the other commonly recorded cause of sickness absence, but it was also recognised that there is some overlap in the two categories (see later). In the rail sector estimates of the proportion of sickness absence accounted for by stress and mental health ranged from 20 per cent in one company to as high as 80 per cent in another. This is likely to be explained by different methods of categorising reasons for absence. A number of employers said they planned to improve management information on reasons for absence, the extent of sickness accounted for by stress and mental health and to identify 'hot-spots' in occupational groups and departments. However, they identified potential problems in interpreting reasons for absence, in under-recording because of stigma, and false claims of stress (see below).

Some employers had carried out staff surveys to establish the extent of work-related stress. These were believed to be better at identifying real levels of stress and mental health problems, which could be under-estimated by sickness absence figures. They were also seen as useful in identifying 'stressors' and pockets of stress. Again, surveys required company resources and stress surveys were not always seen to be justified. A further source of information about stress and mental health was Employee Assistance Programmes delivered externally (see below) which gave employers general information on the nature of the callers' enquiries.

Conceptualising stress and mental health

Common mental health problems were viewed differently from other health issues in being more controllable: most employers saw scope for reducing current levels of sickness absence for these, while absence for other types of illness were seen as less predictable. A few respondents wanted to draw a distinction between stress and mental health disorders, in terms of their relative incidence and nature. This distinction was drawn most commonly by employers in the health sector, as one might expect, who distinguished between milder conditions such as stress and anxiety and more serious mental health disorders such as schizophrenia. Employers in other sectors talked of the need for a different distinction: between stress and 'recognised' conditions including depression and anxiety. There was some suggestion here that stress could sometimes be work-related and that mental health problems were not. Despite such distinctions, it was widely assumed that people with mental health problems would also be experiencing stress and that their performance would be affected by their condition.

Perceived sources and triggers of stress and mental health problems

Employers in most sectors found it easy to identify sources of stress in their industries, although those in the food sector had more difficulty, believing that it is a sector with relatively low stress levels. The sources of stress identified by employers

are presented in Table 2. Although some are specific to the industry, for example suicides and fatalities on the railways, some are found across sectors: these are increased pace of work and excessive workload; organisational change; confrontation with the public and poor management.

Table 2 Perceived sources of stress in the five sectors

Sector	Sources of stress
Local Authorities	Reorganisation and change and poor change management Increased pace of work Constant reviews and inspections leading to stress among managers Jobs with public contact and with enforcement role Changing nature of some jobs towards greater public contact
Health	Excessive workload and 'long hours culture' Reduction in personal control over workload Budgetary constraints Organisational change without consultation Use of targets A culture of blame Confrontation with patients and relatives, including physical assault Poor management at team level
Rail Transport	Train crashes, derailments, near-misses and other incidents Suicides and accidental fatalities Confrontation with members of the public (verbal abuse and physical assault) Company reorganisation, in particular re-franchising
Food Manufacturing	External pressures on production and change in demand for products Fear of redundancy through plant closure Major reorganisation of production leading to redundancies Unskilled and unchallenging work (1 respondent) Poor line management and poor team working Bullying and harassment, from managers and colleagues
Entertainment	Long working hours Commercial insecurity affecting theatre management Intensive working and intense working relationships Stress of performing and managing stressed performers Lack of management training to perform HR role Concern about standards of performance, including affects of injury Demanding behaviour from members of the public Noise and noise regulation in orchestras

The role of work in mental health and stress

Although employers were able to identify a number of sources or triggers of stress in their sector, many employers believed that stress and common mental health problems have their roots in the personal and domestic lives of employees. The tendency to

distinguish between home and work-related stress was strongest in the food and railways sectors. The view of one employer in the food sector that 'work exacerbates problems which are not of the employers' making' was shared by many in the sector. Employers across sectors described domestic and personal problems as 'muddling' the issues and leading to wasted efforts to establish causes of stress in the workplace, such as risk assessments. One local authority manager argued that

> ***'People prefer to align their stress with work than with problems in their lives outside work, because it's like blaming someone else for your problems'*** (Human Resource Manager, local authority with more than 1,000 employees).

Some employers identified a source of stress in the characteristics of employees: on the railways in men with poor eating habits, excessive drinking and gambling; and in theatres in eccentric personalities who are attracted to working in the arts. Age profile was also seen as a factor, with employees in local government and the railways predominantly in their middle years and experiencing divorce and problems with teenage children. Although usually still sympathetic to their problems and often prepared to provide assistance, the assessment that mental health and stress stems principally from home, life-style and life-stage, rather than work inclined employers to the view that there was a limit to how much help they would provide and how tolerant they would be towards poor performance and prolonged periods of absence.

A somewhat different perspective was evident among employers in the health sector who were more inclined to say that stress can originate either in the workplace or in people's domestic lives and that it is very commonly the product of a combination of circumstances. This view was also held by many in the entertainments sector because of a stronger focus on the individual, rather than through any knowledge about mental health. Elsewhere, employers who had looked in more detail than others at individual cases found that often work and home problems frequently interact to cause an escalating problem and that the idea of 'home' or 'workplace' as the source of the problem was not realistic. In the local authority sector the Employers Organisation encourages support for employees suffering stress because of non-work problems because their productivity is still affected. A manager in one large authority stated that,

> ***'We say you can't separate work life from home life because mental health benefits work and bad mental health affects it in negative ways. It just doesn't make sense to ignore what is going on at home and just to tackle the workplace issues'.*** (Head of Occupational Safety and Health, local authority with more than 10,000 employees)

While a HR Manager in another said that '***the problem is rarely all work or all home, but some cocktail of these together.'*** Some employers therefore challenged the distinction between home and work-based problems on grounds of practicality. However, many employers wished to retain this distinction because their principal concern was with their responsibility as employers, which they saw as ending at the office or factory door.

There was some cynicism from managers about absence for stress and common mental health problems such as depression. One theatre manager talked of people 'shouting stress', a food manager about 'jumping on the bandwagon' and a local authority safety manager about 'playing the system'. Only in the health sector was there widespread belief that the stress reported by health service staff was entirely genuine and that it led to common mental health problems in some cases. This was possibly because most interviewees were occupational health specialists. In this sector, the growth in sickness absence recorded as 'stress' was explained by increased awareness among employees and earlier reporting. In other sectors, some employers talked about people claiming stress when they are in fact bored of their job, particularly when demands are high for example train driving. The manager of a food company described work as ***'an easy target to pick on, particularly when things are not right in your career'.*** The possibility that boredom and low job satisfaction might lead to mental health problems in themselves, was rarely considered. Stress at work was seen to be associated with pressure and with high demands, rather than boredom.

The corporate response to stress and mental health

Policies in relation to stress and mental health

All health trusts and most local authorities had stress management policies or similar, many of which had been in place for several years. Stress policies were less common in the other three sectors: half of the rail operators had a stress policy, but others had other documents such as guidelines which served a similar purpose; in the entertainments sector the only organisations with a stress policy were part of larger organisations whose policies they automatically adopted. In the food sector five of the ten companies had a stress policy. Some employers had considered introducing a stress policy but were concerned that it would lead to claims of stress among employees with a grievance. The HR Director of one train operating company asked,

> ***'Would it be helpful to the organisation or would it be used against us? We have a few Philadelphia lawyers in the company. I would worry that a formal policy would encourage more sick leave due to stress.'*** (HR Director, train operator with more than 1,000 employees).

Employers' stress policies varied in content but often included at least a reference to the HSE's six management standards aimed at reducing workplace stress[5]. These frequently stated the employers' duty to identify stress, help overcome its effects and eliminate its causes. They included procedures for risk assessment, sources of help and referred to the role of occupational health.

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[5] These are 1. ensuring staff can cope with job demands; 2. giving staff adequate control over their work; 3. ensuring staff are given support by colleagues; 4. combating unacceptable behaviour, such as bullying: 5. ensuring staff understand their role and responsibilities; and 6. involving staff in organisational change (see HSE, 2005)

Employers without a stress policy, and many with one, said that the issue was covered by other policies and documents. These included policies on sickness absence and managing attendance, recruitment and equal opportunities, bullying and harassment, performance management, flexible working and alcohol and substance misuse. Some organisations considered that their range of policies negated the need for a stress or mental health policy. In many organisations policies on sickness absence were seen as of equal importance as those on stress because they cover the issue of most importance to employers: absence for stress and mental health. Employers without stress policies therefore frequently said that their stress policy was covered by their sickness absence policy. Although many employers were keen not to distinguish between physical and mental health, stress and mental health problems were identified as requiring an early response in these policies. Health trusts and local authorities also had rehabilitation policies aimed at easing an employee's return to work through adjustments. Many employers in these sectors also participated in supported employment schemes.

Only a small number of employers had a policy on mental health or a health policy which referred specifically to mental health: they included three local authorities, one of which had developed the policy with the input of employees with diagnosed mental health problems. This approach was reported to have been useful in strengthening the authority's awareness of employment issues for these employees. A small number of employers had recently introduced 'well-being' policies which included issues of mental health and stress.

A number of companies questioned the need for a separate policy on mental health, or even on stress, on the grounds that physical and mental health should be treated the same, that it is essentially about good management and taking an individual approach. It is possible that they were influenced by the statement of the HSE that *'Our belief is that plain good management can reduce work-related stress where it is already occurring and can prevent it in the first place'* (HSE, 2004).

A review of evidence by the Sainsbury Centre for Mental Health suggests that individual approaches to managing common mental health problems in employees at risk are more likely to be effective than the stress management or 'group' approach preferred by many employers (Seymour and Grove, 2005). Many employers in the entertainments sector emphasised the need for an individual approach rather than one determined by policies and procedures. Therefore, one manager stated, 'We have no formal policies on sickness or stress, but we aim to be supportive' (Chief Executive, theatre with fewer than 50 staff). Even where organisations had written HR policies, they often responded in practice on an individual basis. Examples were given of treating staff more generously than employment contracts or policy required, for example in allowing paid leave.

Some employers who argued the importance of an individual approach sometimes took this a step further, to argue that policies are not important. One employer argued,

> '***In practice, stress is purely down to good management practices and if you have these, you shouldn't need a separate policy'.*** (Head of Occupational Health, food company with more than 10,000 employees)

The small number of employers who were asked whether they agreed with this statement, said that although good management, and particularly communication were important, it was not so simple, and that procedures should specify the steps to be taken. A manager of another food company argued,

> ***'It is also a question of making people aware of the support mechanisms so that they don't feel isolated. It's a bit more than good management. You can be a good manager and spot the signs but you need to go that extra mile to put the support mechanisms in place and you need professional people to help people get over their problems'.*** (Health and Safety Manager food company with more than 500 employees)

For this reason, some companies saw guidelines to managers and employees in relation to stress and mental health as more useful than policy documents and other employers, both with and without stress policies, felt the need for their policies to be more action focused than they currently were. This was to clarify procedures to be followed by managers when employees experience problems and was most strongly felt by respondents identifying poor management as a source of stress, for example in the food industry (see Table 2). One example of good practice was found in a train operating company which had introduced a tool-kit for managers to deal with staff experiencing problems. It included tips on identifying stress and how to assist, including through active listening, and listed company resources including counselling. Although the tool-kit met with some initial resistance, it was widely adopted and was believed to have led to a reduction in absence for stress.

Health promotion

Most companies with stress policies and with provision for employees experiencing stress and mental health problems, such as Employee Assistance Programmes (EAP) and counselling had made efforts to raise awareness of these among staff. Policies were displayed on notice boards and included in staff handbooks. Health promotion covering mental health and stress was limited, although a small number of organisations had hosted talks on stress and mental health issues, sometimes targeted at particular 'at risk' groups, for example social workers in local government. Some of this work was aimed at addressing issues identified in the 'Choosing Health' White Paper (2004) aimed at supporting people to make healthier and more informed choices in regards to their physical and mental health through diet, exercise and other aspects of lifestyle. Some employers in local authorities, the health sector and food companies offered subsidised access to exercise and therapies and had carried out health promotion on the issue of back pain. Some had held special events where staff could have free health checks and treatments such as massage. In one food company, this was provided during its 'Mr Happy Week'.

The health promotion work carried out by employers in the entertainments and rail industry was more limited to physical health issues, such as back pain and noise reduction. The main obstacle to carrying out more health promotion in the area of stress and mental health was resources. Among the train companies only one had carried out any substantial work in the area of stress and mental heath. It had introduced a stress reduction programme which included a series of group workshops

designed to help staff recognise stress and take steps to reduce it through measures including diet, exercise and relaxation techniques. The opportunities for group support through this scheme were seen as a particularly good feature of its design.

Influences on policy development and external assistance in relation to stress and mental health

The influences on policy development in the area of mental health and stress are presented in Table 3. One of the main influences was a perceived need to reduce current levels of sickness absence through stress. Defining stress more clearly and helping to identify it and deal with at an early stage, through policies and procedures, was seen as helping to achieve this. Concern about potential legal action was a strong consideration for some employers particularly in sectors which had experienced legal action over stress, such as the rail industry and in local authorities. Therefore, the HSE was a significant influence and their documents were used for drawing up policies.

There was some concern about the impact of the DDA, but it was seen as less relevant to mental health than to physical health and incapacity. Although some employers were concerned about their image and wanted to be seen as good employers, the role of policy in retaining staff was rarely mentioned. Very few referred to the financial and other advantages of retaining people in employment rather than paying the costs of recruitment and sometimes ill health retirement, yet this benefit has been highlighted in reports by the government's Social Exclusion Unit (2004) and by Mind, who state that ***'….it makes better economic sense for employers to support current employees than to have to recruit and train new ones who, if the proper systems are not in place, will become stressed themselves'*** (Robertson, 2005:38). Although most employers would agree with this statement, it did not appear to be a driver or policy and practice in this area.

Employers were asked about their sources of advice and assistance on issues of mental health and stress from outside of the company. These were surprisingly limited. In most cases this was largely limited to legal advice and guidance produced by the HSE and ACAS. Companies sought legal advice from their solicitors in individual cases of sickness absence, and other legal guidance was obtained through updates on legal cases on stress and mental health or publications on the issue. Where organisations were involved with schemes, such as the Government Access to Work scheme, these were seen as useful sources of advice.

Trade and Employers' Associations were mentioned by employers, but their assistance with mental health and stress was acknowledged to be largely limited to information about new publications on the issue. The exception to this was local authorities where the Employers Organisation was seen as a very useful resource for information about policies and practices in relation to stress and mental health and to provide opportunities for exchange of information between local authorities. Across sectors, some employers referred to professional networks in HR or Occupational Health as sources of information and guidance on practice. The strength of these

Table 3 Influences on the development of stress policies and provision

Sector	Influences on policy development and provision
Local Authorities	The Health and Safety Executive (HSE) The Employers organisation and practice in other local authorities Successful high profile legal cases against local authorities The 'Choosing Health' White Paper (2004) High levels of short-term sickness absence
Health	The HSE and improvement notices on other health trusts DoH policies, including Mental Health and Employment in the NHS (2002) Guidance from the newly established NHS Employers Joint ACAS and HSE initiative to implement stress management programmes among *pilot partner* trusts DoH Improving Working Lives initiative The need for greater efficiency and reduced sickness absence Concern about retention of skilled staff
Rail Transport	Legal requirements Standards and requirements of the Rail Safety Standards Board The HSE The DDA (small number of operators) Change from a 'macho' culture towards taking effects of incidents more seriously
Food Manufacturing	High levels of sickness absence Concern about possible legal claims The HSE
Entertainment	The policies of larger parent organisations (stress policies) Legal obligation (health and safety policies) Retention of valued staff (rehabilitation policies) Arts Council and Employers Organisations Perceived need to compensate for poor working conditions in theatres

contacts depended on the interests of individual managers. The extent to which wider sources of information and guidance were sought also appeared to depend on the initiative on individual senior managers. Therefore a small number of managers had used consultants or researchers to investigate stress and advise on policy and practice and a few had used the resources of mental health organisations.

Despite their limited access to external assistance and guidance, most employers seemed to be satisfied with the resources available to them. This feeling was strongest in the heath sector where most respondents felt they had access to adequate levels of assistance within their organisations. At the same time, employers across sectors said they would welcome more easily accessible information, preferably on-line. A number expressed a particular interest in the practices of other employers, particularly in relation to long term sick leave for stress and mental health.

Recruitment of people with mental health problems

Employers' views on recruiting someone with a mental health problem were explored largely in discussions about the pen portraits, particularly in relation to the case of Ben, with bi-polar (manic-depressive) disorder. These discussions revealed some perceptions held by employers and what appeared to be some common practices. Existing research suggests that discrimination is widespread: thirty-nine percent of respondents to a survey conducted for MIND said they had been denied a job because of a mental health problem and 69 per cent had been put off applying for jobs for fear of unfair treatment (Read and Baker, 1996). At the same time, research by Fenton et al (2003) found that employers did not ask job applicants about mental illness, suggesting that applicants with such problems are not rejected. However, evidence from our research suggests that it is the pre-employment medical questionnaire, used by many employers, rather than the interview which brings mental health issues to their attention and leads to decisions to recruit or to reject applicants. Few employers said they would expect an applicant to disclose a mental health problem at interview.

Medical questionnaires and sometimes medical examinations were used in local authorities and health trusts, in train companies and the food industry. They were rarely used in the entertainment sector where applicants were asked only about registered disability. The form used by one local authority included questions on depression, suicidal tendencies, paranoia and whether they have ever been treated in a 'mental institution' and in another local authority the form asked whether the applicant, or anyone in their family, had been diagnosed with a mental health condition. Across and within sectors there was variation in who took the lead on investigating the implications of problems disclosed by applicants: in local authorities HR tended to have more of an involvement than Occupational Health, while in health trusts Occupational Health took the decisions. Most employers were aware that rejecting an applicant on grounds of mental health could be discriminatory and in breach of legislation. Therefore HR managers were often keen to hand over responsibility to Occupational Health departments and to follow their recommendations. However, it was suggested that Occupational Health providers are sometimes too concerned to follow the DDA and not to consider 'the business case'. In the rail sector two managers said they would want to be sure that someone with a past history of mental health problems could 'make a contribution to the business.'

Occupational Health specialists in the health trusts mentioned a number of criteria that they would take into account when making a decision about recruitment: current state of health, likelihood of relapse, degree of insight, effect of medication on motivation and cognitive ability. Respondents in health and in the rail sector talked about suitability of applicants with serious mental health problems for safety critical jobs and for in the rail sector for jobs involving customer contact. Decisions about recruitment would therefore depend on the nature of the problem and the job applied for. It might include investigation of possible adjustments to the job, if it was thought that the individual might not be able to do the job but that the condition came under the DDA, or offer of an alternative post. A number of employers said that the DDA had made it more difficult to decline applicants with mental health problems who were currently well. However, there was evidence that such applicants were sometimes rejected.

Glozier found that the principal concern about recruiting an applicant with schizophrenia was potential poor work performance (1998). Similar concerns were also expressed by employers in a survey for Mind (McGregor, 1995). These concerns were voiced by some respondents but, as stated above, employers also expressed specific concerns in relation to certain types of work, particularly safety critical roles and jobs involving contact with the public. A number of respondents in train companies said that they would not recruit someone with a history of a serious mental health problem like bi-polar disorder to a safety critical or customer facing job. Given the wide definition of these terms, this would rule out a high proportion of jobs in the sector. The pen portrait of Ben (see Figure 1) described him as a ticket inspector. The following statements were made by respondents from three companies each with more than 1,000 employees:

> ***'It's unlikely that we would have a Revenue Protection Inspector with this kind of illness. He wouldn't have passed the medical'.*** (Health, Safety and Welfare Manager)
>
> ***'If we knew he was manic depressive, he would not be recruited, at least not into a customer facing role'.*** (Employment Relations Officer)
>
> ***'Someone with a mental health problem and who needed medication would not be allowed to take a safety critical post'*** (Safety Manager)

A number of employers in the food industry also questioned the suitability of applicants with a history of mental health problems for jobs involving the operation of machinery and for working at high temperatures. One of these stated that 'It would be like employing someone with a bad back to work in dispatch'. (Health Manager, food company with 5,000 employees). While such concerns might be valid in the case of a condition involving concentration problems or medication side-effects, it would not seem reasonable to generalise about mental health problems, types of job or both.

Employers who expressed reluctance to recruit people with a history of mental health problems to a customer-facing role talked largely in terms of the employee's own well-being and protection. A number of respondents in train companies felt that it was in the individual's own interests that they should not be exposed to the stresses of such work. One manager explained,

> ***'We would need to ask questions: is it fair to put them in a situation with customers shouting? Rarely would we say we're not going to employ them, but would say lets look at it from this point of view. It's not fair to put someone like that in a customer situation. If they don't have self-confidence, it could knock them back further'*** (Safety Manager, train operator with more than 1,000 employees).

Again, this reveals stereotyped views about mental illness, in particular that it inovles lack of confidence and fragility. Few employers in health trusts and local authorities expressed such concerns. Even if they had personal reservations, they believed but that the DDA and sometimes other policies and guidelines, particularly on equal opportunities, would be followed to ensure fairness. Employers in the entertainment sector said that their concerns about employing someone with a history of mental health problems would relate almost entirely to their ability to do the job and a

number of respondents talked of a culture of tolerance in the industry. However, the research did not include the experiences of employers and applicants, and employers may have painted a rosier picture than exists in reality.

Some research suggests that media misrepresentation of mental health, in particular the portrayal of people with mental health problems as dangerous, may influence employers' approaches to recruitment (see Warner, 2002). It is possible that such assumptions were behind some of the concern about safety critical jobs or work involving public contact. However, employers' concerns did not appear to be focused on danger in the sense of personal violence. Perhaps surprisingly, one of the few comments associating mental illness with violence was made by the director of Occupational Health at a large hospital trust who stated that 'questions would be asked' if an applicant with bi-polar disorder left information off his questionnaire, was recruited and then 'attempted to strangle a patient'.

Although the erroneous association between mental illness and violence was expressed by few employers, understandings of mental health were clearly informed by stereotypes and by an assumption that a diagnosis will necessarily affect performance at work in particular ways. A more helpful approach, and one which meets the requirements of the Disability Discrimination Act, would be for such assessments to be specific to the individual and their job. This process should also consider the possibility of making reasonable adjustments to enable the individual to continue working.

What happens when an employee experiences stress or mental health problems?

The focus of the paper so far has been on employers' policies and how they conceptualise stress and mental health. The remaining part explores the core issue for the research of what happens when an employee experiences mental health problems: this includes who has responsibility, how mental health and stress problems are identified, what assistance might be given, what issues are considered and what action employers take.

Who would be involved?

Line managers and professionals in HR and Occupational Health were seen as the key players by respondents in most organisations. The exception to this was the entertainments sector where all management functions were carried out by a small number of senior managers, with occasional external assistance. The finding of research by the Social Exclusion Unit that under half of employees have access to an occupational health service at work, suggests this is not unusual (SEU, 2004) and highlights the key role of line managers. In the other sectors, all organisations included HR professionals and had an occupational health service, although this sometimes consisted of only a small number of part-time staff.

Aside from the less formal role described above, the role of HR in dealing with stress and mental health included investigation of any work-related factors, and arranging risk assessment and possible adaptations or changes to workload; policy development

and investigating compliance, which might include areas such as the DDA or equal opportunities. HR, often with the involvement of Occupational Health, were also involved in monitoring sick leave, in home visits and in agreeing a phased return to work and in decisions over sick pay entitlement, capacity and retirement on medical grounds. The expertise of Occupational Health was described as in assessing an individual's condition, clarifying diagnoses, prognoses and treatment, often in consultation with the GP, and sometimes arranging diagnosis or treatment directly.

How are problems identified?

Employers became aware of mental health and stress problems among employees through four main routes:

- Sickness absence
- Line managers and colleagues noticing short-term changes in performance and behaviour
- Performance management and appraisals
- Individuals reporting to Occupational Health, HR or accessing services such as counselling

Sickness absence

The principal way in which mental health and stress problems were brought to the attention of HR and Occupational Health was by sickness absence. For line managers absence was also often the first indication of a real problem, although changes in performance and behaviour might also be apparent. Stress and mental health problems were treated differently to physical illness, with many employers referring employees with sick notes indicating such problems to occupational health for attention and early intervention. This was seen as necessary to identify causes, prognosis and treatment. As one employer explained,

> ***'Stress cases take a bit more managing because we're trying to get at the underlying reasons. We find the earlier we get in there the better'*** (Occupational Health Manager, train operator with more than 1,000 employees)

For periods of absence of up to seven days, the employee records the reasons for absence, but for absences of more than this, a GP's certificate is required. Many employers talked of the difficulty on interpreting the diagnoses recorded by GPs on these documents. Some felt a frequent need to contact GPs for clarification, as well as for an indication of the likely duration of the condition. Employers experiences with this process were seen as least satisfactory in cases diagnosed as 'work-related stress' or common mental health problems, and more straightforward for serious mental health problems (see below). A number of employers said they would rely largely on the advice of their own occupational health doctor for a diagnosis and for an assessment of the validity of sick leave.

Larger employers also aimed to identify patterns of sickness absence which might indicate problems, for example regular short periods of absence which did not involve a GP's certificate. Some employers used computer programmes for identifying particular sickness absence patterns which might indicate stress or mental health problems. In a drive to cut costs, companies across industry sectors were paying closer attention to sickness absence through methods of analysis and review.

Return to work interviews

Employers in most large organisations referred to return to work interviews as a way of identifying stress and mental health problems. These were relatively informal meetings between an employee and line manager to discuss reasons for absence. Employers pointed out that these are a formal requirement, but were not confident that they were carried out in all, or even most cases, of absence. Some employers said that discussions about sick leave and its causes would certainly take place if such absences were frequent, as part of performance review or as a separate discussion.

Behaviour

Many employers pointed out that problems of mental health and stress do not necessarily lead to sickness absence. Employees often continue working while experiencing such problems. This was particularly apparent in the entertainment sector with its culture of 'the show must go on'. Companies frequently referred to the line manager as the individual responsible for initially identifying stress and mental health problems. Safety considerations also led to an emphasis on identifying unusual or problematic behaviour among some occupational groups, for example train drivers, ambulance drivers, doctors and nursing staff. In these industries colleagues as well as managers were expected to discern such changes and take appropriate action. Close-knit teams found in some occupations, for example on in food processing or in theatres were also reported to assist in the identification of problems. In theatres and orchestras some managers, even in very senior positions, saw watching out for problems in their workforce as part of their role.

A number of respondents referred to changes in personality, rather than behaviour as such, as a key indicator of stress. To recognise such signs requires a manager to know their staff reasonably well. In theatres a particular problem was identified where the tolerance of eccentric behaviour could lead to failure to address mental health problems. One manager explained that,

> ***'Eccentricity to the point of mental illness and minor mental health probems are quite common in the theatre'*** (Theatre Manager, theatre with fewer than 30 employees).

Different norms for acceptable behaviour, and the tendency for colleagues to absorb and work around the behaviour of workers with mental health problems, made it more difficult for managers to identify problems and to judge when to take action. While sickness absence led to concerns about how to bring employees back to work, behaviour suggesting mental health problems sometimes led employers to encourage employees to take time off. Employers in the entertainments sector, with a culture of long hours and commitment, identified a problem in persuading employees to reduce

hours and take leave, and suggested that excessive sick leave was a les common problem.

Performance appraisal

Research by the Department of Health in 1996 found that about half of companies were looking at performance appraisal practices as a way of identifying stress and mental health problems (DOH/MORI, 1996). However, although these were referred to as a means of identifying problems in some hospital trusts, appraisal and performance review was mentioned by only a small number of companies in other sectors. They were then seen as a way of identifying chronic work-related issues rather than acute problems. Other methods were seen as more reliable in picking up problems at an early stage.

Some employers also referred to direct approaches from an employee to HR or to Occupational Health. Some employers appeared to encourage this practice, in recognition of the limited skills of line managers in dealing with stress and mental health problems. In the rail and food industries HR and Occupational Health staff were seen as more able to address such problems because of their training and also because many were women, while many line managers were men and seen as less approachable and able to address personal issues. In the health sector this practice was seen as increasing, which some Occupational Health mangers believed was a result of recent health promotion activities surrounding stress.

Employees with an existing problem

Clearly the question of how problems are identified is different in the case of employees with previous or known mental health problems. Local authorities and health trusts sometimes made a contract with such employees over such issues as performance and behaviour, with indicators of emerging ill health linked to 'trigger points' leading to certain action, such as a meeting with Occupational Health. These arrangements were seen to work well in catching problems at an early stage, although they sometimes involved difficult judgements about acceptable behaviour. A further problem was identified where managers changed and relationships had to be built from scratch. Some respondents in hospital trusts, who were largely Occupational Health specialists, said they had a clientele of staff with a history of mental health problems, who are known to them, and to whom they offered support with occasional crises.

Assistance to employees experiencing problems

The principal types of formal assistance made available to employees were EAP schemes and counselling. Some employers also offered a range of other types of support, such as relaxation therapies, including massage, aromatherapy and reflexology (paid for by the employee and in their own time), HR surgeries (local authorities), a mobile 'stress surgery' (one train operator) and chaplains (hospital trusts). The effectiveness of these was not generally known, although the mobile

stress surgery was seen as highly successful. A summary of the types of formal assistance offered by employers is given in Table 4.

Employee Assistance Programmes (EAPs)

EAPs provide access to a 24 hour telephone help line for advice and guidance on a wide range of matters, including finance, legal questions and relationship problems. Most employers who signed up to this service paid for the enhanced provision which allowed access to face to face counselling, usually for up to 3 or 6 sessions, with extensions subject to the employer's agreement. EAPs were most common in the rail industry: most rail companies offered employees the full provision of telephone and face to face assistance, which they viewed as part of exercising their 'duty of care', particularly to employees suffering traumatic incidents at work. In the health service counselling was usually offered outside of such schemes and only two health trusts operated EAPs, although a third had rejected it on grounds of cost. Only a small number of food and entertainment companies offered EAPs and these did not always include face to face counselling.

Table 4 Formal assistance offered to employees

Sector	Type of assistance offered
Local Authorities	Initial counselling from occupational health staff Referrals for formal counselling, but rationed Some staff trained in counselling skills for mentoring Anti-stress treatments such as massage
Health	EAPs with face to face counselling in 2 trusts Initial counselling from occupational health staff Formal counselling from occupational staff or through sessional counsellors Occasional referral for treatment within other trusts
Rail Transport	EAPs with face to face counselling in most companies Counselling for staff involved in incidents at work Initial counselling by occupational health staff Referrals to counselling for trauma Stress reduction programme, including group and individual sessions in 1 company
Food Manufacturing	EAPs in 3 companies (1 with face to face counselling) Initial informal counselling from occupational health staff Regular referrals for formal counselling in 2 companies Only occasional referrals for counselling in most companies
Entertainment	EAP with face to face counselling in 1 orchestra Access to counselling in one orchestra Access to services of parent organisation in 2 orchestras and 1 theatre Only occasional referrals to counselling in most organisations

Employers had little idea about whether EAPs were effective in dealing with stress and mental health problems. The Sainsbury Review of interventions in the workplace found only limited evidence to support the efficacy of Employee Assistance Programmes (EAPs) in managing common mental health problems (see Seymour and Grove, 2005). This is unlikely to concern most employers, since those in the research generally saw these schemes primarily as a way of meeting their 'duty of care' and as a non-pay benefit to employees. This was stated explicitly in the food sector by two employers:

> ***'We were in a climate where we could not offer large salary increases for two to three years and so we wanted to offer a major benefit but one which wasn't a major cost to the business, so we put the package together.'*** (Head of HR, food company with more than 1,000 employees)

> ***'Rather than just do a pay review, we were thinking of benefits in general so we looked at what we could provide'*** (Health and Safety Manager, food company with fewer than 1,000 employees)

One advantage of EAPs, is that information on their use can be fed back to employers and used to identify sources of stress and areas of intervention (see Gray, 1999; Liimatainen and Gabriel, 2000). Although this feedback was considered helpful in identifying sources of stress, few companies appeared to have the resources to act on this information. Therefore, only the 'headline' reasons for contact were examined. These tended to reinforce employers' view that the majority of calls were about 'non-work' issues, and this was defined very broadly, so that any 'emotional' issues were regarded as non-work.

Counselling

A review of evidence by the Sainsbury Centre for Mental Health suggests that brief individual therapy, especially based on cognitive behavioural techniques is the most effective approach for people already experiencing common mental health problems at work. Such interventions were found to be effective whether delivered face to face or through computer-aided software (see Seymour and Grove, 2005). There appears to be no evidence on the relative effectiveness of face to face and telephone counselling, the assistance offered by most companies who made counselling available.

The availability of counselling through employers, and its extent, varied greatly between sectors. Many employers said they offered counselling to employees experiencing problems, including those on sick leave and those currently in work, particularly in local authorities, health trusts and train companies. However, precisely what this involved varied considerably. It often consisted of 'first line' counselling by an occupational health nurse with limited counselling training. While undoubtedly helpful to some, this is unlikely to be sufficient for employees experiencing even mild mental health problems. In local authorities in-house counselling was described as fairly unstructured and to provide support rather than to resolve problems. Similarly, in train companies both HR and Occupational Health were active in identifying stress and mental health problems following incidents and provided informal counselling. Respondents in the food and rail sectors commented on the informal support given by

sympathetically natured female staff in Occupational Health and HR departments. This was sometimes described in somewhat patronising terms for example 'a bit of a chat, a cup of coffee and some pleasant company'. However, such assistance, described in previous research as 'natural supports' may play be important in preventing stress and mental health problems from escalating (see Secker and Membrey, 2003).

Some local authorities and train operators had trained staff across departments in basic counselling skills. These were sometimes for mentoring employees experiencing bullying and harassment but also had a wider remit. Again, the use and effectiveness of these staff had not been evaluated, but they were regarded as a useful resource. One HR manager had proposed that all managers trained in counselling skills. He was disappointed when senior managers rejected this idea:

'They saw it as a waste of time and resources. They said managers don't have time to sit down and talk about feelings' (local authority with more than 10,000 employees).

Some employers across sectors, but particularly in health trusts, train companies and local authorities provided formal counselling in-house through a series of sessions. In health trusts, trained counsellors were sometimes employed on a sessional or part-time basis. Elsewhere, a few employers targeted counselling at particular groups of employees, for example those high stress areas, such as social services. In one local authority Cognitive Behavioural Therapy (CBT) was used in the redeployment of employees with mental health problems, and considered to be very successful. This authority was also involved in the Government's WorkCare programme, part of the Job Retention and Rehabilitation pilot, aimed at improving employment participation of people on long term sick leave (see Nice and Thornton, 2004). The local scheme used a combination of physiotherapy and CBT which was reported to be highly successful, with most employees returning to work without redeployment.

The use of external counselling services varied greatly between sectors. In the health sector external services were used less than internal provision, because of the greater availability of in-house expertise. Elsewhere, most counselling was accessed externally: train companies arranged counselling for staff involved in incidents at work, including immediate counselling and referral for specialist help. In addition most train companies allowed access to face to face counselling through the EAP, usually of up to 6 sessions paid for by the company, with extension at the discretion of the employer. Train companies saw the availability of this assistance as meeting their legal obligations over safety issues and their duty of care.

Elsewhere, referral for counselling was usually made by agreement between Occupational Health, HR and sometimes the local manager. In local authorities, because of devolved budgets, access to counselling was reported to vary according to managers' willingness to pay. Therefore, a problem of equity was identified by some respondents. There were similar indications of rationing in health trusts where budgets for counselling were sometimes very small: in one trust of 2,750 staff the annual budget for counselling was only £5,500. Although access to counselling was not said to be restricted, a much larger study of the sector by the Royal College of Nursing found that many trusts offer written guidelines that describe clients most suitable for

counselling (Mellor-Clark, 2004). Therefore, employees may be encouraged or dissuaded from using the service. The same research found wide variation in the proportion of staff referred for counselling: from 0.3 to 28 per cent and long waiting times in some trusts (ibid, pp4-5).

Some employers, particularly in local authorities, said that referral to counselling, or to other specialist help, would sometimes be sanctioned by a department or centrally according to the status of the employee. One manager explained that,

> ***'[referral for counselling] only really happens if the employee is valued or if they have a problem with which a manager can sympathise. If they're regarded as a bit of a waster, or not well thought of, they won't get the same treatment'.*** (HR Manager, local authority with more than 10,000 employees)

Other employees would be expected to make own arrangements for counselling. One local authority manager explained that it was sometimes arranged and funded 'for protection' where an employee was likely to be dismissed and the authority wanted to show it had done all that could reasonably be expected of it.

It was not usual practice for employers in food manufacturing and entertainment to refer employees for counselling. The two employers in the food sector who had arrangements in place were driven principally by individual managers with a personal interest in occupational health. Although a number of companies said they offered face to face counselling for employees where there was a particular need, few examples were given of this practice. This included organisations in the entertainments sector where 'piggyback' arrangements could be made with parent organisations. Although some employers in these sectors believed that counselling was effective for stress and mental health problems, there was a belief among others that employees should not expect such provision through their employer. One employer probably spoke for others when he stated,

> ***'The orchestra does not have resources or funding to help players in personal difficulty. People have to arrange health care for themselves. I would go to my GP'*** (Chief Executive, Orchestra with fewer than 10 employees).

At the same time, some employers were aware of the difficulty of obtaining counselling under the NHS and acknowledged that an employee might have to wait many months for such help, or not receive it at all.

Discussion of hypothetical cases, or 'pen portraits'

As part of the research interview, employers were shown 'pen portraits' of employees experiencing problems and were asked how they would deal with these (see Figure 1). They were designed to include what Seymour and Grove (2005) term 'common mental health problems' (Liz with stress/depression and Robert with combined physical and mental health problems), and more serious mental health problems (Ben,

with bi-polar affective disorder and Emma with early signs of schizophrenia)[6]. Among other questions, such as who might become involved, what issues or considerations there might be and what would be done. Employers' responses to each pen portrait are summarised in tables 5.1 to 5.4. The research used qualitative methods to identify the main issues for employers and how they deal with issues of stress and mental health. Therefore, discussion of the pen portraits was aimed at identifying the issues and considerations and main practices which might be adopted.

[6] The pen portraits also included the case of someone showing symptoms of heavy drinking, the findings of which will be presented elsewhere. The original portrait of Emma, shown to the first 5 employers, described her as anorexic. It was changed because employers believed that this was a 'personal' issue with which most would not 'interfere'. It was also felt that the pen-portraits could benefit from more emphasis on mental disorder.

Figure 1 Pen portraits used in interviews

Liz
Liz is a 52 year old [intermediate level employee*] who has worked for [the organisation] for 15 years. She separated from her husband 6 months ago, which coincided with reorganisation in her department and an increase in workload. Since then, the standard of her work has declined. Liz has taken a number of periods of sickness absence, each up to 4 weeks, authorised by her GP as due to stress. The gap between these periods of absence has become progressively smaller.

* *an administrator in a local authority; a ward manager in a hospital; a ticket office clerk on the railways; a food processing operative in a food factory; an orchestra manager and a box office clerk in a theatre*

Robert
Robert is a 35 year old [intermediate level employee**] who has worked for [the organisation] for 8 years. In the past 2 years he has taken long term sick leave for back pain a number of times, one of which was for almost 6 months. Despite a number of medical investigations, as a result of referral by his GP, no cause has been found for his complaint. He has recently started to say that his back pain is so severe that his life is not worth living.

****** *a senior policy officer in a local authority; a staff nurse in a hospital; a train driver on the railways; an engineering process manager in a food factory; a violinist and a lighting technician in a theatre*

Ben
Ben is a 31 year old [intermediate/senior level employee***] who joined [the organisation] a year ago. He has a history of manic depression, which is generally well controlled by medication. He has recently become excitable, working very long hours and talking non-stop. An important client commented to you that Ben 'seems a little strange'.

*** *a housing officer in a local authority; a clinical nurse specialist in a hospital; a customer service inspector on the railways; a customer service representative in a food factory; a head of fundraising in an orchestra and a production assistant in a theatre*

Emma
Emma is a 19 year old [junior employee****] who joined [the organisation] as a trainee at the age of 16. In the last 6 months she has become very withdrawn, rarely speaking to colleagues, but frequently staring without blinking and communicating through long lists which make little sense. A colleague has been telling everyone, and Emma herself, that she is 'crazy'. Emma has complained informally that her colleague is bullying and harassing her.

**** *a payroll clerk in a local authority; a health care assistant in a hospital; an office clerk on the railways; an administrative assistant in a food factory; a clerical assistant in an orchestra and an office clerk in a theatre*

Table 5.1 The pen-portrait of Liz: stress/depression

	Local Authorities	Healthcare Trusts	Rail Transport	Food Manufacturing	Entertainment
Issues and considerations	Seen as largely relating to her personal life Whether workload is too heavy How organisational change was managed	Whether she is suffering from depression Whether she should be at work or at home Impact of her absence on the team	Seen as combining home and work issues Whether the mental health and stress problems are genuine	Seen as combining home and work issues Possible case of problems in adjustment to change at work Is a long serving employee	Is a long serving employee How to restore her to normal productive working Organisational difficulties caused by staff absence
Investigations or information needs	Investigate Her workload Carry out a risk assessment to determine whether stress is work-related	Clarification of her diagnosis and checking her treatment by Occupational Health Possible adjustments to workload	Clarification of diagnosis through liaison between Occupational Health and GP Possible home visit while off sick to establish state of mind	Occupational Health to investigate relative role of home and work factors and the validity of sick leave Possible stress factors such as childcare or alcohol problem	Prognosis of condition (from employee and sometimes GP) and expected period of absence from work
Action	Rehabilitate back to work through shorter hours Supervisor to provide additional support Possible referral for counselling Set attendance and performance standards	Initial or first line counselling through Occupational Health Rehabilitate back to work through reduced duties Possible referral for counselling	Put on Managing for Attendance or performance procedure to identify cause of the problem Set targets for improved performance Possible job adjustments or change in role Referral for counselling	Investigate the increase in workload and whether level is acceptable Put in place measures for improved performance, including targets. If not met, start disciplinary procedures leading to possible dismissal Move from current job (to different department, part-time working or redundancy) Suggest counselling	Refer to Occupational Health and counselling services where available Review her workload and make changes to job Leave of absence to allow job to be covered Dismissal if improvement not achieved

Table 5.2 The pen-portrait of Robert: back pain/depression

	Local Authorities	**Healthcare Trusts**	**Rail Transport**	**Food Manufacturing**	**Entertainment**
Issues and considerations	Whether the back problem is genuine/attendance Possible mental health and stress problems Pressures on colleagues as result of his absence	The link between back pain and depression/possibility of serious depression The need for effective treatment of both The need for action to prevent termination of employment No mention of suicide remark	Whether the back problem is genuine or exaggerated (performance issue) Possible mental health and stress problems The suicide remark His long term employment prospects	Whether back pain is either physical or psychological Possible mental health and stress problems His long term employment prospects	Varied views on relationship between mental health and back pain The suicide remark His long term employment prospects
Investigations or information needs	Need for diagnosis Involvement of GP in back diagnosis and suicide remark Risk assessment of job	Involvement of GP to establish what tests and treatment done or waiting for Whether root cause is physical or psychological	Need for diagnosis and assessment of capacity Involvement of GP to establish what tests and treatment done or waiting for	The demands of the job Whether root cause is physical or psychological	Involvement of GP to establish what tests and treatment done or waiting for Whether root cause is physical or psychological
Action	Key role for Occupational Health Specialist referral for diagnosis and treatment for back pain Possible referral for counselling Possible adaptations to work Action over poor attendance	Key role for Occupational Health in investigating possible treatment Referral to back pain clinic with psychologist involvement Treatment for serious depression Exploration of alternative work	Key role for Occupational Health in establishing validity of absence Possible referral for specialist treatment (valued employee) Possible alternative work Referral for counselling Possible termination of contract on advice of Occupational Health	Key role for Occupational Health, including diagnosis Referral for physiotherapy Referral for specialist diagnosis and treatment through GP Occasional private referral for treatment Possible alternative work	Involvement of Occupational Health where possible Assist in finding him treatment, including through alternative or complementary therapy Possible adjustments to work Possible referral for counselling Alternative employment

Table 5.3 The pen-portrait of Ben: bi-polar (manic-depressive) disorder

	Local Authorities	Healthcare Trusts	Rail Transport	Food Manufacturing	Entertainment
Issues and considerations	Seen as clearly 'medical' rather than performance Whether manager knows about condition Lack of confidence among line managers in dealing with mental health problems	The need to support managers in addressing issue Risk to patients or to individual Lack of confidence among line managers in dealing with mental health problems	Seen as clearly 'medical' rather than performance Lack of confidence among line managers in such situations	Seen as medical Possibility of manager treating as performance issue if not aware of the condition Whether had disclosed condition earlier	Seen as clearly 'medical' rather than performance Whether he had complied with recruitment procedures for declaring existing conditions
Investigations or information needs	Whether he has insight Whether is taking medication Whether is fit to continue work	Whether is taking medication Line manager's assessment of the situation Current ability to do the job	Whether is taking medication Suitability for the job The long hours	Whether is taking medication Whether is substance mis-user The long hours Suitability for the job Whether he has insight	Whether is taking medication The long hours Suitability for the job
Action	Key role for Occupational Health and medical opinion Referral to GP (with permission) to check medication and condition Sign off sick or reduce hours	Key role for Occupational Health and medical opinion Referral to psychiatrist/ GP (with permission) to check medication and condition Mixed views about keeping at work or signing off sick , manager to suspend if considered high risk	Key role for Occupational Health and medical opinion Manager or HR to discuss performance (hours and behaviour) Referral to GP (with permission) to check medication and condition Transfer to other duties Referral for counselling	Discussion with line manager Referral to Occupational Health if recognised as mental health issue rather than performance problem Referral to GP (with permission) to check medication and condition Mixed views about keeping at work or signing off sick	Involvement of Occupational Health where possible Discussion with manager Monitoring workload and controlling hours of work

Table 5.4 The pen-portrait of Emma: early signs of schizophrenia

	Local Authorities	**Healthcare Trusts**	**Rail Transport**	**Food Manufacturing**	**Entertainment**
Issues and considerations	Bullying and harassment Possible health issues	Probable serious mental health problem Bullying seen as secondary issue	Bullying and harassment 'Personal' problems (eg substance misuse, domestic abuse) Dependence on line manager to take action and lack of confidence among line managers in such situations	Seen as performance issue Dependence on line manager to take action. Bullying and harassment 'Personal' problems (eg substance misuse, domestic abuse) Is relatively long serving	'Personal' or 'adolescent' problems Possible under-lying issue
Investigations or information needs	Whether is a case of bullying and harassment If mental health problem considered, whether she has insight	Whether a risk to patients or to herself Whether she has insight and will accept help	Whether is a case of bullying and harassment Whether has personal problems	Whether is a case of bullying and harassment Her behaviour and performance	Whether has personal problems Whether needs support
Action	Address bullying and harassment first through investigation by line manager and HR Encourage to pursue complaint Refer to Occupational Health if seen as a medical problem Possible disciplinary action if treated as behaviour and performance rather than health issue	Refer to Occupational Health Possible referral for psychiatric assessment and treatment Sign off as sick or suspend if not comply	Address bullying and harassment first through investigation by line manager and HR Careful approach to identify possible personal problems Encourage to pursue complaint Refer to Occupational Health	Address bullying and harassment first through investigation by line manager and HR Encourage to pursue complaint Possible referral to Occupational Health to deal with personal problems	Manager to enquire directly about the bullying and the behaviour Refer to Occupational Health or HR if available Or close monitoring of situation Investigate bullying and harassment if complaint is made

Common mental health problems: the case of Liz: stress/depression

It was noticeable that many employers found it easier to discuss common mental health problems such as 'stress' or depression than more serious ones like bi-polar disorder. This may be explained partly by their greater familiarity with the issues. The case of Liz, with a diagnosis of stress was seen as a very common case and one with which most employers said they were familiar because of its combination of personal and work-related factors. In local authorities it was seen as common because it combines work and home problems and because it involves the management of change. Another familiar feature was the short periods of absence which had become more frequent. The question of whether it was legitimate for an individual suffering from stress or depression to take time off was raised by some respondents. One argued that personal problems should not affect work,

> ***'People used to come into work and soldier on but social changes mean that they are not more likely to take time off work. It used to be thought that you have to sort out your own problems and that coming into work would actually help to take your mind off them. Nowadays there's a different mindset'.*** (Employee Relations Manager, Train operator with more than 1,000 employees)

The pen portrait was seen as unrealistic in one respect: many employers across sectors said that the problem would have been dealt with earlier than the pen portrait suggests, either through sickness absence procedures or through the line manager identifying problems or performance or outlook. Some employers felt that managers and colleagues should be aware of personal problems among employees and provide support when needed, although it was recognised that this might not happen in practice. Such problems were seen as easier to identify among employees working in small teams or in close contact with a manager. One employer remarked that,

> ***'Manager to employee is the best way to deal with these things. Keep an open dialogue: "What can I do, we do have facilities, I've noticed your absence is getting worse and we need to do something".*** (Health and Safety Manager, food company with more than 1,000 employees)

What would be done?

Employers saw two courses of action as necessary in Liz's case: investigate the management of change and her workload; and to clarify the diagnosis of 'stress' given by her GP. Employers were concerned to establish the relative role of work through looking at the change in her workload, sometimes through risk assessment. If work was found to play a role, this might lead to reduced duties, and adjustment of her role. Employers in the food industry seemed most prepared to find a change of role, possibly because of the range of jobs available in a food factory. If work load was not found to be excessive, a number of employers said they would want to put in place measures for improved performance, which could lead to dismissal if they were not met: employers in local authorities, rail companies and the food sector said performance would be monitored formally through targets.

The second area of action covered diagnosis, treatment and return to work. Most employers wanted a clarification of the GP's diagnosis. She was also seen to be a candidate for counselling, either through referral by Occupational Health or self-referral through the EAP. Some employers said they would want evidence that Liz was taking action herself, and recognised that her absence and performance was a problem for which she had some responsibility. The manager in the food sector quoted earlier summed up these concerns as follows:

> ***'If they are not prepared to take the olive branch then they are pushing themselves down the disciplinary track. You can take a horse to water, but you can't make it drink. It comes to the point when the employee needs to do something about it themselves or you'd be thinking of the sack'.*** (Health and Safety Manager, food company with more than 1,000 employees)

Previous research refers to the importance of adjustments, including flexibility in working hours, work schedules and job tasks for people with mental health problems (see Secker and Membrey, 2003). Most employers acknowledged the need to assist an employee in Liz's position in rehabilitation back to work. This might include adjustments to her role in the short term and additional support from her manager or colleagues. It was generally considered that employees with combined home and work problems did not benefit from extended periods off work, principally because they miss out on the support of colleagues and become isolated at home. A number referred to the damaging effects of watching daytime television. Therefore, when an employee was not able to cope with a full working week, some employers offered a temporary period of part-time working, or a phased return to work. This practice is recommended by Mind (see Robertson, 2005). Clearly, to be of benefit, this would usually need to be without reduced pay, and it was not always clear that an employee would retain their full-time pay at this time. Although continued working on at least some basis was widely regarded as best for the employee, a small number of employers, across sectors, suggested that a period of time away from work might help in her recovery. Two employers in the health sector felt that a period of work would preserve her relationship with colleague or prevent down-grading of her role. The first of these stated,

> ***' We might almost help negotiate that she goes off sick rather than be at work. One problem is that if she is really irritable with the depression, that can damage work relationships to a point where return ultimately becomes very difficult'*** (Director of Occupational Health, health trust with more than 5,000 employees)

One employer in the food sector simply thought that granting a few months leave would be better than 'letting it drag on'. In the entertainments sector a different perspective was given by some employers who said that a period of leave would be easier for them, because it reduced some of the uncertainty, which can be a particular problem for small establishments, and allowed them to plan cover. One of these stated that,

> ***'It would be better if she took a leave of absence, unpaid or paid, in order to address what is a domestic based problem rather than keep taking leave.***

Then her absence could be covered by someone else' (Director, orchestra with over 100 employees)

Small numbers of employers raised further considerations: some in the food and entertainments sector said they would be more prepared to provide assistance and be patient towards a long serving member of staff (15 years). A small number of employers said that the involvement of other issues, such as childcare problems or alcohol mis-use might need to be considered.

Common mental health problems: the case of Robert: musculo-skeletal and mental health problems

Robert's case, whether seen as musculo-skeletal or as also involving mental health, was also viewed as common, particularly within certain occupational groups such as train drivers and factory workers. The combination of a back problem with depressive symptoms including a suicide remark, was seen as less common. This is possibly because employers would treat such a case principally as a musculo-skeletal problem and view the psychological factors as secondary. It was also seen as potentially one of the most difficult to deal with, because the causes and therefore prognosis were largely unknown. Some respondents in train companies reported cases which had been found not to be genuine. One orchestra manager also commented that, ***'It is quite common to use back problems as a cover for some other problem*** (Director, orchestra with 100 employees).

What would be done?

Employers interpreted this pen portrait in various ways: some saw Robert as having a genuine back problem; some that he may have been exaggerating or fabricating the problem; or that his principal problem was one of stress or mental health. Although these differences were found among employers in the same sector, some differences between sectors were evident; employers in local authorities and rail companies were more likely to question whether he was genuinely experiencing back pain, an attitude which is possibly explained by the drive on attendance and sick leave in those sectors. Employers in the food sector tended to see it as more likely to be a physical problem, possibly because of the incidence of musculo-skeletal problems among manual workers. Employers in the health and entertainments sectors were more likely than others to see the pen portrait as combining physical and mental health problems. In the entertainments sector the suicide remark was regarded more seriously than elsewhere, with the exception of train companies where there was concern for safety implications. The concern expressed by employers in the entertainment sector possibly reflects their position as small businesses with closer relationships with employees.

Employers identified the need for a full investigation into the back problem, either through his GP who could refer him to a specialist, or through direct referral through the organisation's occupational health department. Some employers said that the likelihood of an individual being referred for specialist treatment would depend on their role, including their skill level. Therefore, train drivers as relatively highly paid and skilled employees were seen as eligible for private treatment. Employers in local authorities and train companies were more likely than others to talk of the need for a

physical examination, while those in other sectors talked in terms of a combined physical and mental health assessment. The GP was seen to have an important role in the latter. Surprisingly few employers talked of the need for an investigation of the suicide remark, although those who had experienced such cases emphasised the need for immediate contact with the GP. Some employers expressed some doubt about the seriousness of the matter. One manager stated that:

> ***'People who say life is not worth living are usually making a cry for help, and are not saying they will do it.'*** (Employee Relations Officer, train company with more than 1,000 employees).

Employers in local authorities and the food sector identified the need for a risk assessment and full investigation of the possible link between Robert's back problem and his job. This was seen as particularly important by local authorities who talked of the need for investigation of his working conditions, desk, chair, PC and volume of work. The possibility of alternative work was considered by a small number of employers.

As in the case of Liz, the pen portrait was seen as unrealistic in one respect: many employers across sectors said that the problem would have been dealt with at earlier stage, through referral to and action by Occupational Health specialists. All employers saw a key role for occupational health and specialist diagnosis and treatment, if investigations through the GP were not progressing. Some employers referred to a need for treatment for depression or referral for counselling. Although this could be accessed through an EAP scheme or through the employer, the GP was seen as the preferred route in this case. Many employers said they would not have allowed such a case to continue for as long as two years and that they would have taken action on his attendance. Employers across sectors talked of termination of contract in such a case and a number expressed the view that such problems are often intractable. The following views from employers in two sectors typical:

> ***'In the end it doesn't matter if it is genuine or not. Our expectation is that attendance should be improved and ultimately if it isn't, it will lead to dismissal'.*** (HR Manager, local authority with more than 1,000 employees).

> ***'If there is no sign of him coming back, with or without any adjustments, he'd have to have his employment terminated'*** (OH Manager, health trust with more than 5,000 employees)

Most said they would terminate sick leave considerably earlier than two years, the time given in the pen portrait, unless on-going medical investigations were expected to soon reach a conclusion. Very few referred to the need to consider the terms of the DDA in such a case.

Serious mental health problems: the case of Ben: bi-polar affective disorder

While the cases of Robert and Liz were seen to combine the issues of health and performance, the case of Ben was seen as a medical issue, despite a performance issue being raised in the pen portrait. Whether Ben's serious mental health problem was

familiar or not depended largely on workplace size, with larger employers able to give an example of a similar case and smaller employers seeing it as a very unusual. As stated earlier, some employers suggested that his would be an unusual case for them because he would not have been recruited in the first place. While seeing the situation as serious, many employers did not see Ben's case as particularly problematic because it was seen as a question of sorting out his medication.

A key issue for employers was the ability of the line manager to deal with the issue, with many respondents referring to lack of confidence among managers over mental health matters. Whether the manager, HR or Occupational Health, knew of his existing condition was also seen as a critical factor in whether problems were seen as relating to mental health rather than performance. As a local authority employer observed,

> ***'In a trusting relationship where he has shared this information it's different from one where not much is known'.*** (HR Manager, local authority with more than 10,000 employees)

Some employers in the food sector feared that managers might treat the behaviour described in the pen portrait as a performance issue.

In larger organisations it was sometimes considered good practice for the line manager of a recruit with an on-going mental health problem to be informed of this and advised what to do if such problems arose. Respondents who said they would also prefer that the manager knew of a past mental health problem stated that any sharing of information would have to be with the consent of the individual. However, in others it was considered good practice for Occupational Health to keep such information to themselves and to act if problems actually arose. Sometimes, Occupational Health might decide to tell HR and the department simply that the individual had a medical problem, but that they were still suitable for the job; or they might be told nothing. Respondents in hospital trusts gave examples of employees whose mental health problems were known to them and not always to their managers. Some of these received on-going support from Occupational Health or from neighbouring trusts to preserve confidentiality. The Occupational Health specialist in a food and consumer products company talked of the dilemma in how much managers should know. He explained that,

> ***'The danger is that a manager will say "Ah ha, this person is not normal, let's go down the medical capability route". It's a balance between branding an individual with a label and the stigma of mental illness and trying to be helpful to the individual and their manager'.*** (Head of Occupational Health, food and health care company with more than 10,000 employees)

What would be done?

All employers saw the key issue as being whether Ben is taking his medication. Therefore, the problem was seen as being resolved through a medical check up and possible change to his regime. Whether or not the line manager was aware of his condition, and discussed it with him, most employers spoke in terms of putting him on a 'fast-track' to Occupational Health. Therefore, a key role was identified for

Occupational Health in making an assessment and then working with his GP, with his permission. The relative ease with which this could be done was seen to depend on his degree of insight. The question of his continuing employment, in the short and longer term was raised by employers: in local authorities the question was seen as whether he was fit to continue working in the short term, and to some extent in health where it was considered to be a question for occupational health to assess. However, others wanted to look at his suitability for the job more generally: some in the health sector referred to possible risk to patients or to Ben himself; in the rail, food and entertainments sectors concerns centred around the risk of accident with machinery or vehicles. For example, one theatre manager explained,

> ***'It's a health and safety issue: if he's a production assistant, he'll be dealing with scenery, electrical equipment. I think the issues are quite serious, and we'd have to deal with it fairly swiftly .The primary concern is health and safety, not just of the individual but of anyone else that is coming into the theatre'*** (Director, theatre with fewer than 50 employees);

A further area of risk was identified in dealing with the public in the rail and entertainments sector. Most employers were not specific about their concerns but referred to the stresses of dealing with the public. Most respondents thought it would be best for Ben to be signed off work for a relatively short period until his condition stabilised. Some felt it was best to keep him at work, but to change his duties, particularly in the rail sector where he would be taken away from a customer-facing role, probably permanently. One employer, in the food sector, thought his personal circumstances should be considered, explaining that,

> ***'If he lives alone then it would be better to have him at work where the workplace can offer some kind of support that might substitute for family care. He would be better being in work than being in a bedsit alone with all sorts of temptations, like drink and drugs*** (Head of Occupational Health, food company with more than 10,000 employees).

In addition to health issues, some employers wanted to look at the question of long hours, which appeared to stem from a concern with this issue in train and food companies, particularly with excessive overtime and the need to conform to working time regulations. In the entertainments sector the long hours culture was seen as damaging to mental health and it was therefore seen as necessary to monitor his workload and control his hours. Some respondents in the food sector suggested that Ben might be a substance mis-user, again probably reflecting concerns in the industry as much as mis-conceptions about mental health.

Serious mental health problems: the case of Emma: early signs of schizophrenia

Although the Emma pen portrait was intended to facilitate discussion of early recognition of mental health problems, it was perceived differently by many respondents: in local authorities, train and food companies it was seen as principally a case of bullying and harassment with possible mental health issues as secondary; in the health sector it was recognised as a possible serious mental health issue; and in the entertainments sector as personal or adolescent problems, possibly caused by an

underlying issue, but not necessarily mental health. Perhaps surprisingly, very few employers saw this as a case of inappropriate behaviour towards an individual experiencing mental health problems at work. This is probably because many did not interpret Emma's behaviour as a mental health problem. It was striking how many respondents were ready to explain Emma's behaviour in terms of adolescent problems or boredom and how many were unsympathetic to these. One employer in the food sector stated ***'At this age there are all sorts of problems'.***

Employers in local authorities, train and food companies identified the need to establish whether this was a case of bullying and harassment. This is possibly because, as large employers, many had policy on this issue and saw this as a case where it could be used. Emphasis was therefore placed on pursuing the bullying and harassment allegation, in particular about converting it from an informal to formal complaint, and about how this might be done. Some employers, particularly in train companies, saw this as dependent on the line manager, who might lack confidence in investigating the issue. In the entertainments sector a number of senior staff said they would investigate such a case themselves, and appeared to be confident about doing so.

If mental health issues, or 'personal problems' were seen as requiring investigation, respondents mentioned the question of insight, raised in the case of Ben. This was usually phrased in terms of whether she would accept help or needs support. However, most employers thought a referral to Occupational Health might be helpful, either to investigate possible mental health or 'personal' problems. However, some were concerned that this might be seen as compounding the colleague's bullying behaviour. Only those in the health sector felt a psychiatric referral would be necessary. Only employers in this sector talked in terms of sick leave and sometimes suspension if she did not comply. In some cases this reflected a degree of concern about risk, including to patients.

Whether Emma's case was seen as common depended on how it was perceived: if seen as bullying and harassment, it was seen as reasonably common, but if seen as a mental health problem it was seen as more unusual. It was also seen as problematic because the reasons for the changes in behaviour were both unknown, affected performance and involved others in the team. A number of employers said that such a case might lead to investigations over performance. One respondent remarked,

> ***'With a young girl day dreaming all day, its not so much of a problem because you really wouldn't put up with it for long, but in terms of getting to the root cause, it could be very difficult'.***(Health and Safety Manager, food company with more than 1,000 employees)

As in the cases of Liz and Robert, a number of employers said that action would have been taken in such a case before the period of 6 months described in the pen portrait. These were largely in the health sector, where the post that Emma was described as holding, that of a healthcare assistant, requires communication. However, some employers in other sectors also felt that a good manager should identify such a problem before 6 months, although were not necessarily confident that this would happen. Again, where workplaces or teams were small, as in entertainments or the food sector, such problems were seen as more readily identified.

Mental health in the workplace: key issues identified by employers

Discussion of the pen portraits high-lighted a number of key issues and concerns to employers. These are:

- Reluctance to let cases 'drag on' and the perceived need to take action at an early stage, including through measures to include attendance and performance;
- The importance of the skills of the line manager in identifying and dealing with stress and mental health problems;
- The role of occupational health departments and out-sourced services and the perceived need for these to be more decisive;
- A need for clarification of a GP's diagnosis of stress or work-related stress;
- Concern to establish the relative roles of work and the role of personal and domestic factors in stress and mental health;
- Willingness to provide assistance such as counselling or treatment if considered cost-effective, but the need for assurance that the employee is also taking steps towards 'helping themselves';
- Preference to keep employees in work where possible to prevent estrangement from the workplace;
- Some willingness to be flexible in allowing a phased return to work and adjusted duties;
- The need to place limits on the amount of time off allowed and assistance given with stress and mental health problems.

The most significant of these were the advantages of identifying stress and mental health problems at an early stage, the role of the line manager and the value of a clear diagnosis and prognosis. Discussions also identified some common attitudes, including how much assistance would be given to an employee with mental health problems, what factors might be considered and when it is legitimate to initiate procedures leading to dismissal. Following discussion of these issues, the paper concludes with a summary of the key findings and discussion of how management of stress and mental health could be improved.

Identifying stress and mental health problems: the role of the line manager

Many employers emphasised the importance of identifying stress and mental health problems before they escalated from minor into major problems for the individual and into extended periods of sickness absence. We have referred to the key role of line managers in identifying problems of stress and mental health through problems with attendance, punctuality, performance and behaviour. The effectiveness of day to day management in identifying problems was thought to depend to a great extent on the quality of the individual line manager's skills. A poor or unobservant manager might not notice an emerging problem and seek advice or assistance until it became serious.

Equally, some employers spoke about line managers' lack of expertise or willingness to deal with problems and their tendency to make a quick referral. As a result, the resources of some OH departments were reported to be seriously over-stretched. The need for managers to be aware of emerging problems and to take action at an appropriate point was therefore identified.

A number of publications aimed at employers include guidance on how to recognise stress in an individual (see, for example HSE, 2004). There was evidence that some employers had taken note of such guidance by issuing line managers guidelines with indicators for managers to look for. These include appearance, behaviour, intermittent absence and poor punctuality, inability to perform tasks and to meet deadlines and conflict with other members of staff. Guidelines were usually issued in written form rather than through training, although managers in some sectors, for example health, and a small number in entertainment, had been given training in recognising such problems. A number of respondents saw a need for the use of more formal and systematic ways of identifying stress and mental health problems. However, some scepticism was reported from managers about the need for guidance on such matters. The HR manager of one food manufacturer stated it was 'common sense' and that managers can probably resolve many problems using their own resources. The danger with this approach is that potentially serious problems could be overlooked because of a manager's assessment. It was noted earlier that many employers did not comment on the suicide remark referred to in the pen portrait of Robert, or expressed scepticism. Although their responses to a pen portrait may not reflect what they would do, or advise a manager to do, in such a situation, this indicates the need for training and guidance on recognising potentially serious situations and knowing what steps to take.

The usual points for referral were HR and Occupational Health. HR or Employee Relations managers were more likely to be involved where a problem was seen as relating to performance rather than health, or to involve relations between staff, for example bullying and harassment. Where problems were seen as medical, employees were likely to be 'fast-tracked' to Occupational Health. A potential problem can be identified in line managers' ability to distinguish between a stress or mental health problem and a performance problem. A number of employers made this observation in discussing the pen portraits. One manager in a food company described the case of an employee they had dismissed for poor time-keeping who they later discovered had suffered a serious depressive episode before joining the firm. He said that, had this been known, the company could have worked with her on the issue (although he added that they would probably not have recruited her in the first place). Some employers felt there was then an obligation on employees to disclose their mental health problem. A number of employers saw a safety net in the ability of employees to refer themselves directly to HR or Occupational Health. Some employers and HR departments appeared to make this more accessible to staff than others by regular informal contact between HR and other departments.

Some employers encouraged direct access to HR professionals, because of the limited skills of line managers in relation to stress and mental health. HR departments were seen as professional, to have a degree of 'neutrality' and to be staffed by women, who were assumed to be better at dealing with such problems than men, particularly at encouraging employees to 'open up'. Some employers saw this as appropriate, seeing

a potential problem in line managers 'taking on too much'. As a Medical Officer in the food sector argued:

> ***'Managers can take on more of a role than they should do and put themselves under strain. They should provide sympathy and support but shouldn't be a surrogate parent or counsellor'.*** (Head of Occupational Health, food and healthcare company with more than 10,000 employees)

At the same time, some senior managers interviewed talked of the stress of dealing with employees' stress and mental health problems, particularly in smaller workplaces, and felt that they themselves could benefit from some kind of support, or supervision. Some felt isolated and unsupported in their role. One senior theatre manager expressed this as follows:

> ***'Because I answer to a volunteer Board of Directors, on a day-to-day basis nobody will notice if I was under stress or difficulties, and I think this is a real killing field for this sector'*** (Director, theatre with fewer than 50 employees).

The research findings suggest that managers could benefit from more guidance on what to do when an employee experiences mental health problems. This might be delivered best through training rather than through the distribution of guidelines which can be ignored or lost. There are a considerable number of guides to recognising stress and mental health. In addition, training should include communication skills based on counselling techniques, particularly listening skills. Clearly, an employee may not wish to discuss their mental health problems with their line manager, and other sources of assistance should be open to these staff, including EAPs, Occupational Health and HR departments and counsellors. These routes were available to employees in many of the organisations visited, but the extent of assistance available was not always clear. There was evidence of rationing, based on perceptions of need and on assessments of the employee's value to the organisation. This was driven by considerations of cost. As Professor Richard Layard argues, in his paper to the Downing Street Strategy Unit, there is a need to expand NHS provision of counselling to meet demand. Professor Layard estimates a need for 10,000 extra therapists, including clinical psychologists to provide counselling, in particular cognitive behavioural therapy. This is seen to have the potential to enable people with common mental health problems to return to work and avoid the slide into long-term unemployment. Layard also calls for additional psychiatric training of GPs, the involvement of private providers and provision of self-help materials (see Layard, 2004). It is widely anticipated that these recommendations will soon be given backing by the Department of Health (see Guardian, 2005).

Clarification, diagnosis and prognosis: the role of GPs and occupational health departments

Employers referred to the need for clarification over diagnosis. This was raised in relation to the pen portraits of Liz, with a diagnosis of 'stress' and of Robert with combined musculo-skeletal and mental health problems. It was also raised by employers when discussing the role of the GP. A diagnosis was seen as potentially

helpful in estimating how much leave would need to be taken, and also the individual's continuing suitability for the job. However, many employers were critical of GPs. They were seen as too ready to make a diagnosis of work-related stress without sufficient understanding of the situation.

Employers complained that GPs' sick notes are frequently uninformative. They found diagnoses of 'workplace stress', or even 'stress' as unhelpful. Employers also complained of 'vague' diagnoses, such as 'lethargy' or 'debility' and believed that these were made to avoid the stigma of a diagnosis of depression or stress. GPs' diagnoses, particularly of 'stress' and 'work-related stress' were seen as unhelpful, partly because many employers did not believe that the root causes of many employees with stress and mental health problems were work-related. It was also because prognosis and treatment was unclear, and potentially lengthy.

A number of employers made the point that GPs receive little training in occupational health and rarely know enough about the nature of the work to make a judgement of its impact on the employee's mental health. Therefore, it was believed that the GP was inclined to take what the employee said about work at face value and did not explore other possible causes of stress and mental health problems. The Social Exclusion Unit refers to problems in the occupational health role of GPs, including the reluctance of many GPs to perform the sickness certification role (SEU, 2004). There is also evidence that GPs may under-diagnose depression because of lack of skills and time (see Tylee and Jones, 2005). At the same time, employers report increasing diagnoses of stress, and particularly 'work-related stress'. This suggests that GPs may be more inclined to record depression in such ways.

Many employers believed that GPs make a diagnosis of work-related stress in order to legitimise time off work, which they believed would benefit the employee. It was sometimes argued that GPs are too ready to sign employees off for protracted periods when an early return to work would be beneficial for their mental health. According to one employer, a good GP will try to keep an employee at work and even make contact with the employer to discuss the possibility of alternative work. He explained that,

> ***'A GP has between 8 and 10 minutes to see someone and patients are really only happy leaving either with a sick note or a prescription. They're under pressure to meet targets and just don't have time to spend with each patient. As a result they end up at home, watching day-time TV and it becomes more and more difficult for them to return to a normal working day'*** (Occupational Health Manager, food company with more than 5,000 employees)

The present situation, where there is little dialogue between GPS and employers appears to lead to a silent tug of war rather than discussion of what is best for the employee, given his or her condition and the nature of their work.

Partly because of the perceived shortcomings of GPs, employers' own occupational health services were seen to play a crucial role in relation to mental health and stress cases, which included diagnosis and opinion about when an individual could be expected to resume work. Although the occupational health set up varied widely between organisations, the core work included looking into diagnoses and ensuring

treatment was being given. As stated earlier, other functions include medical screening in recruitment. Most organisations out-sourced at least some occupational health functions, particularly diagnosis of conditions such as musculo-skeletal pain. One local authority employer explained why it had recently hired the services of a private consultant in this area:

> ***'They can tell if someone is swinging the led, whereas before there was no way we could do anything if the GP said that was what they had, and in the end we had to go down the capability route'.*** (Health and Safety Manager, local authority with more than 10,000 employees)

Much of the discussion about occupational health provision concerned the relative advantages of contracting out the service to a private health provider, or running an in-house service. Varying opinions were expressed, but dissatisfaction with contracted out provision was frequently expressed. In local authorities and in some train companies outsourced services were seen to be insufficiently decisive and tend to take the side of the employee. One HR manager complained that

> ***'You rarely have an OHU that carries out an effective service. They aren't prepared to say "there isn't anything wrong with this individual and they can return to work".*** (HR Manager, local authority with more than 10,000 employees)

This reluctance was seen to arise from a concern that an individual returning too early might suffer adversely and then cite this in a legal case against the authority. Another employer explained that the authority had changed providers because,

> ***'They were too employee-focused and not balanced enough. They were into welfare rather than farewell and we are into farewell rather than welfare.*** (HR Manager, local authority with more than 1,000 employees)

This same frustration was expressed by some employers in the rail sector who expressed frustration about the time taken to resolve cases of long term absence, and in particular their reluctance to terminate an individual's employment contract. The HR Director of one company asked,

> ***'I wonder, is [the private health company] taking the line of least resistance? I feel they need to be a bit sharper and bring some of the more difficult, long-term cases to a conclusion. I don't doubt they are genuine, but they still need to be concluded'.*** (HR Director, train company with more than 10,000 employees)

Such complaints were less usual in the food sector, where occupational health services were more often in-house, and seen to have a better 'business focus'. However, the belief among some HR respondents that occupational health services are too 'employee focused' was also made in relation to in-house services, and in relation to recruitment (see earlier). Out-sourced services were also seen as poorer in relation to health promotion. However, the evidence for this is unclear, since companies even in the food sector were not necessarily better at health promotion than those who out-sourced the work.

In the health sector, where most respondents were occupational health specialists, they saw themselves as having a position of some objectivity in arriving at solutions which might meet the needs of both employee and employer. We did not obtain the perspective of HR managers in the health sector, and it is possible that these would have similar criticisms of occupational health as in other sectors. Employers' criticisms with occupational health may stem from an unrealistic perception of their role, and an expectation that they should put the needs of the business first. It may also stem from a belief that occupational health is failing to identify invalid cases or to rule out a work-related element.

When does welfare change to farewell?

The forms of assistance, such as counselling and EAPs were described earlier. In addition to these, employers talked of their willingness to assist with rehabilitation to keep an individual in work. In local authorities, train companies and health authorities, employers offered a gradual return to work in order to build up resilience. A small number said they had a Return to Work programme for employees returning after a physical or mental health problem, consisting of a 12 week package of gradual return to duties, which was reported to be very successful. In addition to such formal arrangements a number of employers said that additional support would be given to ensure that someone returning to employment was not over-loaded. Some respondents emphasised that such allowances would be relatively short-term because of the additional costs involved. An occupational health manager for a train company explained,

> ***'We support rehabilitation but there has to be an end game. We will agree to a phased return to work but only if there is an end in sight….Stress can be spinned out and you sometimes need to have a sharp word with them. Ultimately, it has to be a business decision'.*** (Occupational health manager, train company with more than 1,000 employees)

Redeployment was another option offered by some employers to individuals who cannot resume their previous employment following a period of leave and who were in danger of being dismissed for incapacity. This option was referred to by employers in the health sector and local authorities who saw scope for this option because of the range of jobs available. Employers in train companies also referred to redeployment, although said it was sometimes problematic, particularly where it involved individuals working below their skill level, even though salaries were usually protected.

Many employers expressed a willingness to go some way towards helping an employee to overcome mental health problems. However, they were concerned to place limits on this, and particularly on the amount of paid leave they were prepared to allow. A number of respondents expressed frustration over the management of long term absence. Common complaints concerned the time taken for referrals, diagnoses and treatment, including for stress and mental health. GPs were seen as particularly slow in dealing with such cases. A number of respondents said that, where individuals were dismissed, this was often because of slow progress with diagnosis and then treatment. Several said that they had dismissed employees with conditions such as depression on grounds of capability. These included employees who were considered

by their GP to have a temporary condition, but where the employer was not prepared to wait for an improvement. One HR manager explained,

> ***'It's an enough is enough idea, because there is a big push on absence in this authority and while there is sympathy for repeat absence due to stress, the message from most senior managers is it doesn't matter how good you are, if you're not there you're no good to them'.*** (HR Manager, local authority with more than 1,000 employees)

One HR manager felt that such employees are often let down by the NHS which was found to be too slow in offering treatment and appropriate care for people with problems of stress and mental health. It was thought that an earlier intervention from the GP would reduce the time off sick and therefore allow an individual to keep their job. Such interventions might include counselling, such as cognitive behavioural therapy which, as stated above, is seen to have potential to enable people experiencing problems to return to work (see Layard, 2004).

A number of employers said the most problematic situation for them was when an employee, on sick leave for a stress or mental health problem, does not communicate with them. Some employers said they aimed to keep in regular contact with employees on long term sick leave, including for stress and mental health problems. Some companies felt it was good practice for HR staff to visit employees at home, emphasising that this has to be with the employee's consent. A review of evidence by the Sainsbury Centre for Mental Health suggests that supervisor contact can accelerate return to work if this is well-developed and pro-active, but that it is not effective among more depressed employees (see Seymour and Grove, 2005). Therefore, as the authors point out, much may depend on managers' capability to deal appropriately with employees absent with mental health problems.

Employers found it problematic when such employees avoid contact with the company. One manager argued that ***'If you haven't got any dialogue, you've got nothing to go on'*** (Employee Relations Officer, train company with more than 1,000 employees). There were indications that some employers may have unrealistic expectations of employees with stress and mental health problems in relation to communication during sickness absence for such problems. They appeared to be unaware that avoidance of social contact is often a feature of mental health problems. Several employers gave examples of employees on who refused any contact during sickness absence. It was usually assumed that the employee was being obstructive. Some employers had only realised later, once the individual had been dismissed, that difficulties of communication might be the result of mental health problems. A different perspective was advanced by one local authority HR manager who believed that employers were also at times to blame in such cases. He felt that insufficient effort is made to retain contact with an employee on sick leave. He stated that,

> ***'It is not good enough for an employer to say they wrote five times to an employee when they were sick and that they didn't reply so they had to terminate their contract….. There are lots of things you can do. They have friends in the organisation, you can ask them to talk to them, you can write to them informally and ask to meet up for coffee or to visit them at home,***

> ***accompanied by someone else. You can write to their GP and say you're concerned that they're not answering letters. You should keep coming back and not give up. No employee is worth giving up on until you are absolutely at the end of what you can do.'*** (HR Manager, local authority with more than 10,000 employees)

Clearly, an employee on sick leave should be given space to rest and recover, but low key and friendly contact from the workplace, including through work colleagues and friends, is likely to be helpful in providing support and in ensuring that the link with the workplace is not lost. The employee is then likely to find it easier to return to work when they feel sufficiently well.

The length of sick leave was an issue for all employers. Sick pay arrangements were dependent on service and were also discretionary, leaving employers the right to terminate the arrangements and an individual's contract of employment. Employers talked of the difficulties presented by cases of long term sick leave and particularly in knowing when it is reasonable to terminate a contract of employment on grounds of capability. One HR Manager in the food sector stated that her only interest in the research findings was in how other companies dealt with such cases, and when they said 'enough is enough' to an employee on long term sick leave. Some employers appeared to take a more hard line approach in cases of mental health and stress, and were more ready to terminate employment than for physical illness. One HR Manager said the company were concerned not to 'set a precedent' in such cases.

Conclusions: what is needed to improve the management of mental health and stress at work?

Stress is seen as a key issue, mental health is not

Stress at work is taken seriously by employers because of the legal and enforcement framework and initiatives aimed particularly at reducing work-related stress. Stress was seen to be common, although many employers did not measure its incidence. The relationship between stress and mental health was not well-understood, but some employers were concerned to draw a distinction between stress and mental health disorders, in terms of their relative incidence and nature. Therefore, many employers said they rarely encountered the more serious mental health conditions. There was a widespread belief that stress could be work-related (although in the private sector it was believed to be largely unrelated to work), and that mental health problems were not. Both because it is related to work, and because some claims of stress were believed to be false, stress was seen as possible to control and to reduce.

Stress policies were most common in the public sector and least common among smaller employers. They were seen to be useful in demonstrating 'duty of care', including meeting industry requirements or showing 'good practice'. In addition to stress policies, mental health and stress were seen as covered by sickness absence and managing for absence procedures. Only a small number of employers had a policy on mental health or a health policy with a mental health element, and most of these were local authorities who are encouraged in this work by their employers' organisation.

Although employers with stress policies thought it was necessary to have these, a number said that practical guidelines were more useful than policies. Employees were sometimes made aware of stress policies, but few organisations carried out any health promotion work covering stress and mental health. This is surprising when initiatives promoting physical well-being, for example subsidised gym membership and blood pressure checks are reasonably common. There is scope for extending such programmes to encompass well-being more widely, to include mental health. Indeed, there is a strong business case for improved provision for psychological health: sick leave and turnover among employees through poor mental health is a waste of human resources (see Department of Health, 2002). In addition, as Mind points out, all employees have mental health needs and measures to support people with particular problems are likely to benefit others (Mind, 2000b).

Recruitment of people with mental health problems

Previous research has looked in greater depth at the issue of recruitment (see Read and Baker, 1996; Fenton *et al*, 2003) but does not identify what appears to be a key factor in the use of medical questionnaires. Recruitment decisions, following declaration on such forms, were said to depend on the nature of the mental health problem and the job applied for. There was evidence that applicants with a history of mental health problems might be rejected for jobs involving contact with people and with machinery, particularly in the private sector. A number of employers had stereotyped views about mental illness. The findings suggest a need for improved knowledge about mental health among employers. Of particular importance is the need for employers to consider the suitability of the applicant for the job and possible adjustments, in line with the requirements of the Disability Discrimination Act. Occupational health departments were said to be concerned to meet the requirements of the Disability Discrimination Act, but this was not always with the approval of some HR managers who talked of the 'business case' against recruitment.

Where employees with mental health problems were recruited, there was concern from occupational health and HR departments about how much, if anything, the line manager should know. Greater knowledge was seen to have the benefit of allowing problems to be identified at an early stage and for assistance to be given, but could lead to unfair treatment. The question of disclosure is seen as an important issue by mental health organisations and one in which advise is available to service users. It is also an area in which employers might benefit from guidance from mental health organisations.

The perceived roles of work and home in mental health

Many employers were of the view that stress and common mental health problems have their roots in the personal and domestic lives of employees and were keen to make a distinction between such problems and work-related stress. Although usually sympathetic to home-related problems and sometimes willing to assist, there was a limit to how far this extended and how tolerant an employer might be of poor performance and frequent absence. In reality, however, the distinction between home and work is likely to be over-simplistic. Problems in the two spheres interact to result in poor mental health, particularly in a susceptible individual. Some employers recognised this more complex picture: these were principally the public sector where

this view was promoted by the employers' organisation, and smaller employers in theatres and orchestras who learned this through following a 'person-centred approach'. A recognition that mental health problems are intricate in both cause and effect, could lead to a stronger emphasis on the individual and on measures which might assist in their recovery. This approach is unlikely to be widely adopted while employers continue to dichotomise problems at work and those at home, and focus on legal obligations.

Identifying stress and mental health problems among employees

Employers' principal concern with stress and mental health is with levels of sickness absence, and the principal way in which stress and mental health problems were identified and brought to the attention of HR and occupational health professionals was through absence. Stress and mental health problems were also identified through changes in performance and behaviour. Although many employers said they treated physical and mental health in the same way, they saw the need for earlier intervention with stress and mental health and to identify false claims. In discussing the pen portraits many employers talked of using measures to improve attendance and performance. Mental health was therefore viewed within a performance framework as well as within one of health. The emphasis was on preventing long term sickness absence, but a small number of employers felt that it was sometimes necessary for employees to be encouraged to take time out of the workplace to assist recovery. However, they did not appear to have any guidelines for when time off might be more beneficial than staying at work, and might benefit from such help.

The management of mental health and stress at work: how could it be improved?

One of the key findings of the research concerns the management of mental health: there was evidence of inadequate management of such problems. The findings support the view expressed in the Mind enquiry into employment and mental health, and also by the Work Foundation that employers feel under-prepared and under-informed in dealing with mental health issues (Mind, 2000a; Diffley, 2003). The effectiveness of day to day management in identifying and dealing with common mental health problems at work was said to vary according to the skills of the manager and relationship with the employee. This is likely to lead to inconsistent treatment of employees and to discrimination, particularly where mental health problems are not recognised and are treated as poor performance. Some employers said that good management and an individual approach was most important when dealing with stress and mental health at work. However, at the same time, organisations who had introduced procedures, rather than policy alone, believed these were useful.

Management guidelines on dealing with mental health and stress at work are widely available from a range of organisations (see Mind, 2000b and Royal College of Psychiatrists, 2002). However, they do not seem to be widely adopted. Their use can demonstrate commitment from senior management to improving treatment of people with mental health problems at work. The introduction of such guidelines into a workplace is likely to have more impact and effectiveness if accompanied with management training. One reason for this is the degree of cynicism about stress and common mental health problems which may make some managers resistant to adopting guidelines without training. The Department of Health recommended more

training and education of both management and workforce on mental health issues almost ten years ago (DOH/MORI, 1996). There would appear to be a particular need for guidance in identifying mental health problems so that they are not treated simply as poor performance.

Assistance to employees with common mental health problems

The principal types of assistance made available to employees were Employee Assistance Programmes (EAP) and counselling. Other forms of specialist support, such as private treatment, were largely limited to highly skilled employees. EAPs were seen largely as fulfilling the employer's duty of care or as a non-pay benefit or perk. The availability of counselling varied greatly between sectors and organisations, with greater availability in the health sector than elsewhere. In smaller organisations there was little access to counselling or other specialist support, supporting the findings of the recent review by the Sainsbury Centre (see Seymour and Grove, 2005). Although many organisations across industry sectors said they offered counselling, this often consisted of first-line counselling by an occupational health nurse with limited counselling training. This is undoubtedly helpful to some employees and previous research suggests it may help some problems from escalating (see Secker and Membrey, 2003). Some local authorities and train companies were training staff in basic counselling skills, which may also be of some help where employees are experiencing relatively minor problems. However, a course of counselling is more likely to benefit an individual experiencing a common mental health problem than brief interventions of this type.

Many employers saw counselling as potentially effective but were concerned about the cost. Therefore, it was often limited to key groups or after traumatic incidents. Organisations including Mind and the Social Exclusion Unit have referred to the cost savings to be made in supporting current employees rather than paying the costs incurred through dismissal and recruitment (see SEU, 2004; Robertson, 2005). However, many employers feel that the costs of private counselling are too high. The potential benefits of increased availability of counselling, particularly cognitive behavioural therapy, have been the subject of recent policy discussions, particularly following Richard Layard's submission to the Downing Street Strategy Unit (see Layard, 2004). It is speculated that the Department of Health may respond with plans to expand NHS provision (see Guardian, 2005). It is likely that many employers would welcome the availability of such a resource, and might be prepared to cover some of the costs, for example by allowing time off work to attend sessions, if they were convinced of the benefits.

Clarification, diagnosis and prognosis

Employers would like GPs to diagnose stress or work-related stress less frequently and to make clearer diagnoses. At the same time, GPS may be concerned to protect patients from the stigma of mental illness. In addition, a diagnosis may not necessarily tell the employer much about individual employability or support needs. These have to be explored on an individual basis. There is nonetheless a need for improved communication between employees and GPs to assist employees in returning to work and to prevent job loss when can result from protracted sickness abssnce. Employers would like GP involvement in assessments about capacity to work, but this may be in

conflict with the GP's role in patient care. It may also be unrealistic of employers to expect greater predictability in the progress and resolution of mental health problems. This may indicate a need for greater understanding of mental health among employers through information and training. At the same time, there may be a need for GPs and psychiatrists to be better informed about the adverse effects of protracted sickness absence and the potential benefits of staying at work through a period of poor mental health.

Welfare approaches change to dismissal procedures when employers see little prospect of an employee returning to work within an acceptable time-scale. Delays in diagnosis and treatment extend absence and lead employers to lose patience. A further issue which leads to dismissal is breakdown in communication with employees on sickness absence. This is an area where employers' expectations may be unrealistic, given that mental health problems can lead to social withdrawal, and where they might benefit from guidance. Employers in the public sector had rehabilitation measures in place. There would appear to be scope for more extended use of flexible and part-time working for employees experiencing problems, to keep them in work and to prevent the estrangement which appears to result in dismissal.

Overall conclusions

There is a business case for improving employment practice, first to prevent discrimination against people who have experienced mental health problems at the recruitment stage. These could be productive employees, often with very little adaptation to the job. Employers have shown a willingness to be flexible to meet the needs of other employees, for example in allowing part-time and flexible working for parents. Therefore, provision for people with mental health problems may not involve a seismic shift in employers' practice. A business case also exists in practices surrounding the retention of people with mental health problems, in avoiding the financial and human cost of dismissal.

The findings highlight the importance of the management of common mental health problems in keeping people experiencing such difficulties in the workplace. Employers are concerned to reduce levels of sickness absence, and are frustrated by the uncertainty surrounding absence for common mental health problems. The research findings suggest a need for improvements in current practice in identifying and addressing mental health problems, both common and serious, through training, particularly of line managers. The research identified a strong tendency among employers to distinguish work-related stress from home or personal problems. This appears to stem from a growing concern about legal responsibility, in the light of successful claims over work-related stress. Although the distinction between home and work is made to identify any responsibility on the part of the employer for the individual's problems, in the case of common mental health problems it is likely to be false and unhelpful to the individual. Even mild mental health problems may invade all aspects of life. Susceptibility to mental health problems varies greatly between individuals and it may be impossible to pin-point the cause in either work or home. Yet the distinction between work-related and personal or home problems is used as a basis for decisions about support. Employers are concerned to place limits on the

support they offer to employees, yet some forms of assistance, such as counselling and changes in working arrangements may avoid the costs associated with lengthy sick leave, dismissal and replacement. Improvement of current practice in these areas and the promotion of good mental health are likely to have wider benefits, including in performance and retention. These are likely to extend beyond employees experiencing problems to the workforce as a whole.

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