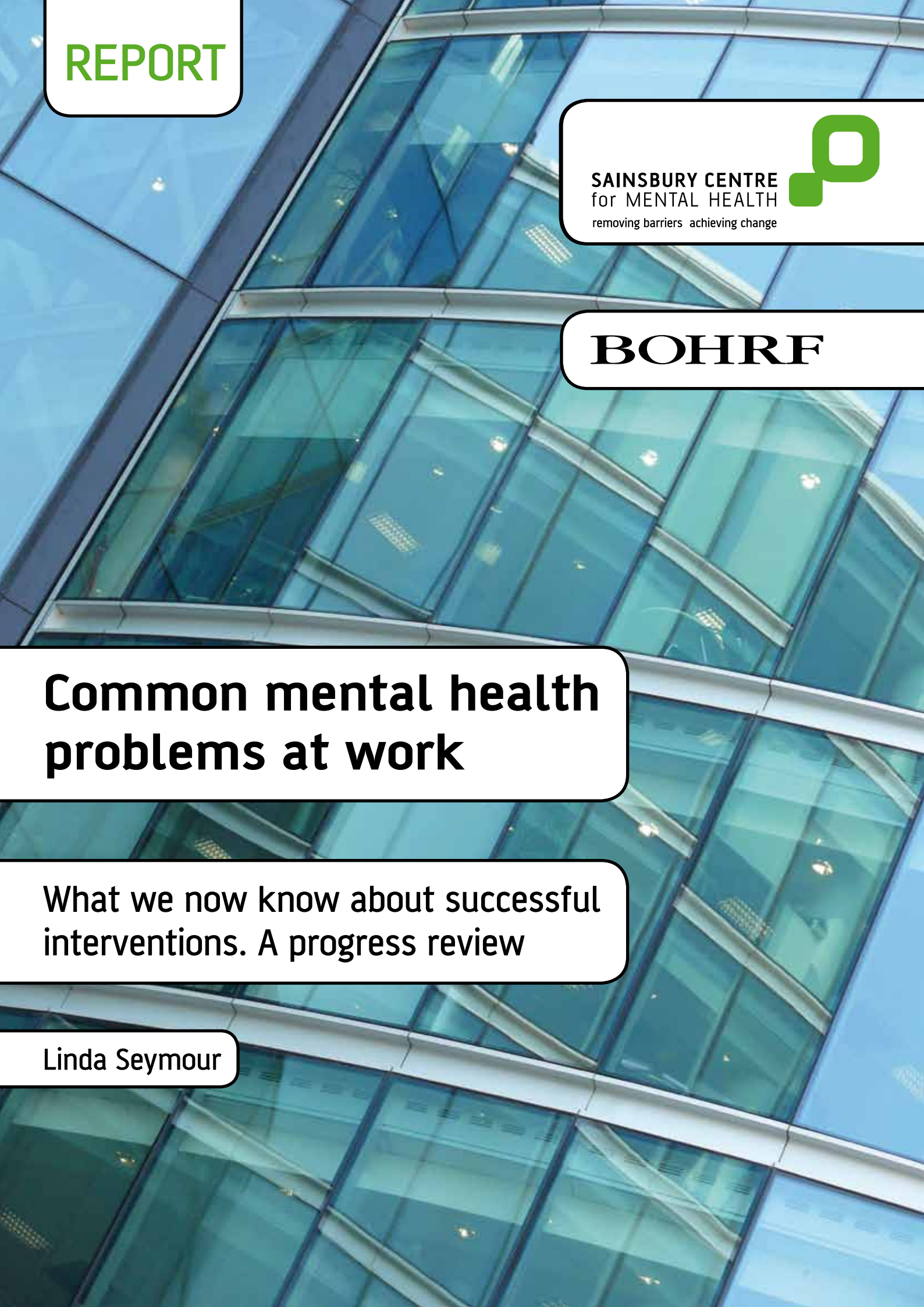

REPORT

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change

BOHRF

Common mental health problems at work

What we now know about successful interventions. A progress review

Linda Seymour

Executive summary

Common mental health problems, such as anxiety or depression, are widespread in the general population and together they are the predominant health problem of working age (HWWB, 2009). In 2005 the British Occupational Health Research Foundation (BOHRF) published a systematic evidence review of published evidence for effective interventions that help people with these conditions to remain in or return to work. The report was written by Sainsbury Centre staff (Seymour & Grove, 2005).

This paper presents the results of an update of that review, examining papers published between 2004 and the end of 2008. We searched the international literature published in English during those years, using key databases and a range of search terms. We selected relevant papers, examined further references of interest and subjected the chosen studies to scrutiny by a panel of experts. This process produced a total of six papers, published within our timeframe, which provided high quality evidence in the area of interest. We have reviewed the findings of the updated evidence against the backdrop of recent developments in policy and practice, as well as an increasing understanding and concern about the human and economic costs associated with mental health problems and work.

Key messages for research, policy and practice

- **People do not have to be entirely symptom free to remain in or return to work successfully.**

Several effective interventions focus on how to stay at work with common mental health problems rather than manage health problems to be fit to return to work. The severity of a person's mental health condition is a key variable, but there are also associations with inadequate access to appropriate therapies and the lack of early efforts to encourage a return to work. The evidence suggests that it is important to differentiate occupational goals from clinical goals and understand that the former is not necessarily dependent on the latter. Therefore less emphasis needs to be placed on employees being symptom-free before returning to work.

- **The workplace is not the only setting for the delivery of appropriate and effective interventions for the management of common mental health problems among working age people.**

The workplace has an important role to play in the management of employee mental health problems, but it is not the sole or principal setting for the delivery of effective interventions. Indeed none of the new studies looked at interventions provided in workplaces. An ongoing UK workplace study is outlined on p8. Nevertheless, policy initiatives such as *Working our Way to Better Mental Health* (HWWB, 2009) have positioned workplaces centre stage on this issue. Partnerships between employers, employees and a range of practitioners can help to maximise the retention and rehabilitation of people with common mental health problems.

- **Different practitioners have valuable and complementary roles to play, in order to achieve positive work outcomes.**

The *NHS Health and Wellbeing Review* (DH, 2009a) made a series of recommendations on the role, function and professional development for occupational health. Evidence from programmes carried out in the Netherlands demonstrates the impact on retention and rehabilitation of timely interventions by occupational health physicians trained and skilled in mental health awareness and with an emphasis on return to work.

Working our Way to Better Mental Health (HWWB, 2009) recognises that primary care has a central role to play in the retention and rehabilitation of employees with common mental health problems. A revised medical statement – the *fit note* – now enables GPs to provide better return-to-work advice for patients to share with employers. Studies in our update focusing on the role of primary care in helping people with common mental health problems back to work present a mixed picture, with no demonstrable effect on return to work rates in the two relevant studies. But there are lessons to be learned even from ineffective interventions, such as the importance of GPs having sufficient time available to implement relevant skills and being able to call upon specialist expertise from occupational health or employment advisers.

- **Independent case management (ICM) by third party specialists, such as labour experts or employment advisers, is critical to achieving successful outcomes for individuals and organisations where employees are not recovering as expected.**

Recent studies have demonstrated the efficacy of third party roles such as employment advisers, which are already in use in the UK. They offer a skilled brokerage service, with vocational and psychological support, to enable the retention and rehabilitation of employees with common mental health problems. The evidence showed that ICM was more effective in producing positive employment outcomes than talking therapies alone; an approach that supports the current policy of integrating employment advisers within the Improving Access to Psychological Therapies (IAPT) programme. The evidence indicates that delivering psychological therapies without some form of employment-focused case management will not produce positive work outcomes for working age adults with common mental health problems.

- **Line managers have a crucial role in supporting employees with common mental health problems to remain in or return to work and they need effective skills development and training to enable them to do so.**

The line manager has a key role in the liaison between employees with common mental health problems, management and occupational health or primary care practitioners. This gap in the evidence base was recognised in the 2005 review and Sainsbury Centre is now developing relevant approaches and interventions to address this omission (see www.impactondepression.co.uk).

- **The need remains for research conducted in the United Kingdom that evaluates interventions that deliver early effective return to work for people who have experienced a period of mental ill health; and also interventions that help to maintain people with common mental health problems in work.**

Research in the UK in this area has not advanced significantly since the 2005 review. Much of the evidence covered in this report comes from research conducted outside the UK and it cannot be assumed that the results of these studies are directly transferable to the UK. The interventions in our identified studies focus on employment outcomes for people with common mental health problems and would benefit from being tested in a UK context. Nevertheless, there is a sufficient body of evidence to inform the development of important services and interventions that can keep people with common mental health problems in work or facilitate their return to work.

Introduction

In 2005 the British Occupational Health Research Foundation (BOHRF) published a systematic evidence review of published evidence for effective interventions that help people with these conditions to remain in or return to work. The report was written by Sainsbury Centre staff (Seymour & Grove, 2005). Copies of the report and summaries can be downloaded from www.bohrf.org.uk.

We defined common mental health problems as those that are especially prevalent in the general population and best described by the categories of depression or anxiety, which often occur together. This review concluded that there was a dearth of relevant research, a view supported by commentators in related disciplines (Waddell *et al.*, 2008).

Since we carried out that review there have been advances in policy and an increasing understanding and concern about the human and economic costs associated with mental health problems and work (HWWB, 2009; NICE, 2009a; Dewe & Kompier, 2008; Sainsbury Centre, 2007). We have now surveyed the research literature to update the 2005 systematic review and have examined a broad range of evidence, published in the last five years, about the management of common mental health problems in the working age population.

This paper presents the outcome of that review and discusses some of the key points of evidence that support developments to improve the management of common mental health problems among working age people. We describe several innovative interventions,

evidence for which is sound enough to support their implementation and evaluation in the UK.

Details of the methodology used in each review are given in a separate paper available from www.scmh.org.uk/employment.

Common mental health problems at work

Common mental health problems are widespread and debilitating. Surveys carried out in Great Britain and internationally indicate that at any one time about one adult in six in the general population has a condition such as anxiety or depression. Incidence is higher among women and in people aged 45-54 years and there appears to be an upward trend in their rates over the last 15 years (Deverill & King, 2009). About three-quarters of adults with a common mental health problem are not in receipt of medication or counselling, including two thirds of those assessed as having a level of symptoms sufficient to warrant treatment (Deverill & King, 2009).

These levels of prevalence are mirrored among working age adults. At any one time nearly one worker in six will be experiencing depression, anxiety or problems related to stress. This increases to one in five when drug or alcohol dependence are included (Sainsbury Centre, 2007).

Although most of these mental health problems are unrelated to issues at work (HSE, 2007), there may be associations with workplace conditions such as long work hours, work overload, lack of control over work, lack of participation in decision making, poor social support and unclear management and work role, with some correlation with poor management style (Michie & Williams, 2003; Stansfeld, 2002; Berkels *et al.*, 2004; Sanderson & Andrews, 2006). High demands and low support at work have been shown to be predictive of depressive symptoms worsening, independent of individual personality traits (Paterniti *et al.*, 2002). Women are at risk of increased depression and anxiety if the management style at their workplace is not inclusive or considerate; and male employees are more at risk if they feel excluded from decision making (Kivimaki *et al.*, 2003a; Ylippaavalniemi *et al.*, 2005; Kivimaki *et al.*, 2003b).

Against the backdrop of an economic recession and a labour market under pressure, people may increasingly be underemployed – that is involuntarily working part-time or for a wage at or below the poverty level because they have lost their former employment. Underemployment is an independent risk factor for worsening mental health and such suboptimal jobs may contribute to depression (Dooly *et al.*, 2000; Friedland & Price, 2003).

The changing nature of work itself adds another layer of risk to mental health. For example atypical work, such as seasonal or casual work or fixed-term or subsidised jobs for people moving off benefits linked to unemployment support, is associated with significantly worse mental health (Sanderson & Andrews; 2006).

In summary, common mental health problems are the dominant health problem in the working age population (HWWB, 2009). Despite high rates of mental ill health, there are indications that almost half of employers think between none and one in twenty of their employees will ever experience a mental health problem during their working lives (Shaw Trust, 2006).

Low awareness among employers about the extent mental ill health, coupled with inadequate levels of treatment for those with these conditions and pervasive stigmatising public attitudes towards mental health problems (TNS Social, 2009), result in the perpetuation of a set of circumstances that are personally and financially costly to individuals, their families and their workplaces. An effective approach to the management of common mental health problems in the workplace could minimise or avert many of the related problems and costs associated with staff turnover, absenteeism and presenteeism (Sainsbury Centre, 2007; Sanderson & Andrews, 2006; Hilton, 2007). But what evidence is there for effective interventions?

The 2005 BOHRF review

The themes of the 2005 review (Seymour & Grove, 2005) were prevention, retention and rehabilitation. We were looking for high quality research papers that provided evidence on the effectiveness of interventions that helped to prevent common mental health problems in the

working age population, or that helped people with these problems to remain in or return to work. We searched the international literature published in English between 1980 and 2004 using key databases and a range of search terms. Over 15,000 references were identified and these were initially reduced to just over 200 papers and finally to 111 relevant papers. 31 papers met the final critical appraisal criteria following the judgement of a panel of experts.

While the review found a large amount of literature on common mental health problems among the working age population, there was a scarcity of evidence for effective interventions that directly addressed their management in the workplace. There was a focus on clinical outcomes that aimed to improve mental health, rather than on work outcomes, such as job retention or return to work. The programmes described in the review covered those primarily delivered in the workplace, and a few in other settings such as primary care.

The main overall finding of the review was that poorly targeted interventions had little effect on prevention, retention or rehabilitation. Cognitive behavioural approaches seemed to be the most promising. Individually targeted interventions that used several complementary methods were more effective than those that used only one. Box 1 sets out the review's main findings.

Box 1: Main findings of the 2005 review

Prevention

- There was moderate evidence to suggest that a range of stress management interventions, especially those using more than one technique or method, can have a beneficial impact on stress in the workplace; but it was not clear whether these measures might prevent common mental health problems.
- There was limited evidence that interventions focusing on individuals produced better results than those targeting the organisation as a whole.

Retention

- There was strong evidence that, for employees who were thought to be at high risk of developing common mental health problems, individual rather than organisational approaches were more effective at helping people keep their jobs.
- The most effective programmes focused on personal support, individual social skills and coping skills training. Multiple approaches had the most long lasting effects.

Rehabilitation

- There was strong evidence that for people already experiencing common mental health problems at work, brief individual psychological therapy, especially cognitive behavioural in nature (such as CBT), was effective in aiding their recovery.
- These techniques had a stronger effect in employees in high-control jobs.
- These interventions could be effectively delivered face-to-face or via computer-based applications, the latter finding being based on one study (van der Klink *et al.*, 2001; Grime, 2004).
- There was strong evidence for increased return to work by employees already experiencing mental ill health related sickness absence after an intervention by occupational physicians that facilitated the development of problem-solving strategies (van der Klink *et al.*, 2003).

(Seymour & Grove, 2005)

The 2008 evidence update

We have now updated the 2005 review, using the same aims and similar methodology, by examining papers published from 2004 until the end of 2008. We identified 129 papers that were of possible interest, 28 of which were relevant for the review. An additional 53 references from these studies were singled out for follow-up, and of these 16 were relevant to the update review. A panel of seven experts in the field rated and appraised these studies. The final outcome was a total of six papers, published within our timeframe, which provided high quality evidence in the area of interest.

We also approached several academic research groups known to be carrying out work in this area to find out about the current status of their studies. Some of these groups published their results after the end of 2008, outside the

Box 2: Research included in the evidence update

Blonk, R.W.B, Brenninkmeijer, V., Lagerveld, S.E. & Houtman, I.L.D. (2006) Return to work: a comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among the self-employed. *Work & Stress,* **20** (2) 129-144.
Type of study: Randomised controlled trial (RCT).
Intervention: Brief intervention based on CBT principles combined with graded activity and a phased return to work, delivered by labour experts – specialists in work efficiency, occupational health, work processes and designing workplace interventions.
Outcomes measured: Psychological complaints, return to work, working conditions and social support.
Sample: Self-employed Dutch people who had been off work for 2-3 weeks with adjustment disorders such as burnout and stress.
Findings: The trial group returned to either full- or part-time work within a shorter period of time than those in the group who only received CBT or the control group who received two brief sessions with their GP.

Brouwers, E.P.M., Tiemens, B.G., Terluin, B. & Verhaak, P.F.M. (2006) Effectiveness of an intervention to reduce sickness absence in patients with emotional distress or minor mental disorders: a randomised controlled effectiveness trial. *General Hospital Psychiatry,* **28** 223-229.
Type of study: Randomised controlled trial (RCT).
Intervention: An intervention in the Netherlands that focused on understanding causes, developing and implementing problem-solving strategies and promoting early work resumption, delivered by social workers in primary care, with GPs offering care as usual.
Outcomes measured: Primary outcome measure was sick leave duration (in days); secondary outcome measures were anxiety and depression.
Sample: Employed patients on sick leave with emotional or mental health problems for less than three months.
Findings: There was no significant difference in outcomes such as sick leave duration, mental and physical health between the study groups and only the treatment group reported higher satisfaction.

Fleten, N. & Johnsen, R. (2006) Reducing sick leave by minimal postal intervention: a randomised, controlled intervention study. *Occupational Environmental Medicine,* **63** 676-682.
Type of study: Randomised controlled trial (RCT).
Intervention: Minimal postal intervention comprising letter offering return to work with adjusted job on sickness benefits; questionnaire about sick leave; and consent form to allow contact by the Norwegian National Insurance Office.
Outcomes measured: Primary outcome measure was probability of returning to work within one year.
Sample: Newly sick-listed people in Norway with either musculoskeletal or mental health problems.
Findings: The trial demonstrated a significant reduction in length of sick leave for those off work with mental health problems. Early intervention, within one month of sick leave

timeframe for our review. These findings are discussed later in this paper.

Despite a narrow evidence base from which to choose, we did identify some international studies that had assessed interventions for employees with common mental health problems. Their findings are summarised in Box 2. Specific details of the interventions are described in a separate paper available at www.scmh.org.uk/employment.

Each of the studies described in Box 2 examined work-related outcomes. Specific interventions yielded better return to work outcomes, although the minimal postal intervention (Fleten & Johnson, 2006) also reduced the length of sick leave taken. None of the interventions was actually delivered in the workplace; rather they were offered in other settings and by a range of practitioners.

commencing, as well as a focus on return to work regardless of mental health symptoms, were critical success factors.

Bakker, I.M., Terluin, B., van Marwijk, H.W.J., van der Windt, D.A.W.M., Rijmen, F., van Mechelen, W. & Stalman, W.A.B. (2007) A cluster-randomised trial evaluating an intervention for patients with stress-related mental disorders and sick leave in primary care. *PloS Clinical Trials,* **2** (6) e26 (www.plosclinicaltrials.org).
Type of study: Cluster randomised controlled trial (RCT) of primary health care practices in Amsterdam.
Intervention: Primary care physicians received training to deliver a minimal intervention for stress-related disorders or care as usual.
Outcomes measured: Primary outcome measure was duration of sick leave in days from first day of sick leave until full (not part-time) return to work lasting for a period of at least four weeks without partial or full relapse into sick leave.
Sample: Primary care practitioners in two districts in Amsterdam consenting to being randomised into either arm of the study; patients with less than three months' sick leave were recruited via the records of the participating primary care practitioners.
Findings: The intervention demonstrated no effect on return to work. Over the course of the study, symptoms reduced in both intervention and control groups.

Schene, A.H., Koeter, M.W.J., Kikkert, M.J., Swinkels, J. A. & McCrone, P. (2007) Adjuvant occupational therapy for work-related major depression works: randomized trial including economic evaluation. *Psychological Medicine,* **37** 351-362.
Type of study: Randomised controlled trial (RCT).
Intervention: Outpatient psychiatric treatment plus occupational therapy, versus treatment as usual, delivered by three supervised senior psychiatric residents.
Outcomes measured: Depression, work resumption, work stress and costs.
Sample: Adults with depression in Amsterdam whose working hours had reduced by up to half because of their mental health problems.
Findings: Those in the intervention group started work three months earlier than controls, even while remaining symptomatic.

Wang, P.S., Simon, G.E., Avorn, J., Azocar, F., Ludman, E.J., McCulloch, J., Petukhova, M.Z. & Kessler, R.C. (2007) Telephone screening, outreach and care management for depressed workers and impact on clinical and work productivity outcomes. A randomized controlled trial. *JAMA,* **298** (12) 1401-1411.
Type of study: Randomised controlled trial (RCT).
Intervention: Telephone screening, outreach and care management delivered by care managers, licensed master's degree-level mental health clinicians, employed by a health insurer.
Outcomes measured: Depression severity and work performance.
Sample: Adult employees enrolled in the United Behavioural Health Plan in the United States and identified via a two-stage screening process as having significant depression.
Findings: The intervention group had significantly lower self-reported depression scores, higher job retention and more hours worked.

Additional findings

None of the studies identified for this update was conducted in the UK. They were delivered in continental Europe and North America. Two current UK projects, however, emerged from identified gaps in the 2005 evidence base.

The role of the line manager

One key finding of the 2005 review was the significance of the line manager's role in managing common mental health problems and the need for specialist skills training to enable them to do this. There was, however, no evidence for effective interventions.

As a consequence Sainsbury Centre has been piloting and monitoring the impact of management training developed by the Australian charity *beyondblue* as part of their National Workplace Programme. The aim of the intervention is to build the knowledge, confidence and skills of managers and staff, in supporting people with depression and other mental health conditions to access timely treatment that can promote their recovery while in work.

The pilot programme in England reached over 250 managers and early impact assessment showed some encouraging results. Managers' knowledge of the prevalence rates for mental health problems in the population – an underdeveloped area of management knowledge – rose significantly after receiving the training; their attitudes towards people with mental health problems shifted in a positive direction; and their confidence to provide support and take action for these groups of employees improved. (www.scmh.org.uk/employment/impact_on_depression/programmeevidence.aspx)

Sainsbury Centre has now negotiated a three-year licensing agreement with *beyondblue* in order to make the full training programme, entitled 'Impact on Depression', widely available in this country. Once the delivery phase is up and running we will commission an independent external evaluation (www.impactondepression.co.uk).

Computerised CBT

The 2005 review also identified limited but promising evidence to support the use of computerised CBT (cCBT) to aid recovery from stress-related absence among employees (Grime, 2004). The study demonstrated a positive association with use of a computer-aided CBT programme, but the effect was strongest at one month and then diminished after three months.

To collect more robust and reliable data, the British Occupational Health Research Foundation (BOHRF) has funded a randomised controlled trial (RCT) of cCBT in an organisational setting. The study has been designed to explore whether internet-based CBT (the freely available MoodGYM) is effective in reducing anxiety and depression; and in improving performance and attendance at work. The trial is also evaluating the user satisfaction and cost effectiveness of the approach compared with alternatives (www.bohrf.org.uk/projects/perfatwk.html#ccbt).

Implications for policy and practice

The two evidence reviews provide a range of insights into the effective management of common mental health problems among working age people and offer evidence-based pointers for practice and policy. We have identified four salient themes: the desired outcomes; the settings for the delivery of interventions; the role of the workplace; and the roles of different practitioners.

Work and clinical outcomes

The data demonstrate that the longer a person is off sick from work with mental ill health related absence, the less the chances of a successful return to work (HM Government, 2006). Clearly the severity of a person's mental health condition is a key variable, but there are also associations with inadequate access to appropriate therapies and the lack of early efforts to encourage a return to work.

There is considerable evidence for the effectiveness of psychological therapies, particularly cognitive behavioural methods

that focus on reduction in symptoms, in the treatment of anxiety and depression (NICE, 2004, 2009c; Roth & Fonagy, 2005). On their own, however, psychological therapies do not improve employment outcomes such as return to work. Additional efforts aimed at getting people back into their employment roles are required (Mintz *et al.*, 1992, van der Klink *et al.*, 2003; Blonk *et al.*, 2006; Wang *et al.*, 2007; Schene *et al.*, 2007; Fleten & Johnson, 2006).

Both clinical and work outcomes are important, and approaches to achieving these positive outcomes should be co-ordinated for best effect. It is important to differentiate occupational goals from clinical goals and understand that the former are not necessarily dependent on the latter. Research studies should clearly delineate clinical from work outcomes and the interventions required to address these.

As shown in studies of supported employment for people with severe mental health conditions (Sainsbury Centre, 2009a), it is not necessary to be without symptoms to function successfully at work. The same applies to people with common mental health problems and less emphasis needs to be placed on employees being symptom-free before returning to work.

One study (Fleten & Johnson, 2006) concluded that focusing on how to stay in work with health problems was seen as more effective for employees with common mental health problems than managing health problems to be fit to return to work. This shift may be the start of an emerging recognition that work itself – if well-organised with adjustments for individual need – can help to remedy common mental health problems.

Settings for delivery of interventions

Workplaces have habitually been seen as key settings for a range of health promotion initiatives targeted at working people. Programmes that assist employees to reduce or give up smoking, eat more healthily or improve their fitness are common. But the published research shows that there are few evidence-based interventions carried out in or by workplaces to address common mental health problems among employees.

The research literature on programmes that address the mental health of employees has been dominated by interventions targeted either at the whole population of employees, for example stress innoculation, or at those deemed to be at high risk of stress-related disorders, for example stress reduction or management. These approaches mirror physical health interventions aimed at individual behaviour change and do not offer a model for organisational approaches to these issues.

None of the interventions described in our update review was delivered in or by workplaces. They were carried out in a range of other settings, by a diverse group of practitioners, often determined by the health insurance arrangements for employed people in those countries.

The role of the workplace and employers

While the evidence points to workplaces not being the sole or principal setting for delivering interventions for people with common mental health problems, employers nevertheless remain key partners. They are, after all, in a contractual and personal relationship with their employees and they have statutory health, safety and disability accommodation duties. The focus of employers' role in the management of common mental health problems among employees should be to ensure that the working environment supports retention and rehabilitation. Recent policy recommendations have highlighted this responsibility.

For example, the National Institute for Health and Clinical Excellence (NICE) reviewed some of the literature on mental health and work, as suggested by experts in the field. In the absence of RCTs on the topic under review, *Workplace Mental Health* suggests that employers take a strategic and co-ordinated approach to workplace wellbeing; that employers provide opportunities for flexible working; and that line managers promote and support wellbeing among staff (NICE, 2009a).

The *NHS Health and Wellbeing Review* (DH, 2009a) acknowledged not only that some employees are likely to have existing common mental health problems, but also that the nature of the working environment can sometimes have a negative impact on staff mental wellbeing. Among the review's recommendations were that all NHS bodies should ensure that their management practices adhered to the Health and Safety Executive's management standards

for the control of work-related stress; that more investment was needed to attract people to take up occupational medicine; that all managers are trained in the management of people with mental health problems; and that all NHS bodies give priority to the implementation of the NICE guidance on workplace mental health in order to signal their commitment to staff health and wellbeing (NICE, 2009a).

A parallel piece of work has complemented the *NHS Health and Wellbeing Review* and described findings from the *Practitioner Health Programme*. The intervention is targeted at doctors and dentists with health problems who might be reluctant to seek help through usual channels. In its first year, a total of 184 practitioners within the M25 area have accessed the service: 57% with mental health problems and 23% with addiction issues (DH, 2010; Crawford *et al.*, 2009; Samuel *et al.*, 2009; Ipsos MORI, 2009).

The Government's Foresight scientific review on *Mental Capital and Wellbeing* (Foresight, 2008) included a chapter devoted to work (Dewe & Kompier, 2008), recommending that employers foster work environments conducive to good mental wellbeing and the enhancement of mental capital, for example by extending the right to flexible working. The chapter also highlighted the importance of integrating occupational health professionals with primary care, the collection of wellbeing data against Key Performance Indicators, and annual wellbeing audits.

All of these recommendations mirror the findings of a longitudinal cohort study on workplace factors that may help to reduce depressive symptoms (Brenninkmeijer *et al.*, 2008). Work resumption, partial and full, and the employer changing the employee's tasks, promoted a more favourable outcome. However, these findings emerged from the Netherlands, where the employer and employee have a legal obligation to sit together and discuss solutions to obstacles preventing return to work, an important factor associated with the decrease in long-term disability in that country (Reijenga *et al.*, 2006). Perhaps a policy shift will be necessary to allow workplaces in the UK to play a central role in the management of common mental health problems.

The roles of different practitioners

Working for a Healthier Tomorrow (HWWB, 2008) included a health professionals' consensus statement on health and work (HWWB, 2008a). Almost 40 different organisations were signatories and they made a strong case for the role of work in promoting and protecting health.

The evidence also supports a significant role for a range of practitioners, such as primary care, occupational health and the emerging brokerage specialists, working singly or in partnership to address employees' common mental health problems.

Primary care

Primary care can play a vital role in the rehabilitation of people back into work and in enabling people to remain in work while they are receiving health treatment.

Eight out of ten of people say they would consult their GP first for treatment if they thought they had a mental health problem (TNS Social, 2009). NICE guidance on long-term sickness absence (NICE, 2009b) acknowledges the key position of the GP and aims to facilitate GPs in handling requests for fit notes appropriately, in supporting people back into work and in avoiding long-term sickness absence whenever possible.

Nevertheless, the picture regarding the role of primary care in delivering effective interventions is mixed. In our review, studies that investigated interventions delivered by or alongside primary care reported no effect on the rates of return to work (Bakker *et al.*, 2007; Brouwers *et al.*, 2006). These findings mirror those from a range of other studies demonstrating that people with common mental health problems in treatment with primary care had lower workforce participation, even if they retained their employment (Yelin *et al.*, 1996; Hilton *et al.*, forthcoming).

However, on the positive side, there is evidence that primary care practitioners trained to diagnose and treat depression can effectively help people to retain employment (Schoenbaum *et al.*, 2001, 2002). A randomised trial in the United States looked at people with depression who used community primary care services where enhanced care was delivered by trained

primary practitioners and care managers. There were cost-effective positive results for absenteeism and work productivity over two years, the effect being more observable among those who were continuously employed over that period (Rost *et al.*, 2004; Sasso *et al.*, 2006).

Occupational health

Occupational health practitioners have a significant role to play in the management of common mental health problems, but there is limited evidence on efficacy of interventions delivered by them. During the time period of our update review we did not identify any relevant evidence, although one of our studies concluded that an intervention delivered in primary care might have been more effective if delivered by occupational physicians (OPs) rather than primary care alone (Brouwers *et al.*, 2006).

However, in 2009, colleagues in the Netherlands sent us the results of a study that explored the role of occupational physicians. In the Netherlands each employee is required to have a rehabilitation consultation with an occupational physician when they are on sick leave. Consequently there has been a determined effort to evaluate their role in the diagnosis and treatment of Dutch employees with common mental health problems.

In 2000 the Netherlands Society of Occupational Medicine published *The Management by Occupational Physicians (OPs) of Workers with Common Mental Health Problems,* a practice guideline that promotes a more active role for the OP in facilitating employees' return to work. Although this guidance was widely welcomed by employers, employees and OPs, its implementation was poor.

A randomised controlled trial comparing an intervention delivered by OPs trained in using the guidance to usual care found no difference in return to work rates between the two groups. However, there were benefits for employees with minor stress-related disorders and guidance-based care was more cost effective than usual care (Rebergen *et al.*, 2009a; Rebergen *et al.*, 2009b).

The results of the study indicate that a combined work and individual intervention by an occupational expert, as proposed in the guideline, could be more effective in facilitating return to work than passive care that offered referral to secondary mental health care.

'Third party' roles

The third practitioner role to surface from the evidence is that of the independent case manager. The new evidence described the efficacy of these 'third party' roles in the management of employees' common mental health problems (Blonk *et al.*, 2006, Wang *et al.*, 2007). Additional evidence for these approaches emerged after we had completed our review, from Dutch colleagues who had carried out a feasibility study for a randomised trial of a participatory workplace intervention to improve return to work for employees with common mental health problems (van Oostrom *et al.*, 2009).

The study targeted employees who had been off work for 2-8 weeks with distress. 'Return to Work' co-ordinators acted as brokers between employees and their workplaces, holding separate one-to-one interviews with the employee and employer, and then arranging a joint meeting for all parties. The co-ordinator's role was considered vital in ensuring increased equality, safety and support in discussions between employees and their employers. Communication and conflict resolution were identified as essential competencies for the co-ordinators.

The UK equivalents of these workers are specialist employment advisers, in particular those co-located in primary care practices. These advisers offer vocational and psychological support to enable people with mental health problems to remain in their job or to find employment elsewhere. In a joint study with the Institute of Mental Health, Sainsbury Centre conducted a Delphi survey of expert opinion, to develop a list of knowledge and skills required by job retention workers. The survey found that this work requires negotiation, communication and conflict resolution skills that are not routinely covered in health professionals' training courses. Key to the role is the ability to collaborate with a wide range of agencies and to understand the complex issues that employers and workers face (Sainsbury Centre, 2009b).

A realistic evaluation framework has been used to assess the impact of employment advisers in

primary care on supporting people to retain their jobs. Interventions that people with common mental health problems found most helpful were careers guidance (including psychological profiling) and developing strategies to negotiate and communicate with employers. These interventions helped individuals to take control, broaden their horizons and move forward (Pittam *et al*., forthcoming).

In the NICE review of the evidence for managing long-term sickness absence and incapacity for work, with particular emphasis on musculoskeletal and mental health conditions (NICE, 2009b) the recommendations focused on preventing or reducing recurring short-term or long-term sickness absence; the transition from short-term to long-term sickness absence; promoting return to work for those on long-term sickness absence; and support for those in receipt of incapacity benefit or similar benefits. Independent, suitably trained, impartial case management was seen as significant, as was open dialogue between employee and employer facilitated by the case worker.

Policy, practice and evidence: convergence or divergence?

There is clearly a body of evidence, albeit thinner than we may like, that suggests some effective ways of managing mental health problems among working age adults. But how do developments in policy and practice map against what is known to be effective from the evidence?

National policy developments

The mental health and wellbeing of employees has moved up the policy agenda, as witnessed by several complementary government policy initiatives.

Working our Way to Better Mental Health: A framework for action is the cross government mental health and employment strategy (HWWB, 2009) responding to a review of employment support for people with mental health conditions (Perkins *et al*., 2009). It supports a dual approach that addresses both wellbeing at work for everyone and better employment outcomes for people with mental health conditions, whether they are currently in work or not. Key areas for action include changing workplace attitudes to mental health, improving health and wellbeing at work and tailoring support for individuals.

Co-ordinated action across government is also seen as fundamental, a stance taken by the new mental health policy *New Horizons* (DH, 2009b). This document lays down the blueprint for mental health policy in the next decade following completion of the ten-year *National Service Framework for Mental Health* (DH, 1999). Mental health and work are highlighted as key in promoting and protecting mental wellbeing. The content describes some of the actions that individuals or employers might take to improve mental health in the workplace. This links across to the mental health and employment strategy, and its promise of a cross- government approach to mental health and work that covers the continuum of mental health from common to more severe conditions.

Beyond government, the NHS Employers' *Open Your Mind* campaign has strategic aims focusing on:

- Reducing mental ill health stigma and misunderstanding;
- Helping to create a better working environment and positive culture for those in the NHS workforce experiencing mental health problems;
- Raising awareness among NHS organisations about the benefits of increasing employment among people with mental health conditions;
- Aiding staff retention, and therefore improving intellectual capital, productivity, performance and business benefits;
- Supporting NHS organisations to be both exemplars in employment of people with mental ill health and local employers of choice.

(www.nhsemployers.org/openyourmind)

Psychological therapies

The role of talking therapies in helping to treat common mental health problems has been recognised in the Department of Health's Improving Access to Psychological Therapies (IAPT) programme (www.iapt.nhs.uk). Delivered through primary care, the IAPT programme offers an opportunity to help people to remain in employment. As already noted, however, the evidence suggests that regaining health does

not necessarily result in return to work (van der Klink *et al*., 2001; Mintz *et al*., 1992). To produce effective employment outcomes, IAPT must be integrated with evidence-based vocational services.

Some of our new evidence corroborates this conclusion. Blonk *et al*. (2006), for example, clearly demonstrated the need for brokerage in addition to talking therapies. However, several other studies (Wang *et al*., 2007; van Oostrom *et al*., 2009) emphasised the need for a skilled brokerage function to act for the employee as an intermediary with other crucial partners in health and employment.

In our view this evidence supports the current policy of integrating employment advisers within the IAPT programme and offers strong pointers to the remit, skills and training that this role requires. Conversely, it appears that delivering psychological therapies without some form of employment focused case management will not produce positive work outcomes for working age adults with common mental health problems.

Sickness certification

Primary care has a key role to play in the management of common mental health problems. The studies identified in our evidence review that were conducted in primary care and looked at work outcomes showed no positive effects for the interventions carried out in this setting (Bakker *et al*., 2007, Brouwers *et al*., 2006). However, these data emanate from the Netherlands. In the UK, there has been a recent marked shift of GP interest and activity in this area, notably in training and practice.

For example, *Working our Way to Better Mental Health* (HWWB, 2009) has advocated changes in sickness certification to promote better health among working age adults. A revised medical statement – the fit note – now enables GPs to provide better return-to-work advice for patients to share with employers.

There is a partnership between the Royal College of General Practitioners and the Faculty of Occupational Medicine to deliver a new education programme for GPs to raise their awareness of the positive links between health and work, and equip them to manage health-related employment discussions with patients. There are also plans to develop e-learning support for GPs and health care professionals in primary care showing the importance of employment for mental health (HWWB, 2009 p.40). In Wales, primary care practitioners are now given 'clear-cut' decision guides to support consultations on health and work (www.healthyworkingwales.com/deskaids/index.html).

Some commentators have argued for the fit note to include an option to recommend a referral for an occupational health assessment (Verbeek & Madan, 2009). But the Government in its official response to *Working our Way to Better Mental Health* decided against this option and has left it to GPs to indicate in the fit note's comment box whether an occupational health referral would be beneficial (DWP, 2010).

Boosting the role of occupational health

Working for a Healthier Tomorrow (HWWB, 2008) emphasised the need for the inclusion of occupational health and vocational rehabilitation within mainstream health care and called for clear professional leadership and standards of practice to revitalise the workforce.

Research from outside the UK points to the potential for occupational health, either on its own or in tandem with primary care, to produce positive outcomes for employees with common mental health problems (Brouwers *et al*., 2006, Rebergen *et al*., 2009a). This embryonic body of evidence emanates from the Netherlands, where there is a legal obligation for employers and employees to discuss solutions to obstacles that might prevent a return to work. Meeting this requirement is associated with the decrease in long-term disability in that country (Reijenga *et al*., 2006).

Tackling stigma and discrimination

The mental health anti-stigma campaign *Time to Change* has a high profile programme to change public attitudes to mental health (www.time-to-change.org.uk). The Government's anti-stigma programme, *Shift,* has set up a panel to assess the quality and impact of materials designed to help employers promote mental wellbeing and manage mental ill health in the workplace (www.shift.org.uk).

Two occupational health physicians have recently acknowledged the barrier that stigma presents to the retention and rehabilitation

of working age adults with common mental health problems. They have argued for a fundamental change in the perceptions and beliefs of employers, employees and health care professionals, in order to give the fit note the best possible chance of achieving its aims (Verbeek & Madan, 2009).

Conclusions

In the four years between the two evidence reviews there have been some new studies testing out interventions to promote retention in or return to work during or after a period of mental ill health. They have reinforced the conclusions of the first evidence review and added some qualitatively different dimensions. The new studies appraised work as well as clinical outcomes. They looked at emerging practitioner roles that did not appear in the 2005 review. And they have highlighted the need to distinguish between interventions aimed at treating the condition and those aimed at getting people back to work.

However, none of the studies was carried out in the UK. There are key differences that could affect transferability. Practitioner roles, statutory requirements or the length of time for which jobs are protected for people on sick leave, all differ between the UK and the countries where the studies were conducted.

None of the interventions was delivered in or by workplaces, although employers remain key players in the management of common mental health problems among working people. As the focus shifts towards supporting people in the workplace, rather than requiring them 'to get better' before returning to work, employers will need to develop appropriate organisational policies such as introducing flexible working and making reasonable adjustments. Regardless of where interventions are delivered or by whom, employers will have a major stake in the outcomes.

There are current practice examples that give cause for optimism. BT has reported that its mental wellbeing strategy has led to a reduction of 30% in mental health-related sickness absence, and a return to work rate of 75% for people absent for more than six months (Wilson, 2007). But these outcomes have not been published in the research literature. There is also UK research, currently in process, on computer-based CBT for employees.

Clearly there is a pressing need to develop a research agenda to test out some of the interventions we have identified in the UK. There is also a need to ensure that innovative and potentially effective practice is systematically evaluated and published. Our view is that government, along with the major research funding bodies, should review and support research and development funding in this area.

Despite the limitations of the research evidence, the systematic studies and the experience of people working in health and employment services provide a sufficient body of knowledge to inform current policy and practice. What is clear is that there is a need to consider all of the key players: health services (primary care, secondary care and occupational health), employers, and employees with common mental health problems.

The need for collaboration and effective partnerships between the key players has emerged repeatedly as the lynchpin for effective outcomes *"an integrative coherent system of care that incorporates close collaboration with mental health specialists and non-statutory services, case management and a recognition and acknowledgement of the importance of the health care professional – patient relationship"* (Boardman & Walters, 2009).

What is also clear is that the management of retention and rehabilitation is skilled work. Practitioners will need to know and understand the research evidence, and keep up-to-date with developments in a fast-moving field.

It is also important to acknowledge that persistent stigma contributes to low expectations of the capability of people with common mental health problems to continue working and can hinder their retention and rehabilitation.

Working our Way to Better Mental Health (HWWB, 2009) provides a focal point around which policy, practice and evidence must now unite. This, together with the application and assessment of some of the interventions we have identified, offers the best opportunity to manage common mental health problems among the working age population effectively and to reduce the negative impact of mental ill health on people's lives and livelihoods.

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Common mental health problems at work

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Linda Seymour

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