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Symptoms of depression and their effects on employment

Karen Steadman

Tyna Taskila

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Chapter 1 Introduction

Mental health conditions and the UK working age population

At any one time around 1 in 6 (17 per cent) people of working age (16-65) in England are experiencing a common mental health condition, such as depression or anxiety (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009; Sainsbury Centre for Mental Health, 2007). Prevalence might be even higher in other parts of the UK, for example it has been estimated that in Northern Ireland prevalence is 25 per cent higher than in England (Bunting, Murphy, O'Neill, & Ferry, 2011).

Depression is one of the most common mental health conditions in the UK (National Institute for Health and Care Excellence, 2013). An estimated one in twenty adults experience an episode of depression each year making it the third most common reason for GP consultations in the UK (National Institute for Health and Care Excellence, 2013).

Depression frequently occurs along with anxiety – more than half of those with a common mental health condition have mixed anxiety and depression (nine per cent of the population) (McManus et al., 2009). By comparison other mental health conditions are much rarer – severe and enduring conditions such as Bipolar Disorder and schizophrenia are each estimated to affect around one per cent of the UK population¹.

What is depression?

Depression often remains undiagnosed (Kessler, Bennewith, Lewis, & Sharp, 2002) and despite the existence of a range of treatments for depression many people remain untreated (McManus et al., 2009; Simon, Fleck, Lucas, & Bushnell, 2004). Bipolar Disorder particularly is fraught with diagnostic difficulties. It has been estimated that 1 out of 3 patients with Bipolar Disorder leave the psychiatrist's office with an incorrect diagnosis of Unipolar Depression (referred to in this report as "depression") (Knezevic & Nedic, 2013). Failure to make an accurate diagnosis can result in treatments that are ineffective or that can even make the condition worse.

Depression is a heterogeneous condition, presenting differently in different people and associated with a wide range of symptoms (American Psychiatric Association, 2013; National Institute for Health and Care Excellence, 2009). The severity of the condition (either Unipolar Depression or Bipolar) is determined by the number and the severity of symptoms as well as the degree of functional impairment (National Institute for Health and Care Excellence, 2009).

Depression is characterised by persistent low mood and/or loss of pleasure or interest in most activities (American Psychiatric Association, 2013; National Institute for Health and Care Excellence, 2013). There are also a range of associated emotional, cognitive, physical and behavioural symptoms (National Institute for Health and Care Excellence, 2013). These

¹ <http://www.rcpsych.ac.uk/mentalhealthinfo/problems/bipolardisorder/bipolardisorder.aspx>

might include: feelings of inadequacy and hopelessness; sleep disturbance; weight change; fatigue; agitation or slowing down of movement and thought; and, suicidal ideation (American Psychiatric Association, 2013; Nieuwenhuijsen et al., 2014). In addition individuals may experience difficulty concentrating and difficulty making decisions (American Psychiatric Association, 2013; Papakostas, 2014). These latter 'cognitive symptoms' are seen to affect working memory, attention and executive functioning and processing speed (Papazacharias & Nardini, 2012). Difficulty concentrating is often highlighted as particularly prominent, for example in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Indeed, it has been identified by patients as one of the most troublesome symptoms of depression (Pandina et al., 2009).

Depression is often episodic, marked by periods of full or partial symptom remission. Full remission of symptoms is associated with better functioning and a lower chance of relapse. A common problem after treatment is partial remission with some symptoms continuing. These might be known as ongoing or residual symptoms. Common ongoing symptoms include insomnia, decreased concentration, difficulty in decision-making and low mood (Kennedy, Foy, Sherazi, McDonough, & McKeon, 2007; McClintock et al., 2011).

It is important to make a distinction between Bipolar and Unipolar Depression as symptoms of depression present differently. Many cases of Bipolar Depression display symptoms of excessive sleeping and high levels of daytime fatigue, there is often also an increased appetite and weight gain. In contrast, people with Unipolar Depression have a tendency to wake repeatedly throughout the night and may also be prone to wake up early. Although some people who experience Unipolar Depression may have increased appetite and weight gain, it is more common to have a loss of appetite and weight loss. Bipolar Depression is much more likely to be accompanied by stronger symptoms of anxiety. One-half to two-thirds of people with Bipolar Depression have a co-occurring anxiety disorder such as obsessive-compulsive disorder, panic disorder or social anxiety disorder (Cuellar, Johnson, & Winters, 2005).

In the results section we focus mainly on (unipolar) Depression although some studies on Bipolar Depression have been included in the literature review in order to gain as a good picture as possible about the impact of symptoms of depression on employment outcomes.

Depression as a barrier to work

Mental ill health has considerable implications for employment. It is the leading cause of work-related illness and sickness absence in the UK, estimated to account for 70 million sick days annually (Sainsbury Centre for Mental Health, 2007), and is linked to reduced work performance compared to those without depression (Lerner & Henke, 2008; Nieuwenhuijsen et al., 2014).

Having a mental health problem considerably increases the chances of both unemployment and economic inactivity.

The unemployment rate for people with a common mental health condition is double that

found among the general population. For those with a severe mental health condition, such as Bipolar Disorder, unemployment is four times the rate (OECD, 2014). It is estimated only 40-60 per cent of people with Bipolar Disorder are employed (Marwaha, Durrani, & Singh, 2013). Mental health conditions are also the most common reasons for UK disability claims – accounting for almost 4 out of 10 (38 per cent) of new claims in 2012, with an estimated 41 per cent of all disability claimants affected by a mental disorder (OECD, 2014). The relationship with work is bi-directional, with long-term unemployment associated with increased depression (Diette, Goldsmith, Hamilton, & Darity Jr., 2012; Paul & Moser, 2009). Several factors are related to depression, such as poor physical health, unhealthy lifestyle and debt and financial strain, but the nature and direction of the association remains unclear (McManus et al., 2009).

The nature and severity of symptoms have been identified as presenting barriers to employment (Lerner & Henke, 2008). The symptoms of depression are the focus of this research. It is important to note, however, that a range of factors are seen as presenting barriers for and in employment for people with depression including stigma around mental illness (McDaid, Knapp, Medeiros, & MHEEN Group, 2008) and associated discrimination (Corrigan et al., 2003; Danson & Gilmore, 2009; C. Manning & White, 1995; Rinaldi & Hill, 2000).

Objectives and research questions

This research seeks to examine the impact of symptoms of depression on employment in people diagnosed with depression and also to examine the effectiveness of interventions that may help people with depression to remain in work or to find employment.

Keeping these broad objectives in mind, this report aims to answer the following research questions:

1. What role do the symptoms of depression (such as cognitive dysfunction) play as barriers to employment and job retention for people with depression?
2. What support and interventions assist people with depression with regards to improving employment outcomes (in terms of job retention and return to work)?
3. What are the barriers for people with depression in accessing effective support/services?
4. What can health policymakers and key stakeholders do to reduce the barriers to employment for people with depression?

Research question 1 looks at the evidence around how symptoms of depression are seen to affect work. This is the focus of Chapter 3 (p7).

Research question 2 considers the evidence on effective interventions (e.g. pharmacological, psychological therapies and occupational therapy) as well as employment

related interventions. This will include policy interventions, like the Fit Note, and local commissioning of vocational rehabilitation and supported employment services, like Individual Placement Support (IPS). This is discussed in Chapter 4 (p14).

Research question 3, also discussed in Chapter 4, explores the barriers to improving employment outcomes for people who are experiencing symptoms of depression in terms of access to, and quality of, services and interventions.

Research question 4 focusses on what more can be done to enhance the current provision of relevant support and services. This question is addressed in Chapter 5 (p48) through a series of policy recommendations on how to improve employment outcomes for people with depression.

Chapter 2 Method and study materials

The following methods were used to collect data to help address the outlined research questions.

Literature review

A search was conducted for relevant studies published between 2000 and 2015 using PubMed². The detailed search criteria are listed in Appendix 1 (p65). Potentially relevant papers were also identified by academic colleagues and the funder. Separate searches were made for research questions 1 and 2 because of expected differences in study design. For the first research question³ we expected the design to be primarily survey-based and for the second research question⁴ we expected to find studies that followed a Randomised Control Trial (RCT) research design.

From number of potentially relevant titles and abstracts, a total of 62 full texts were reviewed for inclusion. The main reasons for exclusion were:

- Study did not include individuals with a diagnosis of Major Depressive Disorder and/or Bipolar Disorder.
- Study did not measure symptoms, such as cognitive dysfunction.
- Study did not include work-related outcomes.

Altogether 15 studies were included in the review of question 1. Three of the studies were systematic literature reviews (Gilbert & Marwaha, 2013; Lagerveld et al., 2010; Tse, Chan, Ng, & Yatham, 2014); as a result of this six separate studies were excluded from the analysis because they had already been included in one of the three systematic reviews. Table 1 (see Appendix 2, p66) contains information of the remaining nine included studies. In six of the included studies data was collected by a questionnaire, four of which were cross-sectional (Banerjee, Chatterji, & Lahiri, 2014; Baune et al., 2010; McIntyre et al., 2015; Schoeyen et al., 2013) and two studies were follow-up studies (Lee et al., 2013; Mora, Portella, Forcada, Vieta, & Mur, 2013). Two of the survey studies had a control group (i.e. case-control design) (Baune et al., 2010; Mora et al., 2013).

A total of eight studies were included in the review of question 2. One of the studies was a Cochrane systematic review (Nieuwenhuijsen et al., 2014), this study already included three

² PubMed comprises more than 24 million citations for biomedical literature from MEDLINE, life science journals, and online books.

³ What role do the residual symptoms of depression such as cognitive dysfunction play as barriers to employment and job retention for people with depression?

⁴ What support can healthcare professionals give people with depression to enable them to return to work/stay in work?

of the other studies identified; Table 2 (see Appendix 2, p66) contains information of the remaining five studies. Three of the studies had a RCT design (Furukawa et al., 2012; Lagerveld, Blonk, Brenninkmeijer, Wijngaards-de Meij, & Schaufeli, 2012; Lexis et al., 2011) and one was an intervention study without a control group (Deckersbach et al., 2010).

Expert interviews

In addition to the literature review, we also conducted telephone interviews with ten professionals with specific expertise in depression and employment. Experts were from the fields of psychiatry, academia, primary healthcare, psychology, vocational rehabilitation, occupational therapy, employment support and mental health advocacy. Each was selected on the basis of their known expertise. Given their differing expertise, some were asked to discuss symptoms in general, while others were also asked to comment on cognitive symptoms specifically.

Experts were invited to participate over email and were provided with full information on the project. Semi-structured interviews were conducted over the telephone (and one face-to-face) and audio-recorded and transcribed verbatim. All of them gave either verbal consent (telephone interviews) or written consent (face-to-face interview) and each interview lasted between 20 and 50 minutes.

The interviews sought to investigate all four of the research questions, with interview guides reflecting these. This was done despite the awareness that the literature review would provide an overview of the academic evidence for questions 1 and 2. It was considered however that experts working in the field might be able to provide broader coverage of what interventions are actually used, including government services for which academic literature is limited. Interviews with experts also allowed investigation of the real life barriers to accessing services and interventions for people experiencing symptoms of depression (question 3). The data gathered from expert interviews was also used to inform the development of policy recommendations in response to question 4.

Chapter 3 Symptoms of depression as a barrier to employment

The following section looks at research question 1 (*What role do the symptoms of depression play as barriers to employment and job retention for people with depression?*), we provide an overview of the academic literature on the impact of the symptoms of depression on employment followed by an analysis of expert views on this topic.

Evidence from the literature review

The literature review involved 46,513 individuals of working age with depression (of which approximately 80 per cent had a diagnosis of Unipolar Depression).

Overall, it was shown that ongoing symptoms play a major role in employment outcomes of people with depression. It was estimated that decreased functioning could partly explain low employment rates of people experiencing depression. It was pointed out that of those who find or remain in employment, a substantial proportion do not work at their full capacity (Tse et al., 2014).

Some evidence suggested that cognitive dysfunction and other symptoms of depression such as insomnia, emotional distress and fatigue, had more significant effect on work-related outcomes than actual illness (Banerjee et al., 2014; Gilbert & Marwaha, 2013; McIntyre et al., 2015). For example, one recent study showed that workplace performance variability was explained to a greater extent by subjective measures of cognitive dysfunction than by total depression symptom severity (McIntyre et al., 2015). In another study, however, it was found that persistence of severe clinical symptoms rather than cognitive dysfunction determined the occupational outcomes (Schoeyen et al., 2013). Other disorder-related factors, in particular co-morbidity (both mental and/or physical disorders) was seen to have a negative impact on employment outcomes, i.e. people who had additional health conditions were less likely to be working (Lagerveld et al., 2010).

Evidence from all three included systematic reviews (Gilbert & Marwaha, 2013; Lagerveld et al., 2010; Tse et al., 2014) showed strong, negative association between the duration of depression and residual symptoms on employment. One study with a long follow-up of six years (Mora et al., 2013) showed that the more severe and the longer the duration of the symptoms, the more likely their impact on work-related outcomes. Moreover in another study, baseline neuropsychological functioning (a composite of memory, working memory and attentional switching) was the best independent predictor of later occupational functioning (Lee et al., 2013). In addition, there was some evidence that employment protected individuals from negative effects of cognitive dysfunction (Tse et al., 2014). In a study by Baune et al. (2010) it was shown that employed individuals with depression performed significantly better in the visuospatial, language and delayed memory domains, as well as on the total score, than their unemployed counterparts.

With regard to socio-demographic factors, all the studies identified included gender and age in their analysis; however gender was frequently studied in relation to finding differences between men and women in occupational outcomes and there was no clear association between gender and favourable employment outcomes. In terms of age, there was moderate evidence from the systematic review by Lagerveld et al. (2010) that older age increased the risk of poor employment outcomes, namely it increased the risk of work disability. There was evidence from two systematic reviews that level of education has an effect on work-related outcomes. Finally, there were some inconsistent evidence that different types of occupation were related to different employment opportunities; namely people working in sales, service or support occupations were more likely to be employed than those working in construction, maintenance and transport (Lagerveld et al., 2010).

Some studies also looked at personal factors, such as personality traits, and their impact on employment outcomes. In the systematic review by Tse et al. (2014) it was found that a personality disorder had negative effect on job functioning. The review by Lagerveld et al. (2010) found evidence that lower self-esteem was related to negative work outcomes. Two individual studies (Lee et al., 2013; Schoeyen et al., 2013) found that patients who had favourable outcomes of employment had a higher premorbid IQ compared with those who did not work. Overall though the evidence of the impact of personal factors on employment in people with depression is weak and requires further investigation.

Expert views

Experts were asked how symptoms of depression might affect employment outcomes – in terms of job retention and seeking a new job, whether returning to the labour market or entering it for the first time. Selected experts were also asked to consider cognitive symptoms in particular.

Experts agreed that symptoms of depression often had an adverse effect on employment. Their opinions were also consistent in that despite having the same diagnosis people with depression will not necessarily experience the same symptoms or the same the severity of symptoms.

I suppose the first thing to say is, symptoms are personal to the sufferer so there is not a one size fits all.

I think the important thing is that every depressive episode is different and unique to the individual who will have their own constellation of symptoms and those symptoms are experienced through the prism of that individual's personality and what they were previously doing and how they were previously functioning. So not everybody has cognitive symptoms and if people have cognitive symptoms, not everyone suffers as a result.

The symptoms most frequently suggested in the interviews as being relevant to employment outcomes were: flat/low mood; lack of interest/motivation; negative thinking (where an individual perceives or interprets things in a negative way resulting in negative and inaccurate thoughts and beliefs); difficulty concentrating; and, being easily distracted. Sleep

disturbances leading to tiredness and lethargy were also highlighted as important as was anxiety, which often co-occurs with depression, and a low tolerance to stress. The relationship of these (and other) symptoms to work is discussed briefly below. Box A provides a summary, as suggested by one interviewee, of how different symptoms might challenge different aspects of working.

Box A: Summary of the relationship between symptoms of depression and elements of work

1. **Getting to work:** Problems sleeping, low mood, lack of motivation, lack of interest in activities may all make the initial task of getting up, getting dressed and then travelling to work extremely difficult. Even more so when combined with anxiety (as is commonly found), which may mean the individual has difficulty leaving the house or getting on public transport.
2. **Doing the job:** Symptoms can be a barrier to performing work tasks. Concentrating on tasks can be difficult for some people experiencing depression, with concentration and attention span sometimes affected. This may mean people find it difficult to focus on one task for a period of time or may have trouble even getting started. Where this is joined by low motivation and low enthusiasm the challenge is even greater. In addition, where anxiety is co-occurring, panic attacks in the workplace may be a further concern.
3. **Working with people:** Most jobs involve interaction, whether with colleagues or customers. In some cases symptoms of depression make it difficult to tolerate being with people or tolerate noise. There is a greater tendency to become irritable and often a lower tolerance to stress.

Symptoms such as **low or flat mood, low interest and motivation** and **negative thinking** were seen as having a number of implications for work. This might include **difficulty interacting** with colleagues or customers, often resulting in withdrawal. This has implications in particular for relationships at work and how people are viewed (and treated) by colleagues.

That's often a criticism of depressed people, people say oh it's like you're in a really bad mood all the time, cheer up, what's the matter with you? So that leads them to withdraw more.

Such difficulties with relationships and interactions at work might be exacerbated by lack of sleep and **general tiredness**. Further, this was seen as problematic in terms of an individual's ability to attend work on time.

Some of them actually struggle to get to work in the morning which means that they have their employer ring them to say that they haven't turned up to work. It might be because they've had a terrible night's sleep or just for the fact that they can't face coming to work.

Distorted or negative thinking can cause people to interpret things more negatively than they otherwise might, for example, feeling that they are not very good at their job, believing that their employer and colleagues think this or feeling overly criticised.

It's always the worst possible explanation for a series of events and always thinking the

worst, not giving people the benefit of the doubt, always assuming the worst.

It was suggested that often people experiencing these symptoms lose confidence in their ability to do their work, causing them to worry about failure and avoid certain tasks (or avoid work altogether). This worry might be so distracting as to affect work performance or self esteem might be affected to the extent that work is affected. This perception of failure can therefore become a self-fulfilling ‘negative cycle’.

You would probably think they were doing their job quite well but they feel like they're not and even if you say no, no, you're doing it fine, it's quite hard for them to accept and believe that.

Such **cyclical negative thinking** (reflecting Beck's Cognitive Theory of Depression⁵) is also difficult for those who are not in work but are seeking work. **Low self-worth and self-efficacy** are often experienced by people with depression. It was suggested that often people find themselves unable to imagine that someone would want to employ them – lowering their motivation to seek work even further and perhaps feeling a sense of hopelessness.

There's the sort of worthlessness and hopelessness part of depression and the drain on your own sort of self-esteem and morale. And then there's the other aspect, your energy and your motivation. Your energy is reduced, you're tired, I don't feel like it, how am I going to work if I can't even get out of bed in a morning?

One expert suggested that to find a job requires a positive mind-set as job seekers need to put themselves out there. This will be a considerable challenge for someone experiencing this type of negative cognition. Here the very nature of the condition can be seen as a barrier for engaging in job seeking.

So the whole selection and recruitment process is geared on people who have got a positive world view, a positive outlook who can project themselves well. If low self-esteem is part of your depression, given the current way in which people are recruited to jobs, you're probably all things being equal not going to do that well.

Symptoms such as **poor concentration, indecision, and difficulty planning and prioritising** (many of which are seen as cognitive symptoms) were raised by experts; described most often in terms of job retention. **Poor concentration** was mentioned most often – associated with making mistakes with work, difficulty with following processes or instructions or getting distracted and losing your place during your task.

When you're there at work if your concentration and attention span is reduced, you're often not able to do things for long periods or even start the job in the first place.

A **subjective memory and forgetfulness** were also noted. Some people might struggle to

⁵ <http://personalityresearch.org/papers/allen.html>

retain new information. Where there is a lot of change in an organisation or a requirement to learn new processes this was seen as particularly problematic – with reversion to old ways and previously retained information a possibility. One expert also highlighted **slowed processing**, emphasising that there may be difficulties where tasks are time restricted.

People's reaction times are often slower; there are often delays in processing as well. So work tasks which may be time restricted, people find it very difficult and struggle in terms of completion of those tasks – they can't meet targets in the way that they might have ordinarily.

One expert identified that often cognitive-type symptoms of depression are late to respond to conventional treatment, continuing as residual even though other symptoms may be in remission. They are to a large part 'invisible' and may therefore go recognised and untreated. This has particular implications in the workplace, for example, where employers are not aware that an individual is still experiencing symptoms of depression and instead see reductions in work performance as a performance management issue rather than as a result of continuing untreated symptoms.

I think often people end up in the performance management arena, rather than supportive – what can we do to help your symptoms – arena.

Experiencing cognitive-type symptoms and being aware of how they are affecting work performance may have secondary consequences for the individual. It was suggested that the frustration for an individual in recognising a change in their abilities can be a source of further stress and anxiety.

Where people previously functioned at a high level and there's a secondary irritation, an anxiety that these symptoms have emerged and it makes them feel as if they might not get better.

This awareness of not being able to work as productively as previously may cause an individual to worry that they are less proficient at their job, or at any job, and exacerbate negative beliefs about self and work – feeding into the negative cycle.

Which, of course, then reinforces the thoughts that people have around the fact that "I'm useless, I can't do this, my employer's going to think I'm not able to do my job."

This might lead to avoidance of certain tasks, making decisions or work altogether possibly through taking sickness absence or delaying return to work after absence.

[Cognitive symptoms] can therefore serve as an obstacle to returning someone back to work because that individual recognises that they are struggling to concentrate. So for example, they can't read many pages without having to flip back to remember what they've written; they can't concentrate the whole way through a film or a TV programme.... So they're aware that their cognitive symptoms are causing them to struggle and therefore that makes them

avoidant about going back to work.

These types of negative belief, which might be exacerbated by cognitive symptoms, may lead someone to believe that they are unemployable – with considerable implications for job retention, as well as for job seeking.

What happens of course is that people, because they have a very low self-worth and self-esteem, and often their sense of self efficacy is so low, they find it hard to imagine anyone would want to employ them.

One expert suggested that for those who are unemployed, symptoms might be exacerbated by the 'lifestyle of unemployment' – associated with low activity, poor self-care and reduced motivation to get up in the morning. If the individual perceives their unemployment as personal failure then this may further reduce feelings of self-worth, feeding into their depression.

Because these people think, "Well I haven't even got a job; I've got no reason to get up in the morning." If people are already depressed that's not going to help with their sense of being a worthwhile citizen who contributes, which is that whole 'self worth' issue.

Another perspective offered by one expert was about how physical symptoms of depression affect employment. This might be seen in two ways – either in terms of the physical manifestations of poor mental health, for example a bad back, or in terms of someone explaining their sickness absence by telling employers (and clinicians) that they have a physical condition to avoid admitting they have depression, given the considerable stigma around mental health.

On the other hand the physical symptoms of depression quite often are what masks the underlying mental health state. People often say they're off because of back pain when the real reason they're off is something that's less palatable to put on a sick certificate; it's actually depression, not their back pain.

Summary and conclusions

In light of evidence from the questionnaire studies included in the literature review (involving 46,513 individuals of working age with depression⁶), it is possible to conclude that there is strong and mainly consistent evidence that cognitive dysfunction and other symptoms of depression have negative impact on employment outcomes of people with depression. There is moderate and mixed evidence that older age and co-morbidity, and moderate but consistent evidence that symptom severity and lower educational level, all act as barriers of employment in people suffering from depression.

Expert interviews reflected the findings of the literature review. All participants highlighted that the experience of depression and the consequences it might have for employment are entirely personal and may be experienced very differently by different people, despite having

⁶ Approximately 80 per cent of whom had a diagnosis of Unipolar Depression.

the same diagnosis.

The symptoms most often suggested by experts as problematic in terms of employment were low mood, lack of motivation/interest, difficulty concentrating, being easily distracted and negative thinking. These were seen as potentially difficult for both job retention (e.g. difficulty getting to work, completing work tasks and engaging with colleagues) as well as creating barriers to seeking employment (e.g. lack of motivation and self confidence to try). It was suggested that the experience of symptoms which might hinder work performance, including poor concentration and other negative symptoms, might exacerbate other symptoms, such as low mood and low motivation, through their impact on self-esteem and self worth. This cycle of negativity is also a factor in unemployment, where being unemployed may be felt to give more weight to an individual's negative view of themselves and possibly worsen their symptoms.

It was suggested that some of the symptoms of depression, particularly cognitive symptoms, whilst present when depression is first diagnosed might also be residual and remain after a period of treatment. This might be particularly problematic where their presence has not been recognised in the workplace, raising the possibility that employers, unaware of continuing symptoms, may not associate a change in performance with their health condition. Similarly it was important to note that often mental health conditions present, or are reported, as physical health conditions, which may also cause difficulties for employment as does the commonly occurring experience of comorbid anxiety.

Chapter 4 Interventions to support employment for those experiencing symptoms of depression

Interventions which improve employment outcomes for people with depression can be seen primarily as those designed to alleviate or manage symptoms as well as those which explicitly focus on encouraging employment. In this chapter we provide an overview of the evidence in the academic literature followed by an analysis of the views of expert participants. This section includes a number of interventions which were identified by experts as having value but which do not have an academic evidence base. Barriers to accessing interventions are also discussed throughout this section.

Evidence from the literature review

The literature review included 6,435 individuals, of which approximately 95 per cent had diagnosis of Unipolar Depression.

The most common type of intervention was psychological, using Cognitive Behavioural Therapy (CBT) approach. There were also two clinical studies on antidepressant medication that had examined their impact on work-related outcomes, namely on the effectiveness of selective serotonin reuptake inhibitor (SSRI) compared to selective norepinephrine reuptake inhibitor (SNRI). Some interventions combined antidepressant medication with a psychological therapy (Nieuwenhuijsen et al., 2014). These interventions were normally provided face-to-face but there were also interventions that were carried out by telephone (Furukawa et al., 2012) or online (Nieuwenhuijsen et al., 2014). Interventions carried out online or by telephone emphasised self-management and included sessions of developing self-care skills and identification and preparation for high-risk situations of depression. One study, for example, compared telephone CBT to usual primary and occupational health care (Nieuwenhuijsen et al., 2014). Even though evidence on the impact of cognitive dysfunction and other symptoms on employment is strong, only one small study on people with Bipolar Disorder focused directly on improving ongoing symptoms of depression (Deckersbach et al., 2010).

Interventions carried out in the workplace were psychological and sometimes preventive by nature, aiming to reduce a risk of long-term sickness absence among employees with depression (Furukawa et al., 2012; Lexis et al., 2011). There were also interventions that aimed to reduce sick-leave among those who were already off from work due to depression (Lagerveld et al., 2012; Nieuwenhuijsen et al., 2014). Workplace interventions normally combined some psychological therapy with a work-focused intervention. One study, for example, compared an extension of Employee Assistance Counselling (EAP) to regular EAP – the counselling programme incorporated both work modification and support whilst work modification was not included in the regular EAP (Nieuwenhuijsen et al., 2014). In addition, another study examined the effectiveness of work-focused CBT against CBT alone

(Lagerveld et al., 2012).

The evidence of the effectiveness of clinical interventions was highly inconsistent in terms of their effect on employment. Interventions that combined psychological interventions with antidepressant medication achieved more consistent, favourable results than clinical studies comparing only medications (Nieuwenhuijsen et al., 2014). Several psychological interventions conducted in the workplace and outside achieved highly positive results, showing higher decline in depression severity for an intervention group compared to care as normal (Deckersbach et al., 2010; Furukawa et al., 2012; Nieuwenhuijsen et al., 2014). In addition, studies focusing on reducing sickness absence and improving return-to-work were found to be effective. For example in a study by Lagerveld et al. (2012) employees in a work-focused CBT group (intervention group) had fully resumed work 65 days earlier than those receiving regular CBT (control group). Similarly, another study found a significant difference in total sickness absence duration (27.5 days vs. 50.8 days) between those receiving Psychological Skills Training (PST) and CBT (intervention group) and those receiving care as usual from occupational health services (Lexis et al., 2011).

Expert views

Experts were asked what type of services and interventions they saw as having a positive influence on employment outcomes for people experiencing symptoms of depression. Along with adherence to medication, experts primarily discussed psychological and vocational rehabilitation services and interventions available both in and out of the workplace. Experts not only discussed how such services were being provided but also highlighted barriers to access and other concerns about services which reduce their ability to effectively support someone to return to or remain in work.

Experts identified that symptoms of depression (e.g. low motivation, loss of interest and negative cognitions around self-worth and ability) can in themselves make it less likely that someone will access a service. This intrinsic barrier to an individual seeking out and engaging with treatment and vocational interventions can be a further hurdle to employment.

It is important to reflect that although the condition itself may be a contributing factor, it is not possible to estimate the extent to which these symptoms are in themselves a barrier to accessing services when the health, welfare and vocational rehabilitation services are far from perfect.

I think the difficulty in understanding the extent to which they [cognitive symptoms] influence can only be really understood when one has gold standard mental health services which would be there and be able to deal with the patient, but for the obstacle put in place by their cognitive symptoms. At the moment there are so many difficulties from a service point of view, from an individual point of view, from a societal stigma point of view, that deciding which of those obstacles is most pertinent for this individual is difficult to ascertain.

The individual nature of symptom pattern and severity, and how different people experience these, also means that such barriers may not be felt by everyone with a diagnosis of

depression. This is important to consider when discussing which interventions and approaches might be useful for helping someone with depression return to or remain in work. All experts emphasised this diversity and the importance of a personalised approach when selecting and using interventions – tailored to both the nature of their symptoms and their individual goals and aspirations.

Treatment interventions

Pharmaceutical and psychological interventions were most often referred to by experts for the alleviation of symptoms of depression which might be forming a barrier to work. The role of occupational therapy, as provided by the NHS and through the workplace, was also raised by several participants. Experts also suggested a number of barriers in healthcare provision more generally which are also discussed below.

Some experts were asked specifically about interventions which might address cognitive dysfunction given the evidence about its impact on employment outcomes identified in the academic literature. It was generally felt that interventions did not necessarily address cognitive dysfunction specifically but more that various interventions are available which would address various aspects of depression, including cognitive dysfunction.

I'm not aware of any direct evidence for specific cognitive, pharmacological agents or psychological strategies that one can directly focus on the cognitive symptoms. It's more making them a whole part of a sustained effort to treat the depressive illness.

When discussing interventions the focus of interviews was therefore on interventions which improved employment outcomes for people with depression in general. Further it is reiterated that selecting interventions should be based on an understanding of which elements or symptoms of the condition are seen as causing a barrier to the *individual* achieving *their* goals – which may include work. This is discussed further in the following section.

A key message from across participants was that in order to achieve the best employment outcomes for someone with depression, treatment alone was unlikely to be sufficient and delivery of treatment in parallel with vocational rehabilitation was more effective.

You cannot just focus on treatment. That will not get people back into work if they're off with depression.

Pharmaceutical intervention

Though most experts mentioned medication as likely to have a positive role in terms of employment outcomes for people with depression, it was not discussed in great detail by any.

Several experts asserted the value of using psychological interventions as an adjunct to pharmacological treatment in alleviating symptoms of depression. One expert described how medication can lift mood, though noting that in order for this to have positive outcomes there

needs to be a positive approach to life and recovery – a positive mind-set to complement the mood shift and get someone to move in a more positive direction rather than causing themselves harm.

There is no doubt that medication is really important in all of this but it's about helping people get to the point where the medication is starting to work and then making sure they're in a more positive frame of mind so the activity doesn't become destructive.

Some participants also raised a concern that side effects of medication could affect functioning and therefore employment outcomes. There was a consequential call for work to be kept in mind when making decisions about medication.

You often are giving people medication which might well affect some of their ability to work. Because your medication makes them tired or it makes them drowsy or they don't concentrate too well because of it and so on. So always remembering that and trying to – either keep the medication down or tailor it such that you are trying your best to not give them too many side effects that might impair their functioning. That's of course easier said than done because there are side effects to every drug, but if you can be aware of that when you're giving people tablets, because some might cause more sedation than others. Then you might help the person right from the start.

Indeed, the importance of considering the aspirations and goals of the individual patient in treatment decisions was a theme throughout the expert interviews.

Psychological therapies and support

As suggested in the literature, psychological therapies are a common and effective treatment for depression. Psychological therapies may be provided by primary or secondary NHS provision. Though depression can be severe and enduring, and people with this diagnosis may be in secondary health services, in the majority of cases psychological therapies are provided through primary care.

The countries of the UK differ in their provision of NHS primary care psychological therapies. In Wales, the Mental Health (Wales) Measure 2010⁷ requires mental health services to be provided in primary care, including short CBT interventions and/or counselling. Provision can be quite variable between the seven health board areas which commission and provide services. One expert suggested that quality of services was also very variable. In Scotland, increasing access to psychological therapies is a commitment outlined to meet HEAT targets⁸. In the last quarter of 2014, an estimated 10,500 people in Scotland used NHS psychological therapy (data from December 2014). A new waiting list target of 18 weeks was to be implemented by the end of 2014. In England, the programme for increasing access to psychological therapy for common mental health conditions is known eponymously as IAPT (Improving Access to Psychological Therapies). Developed in 2008,

⁷ http://www.mentalhealthwales.net/mhw/mental_health_measure.php

⁸ <http://www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/PsychologicalTherapies>

1 million people participated in IAPT in its first 3 years, with almost 700,000 competing treatment (Department of Health, 2012). IAPT accepts both GP and self-referral. The IAPT programme has also recently brought in waiting list targets (75 per cent of people referred to the IAPT programme will be treated within 6 weeks of referral and 95 per cent will be treated within 18 weeks of referral (The We need to talk coalition, 2013)).

Experts raised various concerns around current NHS provision of psychological therapy. Though these were primarily raised in the context of the English IAPT programme, it is anticipated that these issues can be found across NHS psychological therapy services.

Access and flexibility

Demand for psychological therapies outstrips supply in many areas of the UK. In 2013 it was estimated that one in ten patients in England was waiting for over a year (The We need to talk coalition, 2013), and despite recent investment and the introduction of targets, there is little reassurance that this will not continue.

Waiting times were identified as a barrier to people accessing the treatment they needed in a timely fashion.

High demand often means waiting lists and then often people have to then find creative ways of clearing waiting lists that mean people get some treatments and then a triage and then have to wait for the actual treatment.

The introduction of waiting list targets will not make that any better, it will just create secondary hidden waiting lists like it always does. So I know for a fact that one of the IAPT services... is now introducing welcome meetings for people so that they can say they've hit their waiting list targets so somebody will have a welcome meeting but they won't actively have treatment, they will just have been seen and hit the target. And that's not for me a way forward; it doesn't actually help us solve the problem.

Given the evidence that **early intervention** leads to improved outcomes this was seen as problematic by several participants in terms of employment.

There's a huge waiting list for therapy when people are unwell. And my argument is that if you look at Dame Carol Black's report in 2008 which talks about early intervention and prevention, how can you [do this] if people are sitting on waiting lists?

The March 2015 Budget outlined proposals which might provide more timely access to online CBT and to IAPT for some specific groups – i.e. those being supported by the new Fit for Work and those receiving Employment and Support Allowance or Jobseeker's Allowance.

A **lack of flexibility** in how and when NHS services are provided was also seen as an issue. Lack of access to treatment services outside of standard working hours (i.e. 9 to 5, Monday to Friday) presents a difficulty for employed people with depression who may not be able to get time off work to attend appointments during the day – particularly if they have not

disclosed their mental health condition to their employer.

They don't want to ask for time off work because then that would expose why they're going off...too often people feel they can't tell their employer so that creates more difficulty because they don't seek help, because they know they won't be able to get that time off. We're hopeless at offering services at times that suit people who work.

Difficulties accessing affordable childcare and limited provision in languages other than English were also suggested as presenting barriers to access. One expert also suggested that there was a **rigidity** in the way many psychological therapy services are provided which might be seen as a barrier.

Traditionally, I think people who deliver psychological therapies often have some reticence about how they operate. Because they do tend to be slightly rigid about things, the old idea of having a psychotherapist who you go to for 50 minutes/an hour is fine in certain circumstances but might be more or less well tolerated for some people.

In particular it was suggested that some psychological therapists saw their therapy as being restricted to those 50 minute sessions “*and stops when the person leaves the door*”, rather than thinking about how the therapy can be taken into other areas of the patient’s life particularly in terms of work. This might be in terms of self-help strategies which might support a return to work or possibly in communicating with occupational health or the employer.

It's not often actually been traditionally the province of the people who do psychological therapy. In fact, I think they need to think a bit more in terms of how they're providing a treatment and the idea of how people return to work is not outside their remit.

The **referral and assessment processes** for IAPT were seen as a barrier for some people with depression. One expert described a patient who was experiencing such severe depression that they were not able to “*overcome the hurdle*” of accessing the service.

He just couldn't seem to overcome the hurdle of making the phone call to IAPT, waiting for the ring backs, doing assessment sessions where they have to do their initial assessment session, the questionnaires, and coping with all that. In the end he just hadn't bothered so I just felt really sorry, this is a service meant for depressed people and somehow it was almost as though that very service was putting up barriers to the most depressed.

IAPT provided a good example of how in some cases the **symptoms of depression** – such as low motivation, difficulties with planning and working to timeframes, the experience of low self-efficacy and self-worth – as well as comorbid anxiety can be barriers to engaging with services. This is cemented by the strict DNA (did not attend) policy used in IAPT services, where non-attendance can mean a return to the bottom of the waiting list.

A lot of IAPT services have moved to self-referral as their preferred option because it

demonstrates motivation for change. But the reality is people with depression don't have motivation so it's a nonsense.

Types of therapies

As discussed above there is a strong evidence base for psychological therapies, in particular **Cognitive Behavioural Therapy (CBT)** which is recommended by NICE for treatment of adults with depression. This approach was seen as effective for the treatment of depression and consequently in terms of employment. Some participants discussed CBT in general, while others referred to CBT with a more specific work focus.

Where your CBT has a work focus... you're still managing symptoms and you're still moving to recovery but it's an occupational recovery that you're focusing on.

The fundamental aspects were seen as being around addressing negative thought processes and breaking challenges down into manageable elements.

Something that we try and work with is setting small achievable goals with people about how they can get back to work.

There was a suggestion among some participants (particularly those who had experience of working with, or in, the IAPT service) that an overt focus on the importance of “pure” CBT as an intervention was sometimes problematic. This was mainly in terms of the consequences for IAPT waiting lists, with people **waiting to see CBT trained practitioners** specifically, and an unwillingness to partake in other, less promoted (and less well-evidenced) therapies.

I think there is this issue about how do we actually value the treatments and make it clear that actually that is treatment, it's not about waiting to do see the CBT therapist, it's about making use of the treatment that's on offer. People are thinking well I'm not having CBT so therefore I'm not getting any treatment.

Though CBT has the strongest evidence base and should be a treatment of choice, it was suggested that other types of psychotherapeutic treatment might also be valuable for different people with different needs. Unfortunately, the evidence base for alternatives to CBT (particularly in terms of employment outcomes) is much more limited due to a lack of academic evaluation. Consequently, CBT is the most in demand service.

Lots of staff, like nurses and OTs, social workers, actually don't want to be CBT therapists, they want to deliver the interventions that they've been trained to deliver... And actually in health we offer an awful lot of really good interventions but don't have the solid evidence base because no one's ever developed the evidence base. But that doesn't mean that they don't work, but somehow if you're not having CBT then you're not having – it feels a bit like sometimes if you're not having CBT then you're not having anything. Whereas actually a lot of people are offering really useful helpful interventions every day of the week but they don't happen to have a RCT [Randomised Control Trial].

The same expert also mentioned the difficulty for therapists to access training and to upskill themselves in effective therapies.

There is an issue about training availability – because certainly in secondary care, there's such huge demands on the service, this whole issue about how do you release staff to be trained up to offer the particular therapies like Behavioural Activation or CBT or other things. When actually on a day to day basis, in most mental health servicesthose people are really fire fighting just trying to see everyone on their caseload and keep everyone safe.

Greater diversity in interventions was suggested as beneficial for patients who might not be ready to accept they have a mental health condition or those who do not feel ready for CBT. One participant suggested that there may be other treatments and techniques which could help people with depression to “*get going again*” and to begin the pathway to recovery.

Because I think a lot of how people with depression are offered a lot of psychotherapy and I'm not sure that that's what is needed actually. Sometimes people just need help to actually get going again and to actually build their activity level up to get them to a point where actually their therapy will be useful rather than trying to offer them therapy at a time when they're so low they can't really go there I guess.

To this end, some participants suggested other psychological type therapies which have not yet developed a sufficient evidence base to be recommended by NICE but which they saw as having been useful in their practice and their experience, particularly in terms of employment outcomes.

Psycho-educational interventions were raised on more than one occasion, particularly for people assessed as requiring lower-intensity support. This

might be delivered by IAPT Psychological Wellbeing Practitioners⁹. Such lower level interventions were seen as having a preventive role as well, as one expert said:

It hopefully helps to prevent it developing into full blown acute depression and helps them

Box B: Recovery colleges

There are 28 recovery colleges in England, with others in Europe, Canada, New Zealand and the United States.

Recovery colleges deliver comprehensive, peer-led education and training programmes within mental health services – with a focus on providing education as a route to recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Their services are offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus. Many of the courses provided by recovery colleges are focussed on employment, skills and education and therefore it is particularly relevant for work.

There has not been a comprehensive evaluation of recovery colleges though anecdotally they are seen as effective in achieving a range of employment-related outcomes. A pilot study found that 70 per cent of recovery college students went into education, volunteering or paid work.

More information can be found at:

http://www.centreformentalhealth.org.uk/news/2012_Recovery_Colleges.aspx

⁹ <http://iapt.nhs.uk/silo/files/psychological-wellbeing-practitioners-best-practice-guide.pdf>

hopefully, possibly to stay in work as well.

Psycho-education is an approach which teaches individuals about their condition and its causes and therefore empowers them to manage and cope with their condition. The provision of psycho-education is a key part of recovery colleges, which seek to use education as a route to recovery, rather than a form of therapy (see Box B).

Behavioural Activation was suggested by one participant. This approach considers the environmental sources of depression and seeks to target behaviours that might maintain or worsen the depression (see Box C). Some evidence indicates that behavioural therapies are as effective for treating depression as psychological cognitive therapies (Ekers et al., 2014; Shinohara et al., 2013). Academic evidence regarding its effectiveness for employment outcomes is limited but initially positive (Wesson, Whybrow, Gould, & Greenberg, 2014), though an interviewee suggested there was considerable anecdotal evidence for the effectiveness of Behavioural Activation on employment outcomes.

Box C: Behavioural Activation for employment outcomes?

Behavioural Activation (BA) is psychological intervention. In contrast to CBT, which seeks to challenge ways of thinking, BA seeks to help people understand environmental sources of their depression and to target behaviours that might maintain or worsen the depression.

BA is offered through IAPT either as a high-intensity group intervention or a low-intensity 'self-administered' programme. It usually involves 8 x one hour weekly sessions (with a follow up a month after treatment) in which clients and providers work towards the goals identified by clients – often including a return to work or engagement in meaningful occupation.

Evidence shows that BA is likely to be as effective as psychological therapies for treating depression. Evidence on its effectiveness in terms of employment outcomes is however limited, though providers claim there is considerable anecdotal evidence.

The benefits of BA include that providers do not have to be qualified psychologists and that the course is often shorter and easier to administer.

References: <http://www.christophermartell.com/ba.php>; Shinohara et al., 2013; Wesson et al., 2014

Embedded employment support

The value of embedding employment support into psychological therapy services and providing them in parallel was highlighted frequently by participants, many of whom were clear that this was fundamental to improving employment outcomes. This approach was found effective in academic literature as well.

If you're funnelled into IAPT services, there's no use going quickly through your IAPT and hoping you'll get back to work with a bit of cognitive therapy. You really need to be planting in those employment services – people who can support you back into work at some level or other.

Employment support has always been a key element of the IAPT programme in England with 'employment status' included in data collection and a service Key Performance Indicator measuring 'The number of people moving off sick pay or benefits'. In its first three years an estimated 45,000 people were helped off sick pay and benefits through the IAPT programme (Department of Health, 2012).

However, somewhat contradictorily, one expert stated that there was no mention of 'work' in IAPT training programmes.

I trained and delivered training on the university course and IAPT was supposed to impact on work. It was supposed to get people to stay at work and retain themselves in work, yet nowhere in that training was there any work focus at all. No, none. And every single therapist, and myself included, for many years I would treat symptomology first and then you would look once the symptoms had come down, what now?

The original model of IAPT specified there would be one specialist employment advisor for every eight IAPT therapists (Layard, 2006, cited in van Stolk, Hofman, Hafner, & Janta, 2014), who would be embedded in the IAPT team. Unfortunately, this ratio has not been achieved. Though the exact numbers are not available, employment specialists are a part of many IAPT teams, often with a particular focus on job retention. Experts who had experience of this spoke very positively about their addition in terms of employment outcomes for people with depression.

Often that [employment] is what they struggle with, the ...CBT therapists because that's not their area of expertise. They don't know about how to help people get jobs; you need an employment specialist to do that. It's been fantastic, it works really well because we just say to them ok, we've got the clinical expertise, you've got that expertise, let's just work together and it works well because we all know our role.

Employment related support provided alongside primary care therapeutic services is locally commissioned and delivered by the NHS or third sector. Consequently where it does exist it may look different between different IAPT services. One example is the Work and Learning Coordinator role, offered by Mind (see Box D).

Box D: Work and Learning Coordinator

The Work and Learning Coordinator is funded by Mind, who work in partnership with local IAPT Wellbeing services. Patients with common mental health conditions are referred by IAPT to the coordinator, who provides advice, information and support to individuals (whether in or out of work) with their employment-related concerns. This might include wellbeing tips, guidance on workplace adjustments, developing return to work plans or referrals to other employment related support services. The coordinator does not work with employers.

A key goal of the coordinator role is to provide practical support to the individual, so these problems can be fully addressed, alongside treatment. This is particularly useful given the limit to the number of appointments available through IAPT, allowing therapists to use sessions to focus on providing psychological treatment, aware that other needs, not directly in the therapists remit, are also being addressed.

Experts suggested that the value of having such employment specialist roles was in their ability to provide additional support with practical, real-life problems, such as work, allowing

the psychological therapist to use their sessions to focus on treatment.

In therapy we are quite limited on the number of sessions we can offer, we're focusing on the person's depression, and sometimes there's quite practical things that need to be sorted out which we might not really have the time and remit to do within our work.

Having employment support as part of therapeutic services was seen as entirely complementary to the health related goals of treatment.

I guess from a therapeutic point of view, a clinical point of view, we've been looking at it for somebody's holistic wellbeing – actually having a routine, having work to go to or some sort of occupation whether that be volunteering or whatever that may be. If that will help maintain any gains that are made in therapy and help them hopefully not become clinically depressed again in the future because we know how helpful it is to maintain mood and having that regularity of routine and sense of belonging and role in the community.

The specification that employment support and therapy be **delivered in parallel**, with a strong connection and communication between the two types of specialist, is important and allows them to complement each other and keep working towards shared goals.

It's great because if the employment specialist is working with someone who starts to deteriorate or is experiencing more difficulties, then we can just get involved and help them with that element while they're still job hunting. So they never lose that vision of themselves as someone who could potentially work, which is so important.

The difficulty is that when you have an employment advisor who sees the patients separately and you have a therapist who is doing the therapy, and the two do not consult, then though the employment advisor can approach your employer ... in the context of symptoms and treatment and what might help somebody to get back into the workplace it's not joined up, it's not integrated.

There was broad agreement that CBT, though effective in alleviating symptoms, might not on its own provide the support someone needs to in terms of moving forward with their everyday life. The provision of complementary employment specialist support was seen as a valuable way of helping someone progress in terms of employment – where that was a goal – and more should be done to encourage joint provision of therapeutic and employment services.

It's got to be done all together and I guess that will be my main criticism of things like CBT that sometimes it's done in isolation. So someone has their 12 weeks [of] CBT but then they still need help with their life stuff – and I think that's where we really miss a trick often. So I think if there's anything for policy it is around actually it needs to be better integration with the wider system and also that the DWP and the NHS treatment side – we just need to be working together better and we should be mandated to work together, not as two separate entities.

Occupational Therapy

Several participants spoke about the role of Occupational Therapy in influencing employment outcomes for someone with depression. This was mentioned specifically in terms of their role as part of the multi-disciplinary team in secondary mental health services and their often related role in supported employment services (see employment interventions section, p31), where they may supervise or work closely with employment specialists or be a designated Trust “vocational champion”.

One participant explained that, in the past, Occupational Therapists (OTs) had the employment specialist role but that now having this as a separate, specialised position had proved highly valuable.

We managed, but I do think that having people that are absolutely dedicated to that and have all the links with employers and know exactly what's going on, I think that's really beneficial.

The role of OTs in working with patients with depression (as with other conditions) was seen by those in the field whom we spoke to as supporting individuals to work towards their personal goals – what they value and what they believe would help their self-esteem – in many cases including employment.

As OTs, we see so many benefits for people if they're actually in a job that they want to be in and that they value. Social interaction for example, when people have been completely isolated, their self-esteem goes up because they feel valued at work, they get structure and routine back. And they're able, if their income is ok, they can make choices about their leisure activities and they can choose to do things that make them feel good and improve their quality of life.

Expert participants were clear that Occupational Therapy had an important role in terms of helping people experiencing symptoms of depression to work and could be used more effectively by the NHS to this end.

My experience with occupational therapists is that they are [an] underutilised resource in the NHS and often very skilled.

There was a suggestion however, that due to a lack of academic evidence as is required by NICE for use in treatment guidelines, the role of OTs might not be as highly valued as it should be, particularly where it is provided alongside psychological therapies.

So there's a lot of OT that is very effective in terms of helping people to increase their activity levels and improve their cognitive symptoms. But because it's not CBT and they don't have the same evidence base, it's not valued. We're never going to get everyone attending CBT, it's not realistic, and ... I do think people sometimes have, even if they have CBT, they still have wider life/social/emotional problems actually need someone to walk them through, to walk with them while they sort that out. So that's not something that's offered through CBT.

General barriers to accessing treatment

Raised in interviews were a range of other barriers to accessing effective treatment through the NHS to the end of improving employment outcomes for people with depression.

The extent of and commitment to treatment. For one expert, the evidence in terms of treatment which might improve employment outcomes for someone with depression (and particularly for those experiencing cognitive symptoms of depression) was perhaps less about highlighting particular interventions but more generally about the energy which is put into the treatment of the depressive disorder.

So the obstacles are primarily getting energetic-enough treatment of the underlying depressive disorder and there are multiple barriers in our society to that. So they evolve around inadequate psychiatric care, either from primary care or from secondary care. In a sort of non-willingness or a discomfort in recognising the depressive symptoms of themselves and ongoing concerns around stigma in the workplace which means that people would rather press on with their depression disorder rather than step out, get treatment and come back again.

Inadequate psychiatric care, in terms of both primary and secondary care services, was highlighted. In particular it was suggested that treatment may not be sustained for long enough and may not therefore address all of the symptoms of the depression – allowing some symptoms to continue despite having provided treatment which led to the remission of other symptoms.

We need to have a fundamental recognition that residual symptoms represent a poor prognosis and that we don't just treat people to get them a bit better; that we treat people to get them thoroughly better. We treat them hard enough for long enough in order to improve their long term outcomes.

Reflecting this, other experts suggested that the NHS's provision of treatment may not be of sufficient length to fully treat depression. One suggested that IAPT is not always provided within NICE guidelines, which recommends 12-20 sessions for moderate to chronic depression, with many IAPT services capped at eight sessions.

What you get is people not recovering and therefore they just come back through the system. And if you think about that in medical terms, if you have somebody who has a heart condition and needed aspirin you wouldn't prescribe them a subtherapeutic dose and then send them on their way. That wouldn't be acceptable yet in mental health services in order to manage the crisis, what we do is we give people subtherapeutic doses of care because that's essentially our medication and I think that's a real barrier to people recovering and getting back to work because they haven't actually had the care that was required.

Recognition of ongoing symptoms. One reason why treatment may end before the individual has made a complete recovery was suggested to relate to failures in recognition of some of the symptoms of depression. A focus on alleviating the sometimes easier to see

mood-related symptoms may mean that more invisible symptoms, such as those that effect cognition, may not be recognised or addressed. Continuing (yet treatable) symptoms can significantly hinder recovery and return to work.

The first thing is to recognise them. And to appreciate where they fit in in this individual's difficulties and how they relate to the function that they are trying to return to. So not just treating the mood element of depression which is often easy, but looking at the global picture. Be energetic to treat the concept of residual symptoms and cognitive difficulties, it may well be residual symptoms which persist longer and could potentially act as a focus for relapse in the future.

It was also suggested that after a period of depression-related sickness absence many people will seek to get back to work as soon as they can, often out of concern that they will be in trouble with their employer, and therefore return to work despite some symptoms remaining. It was suggested that reporting of a short-term physical ailment was common, meaning that people might return to work claiming they are recovered, while actually they are still experiencing symptoms relating to their depression which are effecting their ability to work. This was suggested to be a further concern, as in this scenario there will be even less willingness to seek treatment, given it is often only available during working hours and the individual may not wish to further raise the suspicions of their employer.

Insufficient understanding of mental health. The complexity of depression was highlighted, with several participants commenting that treatment can be very difficult and understanding among many clinicians was poor. This might be particularly problematic when developing and following care pathways.

I think it's really difficult because there's so much variation in how people with mental health problems respond and that's why it's so difficult to treat mental health problems and have policy because a care pathway for a broken leg is a care pathway for a broken leg.

Several participants felt that mental health was not given appropriate consideration as a specialist area, with many people thinking they are qualified to work in the area, despite not having mental health specialist expertise.

Because there's still this idea, and I come across it day-in day-out in my work, that anybody can do mental health. So what happens is, not anybody can do mental health! I've trained extensively, specialising in mental health and within mental health there are a number of different specialisms. And not many people kind of grasp that and often people believe that anybody can assess whether somebody is depressed or anxious or whatever the condition might be.

This misconception about what is required in order to assess someone's mental health was suggested to not only be a factor in the NHS provision but was also found in vocational rehabilitation assessment and in assessments related to benefits (see employment interventions, p31, for more information).

Low expectations regarding work. Low expectations of healthcare professionals in regard to the possibility of returning to work was highlighted by several experts as a considerable barrier.

The biggest barrier to people with mental health problems getting back to work is their nurse, doctor, psychologist telling them that they won't get back to work. But you've got whatever illness it is and it's going to be a long time before you can manage and cope.

We just have a more pessimistic view, clinicians have, about what you can achieve, what people with mental health problems can achieve, particularly those with psychoses and long term problems. But also the sense of hopelessness that GPs might feel about those people who come into their surgeries with depression and anxiety who can't feel they can get back to work. They sign them off and they spend far too long off work, lose their job and they can't get back again.

This was even described as happening by those clinicians who understood the principles around the value of employment for many people with depression but still find it hard to manage their own persistent low expectations.

I do think the whole issue about staff having low expectations of service users is really important because if we don't believe that they can work then they're never going to believe it. ... We get it all the time – oh this person will never work – and it's like well they might, let's give them the benefit. I do think there's something very fundamental about that low expectation culture that we just, we really do need to own up to and I think again professionals are very bad about owning up to it. We ...no, no, we're always very confident and aspirational, we're not at all! But I think there's a big issue about that, about us actually not believing it in our hearts.

The considerable progress that has been made in recent years in terms of getting the importance of employment for people health conditions on the policy agenda, and in getting the messages across to healthcare professionals, was also noted. Key messages were reflected on, such as: good work is good for health for those with mental health conditions; people do not have to be one hundred per cent well to return to work; and, the longer someone is out of work, the harder it is to return. Efforts are ongoing, however, to spread this message widely among clinicians and to change the culture around it to the end of greater recognition of 'employment' as a health outcome. But as one expert pointed out, changing culture is a long and difficult endeavour.

That's a difficult thing to overcome so what we need to do is integrate, if you want to change people's attitudes and beliefs, then if you integrate it at the training level, then eventually that will seep through into the general population.

Recognition of the patient's goals – including employment. A key message from experts was that treatment needs to be tailored to a particular individual's goals. It is fundamental in making treatment decisions to identify what an individual patient wants to

achieve, what their goal is and work towards it – identifying the barriers of work of each individual rather than focussing on symptoms for symptoms sake.

Ultimately it's got to all be about what is important for the person who is depressed. Because I think often we get a bit locked into let's treat all the symptoms and everything will be fine. But we've got to work out actually what do they value and what are their personal goals. It's very much about recovery, about what is it they want to get better for and what is the thing that will keep them going... I always quote it – patients are much better judges of what is important than we are!

The second thing is to treat the whole of the patient, so not just how they present in clinic, or in the surgery, but to tie your treatment and what you're hoping to do to that person's life. So really emphasising the concept of functional recovery. So what is this person aiming to get back to, what is it that they want to do that they can't do because they are unwell?

Where employment is one of those goals then this needs to be a focal point of treatment decisions. Some experts suggested that proactively asking about employment and ensuring it was on the agenda for those who have aspirations around work should be a regular feature of health consultations.

Whatever that treatment is, whether it's psychological or medication or support or whatever, combining that in parallel with efforts to firstly just even discuss employment with people and think about efforts to keep people in contact with work, to keep them in the back of their mind always thinking that at some point they can return to work. It's the parallel efforts to get people back to work in parallel with treating their disorder as it were.

For me a policy initiative would be to ask people what is it that you do? As part and parcel of any consultation, what is it that you do, what impact is this having on the things that you do at work, what are the barriers to you going back to work, is there anything that we could do to reduce them?

This was expressed as being necessary throughout health exchanges – from the GP to the psychiatrist. For those in work especially it was expressed as important to maintain that continuous connection with work.

So you treat people and you have them off work for ages and then you wonder why you can't get them back to work easily. Because they've not been thinking about it because their employer has given up on them ever coming back or even of course maybe they've just lost their job in the meantime because they've been off work for too long and so on.

Access to multi-disciplinary support. Taking a multi-disciplinary approach to treatment and support was clearly important to participants. As discussed above, having occupational therapists and employment specialists work alongside psychological therapists is important but some experts also suggested a broader model as being valuable for employment outcomes – incorporating peer support and other support workers.

We're very traditional in how we see our workforce. The community team is still five nurses, an OT, a bit of psychology, a bit of medicine, and that's it. And we should be looking at having more peers in the workplace, who actually have a lived experience, more support workers, different types of workforce. But I think we're quite, us professionals, are quite scared of that and I do think that is an issue.

This expert felt the potential of a more diverse team needed to be better recognised, shifting away from the explicit medical model to one that better considered more diverse needs and goals rather than simply the alleviation of symptoms. This might involve incorporating people in the care team who can help with day-to-day activities – such as going out to a café:

Because again it's the public perception of ok, you're having a psychologist and you should be having a doctor. And in the current setup that's far too expensive and we can never afford to do that. And actually that's not always emotionally fulfilling because actually if you're so depressed that you need help just to get out and about and actually just go down to a coffee shop, what you need is a support worker or a peer, not a psychologist actually. It's about understanding what the need is.

Access and early intervention. Waiting times for services were not only raised as a concern regarding primary care psychological therapy but also in respect to delays in entering secondary care mental health services.

Just getting access to that secondary mental health service in the first instance can be quite tough. Going through their GP might take a couple of weeks to get linked into someone or even a couple of months and by that time their depression could have got a lot worse.

Delays to treatment were in general seen as a major barrier to improving employment outcomes for someone with depression.

In terms of the interventions I think there are two key things, whether you're keeping somebody at work or you're returning them to work, early recognition of problems, early intervention, fast access to assessment to be triaged to most appropriate treatment and then quick access to intervention as well. The longer it takes to get all of those things into place the more difficult it is for somebody.

NHS as exemplar. Some experts suggested that poor quality NHS Occupational Health services might be problematic. Poor practice here was seen as important not only in terms of the wellbeing of the UK's largest workforce but also how receiving poor quality Occupational Health support might influence the way NHS employees think about health and work when with their own patients.

I think the NHS is still really poor at supporting people with mental health problems in work. I think some Trusts are excellent, but I think still we're not great at it, even though it should be something that we are excellent at. I think the NHS itself, and probably social care, have got a long way to go in terms of how they support their own staff to go off sick with depression

and anxiety and other mental health problems.

It was suggested that there was a widespread belief within NHS occupational health services that returning to work was not a positive thing when depression was concerned.

I think there is a big need for occupational health departments to get much smarter about dealing with depression and actually what helps with depression. Because traditionally still, if people go off sick with a mental health problem, and certainly with depression, they tend to get signed off for long periods. Well actually the evidence is that if you were to actually help people to stay in work that their depression will get better quicker. It may be difficult but it will get better quicker with the right support. Because if you can maintain a role that you value and is valued by society, then that's much healthier for you than stepping back into being off sick. Because being in the sick role obviously reinforces the symptoms of the depression.... So, occupational health I think that we still haven't really cracked it

One expert suggested that a lack of job retention specialism was often a gap in NHS occupational health provision. This led to the suggestion that occupational health services within the NHS, as in other workplaces, might benefit from incorporating a non-clinical employment specialist role within them. With a particular focus on liaison with the individual manager, to discuss needs, adjustments and generally support that relationship when an employee had had a period of sickness absence with depression.

Someone who's focused on the employment and is talking to the manager about: hey, this member of staff has been off work for six weeks with depression, they're worried about coming back to work, let's think about how we're going to manage that return to work and how we're going to adjust the workplace so that they feel they can come to work more comfortably.

Employment interventions

A number of interventions and services focus explicitly on employment outcomes – it could be return to work, job retention or support finding a job. While some services are focussed on people with mental health conditions, others are for anyone with a health condition or indeed for anyone who is not working.

A clear message from all participants who discussed employment and vocational rehabilitation services was again that effectiveness was significantly improved, or would be significantly improved, by their integration with health colleagues and services. Thus providing complementary, well-rounded health and employment related support. This was emphasised as important in a variety of healthcare settings, leading one expert to conclude that vocational specialists should be working within “*whatever clinical team you are operating in.*”

Unemployment services and support

Unemployment services discussed in expert interviews included government back to work support provided through the Jobcentre Plus (JCP) as well locally commissioned services

(e.g. through NHS trusts, clinical commissioning groups, local authorities and the third sector) – in particular Supported Employment services. Job retention interventions also included those provided by the workplace as well as those provided externally, again through government services or local commissioning. We will discuss these in turn.

Government back to work support: Jobcentre Plus programmes

JCP provides support with finding employment for people with and without health conditions throughout the UK. Unemployed people experiencing symptoms of depression might be receiving either Job Seekers Allowance (JSA) or Employment Support Allowance (ESA) depending on assessments of the severity of their health condition.

Many people with depression are at some stage referred mandatorily to the Work Programme¹⁰ – the government's flagship welfare to work scheme. People with disabilities and/or long term health conditions, which may include people who have depression, might alternatively be referred to Work Choice¹¹, a voluntary programme.

According to the latest official statistics, in the four years and two months since condition-specific data collection began (at the start of 2011), of the 11,680 people with mild to moderate mental health conditions who started Work Choice, 5,000 have been reported as achieving an employment outcome (43 per cent). Of the 690 people with severe mental health conditions who participated, 260 have achieved a job outcome (38 per cent) (Gifford, 2015). Though only one participant mentioned Work Choice, they did so positively, noting that their recorded employment outcomes for those with mild to moderate mental health conditions were much better than those of the Work Programme. Indeed, it was the Work Programme which was the main concern of participants.

Many more people with mental health conditions are entered onto the Work Programme. According to a recent report, of the almost 150,000 ESA claimants with mental health problems who have been through the Work Programme, only 5 per cent have been helped into work (against 24 per cent of people with no health condition) (Mind, 2014).

Among the experts, the Work Programme, and JCP support in general, was not seen as particularly effective for those with depression (as reflected by employment outcome data). It was suggested that the way services have been set up provides little incentive for support to be focussed on people with depression, with people with mental health conditions often seen as harder to help.

A lot of the employment services through the jobcentre are not geared up for people with mental health problems at all... they actually tend to target the easier to help because they get more money faster, because that's the way the system's been set up unfortunately.

One expert felt people with depression were often very wary of the JCP, associating it with sanctions and conditionality rather than trust and support, meaning it was difficult for them to

¹⁰ <https://www.gov.uk/government/publications/work-programme>

¹¹ See <https://www.gov.uk/work-choice> for more details. NB Work Choice is not available in Northern Ireland

work effectively together towards improved employment outcomes.

Just interacting with DWP and Jobcentre Plus, I think people are very afraid of it, and they're very fearful, which doesn't allow that engagement, it doesn't drive that kind of decent relationship between them and the advisor that would allow them to work together productively.

That's really good if people can work, and if we can support people to be in work, that would be really helpful. Although what seems to happen with that, that isn't helpful, is that it seems to happen the opposite way around – that people's benefits get taken and then quite often they're looking at having to go back into work and it creates quite a high amount of anxiety which doesn't really enable people to get back to work, if they're already struggling with depression.... [We need to] help that happen in an opposite fashion of aiming to get people to work and there being a clearer process of how one moves from long term sickness benefit to in to work.

A criticism of the JCP and the Work Programme was that its approach was 'impersonal' and too rigid in its definition of progress – in particular, reference was made to their exclusive focus on paid employment outcomes, with limited consideration that there may be other measures of progress. In particular one expert noted that the Work Programme put up barriers for people wishing to do voluntary work, having too overt a focus on a paid employment outcome.

We hear anecdotal stories of people volunteering somewhere and some Work Programme advisor saying no, no you can't do that, you've got to come and do this, even though it's detrimental to their health and not the kind of support they were looking for.

Others agreed that voluntary work might be an important step on the return to work process for some people with depression – particularly where someone has been out of work for a long time.

There's also things like volunteer services which can help people get back into work, so it's a really helpful and useful step for people who have especially been out of work for some time just to have a bit of routine and build some confidence, just getting back into the workplace.

The narrow view of outcomes adhered to through the Work Programme was therefore not seen as reflecting the needs and the context of many people with depression.

[Permitting] a more personalised approach means that someone could, if they can, volunteer for two hours a week and have that recognised as an outcome, something that they have progressed to do, though it shouldn't obviously just be the end goal. But if someone can manage that, that's good, rather than just saying "right you've got no work"

The lack of integration of health and clinical support with the JCP and its programmes was a chief concern noted by several participants. One expert was concerned that GPs were not

given information about what type of therapeutic support people were referred to by the JCP.

There's very little exchange and no exchange of correspondence, so we don't know, I think we from a primary care perspective, we don't know what they at Jobcentres are doing in terms of psychological support and coaching, and all those areas, therapeutic activities.... that is a remarkable gap in the market if you ask me.

Other experts similarly found there was a lack of acknowledgment of 'health' within the JCP remit, particularly when it comes to assessment of capability to work (i.e. through the Work Capability Assessment).

There needs to be better links and more of an expectation of information flow. People shouldn't be sitting in offices assessing people with severe and enduring mental health problems saying they're fit to work without actually some commitment to talking to clinical teams if they're involved. Because it's just hopeless, hopeless, someone could be seeing a team for ten years and the team would never be asked to give a view – it's ridiculous.

It was argued that in order for someone experiencing symptoms of depression to successfully return to work, in particular when assessed as fit for work, there needs to be parallel health support and health input to help them manage the transition.

I think they really have to address that gap because we get all that anxiety from the service users – some of them who actually should be signed ready to work – and that's fine, but in terms of our treatment with them, [we could] be saying actually maybe you could look at work as an option because they're saying you're fit to work, so let's work with that. But instead we just get this panic and despair of being told they're fit to work without ever having been asked what that means.

Many of the comments made by experts about the role of the JCP and its programmes reflected the idea (suggested directly by some participants) that Work Programme providers do not generally take an evidence-based approach in terms of what works in supporting people with mental health conditions back to work – such as that demonstrated through the IPS model of supported employment.

A number of experts suggested that the DWP's approach to welfare more generally was not conducive to improving employment outcomes for people with mental health conditions. In particular, in terms of the availability of quality jobs which provide a decent wage, making it worthwhile for people to come off of welfare benefits.

You can't just have narrow health-based or even employer-based policies; you've got to think of the role of the state as well in providing the environment which is more healthy for people getting back into work after periods of illness.

A lot of people really worry about if they start work and then they're going to leave their benefits because they feel the wage that they might earn wouldn't match their benefits... So

the actual benefit system in a funny way can be a bit of a barrier at times.

Locally commissioned back to work support: Individual Placement and Support Supported Employment

Individual Placement and Support (IPS)

Supported Employment based services are provided in various areas of the UK. They are commissioned locally, based on local need, priorities and interest, by NHS secondary mental healthcare services, Clinical Commissioning Groups (CCGs) and/or local government. They are often delivered by third sector partners, working with the NHS Trust, and are open to all those in secondary mental health services who want to work – primarily those with severe and enduring mental health conditions (see Box E).

The model requires the integration of employment specialists within the clinical team, often supervised by OTs or another ‘vocational champion’ in the multi-disciplinary team. Being in a secondary mental healthcare service means that the focus is on those with severe and enduring mental health conditions – this was reported as including a substantial proportion of people with symptoms associated with depression.

Box E: What is IPS Supported Employment?

The Individual Placement and Support (IPS) Supported Employment model represents a shift away from traditional pre-vocational models of vocational rehabilitation. It is characterised by its focus on rapidly seeking paid employment for service users ('place then train') rather than spending time preparing people for work ('train then place'). The integration of employment support with the individual's mental healthcare and treatment is also seen as key to IPS. These characteristics form part of eight principles which when followed closely have been shown to increase the effectiveness of the model. These are:

1. Competitive employment is the primary goal;
2. Everyone who wants it is eligible for employment support;
3. Job search is consistent with individual preferences;
4. Job search is rapid: beginning within one month;
5. Employment specialists and clinical teams work and are located together;
6. Employment specialists develop relationships with employers based upon a person's work preferences;
7. Support is time-unlimited and individualised to both the employer and the employee;
8. Welfare benefits counselling supports the person through the transition from benefits to work.

Though IPS is the best evidenced model for supporting people with severe mental health conditions into paid employment on the open labour market, the academic evidence is primarily focussed on people who experience schizophrenia or Bipolar Depression (Crowther, Marshall, Bond, & Huxley, 2001). Expert participants however suggested that they saw IPS as effective for improving employment outcomes for people with depression as well, despite the lack of academic research evidence using a Randomised Controlled Trial design.

I think there is a real need for more research around IPS and people with less severe and enduring mental health problems. Because I do think there's no reason why it wouldn't work.

Many people with depression will not be in contact with secondary mental healthcare services. Recently, however, the Department of Health (DH) and the Department for Work and Pensions (DWP) have been considering whether IPS might be introduced to primary

care to support people with common mental health conditions into work. This followed from a 2014 report, commissioned by DH and DWP, which outlined the anecdotal evidence that IPS was effective for people with common mental health conditions (van Stolk et al., 2014). A six month pilot study was undertaken to test a model of IPS integrated within IAPT in four sites in England. The evaluation report, though primarily meant determine the feasibility of scaling-up the pilot, highlighted that participants who received both IPS and IAPT support achieved many employment related outcomes, including 15 participants who found paid work. The report also highlighted the importance of the relationship between the IPS, IAPT and JCP services and the need for integration of health and employment related services. Several barriers to successful implementation were also found – not least the delay in accessing IAPT, meaning that IPS and IAPT were rarely delivered in parallel within the pilot (Steadman & Thomas, 2015).

In terms of current IPS provision, several of the experts interviewed worked with or were aware of IPS services as part of secondary mental healthcare. All participants who referred to the provision of IPS did so positively, seeing it as improving employment outcomes for people experiencing symptoms of depression.

The integration of health and employment support was the aspect of IPS services mentioned most frequently by experts as key to its success in achieving employment outcomes. This was thought to allow the provision of a more personalised and holistic/rounded approach to an individual's recovery than other employment services, in particular those provided by the JCP.

So the person feels like – ok someone is helping me with my job, but also someone is helping me with my symptoms and my treatment and I know they're being done together so that it's not we'll get better and then we'll give you some employment. It's about we'll get you better at the same time as helping you with your job because it's all part of your life.

You can kind of work in tandem with people and then they get two kind of strands to their treatment. And I think that often benefits them because they are getting on with the employment side of things and sort of hopefully improving their mental health at the same time.

The NHS Trust and the third sector IPS providers having shared values and shared goals in terms of service user outcomes was seen as important for success, with the suggestion that the goals of the Work Programme were fundamentally different.

They've got similar kind of values to the NHS so it works really well because you get each other – we're both on the same page in terms of what we're trying to achieve. Whereas if you're working with the Work Programme, with the best will in the world what they're trying to achieve is getting someone into a job and that's never going to work as a motivator for Health because that's just not how we work.

The greatest concern for participants around IPS was that it is not widely available.

IPS is not available universally so there are lots of places that aren't being offered the best model so people aren't getting the help that they need because its not been commissioned.

I think for secondary services we should be ashamed that we're not commissioning those [IPS services] as a sort of matter of course really given the amount of evidence there is for their value.

Being locally commissioned, one expert explained that the greatest barrier to seeing more IPS services is local motivation.

The only barrier really is the local trust or local council being innovative enough to look towards that.... It's down to locality. So some people might not think about it, they might not have the money or they might focus their funds elsewhere... I know there are a lot more local authorities looking towards it and opportunities are there.

Several experts spoke about the need to enhance and encourage joined-up locally commissioned services – bringing together local health and social service commissioners, public health and local government, as well as employment services, including the JCP. It was suggested that mental health and employment needed to be recognised as part of their remit.

Inclusion of an indicator looking at employment outcomes for those using secondary mental healthcare services in the Public Health England Outcomes framework¹², and more recently in the Clinical Commissioning Group Outcome Indicator Set (CCGOIS)¹³, was suggested to be increasing local interest in commissioning such services, along with 'participation in work' being included in the definition of wellbeing in the Care Act 2014¹⁴. Though it was suggested there was a long way to go.

I was talking to [a GP colleague] who hasn't been able to get to them [IPS services]. And I was saying to him – what are you doing locally? He said well we're doing nothing. And he's not the only one who's doing nothing in this area really. There's clearly an issue about the existence or not of any sort of vocational service which is geared to this.

Even in areas where services have been commissioned, promoting the services to potential users whether through GPs or directly could present a difficulty.

I don't know if there's more ways of trying to promote it and as I said, it's just making the GPs aware and often the psychiatrists as well about that these opportunities are available because sometimes it's quite easy to think down the medical model line and not really look at the whole picture and look at things holistically.

¹² Indicator 1.08iii – Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate.

¹³ Proportion of adults in contact with secondary mental health services in paid employment.

¹⁴ <http://www.tcsu.org.uk/uploadedFiles/TheCollege/Policy/2014%2005%2029%20Care%20Act%20Practice%20Implications.pdf>

Those we spoke to were aware that there would be benefits to the local community if they could spread the word about the service but did not have the time to do so.

Well I think if we had more time to devote to employment, I think in theory as a vocational champion I'm supposed to have half a day a week just to devote to that, but obviously I think everyone would say that, all the vocational champions, you just don't get that time at all. So unfortunately that would probably be the time where you could look into those kind of things and start to try and look at promotion.

Job retention support

Measures to support job retention for people experiencing symptoms of depression were seen as incredibly important. What is seen as fundamental in terms of helping someone with depression to stay in work is the understanding that you do not have to be one hundred per cent fit to return to work. Evidence indicates that in many cases continued exposure to work is beneficial.

If we can keep people in work it's so much better than them losing jobs and having to find them again.

So it's starting to get them into that process at the same point the employer needs and occupational health, in sort of producing a return to work plan, needs to understand which aspects of the patient's illness have got better and which aspects of the patient's illness are still work in progress.

As described by one participant, supporting someone to stay in a job has two elements – you must work with the individual, and you must work with the employer, in order to manage their compatibility.

I suppose there are two sides of the equation, how much can the person adapt and change in order to fulfil requirements of work and how much can work adapt and change in order to fulfil the requirements of the person.

The culture and the values of the organisation were seen as crucial to successful job retention for someone experiencing depression, in particular their attitudes around mental health and their willingness to make changes and provide support to retain an employee. This was particularly discussed in terms of someone returning to work after a period of poor health.

When developing a return to work plan, employers need to have an understanding of "triggers" which might signal a worsening or a return of symptoms for an individual, as well as knowing which symptoms might not have been successfully treated yet and still require treatment – described by one expert as '*work in progress*'. This will help inform what adjustments to work might be made.

Experts raised the importance of specialist knowledge around mental health and

employment in developing an appropriate tailored package of support for individuals. Several also cited workplace interventions, in particular provision of access to psychological therapy, for example CBT (delivered face-to-face, via the telephone, or computerised) through their occupational health service or via private health insurance. It was suggested that many employers now recognised that having such support available to employees was an investment given the costs of sickness absence, of presenteeism (attending work when unwell) and of losing employees.

Most participants cited **workplace adjustments** as an important factor in job retention. These might include changes to tasks, greater flexibility in working hours and times or the provision of extra support. It was suggested by a number of experts that making reasonable adjustments in lieu of mental health conditions was seen as challenging for many employers and indeed that adjustments are underused when it comes to mental health.

There's all this business about thinking in terms of making appropriate adjustments for people. I think to be honest, that's been one of the most difficult areas because it's easier often to think of making reasonable adjustments for people with physical disorders than mental health ones.

It's actually sitting down with employers and talking about things like reasonable adjustments. We still don't use reasonable adjustments enough for people with mental health problems.

In order to develop adjustments which are helpful and reflect both the individual's needs and the business's needs, adjustments should be worked out by the employer and the employee.

In terms of thinking about keeping people in their jobs, I think it becomes important to make the link between the clinician, the employer and the person who is depressed. In the sense that the person who is depressed needs to keep in contact with their line manager and the line managers need to know that they can be helpful in supporting people to get back into work.

Experts provided examples of adjustments which they thought would potentially be helpful for someone with depression, with the caveat that what is helpful and what works will be different for different individuals depending on what they are finding challenging. The most common suggestion was flexible working hours to allow for someone who has trouble sleeping or getting up in the morning. Other suggestions included where someone is having trouble concentrating, deadlines may need to be adjusted or extra support provided; or where someone is having difficulty interacting with people or are easily distracted, working from home may be an option.

Taking a psychological approach to return to work was suggested by one expert as very valuable for someone experiencing symptoms of depression, i.e. breaking down tasks and the activities into achievable sections, setting out daily goals and using positive reinforcement and reflection.

Interventions that improve understanding employers and colleagues were also mentioned, often in some form of education and training programme.

Some of them feel that they're not being supported in the workplace because they feel that nobody really understands what their condition is and how it impacts their employment.

Another suggested that one of the most effective interventions they used in regards to job retention and return to work was **psycho-education with the employer** – giving the employer the skills and knowledge to understand why the employee may not be functioning well in certain respects at work and looking at triggers and prevention to enhance the way they manage and support employees.

Getting the employer to not just ask the individual "how are you?" It's about actually just spending that little bit of time with somebody saying "I've noticed a couple of your triggers in your relapse prevention plan, and I just wondered if would you like a micro break, would you like some support?"

Engaging with managers in this way was also seen as addressing stigma and understanding about depression – particularly how it can affect anyone. Many experts felt that **stigma** around mental illness was still the greatest barrier to accessing support in the workplace.

The fear of what their peers are going to think of them when they return to work. The biggest fear for a lot of my customers is – what will I tell people about why I was off?

Having some form of advocate or support within the workplace to accompany an individual when discussing their depression and their needs with their employer was suggested by several participants, whether external or internal to the organisation.

It's not about disempowering people but it's sometimes just about taking that advocate role to take the worry off them.

[Effective job retention support would include:] an organisation which has some sort of employee support, so for example union membership, trade union membership or advocacy through an HR department, because otherwise you are very much on your own in an organisation with your depression.

This advocate role might also be provided by an external support service, such as is possible through Access to Work or some locally commissioned services.

Government retention initiatives

In terms of other interventions and services in supporting job retention, the most commonly raised by participants were the statement of 'Fitness for Work' (DH), Fit for Work (DWP), Access to Work (DWP) and locally commissioned employment support services (usually through local government, NHS Trusts and CCGs).

The statement of Fitness for Work, commonly known as the ‘Fit Note’ was introduced in Scotland, England and Wales in 2010 (initially in a paper format; an electronic version was rolled out from 2012). It was developed to transform the formal sickness certification process into a way of also providing health related return to work advice to employers. The aim was to enable individuals to return to work quicker after a period of sickness absence, even when not one hundred per cent fit.

For those experts who mentioned it, the Fit Note was seen as entirely positive in principle – signalling a shift in focus onto return to work and what an individual can still do when not completely fit, as well as providing a way for clinicians to communicate the work-related health needs of an employee to the employer.

A Fit Note rather than a Sick Note – even just in terms of linguistics it is a positive step.

In practice however, it is thought that the Fit Note may have fallen short of these aspirations.

I thought they gave a little bit too much emphasis on the Fit Note in the whole system; it seemed to me that it wasn't quite going to deliver all that they thought it was. But that was partly an over emphasis I think on what it could deliver, but it's certainly not without some value I think.

It was suggested that the complexities of depression (in contrast to a physical condition) may not suit the format and the usage of the Fit Note – wherein usually only one condition is put down and GPs have been found in many cases to not provide advice on reasonable adjustments where mental health is concerned.

I think that the evidence suggests that very few Fit Notes have workplace adjustments included and those that do have workplace adjustments included are much less likely to include adjustments for people who've got psychiatric disorders compared to physical health problems such as a musculoskeletal disorder.

One expert explained that it was neither fair nor realistic to expect GPs to be able to provide considered return to work advice in this way.

I think it's asking an enormous amount of a GP to be able to identify [depression] as a particular difficulty in managing the return to work process of an individual, the ins and outs of whose job they are most unlikely to know, and then to devise a strategy to deal with that. I think GPs are fantastic but that is asking too much of them.

It was further suggested that a GP’s knowledge around what works in terms of return to work and in the valuable role work can have in recovery, as well as a persistent culture of signing people off work rather than supporting a return, might be barrier to the positive aspirations of the Fit Note becoming a reality.

Whilst the people on the ground aren't endorsing them you're not going to get a culture shift.

So for instance, the Fit Note, I was recently at a GP's consultation... where the person that I was with was asked by the GP "How long do you want off?" It's up to you. They were told when this sick note runs out if you need extra time off come back and see me, it's up to you how long you have. And when you return to work, your employer must give you a return to work plan and how that happens is up to you and none of that's true and I was quite horrified that that is still happening in today's primary care settings.

It was suggested that national provision of occupational health specialists with specific mental health knowledge would allow this to be done well – something not available in the UK.

In many ways that's one of the limitations of the structure that we have in the UK where primary care through the Fit Note will interact directly with an employer. If one had blanket occupational health coverage with a psychiatrically educated occupational health workforce, I think that would work much better.

Fit for Work (FFW) is the flagship DWP programme for improving access to occupational health in the UK (with some national differences between devolved countries, e.g. Scotland uses a different provider). The service aims to enhance access to occupational health for all employers, particularly smaller employers who are less likely to have access to organisational occupational health services.

FFW has two components:

- Phone and web-based **advice service** – impartial work-related advice to all (including employers, employees and GPs) and an online library of advice on health and work topics.
- **Occupational health assessment** – GPs and employers may refer employees for assessment where the employee has reached, or is expected to reach, four weeks of sickness absence. This includes a phone assessment by an occupational health professional, informing the development of a return to work plan which will include recommendations to help the employee return to work more quickly, and provide direction to sources of further help and advice.

The advice service is now fully operational, while the assessment service commenced a staged roll-out in March 2015.

Experts generally agreed that the new FFW may well have a role in retention of people with depression – though with the assessment service still in the early stages of roll-out, all noted that it is currently too early to tell. Some participants were hopeful about FFW with one expert seeing it as a positive step in supporting people with mental health conditions to address their actual barriers to working, rather than just pushing them harder.

What's interesting is it takes that person first kind of approach. So rather than with the

benefits system where it's assumed if you're out of work it's through lack of motivation or willingness to work and you just need a bit of a nudge. But with Fit for Work, it goes "oh it's your health that's a problem" and they try and sort it out.

Others shared some concerns, in particular around the capacity of FFW to provide sufficiently specialised advice for those experiencing symptoms of depression – given the diverse, individual illness course and the invisibility of many of the symptoms which are seen as affecting work and that may continue residually after a period of treatment.

It's not clear to me how detailed an assessment is going to be and the extent of psychiatric knowledge that any of the occupational physicians who are going to be part of this will have. This is quite fine grained stuff, it's stuff that we do in our service I think quite well but I don't think that that is universal.

A further concern was that treatment to address the symptoms of depression was not going to be available through FFW.

I think if you're just assessing people and giving them recommendations to get people back to work, our understanding is that most people want to be back to work and that the major barrier tends not to be that they don't want to, but the symptoms. So if the symptoms that people are experiencing are the main barrier to a return to work no matter what recommendations you give people, without treatment they're not going to go back.

Instead employers are incentivised¹⁵ to purchase and provide the recommended interventions or alternatively employees would be referred to existing NHS services. One participant suggested that given the waiting list for IAPT, this was a concern.

We seem to have moved just the assessment and recommendation part and I think what might happen is that it isn't successful because there isn't quick access to treatment to help people reduce symptomology.

It is noted that subsequent to the interviews, the government announced (as part of the Budget 2015) plans to provide access to online CBT for FFW users. Whether this will be sufficient to address expert concerns cannot be seen as this time.

Some experts mentioned the **Workplace Mental Health Support Service (WMHSS)**¹⁶, delivered by Remploy in partnership with the DWP Access to Work programme¹⁷. The WMHSS provides back to work and workplace support for people with mental health conditions. It is available to permanent and temporary employees, working for employers based in England, Scotland or Wales (there is a different Access to Work programme in

¹⁵ From 1st January 2015 the government introduced a tax exemption of up to £500 (per year, per employee) on medical treatments recommended to help their employees return to work. This is applicable to treatments recommended by health professionals within Fit for Work and health professionals within employer-arranged occupational health services.

¹⁶ <https://www.remploy.co.uk/en/about-us/welfare-to-work/Workplace-mental-health-support-service/>

¹⁷ <https://www.gov.uk/access-to-work/overview>

Northern Ireland – Access to Work NI¹⁸). Employees self-refer to the WMHSS. They are assigned a vocational rehabilitation manager, who takes an individual, tailored approach to support, assessing needs and identifying strategies and adjustments which might support job retention. Advice and guidance is also provided to employers, should the employee consent to their vocational rehabilitation manager engaging with their employer. Vocational rehabilitation managers are able to access funding which allows them to provide treatment and other interventions for service users. Support lasts for six months and the service reports an over 90 per cent rate of success in keeping service users in work.

A recent government inquiry into Access to Work¹⁹ found that referrals to the WHMSS are not as high as expected, though numbers have been increasing. As suggested by one expert, one reason for the low number of referrals is that the service is not widely known about. Employers are not able to refer into the service so it is largely based on individual employee awareness. It was also considered that government might see the costs of providing the service as high and subsequently might wish to keep numbers of users low, despite the longer term benefits.

It costs about £900 for six months support for Access to Work and it's got a 90 per cent success rate. So even if you're spending a lot more money, the cost benefit of keeping people in work is going to be more than £900, so we need to focus on that.

Another participant suggested that the referral system created a barrier for some people, with those answering the calls not having mental health knowledge or experience. It was suggested that service users did not feel that those taking the referral understood their needs or respected them and that not responding to email was a cause of anxiety.

You're asking very unwell people who are in a state of need to ring up a call centre and speak to... a call handler who has no mental health experience... the advisor who gets information will do a mini assessment. And I don't think they need to do that because for the client, I don't want them to have to keep repeating that story – just process the referral and let them come through to me and I'll give you a support and action plan of what the problems are and you'll be fully updated on the situation, just don't try and do an assessment beforehand because they haven't got the skills.

Locally commissioned retention support

Job retention support might also be commissioned locally, usually offered through IPS supported employment services. Again it was suggested that the presence of such services is largely dependent on the interest of local partners (the NHS trust, CCGs and local authorities) as well as how active local third sector providers are. These services might be commissioned separately or as an 'add on' to the back to work support service.

It was suggested by one expert that at present retention services are given less focus than

¹⁸ <http://www.nidirect.gov.uk/index/information-and-services/people-with-disabilities/employment-support/work-schemes-and-programmes/access-to-work-practical-help-at-work.htm>

¹⁹ <http://www.parliament.uk/accesstowork>

back to work support and should be commissioned separately as a specialised service.

Often what gets commissioned is IPS, and then it's "oh can you do a bit of job retention" and they're actually two very different things. Job retention is a very specialist technical skill, which often requires quite a bit of legal knowledge in terms of people's rights and under employment law and all those sorts of elements.

Though the IPS model includes ongoing support for both the employee and the employer after a job has been found, evidence has not been collected on how well the IPS model works solely as a job retention tool for people with depression. It was suggested by one expert that we need to know more about what works in terms of retention.

IPS is not job retention; it's a different thing, different model with its own evidence base. So I think there's probably a need to look more closely at what is job retention, what does it mean and what kind of models work well?

Another participant, working with a retention service, suggested that in the main those with depression who came to the service did so because they were concerned about the impact their condition was having on their work and were seeking advice.

I would say maybe half of them probably haven't disclosed a mental health issue with their employers because sometimes they think they're going to be stigmatised, either by their employer or by their colleagues if they find out that they've got depression, so they try and hide it. And then other people do discuss it with their employers but perhaps their employers aren't always as supportive as they could be. So obviously they come for more advice and maybe a bit of validation really.

Having noted that majority of service users had most likely not disclosed their condition, or had done so but felt unsupported by their employer, it seems there is a demand for a source of advice and support regarding job retention external to the employer.

Various retention support and rehabilitation services are also available through private providers, commissioned as and when required by employers, insurers, legal services or the government. A fundamental bonus of using these services is that they are better equipped to provide quicker support than is often available through NHS provision.

Our timeframes for intervention are 72 hours for assessment and you'll be in treatment within 10 days. So the fact is that the people we see will be in, assessed, treated and out before they will just even have been assessed in the NHS.

Summary and conclusions

Based on the evidence from the questionnaire studies included in the literature review (involving 6,435 individuals, approximately 95 per cent of whom had diagnosis of Unipolar Depression) it can be concluded that there is positive, moderate quality evidence that psychological interventions, especially those using CBT approach combined with either

antidepressant medication or work-focused psychological approaches, are effective in improving employment-related outcomes of people with depression. Inconsistent evidence exists, however, that clinical interventions (using drug therapies alone) are effective in improving employment related outcomes for people with depression.

Even though evidence is mainly positive, it is worthwhile to mention that there is still a lack of interventions that have particularly focused on improving employment of people with depression. In addition many of the included studies had a short follow-up time (only three to four months) therefore long-term effects of interventions, such as their potentially positive effects on job retention, cannot be determined based on the existing evidence.

Similarly, according to the results of the expert interviews, psychological therapies and occupational therapies were (often alongside medication) seen as having the greatest impact in terms of employment outcomes for people experiencing symptoms of depression. There was some call to broaden the range of psychological interventions recommended by NICE by putting effort into building an evidence base. Increasing the value of other therapies might also help reduce waiting lists, currently prohibitively long in many areas of the UK, which are seen as having a negative effect on employment outcomes. Not having employment specialists embedded in the psychological therapy service was seen as negatively affecting employment outcomes.

Occupational therapy was supported as part of a multi-disciplinary care team for people with depression. Their commitment to identifying and understanding the goals of the individual was seen as complementary to treatment of symptoms, though it was suggested that there was insufficient appreciation of the role of occupational therapy when used alongside psychological therapy to enhance employment outcomes.

In terms of achieving employment outcomes, where the individual with depression has identified employment as a goal, both psychological and occupational health support were seen as enhanced by engagement with employment specialists – national provision is however very patchy. Improving integration of health and employment services was seen as integral to improving outcomes, as was enhancing knowledge about and communication in general between health and employment services – from Jobcentres to GP surgeries.

In terms of the health system, there was a call for more rigour in treatment – in particular to the end of improving the recognition and treatment of ongoing symptoms and improvements in understanding about mental health in both its presentation and in terms of its relationship to employment. The main call was for greater appreciation among clinicians at all levels of the value that work often has for someone's health and that work should be a prominent factor when making treatment decisions.

The low (yet improving) recognition that work is a desired outcome for many people with depression was also seen as barrier to further provision of more effective types of employment support through local commissioning. Despite not having an evidence-base specific to people with depression, experts were confident that IPS was an effective service

with considerable anecdotal evidence to support them. Along with the integration of health and employment support which marks out IPS, it was suggested that IPS is better than Jobcentre programmes as it allows a more personalised approach to someone's needs, not least because the service goals are more in tune with those of the health service than the Work Programme's explicit focus on paid job outcomes.

An important message for clinicians and employers is that people do not have to be one hundred per cent healthy to return to work and for many people with depression a return to work before full symptoms remission can be very helpful. The Fit Note was designed to support this message, though the challenges of completing them for people with complex mental health conditions are likely to be great given that GPs lack specialist mental health occupational health knowledge and thus are not always well placed to refer their patients to specialised services.

Along with the Fit Note, the new Fit for Work was suggested to have a potential role in retention support for those with depression, though again there were concerns that there would not be sufficient specialist knowledge and that the service would not address fundamental concerns about waiting lists for interventions where an employer does not have occupational health or private health insurance provision. The specialist, personalised approach found in the WMHSS was seen much more positively, though the service was not well known, nor widely used – despite excellent outcomes for job retention for people with mental health conditions. It was suggested that locally commissioned retention services were even rarer than back to work IPS services and often thought of as an 'add-on' rather than a specialist service in its own right. More evidence might be needed to ascertain what works for retention, as separate from a back to work service, so quality services can be encouraged and developed locally.

Consistent themes throughout this discussion included the importance of recognising the intrinsic barriers to accessing interventions seen in the common symptoms of depression and consequently ensuring there is specialist mental health and employment support knowledge within services. The diversity of the condition and the individuals who have it requires a personalised approach based on the individual, their goals (particularly where they include employment) and their symptoms – in many cases a one-to-one approach was seen as highly beneficial. The value of early intervention was consistently highlighted in terms of assessment and treatment and a collaborative approach to care (actively engaging with the individual and employers). It was also highlighted in terms of bringing together a range of experts who are equipped to provide specialist support to the different aspects of an individual's life and recovery, both in and out of the workplace. Similarly, participants placed considerable emphasis on the importance of providing treatment and employment support together, in parallel.

Chapter 5 Discussion and policy recommendations

In this report we have considered how symptoms of depression can influence employment outcomes, as well as what interventions can, and are, being used to better support employment and improve employment outcomes for people experiencing symptoms of depression. What we have discovered is that many of the interventions which appear positive at achieving these goals are not always provided optimally or that there are barriers to accessing them.

In this final section we consider the information collected from both the academic literature and interviews with experts and use this to develop six key areas around which we would like to see change. Within these categories we have made a range of recommendations for change which we feel have the potential to improve employment outcomes for those experiencing symptoms of depression.

The areas for change are:

- 1. Working better together**
- 2. Promoting the concept of employment as a health outcome**
- 3. Enhancing understanding and recognition of the symptoms of depression**
- 4. Improving access to job retention support**
- 5. Improving access to evidence-based interventions**
- 6. Developing a welfare system that supports individuals with depression**

Several of the recommendations made reflect those in other recent reports broaching the topic of mental health conditions and employment – these include reports from the OECD (2014), Mind (2014), the Taskforce on Mental Health in Society (2015), the Chief Medical Officer (Davies, 2014) and the think tank 2020 Health (J. Manning & Paxton, 2015).

1. Working better together

We need to improve the way that different stakeholders work together across the health and employment landscape – and actively encourage them to work together – to enhance support for people experiencing symptoms of depression. As we have seen, the best results are achieved when we address health and vocational needs in a co-ordinated and holistic way. Improving integration of services and support between clinicians, vocational specialists, employers, back to work support and individuals represents a positive approach to helping people remain in or return to work. Better working with and between all

stakeholders be they government, voluntary sector or employers should be fundamental to policy in this area.

1.1 Improving the integration and the capacity for joint working of government services – particularly those led by the Department of Health (DH) and the Department for Work and Pensions (DWP).

The ability to provide integrated, in-parallel support for health and for employment was seen as vitally important by the experts. We need to provide individuals with well-rounded, personalised treatment and support which reflects their life goals. However, often we see government health and employment services not working together, nor even in some cases sharing information and knowledge, likely negatively affecting their understanding or knowledge of an individual's needs.

Experts we spoke to highlighted specific examples including poor engagement between Jobcentre and clinicians, especially where someone is being assessed under the Work Capability Assessment, and the need to integrate employment support into health services at primary (i.e. through GP and psychological services) and secondary care levels (e.g. through provision of evidence-based IPS model of employment support).

It is recommended that:

- ***The DH and DWP jointly take action to improve access for people with mental health conditions to evidence-based employment support services across the UK. One way this might be achieved is through engaging with and encouraging local commissioners and key local bodies – including Clinical Commissioning Group, local authorities, NHS Trusts and the Jobcentre – to develop joint strategies to achieve shared outcomes around population health and employment. This might be accomplished by:***
 - ***Issuing joint commissioning guidance to encourage and support the pooling of resources to achieve shared local outcomes; or,***
 - ***Revising and aligning applicable outcomes frameworks to ensure that mental health and employment is a priority for all local stakeholders.***
- ***It should be mandatory for employment specialists to be introduced to NHS IAPT²⁰ teams in England, reflecting the original IAPT brief. Steps to incorporate employment specialist support into NHS psychological support provision in Scotland, Wales and Northern Ireland should also be undertaken. This might be achieved through a national model, led by DH and DWP in partnership, or as suggested in the OECD report this might also be achieved through joined-up local commissioning.***

²⁰ Improving Access to Psychological Therapy

- ***Jobcentre staff (and particularly Disability Employment Advisors) who work with people with depression should be instructed to seek engagement with the client's clinical team (where permission is granted) throughout the process of the Work Capability Assessment. In particular, it is important to ensure that someone who is assessed as 'fit for work' has access to appropriate health support to help them to return to work.***

1.2 Improving integration of the third sector into employment support provision.

Some experts spoke of energetic third sector providers in their local areas who are leading the way in developing evidence-based employment support services for people with mental health conditions. The inclusion of such specialist support needs to be encouraged. We need to address the barriers which prevent smaller, specialist, third sector organisations from providing specialised employment support services as part of the mainstream provision of Work Programme funding – allowing enthusiastic local services to provide evidence-based solutions which reflect both the goals of the health system and of DWP.

It is recommended that:

- ***DWP revise the guidance for prime providers of the Work Programme to include a requirement for specialist mental health support and to enable smaller third sector specialist organisations to be sub-contracted to provide services, without considerable risk.***

1.3 Improving capacity for knowledge-sharing between employers, individuals and clinicians.

Enhancing employer knowledge about the needs of their employees is beneficial in terms of addressing stigma and the many implications that it has for workplace culture, as well as to improve their ability to make workplace adjustments which better support employees with depression to remain in work. Although the 'Fit Note' provides a means for clinicians to communicate patient needs with employers, current practice is often not effective in conveying sufficient information to support a sustained return to work for people with depression. A more comprehensive approach would include input from GPs on an individual's health, employers on their work and what adjustments can be made and from the employee's perspective on how particular aspects of their condition are affecting their functional capacity at work. Preferably occupational health input would also be included. It is only together that a tailored return to work plan can be achieved. It is suggested that an employee-owned 'record' of health and work, to complement and extend the Fit Note, could be developed for piloting. This would facilitate collection of information from all the above stakeholders; it would be possible to update it on an ongoing basis and to share it between stakeholders, with employees empowered to take a lead. The 'Disability Passport' designed and used by BT, for example, may be useful model to consider.

It is recommended that:

- ***A template for an employee-owned 'health at work' record is developed, to provide employees with a personalised and authoritative record on how their***

condition affects their work. This would highlight ongoing symptoms, what employers need to be aware of and what an employer can do to help them to stay in work. This should be piloted to ensure it is valuable for all stakeholders involved – employers, employees, GPs and other clinicians and occupational health.

2. Promoting the concept of employment as a health outcome

Recognition of employment as an outcome of clinical care has been slowly increasing but we need to keep this on the agenda and spread the message further. Many clinicians still have a poor understanding of the potentially beneficial nature of work for someone with depression – getting this message to GPs and primary care health professionals is an ongoing task.

2.1 Employment as a health outcome and treatment goal for people with depression. According to experts, GPs signing an individual with depression off work sick for a long period of time could harm employment outcomes. Getting work on the agenda during primary care consultations might be a way of improving understanding about work and developing treatment plans which reflect this. This was raised in the Chief Medical Officer's report, where it was recommended that: "**employment status should be a routine and frequently updated part of all patients' medical records. This will provide the baseline data for employment status to be an outcome of all medical specialties, including primary care**" (Davies, 2014).

To this end, we recommend that:

- The Health and Social Care Information Centre, working with the Royal College of General Practitioners and other Royal Colleges, should review the existing taxonomy for the routine collection of employment data to ensure that it is usable and can be coded across all care settings. Employment status should then become a routine part of all patient records.**

This is a change in process and the recommended activities need to be part of a comprehensive push to change the knowledge and culture of primary healthcare professionals regarding the role of employment for many people with mental health conditions. We need to continue the good work we have started and explore new ways in which we might make these changes.

Further it is recommended that:

- An assessment is undertaken of the impact of measuring employment for those in secondary mental healthcare services in the Clinical Commissioning Group Outcome Indicator Sets. Should the outcome be positive we should consider expanding this to include people with any mental health condition, not just those in secondary care.**

- *Medical Colleges continue to encourage clinicians (in particular GPs) to undertake training and CPD on the therapeutic benefits of vocational rehabilitation and employment for people living with mental health conditions.*
- *The role of employment and its relationship to mental health are included in NHS psychological therapist training.*

3. Enhancing understanding and recognition of the symptoms of depression

As highlighted in the Chief Medical Officer's report, in many cases depression goes unrecognised by individuals themselves, by their clinicians or by their employers meaning many people don't receive any treatment or intervention for their condition. In order to improve employment outcomes for people with depression we need to get better at recognising symptoms of the illness so we can provide the best support.

Even where depression is diagnosed, some symptoms, including cognitive symptoms such as difficulty concentrating, may be missed. Any ongoing symptoms of depression missed in treatment (particularly if access to treatment is limited) can provide an ongoing barrier to work.

3.1 Improve recognition and understanding of depression and the wide range of associated symptoms, across health settings. All those involved in the care and treatment of people with depression (e.g. GPs, psychologists, psychiatrists, occupational therapists) need to be upskilled to ensure they are aware of the specific nature of depression, the range of symptoms which might be part of it and the nature of ongoing symptoms.

It is recommended that:

- *Measures to increase awareness of mental health conditions are introduced into GP surgeries, for example, considering the reintroduction of the Patient Health Questionnaire 9 (PHQ-9)²¹ as a Quality and Outcomes Framework (QOF) measure.*
- *Training and guidance for clinicians involved in mental healthcare (in particular GPs and psychiatrists) emphasises the nature, role and likelihood of mood, cognitive and physical symptoms of depression and provides guidance on how to identify and treat them. A period of specific mental health training could be included within GP training as recommended in the Chief Medical Officer's report.*
- *In some cases NHS-funded psychological therapy services should be provided on a long term basis, to improve the capacity to treat ongoing*

²¹ The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.

symptoms.

3.2 Improve recognition and understanding of depression and the wide range of associated symptoms among employers and back to work support services. This need is perhaps as acute in the health environment as it is in the workplace and in employment support services. The workplace provides an important location for health and work interventions and often plays a vital role in the recognition of health conditions as well as their management. Managers need to be better equipped to support employees with mental health conditions, including in terms of preventing symptoms to escalate.

It is recommended that:

- *Mental health awareness and management training is provided to managers to enhance their understanding of employee needs. Training needs to be of a high quality, and evidence-based where possible – techniques such as psycho-education may be useful. As suggested in the recent report of the Taskforce on Mental Health in Society (2015), this might be incentivised through inclusion in professional management standards and employer accreditation schemes. Alternatively, tax breaks may provide an incentive.*
- *As a minimum, employers are encouraged to know about local mental health support and services to which they might refer employees when there are concerns (e.g. the local IAPT).*

We would also concur with recommendations of both Mind (2014) and the Taskforce on Mental Health in Society (2015) that:

- *Frontline staff in the Jobcentre and Work Programme providers receive training and upskilling to improve their understanding mental health conditions (including depression), helping them to better understand the needs of their clients and provide more appropriate support.*

3.3 Recognising the barriers intrinsic to depression. The symptoms of depression (e.g. poor motivation, lack of interest and negative thinking) can in themselves provide barriers to accessing services. IAPT services may not always be easy for people to access. It requires proactivity from the individual who may have already waited weeks or months to be contacted by the service only then to be unable to engage due to poor health, be branded as a 'did not attend' and sent to the back of the queue. Though the pressure on NHS psychological therapies is acknowledged, more needs to be done to break down these barriers to access and to engage patients with the available services and support. It was suggested that lessons on how to reach out to people with depression might be learnt from Assertive Outreach programmes, currently used for people with a severe and enduring mental illness, and a low-level approach might be considered. This could include health or social support staff (public or third sector) following up with people who have failed to engage with psychological therapy to identify the issues and provide support.

It is recommended that:

- **A form of low-level Assertive Outreach is developed and trialled to identify whether it can be used to improve engagement of patients with depression in treatment, in particular psychological therapy.**

3.4 Ensure the complexities of depression are a focus of Fit for Work. For those who have had or are expected to have four weeks of sickness absence due to their depression, Fit for Work will be an option. The service will need to be monitored to see how well it is reaching people with depression and how successful it is with supporting their long-term return to work. Fit for Work assessors will also need to recognise ongoing symptoms associated with depression, which might remain a long time after remission of other symptoms and continue to cause problems at work, possibly affecting the long term sustainability of the return to work. The assessors will also need to recognise the difficulties many people with depression experience in engaging with treatment. Mitigation of the risks to the sustainability of return to work and the risks of relapse need to be addressed in return to work plans.

It is recommended that:

- **Guidance is provided to Fit for Work assessors to ensure they are aware of the likelihood of people with depression experiencing ongoing symptoms; these symptoms may be harder to spot but can have a substantial effect on return to work. In some cases there will be a need for more substantial, long term treatment of depression to ensure complete remission of symptoms.**
- **Evaluation of Fit for Work should include specific attention to the management of depression in the longer term.**

4. Improving access to job retention support

Preventing people from losing their job in the first place is often seen as easier than finding a new job. More attention must be given to improving job retention for people with depression.

4.1 Increasing focus on retention. External support for job retention was seen as limited – especially access to specific locally-appropriate, retention-related information (e.g. employment law and employee rights guidance) and advocacy and direct support with employers (e.g. attending meetings and explaining needs). This might be provided through a comprehensive specialist retention service, for example by enhancing the offer of the Access to Work Mental Health Support Service provided by Remploy, or perhaps it could be delivered through an alternative source, such as Citizens Advice or ACAS.

It is recommended that:

- **Commissioning guidance is developed that considers the distinct requirements of both return to work support and retention support for people**

with depression.

- ***Local provision of employment law resources and advice is enhanced – possibly through inclusion in the Mental Health Support Service or a consumer service such as Citizens Advice.***

4.2 NHS as an exemplar of good practice. Positive role models can be used to drive change and improve practice. The NHS, as the provider of health services to the UK, should (as suggested in the NHS Five Year Forward View²²) strive to be an exemplar of good practice in supporting employees with depression to remain in work and to drive positive change elsewhere. A lack of specialist employment and occupational health knowledge and expertise within the health trusts was noted by the experts, in particular advocacy-related support for employees with health conditions.

It is recommended that:

- ***A requirement is placed on each NHS employer to provide:***
 - ***A Health and Wellbeing strategy which includes provision for interventions which focus on job retention and return to work for staff with mental illness.***
 - ***Minimum referral times for access to Occupational Health for people with mental health-related absence.***
 - ***Compulsory return to work plans for staff with depression after four weeks of absence.***

4.3 Improving access to the Access to Work Mental Health Support Service for people with depression. Various barriers were identified around accessing the Mental Health Support Service in this as in previous research. Given the effectiveness of this service in supporting retention of people with common mental health conditions, including depression, it is important that these barriers are removed to improve access for the many people who would likely benefit from it.

We support the recommendations made in the recent Mind (2014) report that Access to Work should be better promoted and made more accessible for people with mental health problems. Once the hurdles to access are addressed, then we agree that Access to Work should aim to direct at least ten per cent of the budget towards this group. To this end we recommend reforms to those barriers to access identified in this research.

²² <http://www.england.nhs.uk/ourwork/futurenhs/>

It is recommended that:

- ***Employers are permitted to make referrals.***
- ***An assessment of call-handling is undertaken to investigate whether and how potential service users are being put off from using the service at an initial stage.***
- ***Greater effort is made to promote the service.***

4.4 Improve access to treatment services for people in employment. Limited access to health services outside of working hours creates a further barrier to treatment for those in work who are seeking to remain in work. GP services are increasingly acknowledging this and there has been an (albeit slow) expansion of out of hours GP access. This has not thus far extended to the IAPT service in England. Again, the limitations within IAPT services are well known but in order to keep people with depression in the workplace access to effective treatments must be available to them outside of working hours.

It is recommended that:

- ***Government commits itself to improving job retention for people with mental health conditions through taking steps to improve access to out of hours treatment.***

5. Improving access to evidence-based interventions

There is considerable anecdotal evidence around the effectiveness of several employment support interventions for people with depression; the barriers to accessing such interventions are also apparent. Investing in improving the academic evidence-base will enable us to make the case to commissioners and therefore encourage local commissioning of quality services. In the meantime, while the evidence-base is developed, we should enhance access to those interventions for which anecdotal evidence looks positive to get the ball-rolling – providing services which professionals see as positive while collecting data which will lead to service improvement.

5.1 Building the evidence-base on supported employment for people with depression. The better the quality of evidence, the better chances there are that we can provide effective, quality services which improve employment outcomes. This is true at local and national level. In order to commission services, commissioners need to know ‘what works’. Though much of the academic evidence around Individual Placement and Support (IPS) services is focussed on people with schizophrenia, practitioners believe it is beneficial for people with depression as well as other common mental health conditions. Enhancing the evidence base around the value of supported employment services for people with depression will further encourage local commissioners to see these services as valuable in their community. Further, where programmes are introduced nationally, we need to be sure they are informed by evidence and providing the best offer for users.

It is recommended that:

- ***Gaps in evidence around what works in terms of employment support for people with depression are identified and addressed to enhance the case for commissioners seeking to commission local services.***
- ***Long term pilots are established to more thoroughly test the IPS in IAPT model of employment support with attention paid to employment (and progress towards employment outcomes) for people with common mental health conditions. It should consider the different outcomes for people with different symptoms and diagnosis, to improve understanding of who this approach works for and what the potential financial savings are.***
- ***Recent budget announcements, i.e. on the integration of IAPT in Jobcentres, and the provision of online Computerised Behavioural Therapy (CBT) for users of Fit for Work as well as welfare claimants, are thoroughly evaluated. This is required to build the evidence base around these approaches, in terms of both employment and wellbeing outcomes and***
- ***Evaluation of 'recovery colleges' is commissioned to improve understanding of how well they achieve employment outcomes for people with depression.***
- ***Investment is put into testing how innovative solutions like Vocational Rehabilitation prescriptions (developed by Macmillan Cancer Support for people with cancer) might be adapted for people with depression. These provide a simple way for Clinical Commissioning Groups to refer patients to case managed, tailored, multi-disciplinary vocational rehabilitation support (Gilbert & Marwaha, 2013).***

5.2 Building the evidence base around the relationship between health interventions and employment outcomes. We need a clearer understanding of what is effective in terms of psychological interventions and employment outcomes. Much of the academic evidence is around CBT and its effect on employment outcomes among people with depression. Should interventions other than CBT be effective in terms of work outcomes (e.g. psychoeducational and behavioural activation approaches) then this should be reflected in NICE guidance. This might have knock-on implications for the provision of psychological therapies, the training requirements for those practicing and therefore on waiting lists.

It is recommended that:

- ***There is investment in testing alternative psychotherapeutic approaches which are suggested to have positive outcomes for people with depression to ascertain their effectiveness in terms of both their health and employment outcomes and potentially widening the evidence-based interventions offered***

through NHS psychological services.

5.3 Promote effective services which are already available. Even where services exist, many people in the community with depression may not be aware of them. There is poor awareness of the Access to Work Mental Health Support Service, as well as other local employment support – including IPS back to work services. One method maybe using GP surgeries as a way to improve access to knowledge about local and national employment support services. The Work and Learning Coordinator role might be a model worthy of further exploration.

It is recommended that:

- ***The DWP explore and assess the role of local Work and Learning Coordinators to see whether there would be value in expanding this role across the UK.***
- ***Methods to enhance the role of GP surgeries as places of information on employment support are considered – including encouraging the addition of employment advisors in primary care settings to provide support or ‘signpost’ to other services.***

6. Developing a welfare system that supports individuals with depression

The outcomes for the Work Programme are poor for people with mental health conditions. We suggest that this model needs to be adapted.

6.1 Recognition of ‘progress’ for people with depression engaged in back to work programmes. The exclusive focus of government back to work schemes, such as the Work Programme, on paid employment outcomes can be barrier for people with depression trying to start on the path back to work. Voluntary work can be highly valuable in getting people back to work and such steps demonstrate considerable progress in moving towards the competitive employment but this is not recognised or supported by the Work Programme.

We support the recommendations made in the recent Mind (2014) report that the benefits and back-to-work system require a redesign to support positive and open engagement with people with mental health problems rather than focussing on unfair assumptions about a lack motivation or willingness to work.

It is recommended that:

- ***‘Progress’ measures are included in the Work Programme and other employment programmes – to identify and support where people with health conditions have made significant positive progress on the pathway towards paid work.***

Given the failure of the Work Programme to improve employment outcomes for people with

depression, we also agree with recommendations made by Mind (2014) that people with mental health problems on Employment and Support Allowance should be referred into a new specialist back to work scheme, rather than entering the Work Programme.

It is recommended that:

- ***Providers of Jobcentre Plus mandated back to work services provide only services which have an evidence-base (such as IPS) to focus on achieving the best employment outcomes for people with depression.***

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Appendix 1 Search strategy January 2000 to February 2015

MEDLINE (via Ovid)²³

1. depressive disorder
2. depression
3. mood disorders
4. 1 OR 2 OR 3
5. chronic symptoms
6. ongoing symptoms
7. cognitive\$
8. 5 OR 6 OR 7
9. work
10. \$employment
11. job
12. 9 OR 10 OR 11
13. return to work
14. occupational\$ intervention
15. vocational\$ rehabilitation
16. absenteeism
17. sick leave
18. sickness absence
19. disability\$
20. 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19
21. 4 AND 8 AND 20

²³ OVID provides access to online bibliographic databases (including MEDLINE), academic journals, and other products, chiefly in the area of health sciences.

Appendix 2 Data tables

Table 1: Characteristics of the studies on impact of cognitive dysfunction and other symptoms on work-related outcomes of people with depression

Authors and publication year	Country	Study design (including follow-up time)	Objective/aims of the study	Study population (Type of condition and number)	Main results (relevant to this review)
Banerjee et al. (2014)	USA	Cross-sectional national survey.	To identify the mechanisms, or most important symptoms, through which psychiatric disorders (focusing on major depressive episode) affect labour market outcomes.	Data of 4,235 women and 3,331 men of working age were obtained from the National Comorbidity Survey Replication and the National Latino and Asian American Study.	For major depressive episode, symptoms of insomnia/hypersomnia, indecisiveness, severe emotional distress, and fatigue are crucial for labour market outcomes.
Baune et al. (2010)	Australia	Case-Control cross-sectional study.	<ul style="list-style-type: none"> - To investigate the association between cognitive dysfunction and Unipolar Depression as compared with a healthy control group; - To examine the effects of current versus previous Unipolar Depression on domains of cognitive function. - To investigate the relationship between cognitive performance and quality of life, impairments in activities of daily living and employment in Unipolar Depression. 	70 cases were recruited from community and outpatients services and controls (n=206) through pre-mortem tissue donor programme. 37 per cent were male and aged from 23-71 years. All cases had been or were currently employed.	Participants with previous Unipolar Depression but who were currently employed performed significantly better in the visuospatial, language and delayed memory domains as well as on the total score than their counterparts without employment. In this analysis, the investigation of interaction effects between employment status and depression showed no significant interaction effects between the two variables for all cognitive domains.

Authors and publication year	Country	Study design (including follow-up time)	Objective/aims of the study	Study population (Type of condition and number)	Main results (relevant to this review)
Gilbert and Marwaha (2013)	Several	Systematic review.	To identify predictors of employment in people with Bipolar Disorder.	Nine papers were included in the review consisting of 2,176 patients of working age. All studies were longitudinal, follow-up time varying from six months to 15 years.	Studies included in the review identified cognitive deficits, depression and level of education as predictors of employment in Bipolar Disorder patients. Bipolar Depression not only affects whether someone is employed but also time off work. Even sub-syndromal depression appears to damage employment prospects. Verbal memory and executive functioning appear to be predictors of work functioning.
Lagerveld et al. (2010)	Several	Systematic review.	To identify factors predicting work participation and work functioning.	A total of 30 studies, published in 1995-2008 were identified. There were total of 29,703 patients with Unipolar Depression of working age. Half of the studies were cross-sectional.	Strong evidence was found for the association between a long duration of the depressive episode and work disability. Moderate evidence was found for the associations between more severe types of depressive disorder, presence of co-morbid mental or physical disorders, older age, a history of previous sick leave, and work disability. In addition, severe depressive symptoms were associated with work limitations, and clinical improvement was related to work productivity (moderate evidence).

Authors and publication year	Country	Study design (including follow-up time)	Objective/aims of the study	Study population (Type of condition and number)	Main results (relevant to this review)
Lee et al. (2013)	Australia	Follow-up survey of average follow-up time of 21.6 months.	To determine whether neuropsychological functioning longitudinally predicts socio-occupational functioning over and above symptomatology.	At baseline, 183 young psychiatric outpatients were assessed. Ninety-three returned for follow-up. Primary diagnoses were Unipolar Depression and Bipolar Disorder. Fifty-one per cent were male. The average age was 21.3 years old.	Baseline neuropsychological functioning (a composite of memory, working memory and attentional switching) was the best independent predictor of later occupational functioning outcome.
McIntyre et al. (2015)	Canada	Cross-sectional survey.	To determine the extent to which measures of depression severity and cognitive dysfunction were associated with perceived global disability, workplace performance and quality of life.	260 participants of working age with diagnosis of Unipolar Depression who were enrolled in the International Mood Disorders Collaborative Project. The majority were female (64%) and employed (87%). The average age was 41.09 years.	Workplace performance variability is explained by subjective measures of cognitive dysfunction to a greater extent than total depression symptom severity. Conversely, total depression symptom severity accounts for a greater degree of variability in global measures of disability relative to cognitive measures.
Mora et al. (2013)	Spain	Case-Control follow-up study with 6 years of follow-up.	To investigate the Longitudinal neuropsychological profile of euthymic Bipolar out-patients compared with healthy matched controls in a 6-year period of follow-up and to examine the psychosocial disabilities as related to cognitive deficits.	A total of 28 patients with Bipolar Disorder and 26 healthy controls matched for age, gender and education. The patient group was obtained from a hospital and controls were recruited via word of mouth and advertisements.	There were strong relationships between poorer psychosocial functioning, including occupational functioning, and a worsening of cognition.

Authors and publication year	Country	Study design (including follow-up time)	Objective/aims of the study	Study population (Type of condition and number)	Main results (relevant to this review)
Schoeyen et al. (2013)	Norway	Cross-sectional survey.	The study addressed the role of premorbid functioning [assessed with the Premorbid Adjustment Scale (PAS)], intelligence, course of illness, and socio-demographics on occupational outcome in Bipolar Disorder.	Total of 226 patients were recruited from four large hospitals. Thirty-nine per cent were males and the mean age was 33.9 years.	Occupational outcome was unrelated to PAS, premorbid and current IQ, as well as decline in IQ. This suggests that the persistence of severe clinical symptoms, rather than global cognitive functioning, determines occupational outcomes in BD.
Tse et al. (2014)	Several	Systematic review and meta-analysis.	The study explored which of the socio-demographic, clinical, psychosocial and/or cognitive variables were associated with positive employment outcomes in people with Bipolar Disorder.	A total of 22 studies (14 cross-sectional and eight longitudinal) were identified. The articles were published between 2000-2011 and included a total of 6,301 patients.	Significant predictors of favourable employment outcomes included: cognitive performance (e.g. verbal memory), socio-demographic factors (e.g. years of education), course of illness (e.g. number of lifetime psychiatric hospitalisations), symptomatology (e.g. depression), and other personal factors (e.g. personality disorder). Overall, the cognitive performance and course of illness had bigger impact than symptomatology or socio-demographic factors on favourable employment outcomes.

Table 2: Characteristics of the interventions aiming to support employment of people with depression

RCT=Randomised Controlled Trial, CBT=Cognitive Behavioural Therapy, PST=Psychological Skills Training

Authors and publication year	Country	Objective/aims of the study	Study population	Description of intervention	Main results (relevant to this review)
Deckersbach et al. (2010)	USA	To explore whether a new cognitive remediation (CR) treatment designed to treat residual depressive symptoms and, for the first time, to address whether cognitive impairment would be associated with improvement in psychosocial functioning.	14 outpatients of one hospital were recruited for the study. The patients were working age with Bipolar Disorder, of which 10 were female.	Cognitive Remediation (CR) consisted of 14 individual 50 minute-treatment sessions conducted over four months. For the first three months, treatment sessions were held weekly (sessions 1–12) followed by bi-weekly sessions for the next month (sessions 13–14). Treatment consisted of three separate modules each of which comprised four CBT sessions. The modules focused on (1) Mood monitoring and treatment of residual depressive symptoms, (2) Organization, planning and time management, and (3) Attention and Memory and were delivered in this order. The first module introduced patients to daily mood.	Results indicated that at the end of treatment, as well as at the 3-months follow-up, patients showed lower residual depressive symptoms, and increased occupational, as well as overall psychosocial functioning. Pre-treatment neuropsychological impairment predicted treatment response. Improvements in executive functioning were associated with improvements in occupational functioning.
Furukawa et al. (2012)	Japan	To investigate feasibility and acceptability of a workplace intervention aiming to support employees with depression.	118 employees with Depression in 13 factories and offices of a large manufacturing company. Average age was 39.4 years and 79% were men.	Parallel-group, non-blinded randomized controlled trial of tCBT in addition to the pre-existing Employee Assistance Programme (EAP) versus EAP alone. Altogether 118 subjects were randomized to tCBT+EAP (n = 58) and to EAP alone (n = 60). The telephone CBT is a structured, manualized 8-session programme. Each session began with a brief structured assessment of depressive symptoms with a review of the previous session and the homework.	The depression scores reduced significantly from baseline in the intervention group compared to the control group after 4 months. However, there was no statistically significant decrease in absolute and relative presenteeism.

Authors and publication year	Country	Objective/aims of the study	Study population	Description of intervention	Main results (relevant to this review)
				The initial session included psycho education of the CBT model and provided the rationale of the whole program. Sessions 2–4 focused on increasing pleasant activities through personal experiments. Sessions 5–7 focused on identifying, distancing from and challenging negative automatic thoughts. In Session 8 the participant and the therapist together reviewed the cognitive and behavioural skills covered in the program and created a personal self-care plan for self-monitoring, identification and preparation for high risk situations, and self-management. All sessions included a motivational assessment of each participant's degree of interest and confidence in completing homework assignments in their daily lives.	
Lagerveld et al. (2012)	Holland	To compare the effectiveness of two individual-level psychotherapy interventions: (a) treatment as usual consisting of cognitive-behavioural therapy (CBT) and (b) work-focused CBT (W-CBT)	Total of 168 employed with depression recruited from an outpatient health centre. Average age was 40.7 and 60% were female.	The CBT Group consisted 79 clients and the W-CBT group 89: follow-up time was 12 months. Work-focused cognitive-behavioural therapy (W-CBT) consisted of the regular treatment (CBT) plus a module focusing on work and the return to work. The W-CBT treatment consisted first of specific work-related (homework) exercises/interventions that were additional to regular CBT interventions (such as drawing a RTW plan). Second, regular	In terms of return to work, robust and large effects in favour of W-CBT were found: these clients fully resumed work 65 days earlier than clients receiving regular CBT. Most clients (over 90%) from both groups had resumed work within 1 year, but W-CBT achieved this result about 2 months earlier. It was also found that gradual work

Authors and publication year	Country	Objective/aims of the study	Study population	Description of intervention	Main results (relevant to this review)
		that integrated work aspects early into the treatment.		<p>CBT interventions or exercises were framed as much as possible in the work context (such as work-focused psycho-education or work-focused behavioural experiments to challenge dysfunctional thoughts). In addition to these two work-related components, treatment time could also be spent on non work issues (e.g., marital problems).</p> <p>However, even in these cases, therapists were encouraged to relate these non work issues (at least partly) to work (e.g., by asking how work could help to decrease extensive worrying about marital problems). A more detailed description of the specific work-related interventions in each subsequent session is described below.</p>	<p>resumption occurred earlier and was implemented more often in the W-CBT intervention group.</p> <p>Participants in the W-CBT group reported earlier partial RTW and used more (and consequently smaller) steps to reach full RTW compared with those in the regular CBT group.</p>
Lexis et al. (2011)	Holland	To examine the efficacy of early intervention on the prevention of long-term sickness absence and major depression among employees at high risk of future sickness absence and with mild to severe depressive complaints.	Total of 139 employees who had a history of sickness absence due to depression and were working in a large banking company were recruited. Average age was 48.1 years and 43 per cent	<p>Employees were randomly assigned to the intervention group (n=69) or the control group (n=70). They were assessed at 12 and 18 months.</p> <p>The intervention consisted of a psychological treatment based on the principles of PST and CBT. The main goal of the intervention, which had an individual orientated approach, was to offer guidelines to enhance problem-solving skills in order to prevent long-term sickness absence and to reduce depression and to stimulate personal well-being. The control group participants received</p>	<p>There was a significant difference in total sickness absence duration between the intervention (27.5 calendar days) and control group (50.8 days) over 12 months of follow-up, a reduction of 46%. The intervention group showed a non-significantly lower proportion of long-term sickness absence spells compared with the control group.</p> <p>Statistically significant and</p>

Authors and publication year	Country	Objective/aims of the study	Study population	Description of intervention	Main results (relevant to this review)
			were male.	<p>an occupational health care as normal.</p> <p>The basic part of intervention contained seven sessions of 45 min each, based on the major steps of PST.</p> <p>In the seventh session, the psychologist and employee decided in consultation to end treatment in case the participant had recovered or to move on with the specific part of the protocol. For the specific part, the employee could indicate the subject to focus on during the sessions, such as training of social skills or cognitive restructuring.</p> <p>At the end of each session, homework assignments were given which were discussed in the next session.</p>	<p>clinically relevant differences in depressive complaints were found after 12 months in favour of the intervention group.</p>
Nieuwenhuijsen et al. (2014)	Several	To evaluate the effectiveness of interventions aimed at reducing work disability in employees with Unipolar Depression.	Total of 23 studies were included in the systematic review, involving 5,996 patients of working age.	The impact of Work-directed interventions and Clinical interventions were examined. Clinical interventions could be either antidepressant medication or psychological or psychological combined with antidepressant medication and interventions on exercise.	<p>Moderate quality evidence was found that adding a work-directed intervention to a clinical intervention reduced the number of days on sick leave compared to a clinical intervention alone.</p> <p>Moderate quality evidence was also found that enhancing primary or occupational care with cognitive behavioural therapy reduced sick leave compared to the usual care.</p>

Authors and publication year	Country	Objective/aims of the study	Study population	Description of intervention	Main results (relevant to this review)
					A structured telephone outreach and care management program that included medication reduced sickness absence compared to usual care. However, enhancing primary care with a quality improvement program did not have a considerable effect on sickness absence. There was no evidence of a difference in effect on sickness absence of one antidepressant medication compared to another.

Appendix 3 List of expert participants

(Names and job titles included with permission)

- **Dr Mark Ashworth**, DM, MRCP, FRCGP, Hurley Group Medical Director and Clinical Senior Lecturer, King's College London
- **Chris Bartlett**, Vocational Rehabilitation Association Trustee & RehabWorks Case Management Services Lead
- **Dr Jed Boardman**, Consultant/Senior Lecturer in Social Psychiatry, Lead for Social Inclusion for the Royal College of Psychiatrists, Senior Policy Adviser at the Centre for Mental Health
- **Kate Bones**, Director of Occupational Therapy and Recovery Practice, Sussex Partnership NHS Foundation Trust
- **Andrea Brown**, Occupational Therapist, Eastbourne, Hailsham and Seaford Assessment and Treatment Service
- **Andy Kempster**, Policy and Campaigns Officer, Mind
- **Clare Price**, RMN PG Dip CT, Psychological Therapy Service Lead, Psychological Therapy Services, RehabWorks Ltd
- **Dr Max Henderson**, MBBS MSc PhD MRCP MRCPsych, Psychiatrist and Senior Lecturer in Epidemiological & Occupational Psychiatry, King's College London

Awaiting confirmation of permission:

- Remploy
- CBT Lead, Counselling Psychologist

Appendix 4 Interview guide: Symptoms of depression and employment

Introduction:

- Research on the symptoms of depression (including cognitive symptoms) and their relationship to employment
 - The research is funded by Lundbeck, via Munro Foster
 - Seek permission to record. Explain how report will be anonymised
-
- **What is your role?** (re. work with people with depression?)
 - **What are the symptoms associated with clinical depression which you see as having implications for employment?**
 - *Prompt if required: What is your understanding of cognitive symptoms?*
 - **In what ways might these symptoms be seen as barrier to employment?**
 - a) job retention
 - b) return to work/finding a job
 - **What support and interventions do you see as effective in improving employment outcomes for people experiencing symptoms of depression?**
 - a) job retention
 - b) return to work/finding a job
 - *Prompts if required:*
 - Treatment? e.g. pharmaceutical, psychological therapies, OT
 - Workplace interventions e.g. EAP, OH, stress management
 - Other support or services e.g. Fit Note, FFW, JCP, and locally commissioned vocational rehabilitation services.
 - **What (if any) are the barriers for people experiencing symptoms of depression in accessing these interventions?**
 - *Prompt: policy, local service availability, access requirements, stigma, nature of condition?*

- **How might such barriers be addressed? How can access be improved?** (to the end of improving employment outcomes)
 - *Prompts: the health system, the employment/welfare systems, access to interventions etc.*

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The Work Foundation transforms people's experience of work and the labour market through high quality applied research that empowers individuals and influences public policies and organisational practices. Through its rigorous research programmes targeting organisations, cities, regions and economies, The Work Foundation is a leading provider of research-based analysis, knowledge exchange and policy advice in the UK and beyond. Organisations from across all industry sectors can sign up as partners to gain access and active involvement in research, thinking and practice emerging from its work. The Work Foundation is part of Lancaster University – an alliance that enables both organisations to further enhance their impact.

Contact details

The Work Foundation
21 Palmer Street
London SW1H 0AD

info@theworkfoundation.com
www.theworkfoundation.com

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