

WORK IN PROGRESS



Improving employment outcomes for people with depression

UK report



This report has been supported financially by a grant from Lundbeck. The content has been developed by Depression Alliance, Action on Depression, Gofal and Aware. It does not necessarily reflect the views of Lundbeck. It is part of the UK-wide "Work in Progress" campaign which is also being sponsored by Lundbeck, within the guidance of the ABPI code of practice.



Contents

About Us	2
The “Work in Progress” Campaign	3
Foreword	4
Part 1: Introduction	5
Depression and Employment	5
Depression and Unemployment	6
Stigma and discrimination	6
Improving Employment Outcomes	6
Part 2: Understanding Depression	8
Types of Depression	8
Symptoms of Depression as a Barrier to Retaining Employment	9
Symptoms of Depression as a Barrier to Finding Employment	12
Part 3: Policies and Practice across the UK	14
England	14
Scotland	18
Wales	21
Northern Ireland	24
Part 4: Policy Recommendations	27
Acknowledgments	28
References	29

» About Us



Depression**Alliance**

Depression Alliance is the leading charity in the UK for anyone affected by depression. It has almost 40 years experience of working with healthcare professionals and government agencies to improve local services, and delivers campaigns to end the stigma of depression and raise awareness of what it means to live with it.

Depression Alliance supports people on Employment and Support Allowance on employment issues and launched the Friends in Need community to provide a free supportive hub for everyone affected by depression in the UK. Friends in Need seeks to build resilience and help people find and remain in work.



Action on Depression is the only national Scottish organisation working with and for people affected by depression. It is a user-influenced organisation committed to providing support, raising awareness of depression and treatment options and reducing the stigma that still surrounds the condition.

Action on Depression deliver the 'Living Life to the Full' self-management course in GP practices. The course uses a CBT approach and has been developed in response to the long waiting lists for face to face therapies. The first pilot course has two more sessions remaining and has already proved to be a successful example of social prescribing working well and in partnership with the voluntary sector. More courses are planned over the coming months in GP practices.



Gofal is a leading Welsh mental health and wellbeing charity, which provides a wide range of services to people with mental health problems, supporting their independence, recovery, health and wellbeing. It advocates to improve mental health policy, practice and legislation, as well as campaigning to increase public understanding of mental health.

The Pathways to Employment project supports people with depression to set and achieve their goals and aspirations, by improving the management of their mental health, and developing their skills and confidence. This is a crucial combination for many people who are failed by traditional back-to-work programmes.



AWARE is a leading mental health charity and the only charity in Northern Ireland with a specific focus on helping those with depression and bipolar disorder. The focus of their work is to support people with depression, provide services that help those with the illness recover and to educate people on how to protect their mental health. AWARE has a suite of wellbeing programmes designed to help those with the illness overcome it, to help people recognise the signs and symptoms of depression and to seek help early in order to aid their recovery from the illness. The organisation also delivers programmes into schools to help prevent depression by building confidence, resilience and emotional literacy within young people.

AWARE runs free self-help support groups facilitated by highly trained volunteers. By offering provide an opportunity to meet others with similar experiences, the groups help people identify self-help strategies and coping skills that will help in the recovery process, including returning to or remaining in work.

» The “Work in Progress” campaign

WORK IN PROGRESS



“The majority of MPs agree that this should be a priority of the Government, so we call on the incoming class of 2015 MPs to work with us to improve employment rates for people with depression.”

**Emer O'Neill,
Depression Alliance**

In April 2015, Depression Alliance launched the UK-wide “Work in Progress” campaign aimed at improving the employment rates of people with depression.

The campaign consists of a series of publications and meetings which seek to raise awareness of the challenges to employment faced by people with depression, and drive policy initiatives that support improved employment outcomes across the UK. It has received the support and engagement of a wide range of stakeholders and partners including Action on Depression, Gofal and Aware who have contributed to and developed this report.

The report and the “Work in Progress” campaign have been sponsored by Lundbeck, within the guidance of the ABPI code of practice. Lundbeck has funded Munro & Forster to provide secretariat services and carry out public affairs activities to support the campaign across the UK. The content of the report has been developed by Depression Alliance, Action on Depression, Gofal and Aware. It does not necessarily reflect the views of Lundbeck.

On Depression Awareness Week 2015, as part of the campaign, a survey of MPs was carried out by the independent polling survey company ComRes to gauge key opinions on the issues. ComRes interviewed 50 MPs online - 24 from the Conservative Party, 22 from the Labour Party, 2 from the Liberal Democrats and 2 from other parties – between February and March 2015. The results were analysed by ComRes. The results of the survey, funded by Lundbeck, revealed that:

72% of MPs thought that the incoming Government should prioritise support for people with depression to get back into employment.

76% agreed that cost-effective mental health services should have the same mandatory funding as physical health services.

8% believed that the NHS was sufficiently prepared to manage depression efficiently.

Full data tables are available at www.comres.co.uk

» Foreword

Depression is the most common psychological disorder in the Western world. In the UK, it is estimated that one in every six people of working age will experience some kind of mental health problem in the course of a year, with mixed anxiety and depression the most common.

Whilst there are a number of complex and interrelating factors that contribute to an individual's mental health, a hugely important area, and one that is often overlooked, is that of employment.

There is no doubt that employment can be beneficial to the health and wellbeing of people with depression. Beyond providing income, good work offers structure, focus and a social environment that can support self-fulfilment and provide an important sense of achievement. Conversely, poorly designed work, lack of understanding and unemployment are major social determinants of health inequalities and mental ill health.

The employment rate for adults with mental health problems remains unacceptably low. Evidence shows that over a third of people with mental health problems such as depression are unemployed and indicates that mental illness is the leading cause of sickness absence in the UK. It is also a leading cause of lost work productivity, long-term disability and early retirement. We know that symptoms of depression can have an effect on employment outcomes, creating challenges in retaining and obtaining employment. We also know that people with depression tend to have worse employment prospects due to stigma and a lack of understanding.

At over £100 billion a year – roughly the entire cost of the NHS – the cost of mental illness to the UK economy is significant. The picture, however, is mixed across the UK. For example, it has been estimated that in Northern Ireland the prevalence of depression is 25 percent higher than in England. Distinct approaches have been taken in England, Scotland, Wales and Northern Ireland on this issue, with separate policies implemented at different times.

This report seeks to share the experiences of our four organisations, highlighting the range of interventions, services and policies that have been designed to support people with depression – including health and employment services – across the UK. It aims to encourage policy-makers to re-double their efforts to support people with depression, and all mental health conditions, to improve their employment outcomes.

There is a real and pressing need to address this issue as a matter of priority. The views of people with first-hand experience of depression should be central to the development of policies and must be heard more widely. We therefore strongly urge policymakers, employers and stakeholders to consider our recommendations carefully.

YOURS SINCERELY



DepressionAlliance



» Introduction

Depression is the leading cause of disability worldwide and a major contributor to the overall global burden of disease.¹ In the UK, mental health problems represent the largest single cause of disability with estimates showing that one in every six people of working age will experience some kind of mental health problem in the course of a year, with mixed anxiety and depression the most common.^{2,3}

The relationship between depression and employment is complex and multifactorial but the link between depression and poorer employment outcomes is clear.

Depression and employment

Mental illness is the leading cause of sickness absence in the UK. It is estimated to account for approximately 70 million sick days annually. Between 60 to 70 percent of people with common mental health disorders such as depression are currently in work. Since 2009, the number of working days lost to stress, depression and anxiety has increased by 24 percent.⁴

Depression is also a leading cause of lost work productivity, long-term disability and early retirement.⁵ It accounts for one of the largest forms of 'presenteeism', the practice of an individual failing to take sick leave when they need it.⁶ Among people with mental health problems, the costs of 'presenteeism' are suggested to be at least five times greater than those from absenteeism.⁷

"I was reluctant to tell work about my depression, but it was pretty obvious that I was not coping. It was a relief to admit that I felt so ill. Work have been good, but like most places, mental health problems are not understood by everyone. I know that I can have reasonable adjustments to my duties, and for me that has been a big help. Even small things, like where I sit, make my life at work easier. Now that work is on board, I can cope better. I wish I had spoken up sooner, as I struggled on my own for many months, fearing I would lose my job."

Those with depression are more likely to be in lower paid and less secure forms of work, particularly if they have a low educational attainment level.⁸ Workers in low-skilled jobs are more likely to report job strain, which increases the risk of mental illness.⁹ Low-skilled workers tend to be on short-term or temporary contracts. In this challenging economic climate, perceived job insecurity has risen and is associated with a 33 percent greater risk of common mental disorders.¹⁰

If a mental health condition meets the definition of 'disability' under the Equality Act 2010 – namely, if it has a substantial, adverse and long-term effect on the sufferer's day-to-day activities – then it is unlawful to discriminate against them on the grounds of that condition. However, the legal situation may not be well-understood, particularly

in the workplace. In a 2009 survey, Time to Change found that 92 percent of people believed that admitting to a mental health condition would damage someone's career, and 56 percent would not employ someone experiencing depression, even if they were the best candidate for the job.¹¹ Needless to say, stable employment is an important contributor to maintaining good mental health.

"Work Me is a lot tougher, altogether a lot more capable, Work Me has a skin. I have a role at work, a place, a reason to interact, I am good at what I do, I need to be good so I understand the value that I bring. I can't be the real me at work, because I would be just too socially awkward, too sensitive to the environment I am in. So over the years I have become a good actor. On bad days it is possible to smile and laugh even though there is no corresponding actual emotion happening inside of me... work for me is a blessing, it allows me the illusion of being part of something. I think we all need a 'pack', to be part of a group."

Depression and unemployment

The unemployment rate for people with a common mental health condition such as depression is double that found among the general population. In 2013, over 40 percent of Employment and Support Allowance (ESA) recipients had a 'mental or behavioural disorder' as their primary condition. Mental illness is now thought to account for more than double the ESA and Incapacity Benefit (IB) claims compared to musculoskeletal complaints.¹² Likewise, mental health problems disproportionately affect people those who are unemployed.

The true impact of mental illness on sickness and unemployment benefits is still not known and underestimated in routinely collected data. Many people receiving ESA and IB are undergoing a Work Capability Assessment (WCA). In 2013, data suggested that 40 percent of recipients are found 'fit for work' and invited to claim Jobseeker's Allowance where health data is not recorded.¹³ Numerous concerns have been raised about WCA in relation to people with mental health problems, particularly about the lack of understanding of mental health demonstrated by staff and the stress that this process has put on people with mental health problems.

"My depression and anxiety have just cost me yet another job. I've decided to take on night-care work as I feel it's the only way I can function and earn money in a quiet environment with few other people to bother me. I need to work, but it is so hard to do it when you feel so depressed and upset."

Charities and academics have also expressed concerns about sanctions applied to people with mental health problems who are in receipt of ESA, an element of social security that recognises that an individual has an illness, health condition or disability that makes it difficult or impossible to work. Recent analysis by the Independent and Mind found that 19,259 people with mental health problems had their benefits stopped under sanction in 2014-15 compared to just 2,507 in 2011-12 – a 668 percent rise.¹⁴

Commentators have described the system as difficult to navigate and said that it can place unfair or unrealistic demands on people with mental health problems. As charities that support people with depression, we know that person centred support is more effective for helping people to set and achieve work related goals than threats of sanctions.

This is a real world example. Jane has depression and anxiety and is in receipt of ESA. In January 2015, she was told that she was being sanctioned but was not told why. The sanction left her to live on £12.80 per week. This led to a deterioration in her mental health and additional financial penalties and debt from her inability to pay bills and her TV licence. She described the experience as "inhuman" and said that "no-one can live on that amount of money." In November 2015, it was determined that the sanction had been applied unfairly and the Department for Work and Pensions reinstated her ESA. She received back pay for the previous eleven months but is still in considerable debt because of the financial penalties she incurred while she was sanctioned.

Stigma and discrimination

People with depression may not disclose their condition on job applications due to expected prejudice and stigma. This reticence is understandable. In England, one-third of people with mental health problems report being dismissed or forced to resign. Two-fifths say that their history of psychiatric treatment resulted in them being denied a job. In a theoretical study employers were seven times more likely to hire a wheelchair user than a person currently taking medication for anxiety and depression.¹⁵

In a recent survey of over 7,000 people conducted by Time to Change, 56 percent of respondents said they had experienced stigma or discrimination in the workplace as a result of their mental health problems and 44 percent had experienced stigma and discrimination from employers. 48 percent said that stigma or discrimination – or other people's reactions to their mental health problem – had stopped them from looking for work or returning to work. Campaigns to combat mental health stigma and discrimination are being run in each of the four nations and progress has been made – but it is clear that there is still a lot of work to do.¹⁶

After many years of decline, suicide rates are steadily rising across the UK. This is most marked amongst middle aged men, with suicide now being the leading cause of death for men aged between 15 and 49.¹⁷

Improving employment outcomes

People with mental health problems have amongst the highest 'want to work' rate of any

"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."

unemployed group. A recent survey found that up to 90 percent of people with mental illness across the UK wanted to return to work.¹⁸ The UK Government has highlighted the need to get people with physical and mental health issues back to work. When it comes to people with depression, they are pushing at an open door.

Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.¹⁹ It is critical that the right policies are put in place to address this complex and negatively reinforcing relationship. Individuals too often get trapped in a cycle where their mental illness creates and maintains their worklessness, which in turn worsens their mental health.

Mental illness is both a risk factor for unemployment and an outcome of it.²⁰ Simple changes to health, economic, employment or benefit policies alone, which do not complement each other and take into account wider factors, will do little to address the problem.

Data from the Organisation for Economic Co-operation and Development (OECD) highlight that improved employment and occupational outcomes are achieved when specialist advice is available. Yet

only 30 percent of the UK workforce has access to specialised occupational healthcare.²¹ Exiting the labour market negatively impacts on self-esteem, identity and can extend to partners, children and family. Debt is known to double the risk of depression,²² with suicide rates greater in the unemployed than the employed by at least a factor of two and self-harm up to 10 times higher.²³

It is said that the loss of opportunity to work, makes the single greatest contribution to the costs of depression and other mental health problems in Europe.²⁴ Every year, mental illness costs the UK economy over £100 billion – roughly the entire cost of the NHS.²⁵ It is clear that failing to support people who experience symptoms of depression to improve

"The statement – 'good work is good for your health' – is widely recognised. Employment is, for most people, fundamental to quality of life, their main source of income, a major influence on their social network and helps define social status. Employment offers valued opportunities, social status and identity, a sense of achievement and structure to time. A lack of employment increases the chance of poor mental health. Not surprisingly, being without work "compounds the sense of failure among individuals with depression". As such, employment is a central component of recovery."

**Dr Max Henderson and
Dr Ira Madan (Chief Medical
Officer Report)**

their employment outcomes imposes additional public costs, such as housing, homelessness and social services.

Employment is vital to health and should be recognised as a health outcome. Individually, but especially in combination, mental illness and poor occupational outcomes are powerful contributors to a range of health and social inequalities.²⁶ Given all that is known about the close association between health and work, if an individual moves out of work, or is at risk of moving out of work as a result of mental illness, this should trigger the deployment of additional input.

Local and national health services across the UK must play a greater role in supporting people to find or keep a job, with expanded access to psychological support, an increased number of placement support programmes and further investments in health-led interventions that are proven to work for people with mental health problems.

This report provides a comparative summary of the policies that have been put in place across the UK, with the aim of encouraging policy-makers to implement the most effective policies to support the growing number of people who experience symptoms of depression to better retain their jobs, and find suitable employment opportunities in England, Scotland, Wales and Northern Ireland.

» Understanding depression

Depression is a heterogeneous condition made up of a broad mix of symptoms that affect different people in different ways. It is unlike the low mood everyone experiences. Depression is a profound, debilitating, pervasive mental and physical lethargy, an intense sense of loneliness and from time to time unshakeable, overwhelming sadness. Its impact on quality of life is equivalent to that of a severe physical illness. Because symptoms can vary in type, duration, number and severity, one person's experience of depression can be very different to another's.

Types of depression

The following terms may be used to describe specific types of depression:

- » **Dysthymia** is an on-going form of the illness where those affected may not meet the diagnostic criteria for depression but nevertheless experience chronic low mood, which can last for a period of years and affects their enjoyment of life.
- » **Postnatal depression (PND)** is an illness affecting up to 15 percent of mothers. About one third of these will have developed the symptoms during pregnancy. These symptoms include tiredness, anxiety and irritability but with PND, there may not be strong feelings of sadness or unhappiness. This may mean that those affected don't seek help as they believe it is a result of sleep loss and coping with the demands of a new baby. It is different from the 'Baby Blues' in that these are experienced by about 60 percent of women, usually starting on the third day after birth. Symptoms include feeling tearful and/or irritable for little or no reason. These are due to hormonal changes and for most women last only one or two days but no longer than 10 days. PND generally starts a few weeks after the birth and lasts longer.
- » **Psychotic depression** is a severe form of the illness where, in addition to the other common symptoms, those affected may at some time lose contact with reality and experience hallucinations or delusions. Many people experiencing psychotic depression will require hospital treatment at some stage.
- » **Bipolar affective disorder** (previously known as manic-depression) is a serious illness and those affected may experience depression lasting weeks or months, alternating with bouts of elation or mania ('highs') of variable duration. For people with elation, who do not have the accompanying depressive episodes, it is referred to as bipolar disorder. Those affected by the illness may have 'normal' mood for months or even years. The mood-swings of bipolar disorder should not be confused with the mood changes that we all experience from time to time. They are much more intense and prolonged and can have a devastating effect on the individual and their relationships.
- » **Reactive and endogenous depression** are old terms based on the supposed causes of the illness which are now rarely used. Reactive or exogenous depression, meaning coming from external factors, was seen as a depression brought on by life events or circumstances. Endogenous meaning coming from within or having no apparent external cause, was believed to have a strong genetic basis i.e. it was hereditary. However now it is generally acknowledged that all cases of the depression are to some degree partly reactive and partly endogenous. The severity of the illness is seen as more important than the cause and so as stated above depression is generally classified as mild, moderate or severe and treated accordingly.
- » **Recurrent depression** is where someone experiences more than one episode of the illness. It is quite common, although episodes can vary in severity and individuals may have periods where they are well between episodes.
- » **Seasonal affective disorder** is a form of depression, which seems to be brought on or made worse by lack of sunlight during the winter months.
- » **Secondary depression** refers to depressive episodes that occur in response to other mental illnesses such as schizophrenia, as a result of alcohol/drug abuse or arising from a physical illness such as a viral infection or Parkinson's disease.
- » **Unipolar depression** is an umbrella term for all the types of depression where an individual experiences one, or more, episodes of low mood, loss of enjoyment and/or extreme tiredness sufficient to warrant a diagnosis of depression.
- » **Depression is a co-morbidity** of numerous physical diseases, including cancer, diabetes, stroke, back pain, neck pain and heart attacks. For example, in England 15 million people have a long-term condition such as arthritis or coronary heart disease. Of these, 30 percent also have mental illness, most often depression or anxiety.

Symptoms of depression as a barrier to retaining employment

Depression tends to be categorised as 'mild', 'moderate' or 'severe' depending on the intensity of symptoms present. However, these distinctions are redundant and, in reality, based almost solely on diagnosis rather than functional impairment. So-called 'mild' disorders can produce adverse occupational outcomes.²⁷

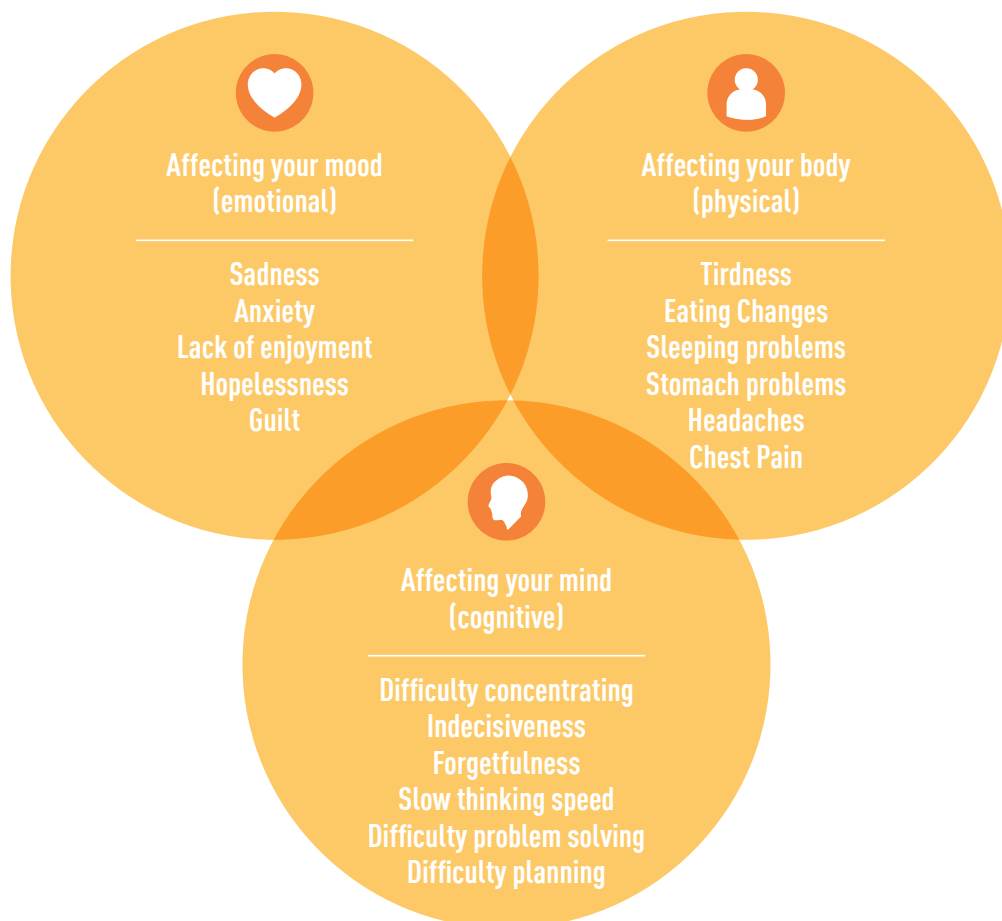
Every depressive episode is different and unique to the individual. The experience of depression, and the consequences it might have for employment, are entirely personal and may be experienced very differently by different people, despite having the same diagnosis.

The symptoms of depression can be split into three main categories. Various examples are included in Fig.1 but do not represent a list of all the symptoms that are associated with depression:

The symptoms of depression can cause difficulties in all aspects of daily life, including employment. The cognitive symptoms of depression - concentration difficulties, indecisiveness, forgetfulness, slow thinking speed, difficulty problem solving, difficulty planning - are present up to 94 percent of the time during an episode of depression.²⁸

Therefore, for many, coping with depression while holding down a job can be hard. For example, at work, depression can affect an employee's ability to make decisions, get started on tasks, keep an accurate work diary, remember to attend meetings, recall the details of conversations or requests, find the words to enable them to communicate their ideas effectively, plan their working day, work accurately, concentrate on tasks, complete work on time, understand complex matters, control their emotions and maintain good working relationships.

Fig. 1



"My boss and colleagues have been supportive. It helps that we work in science, so they have more understanding than the average person who hasn't been through mental illness. I have seen them for lunch a few times since I've been off. I want to get back to work, but it's a stressful, deadline-driven job and I have so little energy that little things get on top of me really easily. I'm aware that they're little things but somehow that makes it even worse because I feel I should be able to deal with them."

Where employers are unaware of such symptoms, they may see a change in an employee's work performance as a performance management issue rather than a result of a health condition. This can be particularly problematic where symptoms of depression become chronic and remain a long time after a period of treatment.

There are a number of work-related triggers for depression. Several studies underscore the link between job insecurity and depression, a link exacerbated by the economic uncertainties of the last few years. Work-related stress can also result in a new-onset or a recurrence of mental illness, especially in vulnerable people, such as those with a history of depression. In an Australian study, work-related stress increased the risk of depression or anxiety by 54 percent.²⁹ Studies consistently link several factors to an increased risk of depression:^{30,31,32}

- » A lack of authority to make decisions
- » Job insecurity
- » High job strain
- » High psychological demands
- » Low social support at work
- » Over-commitment
- » Imbalance between high effort and low reward

"I still struggle quite often, but since work has always been very important to me, I persevere. Work have been very mixed, with one member of the human resources department phoning me up to threaten and harangue me, while others have been understanding and sometimes helpful. Most of my colleagues have been very supportive, though one or two clearly have issues with mental illness and have problems dealing with me."

Job strain and imbalance between effort and reward seem to have the greatest impact on the risk of developing depression.³³ For example, one analysis that looked at 38 studies evaluating the link between stress and mental disorders found that:

- » People with limited opportunities to make decisions were 21 percent more likely to develop a mental health problem than those with more control.
- » Those who experienced poor relationships at work were 32 per cent more likely to develop mental health problems.
- » People who felt there was a marked discrepancy between the effort they put in and their reward were 84 per cent more likely to develop mental health issues.³⁴

Under the Disability Discrimination Act (1995) employers have to make reasonable adjustments to their working conditions or arrangements to make sure that disabled people – including those with depression – are not treated less favourably than other employees. However, many employers fail to adequately support people with mental illness. In some cases, this reflects a corporate culture that regards mental (or physical) disability as a 'weakness'. More often, however, employers want to help, but do not know how.

"In the past, I have kept my condition hidden from co-workers for fear of being perceived as lazy or unsuitable for promotion. My current employer has been extremely supportive in making changes that have enabled me to continue working and reduced my anxiety. At the moment, I work compressed hours where I am able to take one day off a week. Having this flexibility is vital in helping me to manage my symptoms and take positive steps forward, such as undergoing counselling."

It is critical that workplaces offer appropriate support. Autonomy at work and flexible working patterns increase the likelihood that a person with depression will remain in employment. Employees could, for example, shorten their working day, adapt their tasks or working conditions, as well as using mentoring programmes or receiving more tailored individual support. Whilst it is important that such autonomy is not used to conceal the condition, flexible working seems to be underused. For example, in a survey of over a thousand managers and employees in the UK, only 12 percent of managers offered people with depression a flexible working pattern.³⁵

"Other businesses who don't want to talk about it, don't want to know, and have the attitude that 'it's nothing to do with me, I just want the job to get done' are missing a trick because I think you actually get more from people."

The majority of employers are not large companies but small and medium-sized enterprises which make up our high streets. They need our support to take the small steps which will help them effectively manage depression in the workplace and protect the sustainability of their business.

UK SURVEY

A survey of 1,200 people from across the UK by Depression Alliance (2014) showed that a third of those interviewed struggle to cope at work because of depression, stress or burn out. Of these, 83 percent experienced isolation or loneliness because of their symptoms. Only half of those feeling lonely or isolated had confided in a colleague, yet 71 percent found that discussing their condition with someone at work helped them feel better.

Symptoms of depression as a barrier to finding employment

Many of the symptoms of depression undermine the chances that people will find a job, return to work rapidly from sick leave or reach their full potential. People with depression often show impairments of mental-interpersonal tasks, time management, output task and physical tasks.

“It’s like trudging through mud and going under the speed limit; driving with the handbrake on – it’s frustrating as you are performing under your potential”

Persistent symptoms of depression do not just continue to impact daily life and work, they can also restart the cycle of depression. For example, loss of attention can lead to feelings of negativity and perpetuate a depressive state (i.e. negative cycle of depression) – illustrated in Fig. 2.³⁶ These symptoms can therefore be difficult for both job retention as well as creating barriers to seeking employment (e.g. lack of motivation and self-confidence to try).

Fig. 2

- Make Mistakes**
 - » Feel guilty / ashamed
 - » Frustration / embarrassment
 - » Feel stupid
- Impact on other areas of cognition**
 - » Forgetful (Memory)
 - » Difficult to plan and prioritise (Executive Function)

Recovery from depression can mean different things to different people. For some people recovery is about taking care of yourself, leaving the house in the morning and feeling pleasure when you speak to friends. For others, recovery means having an active social life, picking up hobbies and going to work. For most people with depression, recovery means accepting the condition and finding ways to manage long term: an 80 percent improvement is an accepted outcome for many physical illnesses. Living a fulfilled life does not necessarily depend on eliminating depression, but on its effective management.

“People with mental health conditions ultimately want to be successful and contribute to society. If they are able to receive the right support when they are struggling, they will be even more committed when they return. I think there is a missed economic opportunity in failing to support people suffering from depression in getting back to work.”

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. About 60 percent of individuals who have recovered from a depressive episode experience a recurrence within five years.³⁷ Some people recover completely in between episodes. However, between 30 and 50 percent experience residual symptoms such as low energy, guilt, sleep disturbances and fatigue.³⁸



During treatment, improvements in the ability to think, concentrate, remember and process information often lag behind improvements in mood, and these symptoms can even persist after an individual's treatment has been completed. Persistent symptoms of depression can continue to affect daily functioning and performance at work. However, people do not have to be one hundred percent well to return to work and for many people with depression return to work before full symptom remission can be very helpful.

Despite these challenges, it is important to remember that people with depression can and do work, that many people with depression are employed and make important contributions to individual workplaces and the economy as a whole.

FIVE WAYS TO WELLBEING

The Five Ways to Wellbeing developed by the think tank New Economics Foundation (Connect, Be Active, Take Notice, Keep Learning and Give) offers another framework to address the issues faced by people with depression in the work place. The Five Ways to Wellbeing are based on "state-of-the-art research about mental capital and mental wellbeing through life". The Five Ways to Wellbeing helps develop organisational strategy, assess need and measure impact for staff development, and helps people to incorporate wellbeing-promoting activities into their lives.

Source: New Economics www.neweconomics.org/projects/entry/five-ways-to-well-being

» Policies & practice in the UK

The prevalence of depression and its subsequent impact on employment outcomes is different across the UK. For example, it has been estimated that in Northern Ireland the prevalence of depression is 25 per cent higher than in England.³⁹ Distinct approaches have been taken in England, Scotland, Wales and Northern Ireland on this issue, with separate policies implemented at different times.

» England



It is estimated that one person in four has at least one mental health condition in England.⁴⁰ According to the Care Quality Commission, only 25 percent of those in England who wanted support said that in the last 12 months, NHS mental health services ‘definitely’ gave them help or advice with finding support for finding or keeping work. Another 28 percent said that they had received support “to some extent”. In other words, almost half of respondents did not feel that they had received the help or advice they wanted.⁴¹

The overall cost of depression in England was estimated to be £9 billion in 2010. More than £8 billion of this cost was due to lost productivity as a result of work days lost resulting in claims for incapacity benefits. This figure is 23 times larger than the estimated costs falling to the NHS, which were £8 million for primary care consultation, £51 million for secondary health care and £310 million for medication.⁴²

In the last Spending Review (November, 2015), the Government pledged to improve links between health services and employment support, recognising timely access to health treatments can help individuals return to work quicker. Over £115 million of funding was pledged to the Joint Work and Health Unit, including at least £40 million for a health and work innovation fund, to pilot new ways to join up across the health and employment systems.⁴³

It was also announced that, where it has been agreed as part of a devolution deal, local areas will co-design employment support for harder-to-help claimants in order to further integrate services and help people back into work. A White Paper is expected in 2016 that will set out reforms to improve support for people with health conditions and disabilities, including exploring the roles of employers, to further reduce the disability employment gap and promote integration across health and employment.⁴⁴

HUMAN RESOURCES TEAMS

Depression Alliance recently held a session with senior Human Resources teams from global companies. During the session, discussions revealed that employers are unable to distinguish between work-related stress and depression. They also expressed concerns about managing people with histories of, for example, child sexual abuse and alcohol dependency, but who attributed the current episode to job-related stress.

Mental health services in England

Most mental illness is managed by GPs. Depression is the third most common reason for GP consultations and GPs issue the majority of Statements of Fitness for Work (‘Fit Notes’).⁴⁵ Given that only 30 percent of the workforce has access to specialised occupational healthcare professionals,⁴⁶ GPs are often seen as the default source of most occupational health advice. Primary care professionals therefore play a critical part in the provision of support for those with depression and have an important role in their patients’ employment outcomes.

People do not have to be 100 percent well to return to work, and, for many people with depression, return to work before full symptom remission can be very helpful. The Fit Note was designed to support this message; however the task of completing this for people with complex mental health conditions can be challenging for some GPs given their lack of specialist knowledge in occupational mental health.

Indeed, correct identification and diagnosis of common mental disorders is not simple. A recent systematic review and

meta-analysis, showed that GPs are able to accurately exclude depression in 80 percent of cases but only diagnose but only diagnose about half of the “true” cases they see.⁴⁷ Thus they are not always well placed to identify needs and refer patients to specialised services.

“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”.

In 2015, the Department of Work and Pensions (DWP) implement the Fit for Work programme in England and Scotland. Fit for Work provides an occupational health assessment and general health and work advice to employees, employers and GPs. It is free and aims to complement, not replace, existing occupational health services provided by employers, with a view to helping employees stay in or return to work. It seeks to fill the gap in support that currently exists and benefit those employers who currently have limited in-house occupational health services.⁴⁸

On employment, DWP forecasts that it will spend £2.8 billion in total payments to contractors to help people into work under the Work Programme between June 2011 and March 2020. Yet fewer than one in 10 people with mental health problems have gained employment through the Work Programme. We know psychological therapies and Individual Placement and Support (IPS) services have proved highly effective – with around 30 per cent moving into jobs through IPS – but these are not being commissioned at scale.⁴⁹

The newly established Joint Unit for Work and Health is currently piloting new approaches and recently secured significant new investment for an innovation fund.

Interventions to support improved employment outcomes

As the Chief Medical Officer’s (CMO) Annual Report pointed out, most mental illness comprises common mental disorders such as depression, and yet mental health services for some time have been focused “almost to the point of exclusion” on psychotic illness such as schizophrenia. Care for these patients has improved but the somewhat unbalanced approach to other mental

illness has led to a number of unintended consequences. GPs and other non-psychiatrists (including occupational physicians) find it hard to access specialist support for hard-to-treat patients with non-psychotic illness.⁵⁰

One service that has been developed predominantly for patients with common mental disorders is Improving Access to Psychological Therapies (IAPT). This began in 2006 and was extended in 2010 and again in 2011. In 2012, it reported on its first 1 million patients. Uptake has been strong but the occupational outcomes have been seen as questionable. In 3 years, only 45,000 people have moved off benefits. It is not known how many have moved into employment. According to the CMO Report, the ability of IAPT to successfully manage clients back to work remains to be demonstrated.⁵¹

“Keeping people in work is so much better than them losing jobs and having to find them again”

A range of interventions are seen as having an important role in improving employment outcomes for people experiencing symptoms of depression. Psychological and occupational therapies, especially those using Cognitive Behavioural Therapy (CBT), are cited as the most effective in improving employment-related outcomes of people with depression, particularly when used alongside medication.

Against this background, a randomised controlled trial included 1,193 participants on sick leave, at risk of going on sick leave or on long-term benefits. More participants who received work-focused CBT and individual job support increased or maintained work participation after a year compared to controls (44 percent and 37 percent respectively). The difference remained significant after 18 months (difference 8 percent) and the benefits were especially marked for those on long-term benefits (difference 12 percent). Work-focused CBT and individual job support reduced depression and anxiety symptoms and improved quality of life.⁵²

To enhance employment outcomes, there must be improved recognition of the value of therapies such as CBT, behavioural activation, vocational rehabilitation and support, as well as greater rigour in treatment and also for improved recognition and treatment of ongoing symptoms which can affect work as well as other aspects of an individual’s life. Many common mental disorders such as depression are still not diagnosed, those diagnosed are not treated and those treated are often

FRIENDS IN NEED STORY

"I became seriously depressed soon after I started with a new employer. I had been feeling mildly depressed for several months and changed my job to try and improve my symptoms. Unfortunately, I very quickly realised that things were not improving and that I was never going to enjoy my new job. I felt increasingly trapped and isolated and my symptoms quickly escalated to full-blown depression. I had panic attacks at work and felt physically sick at the thought of going into the office. I sought advice from a private psychiatrist who changed my medication. I was signed off work about 3 months ago.

My new employer was a lot more understanding than I would have imagined. I very much feared for my job. They offered a generous final payment, so that I could continue living without having to worry about finances. The removal of this concern was a significant factor in the recovery.

The time out gave me a time to reflect on why I was feeling the way I was. With the help of a psychotherapist I was able to unravel my thought patterns and seek solace in the Friends in Need support groups. It was so liberating to meet people who understood depression, who welcomed and befriended me, unconditionally and without judgement. The group gave me a reason to get out of bed, a time table and structure of activities to look forward to while I have been unemployed

I am happy to say that I'm feeling a lot better, the path forward is clear and the feeling of hopelessness that accompanies depression is a distant memory. I'm fully aware that this is a life-long mission and although I won't be attending the daytime sessions anymore (I am returning to my former employer, who I have made aware of my illness) I intend to keep my vigilance up by attending sessions in the evenings wherever possible. Friends in Need has been instrumental in my recovery and I cannot commend the work they do highly enough."

under-treated. The commitment of Occupational Therapists to identify and understand the goals of the individual is complementary to the treatment of symptoms.

The integration of health and employment support – from Jobcentres to GP surgeries – is obviously crucial in improving employment outcomes. However, the ability of Jobcentre programmes to support people with depression back to work must be viewed with caution. Their role is often seen as having too narrow a focus on outcomes and being too impersonal in its approach to really be able to help people with depression.⁵³

"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."

A national approach to mental health policy-making

In March 2015, NHS England formed the Mental Health Taskforce to lead a programme of work to create a mental health Five Year Forward View. The taskforce is chaired by Paul Farmer, Chief Executive of Mind, and brings together health and care leaders, people using services and experts in the field for the NHS in England. It is the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and care system, in partnership with the health arms-length bodies.

To help inform decisions about priorities for the new strategy, the taskforce sought the views and expertise of people with personal experience of mental health problems, families, carers and professionals as well as reviewing clinical and economic evidence. From that consultation a strong message was received: that within mental health settings, particularly within inpatient and secure care, all aspects of a person's life, including healthy relationships, education and employment needed to be actively supported through collaborative care planning.

The areas of change that were noted on mental health and work were:

- » Support into work (support to help those with mental health problems find and retain meaningful employment)
- » Welfare issues (support in accessing benefits, fair benefits - sanctions)
- » Sick pay (for those on leave from work because of a mental health problem)⁵⁴

The Mental Health Taskforce published its recommendations in the report “The Five Year Forward View for Mental Health” in February 2016, strongly emphasising the important focus on supporting improved employment outcomes for people with mental health conditions. It states that more people with common mental health problems, such as depression, should be supported into work through psychological therapies and expanding employment support in primary care, and calls for employment to be recognised as a health outcome.

In particular, the report puts forward the recommendation that: “By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems.”⁵⁵ We strongly support this recommendation and look forward to working with partners to realise the ambition.

FRIENDS IN NEED

Depression Alliance developed Friends in Need as a free and supportive community for everyone affected by depression. Friends in Need encompasses local groups and an online community and provides a safe and friendly space for people with depression. The groups provide a network of support running through the week and weekend and support IAPT in making recovery work. By the end of 2015, 21,870 people had registered in 856 Friends in Need groups. In a survey of 215 people from those groups, 50 per cent of those who attended a ‘meet up’ found it supportive and 52 per cent said it has been beneficial to their health. Moreover, 76 per cent would recommend the group session to a friend. The peer support offered by initiatives such as Friends in Need helps people build the resilience needed to return to and remain in work.

It is estimated that one in every four people will experience a diagnosable mental health problem each year in Scotland, with anxiety and depression being the most common.⁵⁶ Those with mental health problems have the highest unemployment rate of any group in Scotland, suggesting that this is a key area in which improvements should be targeted.⁵⁷ Depression also represents a major challenge for workplaces, costing Scottish employers over £2 billion a year.⁵⁸ Research from the Scottish Association for Mental Health (SAMH) suggests that the total costs of mental health problems in Scotland in 2009/10 was £10.7 billion.⁵⁹

Data show that people with mental health conditions account for as much as 43 percent of social welfare benefits or disability pensions in Scotland.⁶⁰ Welfare reforms have negatively impacted people with mental ill health. A survey of service users undertaken by SAMH (2014) reported that 98 percent of respondents stated that their mental health had suffered as a result of welfare reforms, including increased stress and anxiety.⁶¹ Data from the Audit Scotland shows a health inequality with those living in deprived areas having been found to have a lower level of mental wellbeing, and have more GP consultations for conditions such as depression and anxiety.⁶²

The Scottish Government has introduced a number of measures in an attempt to minimise the negative impact of welfare reform, including 'bedroom tax' mitigation and the introduction of the Scottish Welfare Fund.⁶³ Specific population health priorities also now encompass poor mental wellbeing alongside health inequalities with their social determinants, inactivity, nutrition and obesity, concurrent with the demography of an ageing population.⁶⁴

Scotland has lower life expectancy than its European counterparts and high levels of multi-morbidity in particular concurrent physical and mental health conditions. Mental illness is associated with a 15 year reduced life expectancy compared to the general population, mainly due to cardiovascular disease. A striking and increasing number of people are living with multiple conditions impacting on their health, wellbeing and ability to function.⁶⁵

As part of the devolution process, the Scottish Government will take over responsibilities for 'into work' employment support programmes. This will offer the new Scottish Parliament greater freedom to develop its own long-term programme to

support those with depression to improve their employment outcomes for the first time.⁶⁶

SEE ME PROGRAMME

Scotland's national See Me programme has been tackling mental health stigma and discrimination in Scotland for the last decade. It is currently funded by the Scottish Government and Comic Relief and managed by the Mental Health Foundation and Scottish Association for Mental Health.

The programme aims to:

- » Reduce self-stigma for people with mental health conditions
- » Reduce stigma and discrimination among communities and organisations with the potential to have a positive effect on people with mental health conditions
- » Increase societal understanding that people can and do recover from mental health conditions
- » Ensure that people who experience mental health conditions are able to participate in society and live full lives without fear of discrimination

In 2015, See Me launched a new mental health stigma and discrimination programme specifically targeted at the workplace, called See Me at Work.

Mental health services in Scotland

The majority of mental health services in Scotland are delivered through the NHS and local authorities, in partnership with the third sector. The 14 NHS Scotland Health Boards hold responsibility for the treatment of people with mental health problems in community or acute settings, whereas local authorities are responsible for securing social care and support services in the community. Most NHS services are carried out in the community and delivered in primary care settings and through community mental health services. Third sector organisations including charities and non-profit organisations also play a vital role in service provision as well as offering support for people with mental health conditions.⁶⁷

The Mental Health (Care and Treatment) (Scotland) Act 2003, established core principles to apply to mental health services in Scotland and that approach has firmly embedded rights at the heart of practice within services:

- » The principles of the Act underpin many of the values of inclusion, reciprocity and dignity which are key to effective, person centred mental health services.
- » The Dementia Standards built on this approach to establish a framework for care and treatment standards for those with dementia and their carers; the standards apply irrespective of who delivers care or treatment, or where care or treatment are delivered and create a common understanding of how the quality of care and treatment should be assessed.
- » The Scottish Human Rights Commission has established a framework for embedding rights within care and treatment settings and services.⁶⁸

The 2015 Review of Public Health in Scotland stated that greater integration of services was being achieved by bringing together health and social care through the creation of Integration Joint Boards (IJBs). Together with NHS Boards and Local Authorities, these IJBs are required to demonstrate their contribution to tackling health inequalities and improving healthy life expectancy. Contributing processes include more joined-up working and budgets; a greater focus on prevention and population-based health improvement; and person-centered care.

Interventions to support improved employment outcomes

The use of recovery-orientated practice and person-centred practice in services have been successful through the development of the Scottish Recovery Indicator. Employability is embedded and integrated into the work that enables service users to develop personalised wellness recovery action plans. These approaches demonstrate how services, service users and those who support them can orientate themselves towards work.⁶⁹

The Scottish Government is seeking to change the culture around mental illness by reinforcing a message that highlights the importance of employment in promoting and maintaining health and for community mental health teams to more effectively incorporate vocational information and activity into care plans.⁷⁰

To do this at a local level, NHS Lothian and NHS Lanarkshire trained occupational therapists to be aligned with community mental health teams to lead this role. In other places this role has been taken on by a dedicated support worker. NHS Tayside and NHS Fife developed an electronic resource in partnership with work agencies to help signpost staff to resources. A community of practice has also been established

and employability training made available to health professionals through NHS Education for Scotland (NES).⁷¹

There are good examples of the “place then train” model being implemented in Scotland. The WORKS is an NHS Lothian vocational rehabilitation service for people living in Edinburgh that supports people with mental health conditions to stay in work, return to work, or gain work for the first time. It provides ongoing practical and emotional support that can include on-the-job support to manage a mental health condition, advice about informing employers about a mental health condition and other tailored support for as long as is required. It also offers employers advice around good working practices, including disability discrimination legislation and reasonable adjustment.⁷²

In Scotland, increasing access to psychological therapies is a commitment outlined to meet HEAT targets. In the last quarter of 2014, an estimated 10,500 people in Scotland used NHS psychological therapy. A new waiting list target of 18 weeks was implemented at the end of 2014.⁷³

A national approach to mental health policy-making

Over the last decade, there has been a strong drive to prioritise a national strategic approach to mental health policymaking, as evidenced by the wide range of legislation and national initiatives related to mental health in Scotland. The Mental Health (Care and Treatment) Act 2003 was introduced in 2005 and has been internationally recognised as one of the most advanced pieces of mental health legislation in the world, particularly in regards to its focus on human rights.⁷⁴

Currently, the Scottish Government’s flagship mental health policy is the “Mental Health Strategy for Scotland 2012–15”. Introduced in August 2012, the strategy sets out 36 commitments, aimed at driving the delivery of effective care and treatment options for people with mental health conditions in Scotland. It is focused on seven key themes which include:

1. Working more effectively with families and carers.
2. Embedding more peer to peer work and support.
3. Increasing the support for self-management and self-help approaches.
4. Extending the anti-stigma agenda forward to include further work on discrimination.
5. Focusing on the rights of those with mental illness.

JACK'S STORY

For more than 16 years, Jack had an excellent work-record at a large national company. However, Jack started to experience major depressive episodes, which began to affect his performance at work.

Initially, Jack was very run down and struggled with the pressures of increased workload. He was disciplined constantly for minor mistakes, despite requesting support. On several occasions, managers told Jack to "take ownership of his issues" and "come back to work in a better frame of mind". Jack was often reported to management for "being in a pretty dark mood" or "not in great shape today". Jack's manager said that there was "nothing wrong" from what they could see and he was capable of carrying out his work. The managers' attitude, extreme lack of support and misunderstanding verged on bullying.

After two 6-month periods of sick leave, Jack sought assistance from Remploy to act as an intermediary with the company and help him get back to work. Jack's manager refused to meet with Remploy's representative and dismissed the proposed 'Return to Work' plan.

Jack feels that current employment laws represent the employer's interests. This leaves employees feeling trapped and discriminated against. Jack's experiences exacerbated his depression and have led to self-harm. Jack is currently on benefits, although he hopes to return to work with help and support.

6. Developing the outcomes approach to include, personal, social and clinical outcomes.
7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services.⁷⁵

The Strategy also identifies four 'key change areas' for continuous improvement:

1. Child and adolescent mental health.
2. Rethinking how we respond to common mental health problems.
3. Community, inpatient and crisis services.
4. Other services and populations.⁷⁶

In 2014-15, the Scottish Government spent £22.3m on mental health improvement and service delivery.⁷⁷ However, a key criticism fielded against the 2012-15 Strategy has been the lack of regular monitoring and review of progress against the commitments.⁷⁸

LIVING LIFE TO THE FULL

During the Living Life to the Full (LLTFF) community-based programme, people with depression take part in weekly life skills classes lasting 1.5 hours for 8 weeks. Class leaders guide participants through written self-help booklets teaching key life-skills, based on CBT concepts. For example, participants examine how events and situations affect how they think, feel and behave. People with depression learn how to change counterproductive thoughts and behaviours to, for example, returning to and remaining in work.

A recent study from the University of Glasgow randomly allocated 142 people to Immediate Access to LLTFF or a control group, who participated after waiting 6 months. Sixty-eight percent of participants had experienced depression for more than five years and 49% were taking antidepressants. The Immediate Access group showed significant reductions in depression and anxiety scores as well as improved social function. These improvements were greater than in the control arm. People who were more depressed at baseline showed the greatest improvement. The classes were cost-effective with a cost per quality-adjusted life year between £20,000- £30,000.

The most recent Welsh Health Survey found that 9 percent of adults in Wales are being treated for depression.⁷⁹ This research also showed that people in higher areas of deprivation suffered most with mental health problems and there is a growing consensus that the recent economic downturn has had a significant impact upon mental health outcomes in Wales. Over half of all women in Wales are believed to suffer from low level mental health problems, whilst the rate of suicide for men in Wales is higher than in England, Scotland or Northern Ireland.⁸⁰ The overall cost of poor mental health in Wales is estimated to amount to £7.2 billion per annum including £1.2 billion in workplace costs such as absenteeism, presenteeism and staff turnover.⁸¹

Although mental health problems are common, a number of health conditions lead to stigmatisation in Wales; mental health problems are second only to HIV/AIDS in regards to discrimination and ostracisation.⁸² A recent survey conducted by Time to Change found that 59 percent of the Welsh respondents had experienced stigma or discrimination in the workplace and 54 percent said stigma and discrimination had stopped them looking for or returning to work.⁸³ The role of stigma in preventing people with poor mental health to seek help can be even more pronounced in rural areas in Wales.⁸⁴ However, the Time to Change Wales campaign, which has been running since 2012, has reached over 19 million people through its social marketing campaigns, developed a network of over 300 champions, worked with over 250 organisations and delivered a 3.5 percent positive public attitude change since its inception.

DEPRESSION BUSTING

This is an award-winning, self-management course, which offers a toolkit of skills and strategies. Journeys (now part of Gofal) developed the course with input from people from various backgrounds including training, teaching, CBT, counselling and mind-body therapies, as well as those who have experienced depression. Depression Busting is aimed at people with mild to moderate depression, or people who are recovering from depression, who willing to make some of the lifestyle changes explored during the course. Depression Busting is a 16-hour course, delivered over eight weeks, enabling people to practice and develop the skills they learn supported by the trainer and the rest of the group.

Mental health services in Wales

Whilst the Minister for Health and Social Services is ultimately responsible for the NHS in Wales, delivery of health services, including those for mental health, falls under the auspices of seven Local Health Boards (LHBs) across the country. Each LHB is expected to plan and provide mental health services for their resident population according to broad priorities set out within an overarching “Together for Mental Health Wales” strategy, and typically operate within a three year planning process. Each LHB is responsible for the planning and delivery of both primary and secondary health services within its area and is required to produce an annual report in relation to the delivery of Together for Mental Health locally. Local health and wellbeing interests are represented by seven corresponding Community Health Councils.⁸⁵

In Wales, mental health spending has been ring-fenced and totaled £587 million in 2014-15, which is 11.4 percent of the total Welsh NHS budget. A recent Welsh Government report, commissioned by PriceWaterhouseCoopers, found that the ring-fence has helped to protect expenditure on mental health services. It also recommended that these arrangements should be retained, and strengthened by the adoption of an outcomes-based approach. The Welsh Government has already required that in future, health boards should report on their expenditure against the ring fence as part of their Together for Mental Health annual reports and plans to move towards the outcomes-based approach recommended in the report. We believe that linking expenditure with outcomes, including employment related outcomes, is crucial for measuring the impact that mental health spending has on people's lives.

Interventions to support improved employment outcomes

The Welsh Government has undertaken a number of policy initiatives that have sought to drive forward improvements in the focus and delivery of mental health services in recent years. In 2010, the Mental Health Measure was passed in the National Assembly for Wales with the aim of improving the assessment, care and treatment of people with mental health problems. The Measure was widely regarded as unique and ground-breaking legislation and was implemented in 2012.

» **Part 1** focuses on improving information, advice and support services in primary care, predominantly for people with low to moderate level mental health problems. Gofal research shows that many of these people are currently in employment and effective primary mental health services can be crucial in providing effective early interventions to help people remain in work. However, provision can

vary between the seven health board areas which commission and provide services, as can waiting times and the quality of services.⁸⁶

- » **Part 2** includes a legal requirement for people using secondary mental health services to have a care coordinator who works with the patient to agree outcomes in a Care and Treatment plan. The legislation specifies the content of care and treatment plans and includes sections on education, training, work and occupation.⁸⁷
- » **Part 3** enables people who have used secondary mental health services within the past three years to refer themselves back to those services
- » **Part 4** enables every in-patient to access an independent mental health advocate if wanted.

Although Part 1 of the Measure has delivered improvements to primary mental health care, it has been recognised in the Welsh Government's Duty to Review report, Gofal research and Royal College of General Practitioners (RCGP) research that access to psychological therapies remains an issue for many people. Although the Welsh Government has provided additional investment in this area, we believe that there needs to be a sustained focus on reducing waiting times for psychological therapies. At a primary care level, this could be crucial in supporting people to remain in employment. With regards to Part 2, the holistic approach to care and treatment planning has been welcomed, but more needs to be done to ensure the quality and effectiveness of care and treatment plans. Employment or occupation-related outcomes should be, in our view, a core feature of every care and treatment plan.

A national approach to mental health policy-making

The flagship cross-Welsh Government strategy "Together for Mental Health" was launched in 2012, looking to "build on improvements in mental health services over the last 10 years" and provide "a long-term commitment to improve mental health and wellbeing."⁸⁷ Together for Mental Health calls for a cross-Government, holistic approach to improving mental health outcomes in Wales and is focussed around six high level outcomes, including "the impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced."

The strategy includes an ambition to deliver "increasing levels of education attainment and employment". It also states that "people with mental health problems should therefore receive support to gain jobs and remain in employment. Our Programme for Government...sets a strategic aim of 'improving the health of the working age population' and this includes mental health." Recognising the "significant economic and productivity benefits" that can be achieved as a result

ENGAGING WITH UNIONS

Trade union activists reported increased levels of mental health problems in the workplace and asked the Wales Trade Union Committee (TUC) for more information and training. So, in 2014, Gofal and the Wales TUC published a mental health toolkit for trade union representatives. Gofal and the Wales TUC also recognised the potential for trade union reps to campaign for and support mentally healthy workplaces.

Trade union reps from across Wales contributed views and ideas during the toolkit's development, which includes:

- » Information about mental ill health and the impact on workers, the workplace and the economy
- » Myths and facts about mental health
- » Five ways to wellbeing
- » Information about Time to Change Wales, which aims to counter stigma
- » Actions and activities that trade union reps and employers can take to improve mental health and wellbeing
- » A list of helplines and advice agencies
- » Information about local primary mental health services
- » Information about the law and discrimination

Gofal delivered mental health workshops to hundreds of trade union reps across Wales. The toolkit and workshops increased knowledge and understanding of mental health, how unions and employers can signpost and support people with mental health problems, and actions that improve mental health and wellbeing at work. Following on from this work, the TUC in England commissioned Gofal to develop a young workers' guide to mental health at work, which was published on World Mental Health Day 2015.

of realising this ambition, the Strategy also makes the case for greater uptake of several existing initiatives, including:

- » **Healthy Working Wales:** Supports employers, employees and health professionals to improve health at work, prevent ill-health and support a return to work following an episode of ill-health.
- » **Corporate Health Standard:** A progressive programme run by the Welsh Government that challenges employers across the public, private and third sector to implement practices that promote the health and wellbeing of employees. Bronze, silver, gold and platinum award categories are available and mental health promotion is included as a specific envisioned focus area.

- » **Small Workplace Health Award:** A similar award-based health promotion scheme, but with a focus on businesses and organisations employing fewer than 50 people. The programme encourages work-based health plans that incorporate managing pressure and stress, as well as taking into account how the wider environment can impact upon an individual's sense of wellbeing.
- » **Fit for Work (Wales):** Replacing the former Health at Work Advice Line Wales, this UK Government-funded programme provides expert and impartial workplace advice for employers across England and Wales, as well as a referral service for individuals who have been, or are likely to be, off sick for four weeks or more. Employees who undergo a referral assessment will receive a tailored Return to Work Plan designed to facilitate an earlier return to work, and which can also be shared with their employer and/or GP. As the service is voluntary, employees must provide consent before any referral takes place and that they are happy for information to be shared with any other parties.⁸⁹
- » **Time to Change Wales (TTCW) Organisational Pledge:** The Time to Change Wales pledge is a public declaration that an organisation wants to tackle mental health stigma and discrimination. All organisations who want to pledge must complete an action plan, which may include looking at policies and culture, running internal anti-stigma campaigns and inviting TTCW educators to deliver anti-stigma training.

Together for Mental Health also commits to working with partners in the third sector to encourage more people to get involved in volunteering and support people to access or return to work. We believe that partnerships with the third sector can provide person-centred support and deliver positive results for both individuals and the Welsh economy.

PATHWAYS TO EMPLOYMENT

This Gofal project provides a specialist service to people with mental health needs, assisting them to access or retain employment, access education and vocational opportunities, or re-discover skills and abilities that they may have lost. Funded by Caerphilly social services department, Gofal staff work with people to identify and pursue training, as well as supporting and mentoring individuals relating to work opportunities. Using the Workstar Outcome model, the service focuses on aspirations, strengths, experience and the re-learning or development of new skills. Gofal also developed positive relationships with several employers and training providers to help meet individual needs and support people on their recovery.

MARK'S STORY

Mark was diagnosed with severe depression and anxiety more than 10 years ago. In 2011 he reflected on the stigma that faces people with mental health problems and recollected his feelings when filling out a job application: "do I really want to disclose the fact that I've had depression for a number of years? What are they going to think of me? Is this going to affect my chances of being shortlisted and, even if I am shortlisted, will I be the token person on the shortlist with a mental health problem?" ... and then you think "to hell with it" and put the application form in the bin".

Four years on, Mark now works at the Wales Co-operative Centre and speaks more positively about how understanding employers can make a difference. Dealing with depression at work was a "learning curve" for Catherine, his manager, and himself. Catherine had no previous experience of depression. She worried about her lack of knowledge, especially what to say and the impact on the work place. However, once Mark had told her about his depression she went away and "did a lot of homework".

Catherine now feels that she can take depression in her stride. Because she can talk openly, they can manage things at work so that Mark is better able to deal with his depression. As a result, the business gets a much better performance out of Mark. "Other businesses who don't want to talk about it, don't want to know, and have the attitude that 'it's nothing to do with me, I just want the job to get done' are missing a trick because I think you actually get more from people," Catherine says.

"Knowing that I can talk to them about it without them being discriminatory towards me means I can go about my business, I can be myself and I can work to the best of my ability at all times," Mark adds.

It has been estimated that the overall prevalence of mental health conditions in Northern Ireland is up to 25 percent higher compared to England,⁹⁰ costing over £3.5 billion per year which is equivalent to about 12 percent of the country's total income.⁹¹ In comparison with other parts of the UK, it is clear that Northern Ireland continues to have a distinctive profile of mental health needs reflected by high levels of socio-economic deprivation and the effects of over thirty years of civil and political conflict.

Figures from the Department of Health show that 13 percent of adults in Northern Ireland have been officially diagnosed with depression but the actual numbers are likely to be much higher.⁹² At any one time, 250,000 people will have a mental health need (a sixth of the population) and 17 percent of men and 32 percent of women aged 35-44 show signs of depression.⁹³ The rates of depression in Northern Ireland are associated closely with unemployment, low educational achievement and social deprivation, and the overall suicide rate is 9.7 per 100,000 which has been increasing in recent years, particularly in men under the age of 35 years.⁹⁴

The associated human capital costs of mental health problems, including the numbers of people claiming incapacity benefit, loss of employment through mental illness and reduced quality of life have also been found to be significantly higher in Northern Ireland compared to the rest of the UK. When higher levels of deprivation and social need are taken into account, Northern Ireland's health and social care system spends between 7 to 16 percent less than England on health and social care. In addition, Northern Ireland spends less than half of England's per capita spend on supporting people with mental health problems and learning disabilities.⁹⁵

"Coming out of the Troubles, people are beginning to talk about and recognise post-trauma anxiety, depression and stress. Nobody's shouting from the rooftops, but depression is sitting under the sofa, gathering momentum."

Mental health services in Northern Ireland

Northern Ireland's health and social care services have been structurally integrated since 1973, which has supported efforts to offer mental health services and continuity of care from hospital into the community. However, the area of mental health is still often not viewed as a priority within health and social care and, although the structures for integration are in place the integrated health and social care system has not realised its full potential, largely because the model over consumes resource in hospital provision.⁹⁶

The most recent "Transforming Your Care: A Review of Health and Social Care in Northern Ireland" (2011) set out an overarching road map for change in the provision of health and social care services in Northern Ireland. It aimed at delivering care closer to home to suit service user and carer needs in different programmes of care, including mental health. With regards to the provision of mental health services, it outlined a consistent approach through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.⁹⁷

Mental health treatment services have since been made available at home, provided by Crisis Response and Home Treatment teams, resulting in reductions in inpatient care. Urgent care models are now implemented in every area to provide 24/7 access to urgent care services. These services are planned in accordance with local need and take account of local circumstances. The system of urgent care seeks to ensure that each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.⁹⁸

Interventions to support improved employment outcomes

A wide range of initiatives which promote positive mental health and well-being are taking place in Northern Ireland. For example, the Health and Social Care Board (HSCB) have established Primary Care Talking Therapies Hubs in each Health Trust area, with an initial investment of £1.7million to support their establishment and to extend the range and scope of psychological therapies across mental health services.⁹⁹

However, serious concerns have been expressed about fragmentation of mental health services and poor communication between the different parts of the system. In 2015, a study by Queen's University showed there was considerable concern about the under-financing of mental health services, describing the problem as a "systemic and long-term issue that is set to exacerbate in coming years". It found that between 2008 and 2014, spending on mental health services by Trusts was around 25% less than previously proposed. In comparison with other types of healthcare, there has been year on year decreases in funding since 2009.¹⁰⁰

PATIENT PATHWAY

Joe feels increasingly depressed having been made redundant from his job. He feels disconnected from his friends and experiences disturbed sleep. Joe picks up a booklet in a local takeaway produced by a local community organisation. It encourages young men to look after their mental health and explains how to get help if necessary. Joe had been worried that there would be a social stigma attached to seeking help for mental health problems, but when he sees this advice he feels reassured that he could seek help. Joe went to his GP who listened to his problems and advised that he should attend cognitive-behavioural therapy sessions. Joe now meets his therapist once per week at the local health centre, and also has regular review appointments with his GP to monitor his progress. Joe was glad that he had seen the advice about seeking help with mental health problems at an early stage. He is now feeling much better and his illness is under control.

JENNY'S STORY

"Self-employment had long been my dream. I had various family members who were self-employed, so I could see all sides of it – excitement, stress, freedom and responsibility. However, I wasn't sure what to do, so when I left school, I got an office job. That would suffice until I worked out what I wanted to do. Ten years, a couple of promotions, and one baby later, I was quite happy in my job, but it still wasn't the dream. I had started thinking about self-employed options that would work in with the family. Then baby number 2 arrived. Then I got depressed. I shelved all hopes of self-employment. Surely if I was prone to depression I could never be strong enough to hold the responsibilities of self-employment?"

Then I learnt something through the Living Life to the Full course run by the charity AWARE. I learnt that shelving those dreams had just left me feeling hopeless and disillusioned. I had essentially given up on myself. I learnt that part of my recovery was to learn to believe in myself again. As well as teaching me how to believe in myself again, the course equipped me with many personal skills which gave me the confidence to finally take that step and become self-employed. I have now been a childminder for four years. I am fully involved in my own children's lives, while taking care of others too. I am a stronger person than I have ever been before, and I have realised my dream."

A national approach to mental health policy-making

The Department of Health Social Service and Public Safety (DHSSPS) in Northern Ireland has stated that it intends to promote good mental health through an integrated partnership approach across government, community and business sectors.¹⁰¹ It is seeking to build on the various policy processes that have taken place on mental health over the last decade. These include: the Bamford Review of Mental Health and Learning Disability which set the overarching vision for mental health services in Northern Ireland (2007); the Programme for Government (2011-2015) which was the highest level political statement of policy priorities for mental health; and the Transforming Your Care reform agenda for health and social care in Northern Ireland as the clearest statement of the challenges facing health and social care and the solutions needed to address these.

Whilst there is some evidence to suggest that progress has been made in realising the actions for improving mental health services, as outlined in the Bamford Vision, concerns remain about the continuing impact of health inequalities and the legacy of the Troubles on the population of Northern Ireland. In November 2012, the DHSSPS published a second action plan, referred to as Action Plan 2011-2015. The tasks in this plan consist of: uncompleted actions carried forward from Action Plan 2009-2011; actions which were a consequence of completed actions from the Action Plan 2009-2011; and new areas of work, including some highlighted in the 2008 consultation on the Northern Ireland Executive's Response.

THE VALUE OF MINDFULNESS

Mindfulness is used increasingly by people with depression and is supported by all four charities involved in this report. Mindfulness reduces stress, anxiety and depressive symptoms. By making people more aware of their feelings, thoughts and emotions they learn the skills that prevent the recurrence of depression. Mindfulness helps people live their life in the present. As such Mindfulness can help engender the skills and resilience that help people with depression return to work and remain in employment.

AWARE, for example, runs a Mindfulness programme that costs £150 and lasts for six weeks. Each session lasts two hours. Participants receive a CD to facilitate their personal practice and resources that will help greatly in integrating Mindfulness into daily life. The resources will contain each session's content and past participants have said that this greatly enhanced their learning experience between sessions. Each participant is offered four follow up classes in the year following completion of their course.

» Policy recommendations

In this section, we outline our recommendations for the UK and devolved Governments. Several of the recommendations made reflect those in recent reports on the topic of mental health conditions and employment. These include reports from the OECD (2014), Mind (2014), Chief Medical Officer Annual Report on Mental Health (2014), Taskforce on Mental Health Society (2015), 2020 Health (2015) and The Work Foundation (2015).

We recommend that the UK Government should:

- » Continue to assess and review the impact of welfare reforms on people with depression and other mental health problems, take a supportive approach to helping people to engage in employment, and stop sanctioning people in receipt of Employment Support Allowance.
- » Assess, record and monitor the health status of those claiming Jobseeker's Allowance so that those with a mental illness are signposted to local services, or alternatively, enable medical services – and in particular psychiatric services – to in-reach to Jobcentre Plus, as they do to the criminal justice system.

We recommend that the UK Government should:

- » Make a cross-government commitment to improving mental health and wellbeing, which includes commitments from the Ministers responsible for the economy, business and the public sector workforce to improve mental health and wellbeing in the workplace.
- » Ensure that depression and its wide-range of associated symptoms are better recognised and understood by all professionals and organisations working across health and employment settings.
- » Recognise employment and occupation as a specific health outcome and treatment goal for people with depression and other mental health conditions and improve support in this area.
- » Include employment status as a routine and frequently updated part of all patient's medical records to provide the baseline data for employment status to be an outcome of all medical specialties, including primary care.
- » Ensure that primary care, mental health and occupational health services are more closely integrated with each other and with providers in the third sector to help improve employment outcomes for people with depression and other mental health conditions.

- » Steer the commissioning of secondary psychiatric services towards a model based more on functional impairment than on diagnostic category with more focus placed on improving overall function.
- » Prioritise and increase access to person-centred employment support, treatments and services for those with depression and other mental health conditions.
- » Develop mechanisms to improve sharing of knowledge and best practice about depression at work between employers, third-sectors services, individuals and clinicians, including peer support networks.
- » Provide clear guidance and support to employers to promote the wellbeing of their employees and tackle the rise of depression in the workplace by considering depression within a health and safety context.
- » Continue to fund campaigns to tackle mental health stigma and discrimination, including a specific focus on reducing stigma and discrimination in the workplace.

We recommend that employers* should:

- » Ensure that line managers have training to understand how mental illness might present in the workplace and to understand their role in facilitating retention of employees with depression or other mental health conditions in the workplace.
- » Work with trade unions and other employer representatives to develop mentally healthy workplaces and ensure that appropriate information and support is available to employees who experience depression and other mental health problems.
- » Promote local and national peer support networks to employees as they are accessible to all, completely free to use, self-referable and proven to be an effective way to meet likeminded people and improve mental wellbeing – there is no waiting list for access to peer support networks.

* The public sector, which includes Government, Local Authority and NHS employees, should lead by example as the biggest employer in the country. It should not be forgotten that depression and other mental health conditions can affect politicians, doctors and police officers, just as it can managers and office staff, with the same issues of stigma and lack of understanding.

Acknowledgments

This report has been supported financially by a grant from Lundbeck, with research and project management support from Munro & Forster, a communications consultancy. The content has been developed by Depression Alliance, Action on Depression, Gofal and AWARE. The medical writer, Mark Greener, has also provided editorial services. The report does not necessarily reflect the views of Lundbeck. It is part of the UK-wide “Work in Progress” campaign which is also being sponsored by Lundbeck, within the guidance of the ABPI code of practice.

Contributors to this report

Depression Alliance (www.depressionalliance.org) is the leading charity in the UK for anyone affected by depression, who campaign to end the stigma of depression and to raise awareness of the condition. Depression Alliance has almost 40 years’ experience working closely with healthcare professionals and government agencies, to improve local services and to ensure a healthier, happier life for the millions affected by depression.

Action on Depression (www.actionondepression.org) is the only national Scottish organisation working with and for people affected by depression. Action on Depression is committed to providing support, raising awareness of depression and treatment options, and reducing stigma.

Gofal (www.gofal.org.uk) is a leading Welsh mental health and wellbeing charity, which provides a wide range of services to support the independence, recovery, health and wellbeing of people with mental health problems. Gofal lobby to improve mental health policy, practice and legislation, and campaign to increase public understanding.

AWARE (www.aware-ni.org) was founded in 1996 and is the only charity in Northern Ireland working exclusively for those with depression and bipolar disorder. AWARE has a network of 23 support groups in rural and urban areas across Northern Ireland and provides community and workplace programmes to support people to look after their mental health and build resilience. In 2014, AWARE delivered direct support to over 20,000 people in Northern Ireland.

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