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Effects of prescribed medication on performance in the working population

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RESEARCH REPORT 057



Effects of prescribed medication on performance in the working population

**Professor Cheryl Haslam¹, Sue Brown²
Sarah Hastings², Dr Roger Haslam²**

¹Department of Health & Social Care
Brunel University, Osterley Campus
Borough Road
Isleworth
Middlesex TW7 5DU
[*see over for current address]

²Health & Safety Ergonomics Unit
Department of Human Sciences
Loughborough University
Loughborough
Leicestershire LE11 3TU

Findings from an investigation of the effects of medication prescribed for anxiety and depression on working life are presented. The research used focus groups with sufferers to collect data on the personal experiences of mental health problems and the impact of psychotropic drugs. Focus groups were also conducted with staff in human resources, personnel, occupational health and health and safety departments, to explore the organisational perspectives on mental health in the workplace. As part of the validation process, the results were presented to an expert panel comprising trades union representatives, researchers and practitioners in occupational medicine, health and clinical psychology, health and safety and psychiatry.

Workers found it difficult to distinguish between the effects of medication and symptoms of anxiety and depression. Both the symptoms and the medication were reported to impair work performance. Participants described a variety of accidents and near misses that they attributed to their condition or to the side effects of medication. Workers with responsibilities for others, such as teachers, health care workers and managers, appeared to present a particular risk to safety in the workplace.

Non-compliance with medication was common due to unpleasant side effects, lack of improvement in symptoms or because the medication initially made them feel worse. Employees were largely ill prepared for their medication regimens and would have welcomed more information from doctors.

Drawing on the evidence collected, the report makes recommendations for the prevention and management of anxiety and depression in the workplace and outlines areas for improvement in health care.

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*Cheryl Haslam is now Professor of Health Psychology at:
Institute of Work, Health and Organisations
University of Nottingham
William Lee Buildings 8
Nottingham Science and Technology Park
University Boulevard
Nottingham NG7 2RQ
United Kingdom

EXECUTIVE SUMMARY

PROJECT AIMS

The prevalence of depression and anxiety has increased sharply in recent years leading to extensive use of medication. But little is known of how the symptoms of anxiety and depression and the medication for these conditions impact on health and safety at work. The aims of the study were therefore to:

- examine the relationship between psychological morbidity, prescribed medication, and work performance, in different groups of workers
- investigate the relationship between prescribed medication and self-reported incidence of accidents and ‘near miss’ experiences
- explore the issue of mental health problems among employees from the employer’s perspective
- review the implications for the advice that should be given to workers and employers

METHOD

The study used twelve focus groups to gather detailed information about the personal experience of anxiety and depression and the impact of psychotropic drugs on work performance.

Employee groups

Nine focus groups were conducted with people who had experienced anxiety and/or depression in the previous two years and had taken medication for these conditions at some stage during that period. These groups comprised:

- Individuals sampled from a variety of work sectors (health care, social services, education, manufacturing, engineering, retail, service industries) with personal experience of anxiety and/or depression and who had used prescribed medication for these conditions (6 focus groups)
- Individuals attending anxiety management courses. Participants in these courses came from a wide range of occupations (3 focus groups)

These nine focus groups included both managers and workers with non-managerial responsibilities.

Organisational representatives

Three focus groups were conducted with staff having responsibility for human resources, personnel, occupational health and health and safety. These individuals were drawn from a wide range of occupational sectors. The aim of these focus groups was to explore the organisational perspective on mental health in the workplace and examine organisational policy and practice relating to workers with anxiety and depression.

Validation

The results obtained from the 12 focus groups were subsequently presented to a panel of invited experts. The panel members comprised trades union representatives, practitioners and researchers in the disciplines of occupational medicine, health and safety, health and clinical psychology and psychiatry. The results were presented to this group for discussion and comment and to consider the implications of the findings for occupational health policy and practice.

EXPERIENCES OF ANXIETY AND DEPRESSION

Many people were initially unaware that they were suffering with anxiety and depression and before being diagnosed, some workers had attributed their symptoms to a physical illness. It was often colleagues or family members who recognised there was a problem.

The physical symptoms associated with anxiety and depression included: nausea, headaches, dizziness, trembling, insomnia and lack of energy. Psychological symptoms involved: poor concentration, extreme emotional distress and lack of motivation. Respondents reported that these symptoms impaired their work performance and they felt unable to cope with the demands of their work. Workers reported that they were unable to concentrate, they forgot things and found it difficult to absorb information or to make decisions. Generally, they were not able to complete work and even routine tasks became difficult.

EXPERIENCES OF MEDICATION

Respondents reported that the side effects of medication were very similar to the symptoms of anxiety and depression. The side effects reported included: confusion, dizziness, shaking, nausea, weight loss, dry mouth, sleep disturbance and difficulties with decision making. Side effects of medication were usually apparent as soon as the treatment was started, whereas improvement in symptoms of anxiety and depression took rather longer. In some instances, medication made people feel worse in the early stages of treatment. Workers noted that medication made them unresponsive to events such that they no longer cared about their work. Concentration and memory were impaired and work performance was thought to deteriorate. There were no obvious differences in experiences reported between workers in the different employment sectors examined by the study.

Non-compliance with medication was widespread, both at the start of medication and further on in the treatment regimen. At the start of medication, people tended to take less than the prescribed amount or ceased medication due to the unpleasant side effects, or because the medication failed to improve their symptoms or made them feel worse. Further on in the treatment, workers ceased medication as soon as they started to feel better because they were

concerned about developing a dependency. Despite being reassured by their GPs that they could not become physically addicted to the modern antidepressants, many people felt that they were dependent and experienced unpleasant withdrawal symptoms if they missed a dose of medication. The validation group felt that patients' concerns about dependency were understandable since even modern generations of antidepressants, such as the selective serotonin re-uptake inhibitors, (SSRI) are associated with a discontinuation syndrome.

PATIENT INFORMATION

Most respondents did not feel well informed about their medication. They were unprepared for the fact that initially the medication could make them feel worse, for example, producing increased anxiety in the early stages of treatment. Patients said that where they were given adequate information they were more likely to comply with their drug treatment.

Patient information leaflets issued with the medication were reported to be of very limited use, as it was felt that their purpose was largely as a disclaimer for drug companies rather than provision of practical advice for patients. Patients sought further information from a variety of sources: the internet, books, family and friends. The validation group remarked on the problems associated with these sources of information noting that web sites vary greatly in terms of accuracy, and information from family and friends may relate to older generations of psychotropic drugs and is not applicable to current medication.

Participants thought there was a good deal of trial and error in their medication treatment and they generally lacked confidence in the treatment they received. While patients were reviewed on a regular basis, this often involved different GPs and it was felt there was a lack of continuity in their health care.

SAFETY AT WORK

Generally employees found it difficult to distinguish between the effects of symptoms and the effects of their medication. They reported that the side effects of the medication and the symptoms of their conditions both involved: confusion, dizziness and lack of concentration. They felt this impaired their ability to function at work and made them more liable to accidents. Workers described a range of accidents, which they attributed to their condition or medication, including falls and minor injuries. Driving was thought to be particularly badly affected, due to poor concentration and fatigue.

Employees with responsibility for others (teachers, health care professionals, managers, mechanics and electricians) felt they were at particular risk with respect to the impact of anxiety and depression and their medication. People with responsibility for health and safety at work described how they failed to take action in connection with those responsibilities because they were too depressed and tired to respond. A mechanic and electrician explained how they had to check and double check their work because they lacked confidence in their abilities. Health care professionals acknowledged that, as well as placing themselves at risk, they also posed a risk to their patients. Particular risks highlighted by health care workers included: impairment in clinical judgement, making clinical errors, unsafe behaviour during the handling of materials such as blood and problems in the administration of drugs and needle injuries.

RELATIONSHIPS AT WORK

Respondents felt that anxiety and depression were associated with stigma and were reluctant to tell people at work about their illness. They perceived a general lack of understanding about the nature of anxiety and depression among their colleagues and managers. Some workers told their immediate colleagues, but did not feel able to tell managers. When managers were informed their responses varied. While some were sympathetic, many were dismissive and offered little support. It was often immediate colleagues who provided practical help and the opportunity to talk about problems. These important networks were lost when people went on sick leave. Workers with anxiety and depression said that they would have welcomed practical help with workload, support services from occupational health departments, counselling or just the opportunity to have a quiet confidential chat/discussion.

The organisational representatives and validation group thought that employees with anxiety and depression did not always require time off work and that periods of sickness absence could be detrimental to work relationships and longer term career progression. However, they noted that it was important to conduct an assessment of risk relating to symptoms and medication when maintaining an employee at work. Occupational health staff commented that confidentiality often hindered the support they could give workers with anxiety and depression. They were unable to disclose information to managers and consequently there was a lack of coordination between the employee, manager and occupational health staff. Lack of flexibility in organisations, especially in SMEs, often meant there was little scope for maintaining people in the workplace and employees had to leave when they would have chosen to remain at work.

Most workers believed that unmanageable workloads contributed to the development of their anxiety and depression. Managers, in particular, felt that they had to cope with ever increasing workloads and responsibilities without adequate assistance or resources. The organisational representatives and validation group acknowledged that managers have a difficult task in managing people with anxiety and depression. Employees with mental health problems may have inaccurate perceptions about the standard of their work and maintaining such employees at work necessitates understanding and sensitivity from managers. Managers in this situation need support and guidance from occupational health, human resources and health and safety staff.

All of the participants (workers, organisational representatives and validation group) believed that there needs to be greater awareness of mental health issues in the workplace and that training should be provided to help managers recognise anxiety and depression, understand these conditions and offer appropriate support to workers. There was also a strong view that organisations have a responsibility toward the mental health of their employees and that they should conduct risk assessments for mental health.

THE ORGANISATIONAL PERSPECTIVE

Staff with responsibility for human resources, personnel, occupational health and health and safety commented that while the Disabilities Discrimination Act (DDA) legislates against discriminating on grounds of disability, candidates with mental health problems may have lengthy sickness absences on their records and this could disadvantage them in the job market.

When job candidates disclose a history of mental health problems, assessing their ability to cope with a job and risk in relation to work was perceived as being very difficult. Organisational representatives felt that as applicants are reluctant to declare mental health problems there is probably a large amount of undetected psychiatric morbidity in the working population.

Availability of support services and policies to assist workers with anxiety and depression varied according to the size and culture of organisations. The validation group commented that companies need to build effective communication networks if work and relationship problems can be detected and addressed. Organisational representatives described a range of methods that can be used in rehabilitating workers with anxiety and depression including phased returns to work and modifications to duties, but often this was restricted by difficulties with flexibility within organisations.

RECOMMENDATIONS FOR BEST WORKPLACE PRACTICE

Awareness

There is a general need to raise awareness of mental health problems and increase understanding of how these conditions impact on working life:

- current information on mental health in the workplace should be further developed to cover specific disorders, such as anxiety and depression, explaining their effects on performance and safety at work
- mental health issues ought to be an integral part of health and safety training for managers

Prevention

Several measures would assist in the prevention of anxiety and depression in the workplace:

- organisations should conduct risk assessments relating to mental health in the workplace to highlight any 'hot spots' among their workforce
- valid tools need to be developed to enable organisations to measure workplace stress
- information should be collected from: questionnaires, appraisals, staff comments in meetings, sickness absences, productivity data, staff turnover and exit interviews and data need to be stored in a retrievable form and subject to periodic analysis and review

Rehabilitation

Maintaining workers suffering with anxiety and depression at work or rehabilitating workers following sickness absence requires:

- coordination between managers and staff from human resources, personnel, occupational health and health and safety departments to support workers
- assessment of the risk relating to an individual worker's condition and/or medication with regard to safety in the workplace
- flexible working practices to accommodate an employee's capabilities along with careful monitoring and regular review of their workload

RECOMMENDATIONS FOR BEST HEALTH CARE PRACTICE

The results of this study point to a number of ways in which the medical care of people with anxiety and depression could be improved:

- patients need careful monitoring and information provision at the start of treatment, when the medication may not initially improve symptoms, or make them feel worse
- patients need regular review and information later on when they feel better and are tempted to prematurely discontinue medication
- doctors need to explore patients' attitudes and beliefs about their medication, addressing any misconceptions
- there is a need for accessible patient information leaflets, explaining the actions of the medication, potential impact on work performance and safety, and what patients should expect with regard to symptom improvement
- more liaison is needed between health care professionals and employers during the rehabilitation of workers with anxiety and depression, to assist in assessments of risk

CONCLUSIONS

Participants in this study described how, in their experience, anxiety and depression are associated with impaired work performance, accidents and poor job satisfaction. There is a need for employers to be persuaded that measures aimed at prevention and rehabilitation will lead to significant social and financial benefits for organisations resulting in improved productivity and staff morale and reduced numbers of accidents, sickness absences and rates of staff turnover. Successful rehabilitation of workers suffering with anxiety and depression depends on proper coordination within an organisation and liaison between the organisation and external health care professionals.

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1. INTRODUCTION

1.1 MENTAL ILL HEALTH IN THE WORKPLACE

It is estimated that 3 in 10 employees will have a mental health problem in any one year, mainly depression and anxiety (Department of Health, 1996). A large scale survey of a random sample has shown that 20% reported very high or extremely high levels of stress at work (Smith, 2000; Smith et al., 2000a; 2000b). Stress in the workplace can adversely affect health, causing psychological problems such as depression and anxiety.

In recent years mental ill health in the workplace has increased sharply. Work related mental ill health cases seen for the first time by occupational health physicians rose to 3135 in 2000 compared to 2570 in 1999 (HSE 2001a). In 1999 the Health and Safety Executive estimated that over 6 million working days were lost in the previous year due to depression, anxiety and stress ascribed conditions (HSE, 1999).

In the Health and Safety Executive's survey of self reported work-related illness in 1995, stress, depression and anxiety was the second most commonly reported condition. Some 14% of respondents reported stress, depression or anxiety which equates to 279,000 people. A further 12% ascribed a physical condition to 'stress' at work. The survey estimated that over half a million people were suffering from stress, depression or anxiety (Jones et al., 1998).

1.2 PRESCRIBED MEDICATION AND WORK PERFORMANCE

As the incidence of psychiatric illness is increasing (Potter, 1990), the number of prescriptions for psychotropic medication have sharply increased. Middleton et al. (2001) reported that the number of antidepressant prescriptions increased more than twofold in the period 1975-1998 and in 1998, a total of 23.4 million antidepressant prescriptions were issued by GPs in the UK. Lawrenson et al. (2000) investigated UK GP prescribing patterns for antidepressants and noted that between 1991 and 1996 there was a 40% increase in the prescribing rate of older tricyclic antidepressants compared to a 460% increase for the newer selective serotonin reuptake inhibitors (SSRIs).

The extent to which medication is used to treat minor psychiatric illnesses in the working population is unknown, although levels are thought to be considerable (Dunne et al., 1986; Potter, 1990). However, it is known that certain conditions have a substantial gender difference with, for example, women seeking treatment for depression at twice the rate of men (Middleton et al., 2001).

A number of studies have highlighted the poor knowledge that exists concerning the effects of prescribed medication on work performance (Dunne et al., 1986; Potter, 1990; Tilson, 1990). Psychotropic medicines impair performance on a wide range of laboratory measures, with effects found for attention, vigilance, memory, problem solving, learning, motor coordination, gait and visual accommodation (Dunne et al., 1986; Potter, 1990; Edwards, 1995). However, it is not clear how these findings translate to performance in the complex setting of the workplace (Dunne et al., 1986; Nicholson, 1990).

Problems with generalising from the findings of laboratory investigations to the occupational context include:

- laboratory investigations of performance effects are often limited to testing with young, healthy subjects
- minor decrements in performance on sensitive laboratory tasks may have little relevance to real world activities (Cohen et al., 1984; Nicholson, 1990)
- laboratory studies usually do not simulate the effects that workplace environments may have on pharmacokinetic pathways or physiological homeostasis (DeHart, 1990)

With regard to this last point, work can affect both an illness and the action of medication used to treat it. Stress may worsen psychiatric illnesses, or shift work can precipitate mania, for example. Heavy work in the heat may lead to dehydration, affecting blood concentrations, perhaps leading to symptoms from toxicity (Potter, 1990).

It is not clear, therefore, to what extent medication taken for psychiatric illness may affect a person's quality of work and productivity. Perhaps more importantly, very little is known about possible consequences for workplace safety. A study by Mintz et al. (1992) evaluated the effects of antidepressants and psychotherapy on work impairment in depressed individuals from ten published treatment studies. They found that improvement in work performance lagged behind improvement in psychological symptoms. This has important implications in terms of the advice offered by health care professionals and the expectations of patients and employers.

1.3 EFFECTS OF ANXIETY AND DEPRESSION ON WORK PERFORMANCE

A further issue is that it has been suggested that lack of treatment for psychiatric illnesses may actually be a greater problem in terms of work performance than the side effects of medication (Potter, 1990). Employees suffering with depression or anxiety are likely to experience a range of symptoms that would impair performance at work.

Anxiety is characterised by uncontrollable worry and other symptoms including restlessness, being easily fatigued, having difficulty in concentrating, irritability, muscle tension and sleep disturbance. The symptoms cause distress or impairment in social, occupational and other important areas of functioning (American Psychiatric Association, 1994). Depression involves feelings of sadness, hopelessness and depressed mood. These feelings may be accompanied by reduced appetite or weight, sleep disturbance and decreased energy. The depressed individual may experience difficulties with concentration, thinking and decision making (American Psychiatric Association, 1994). Depression often coexists with anxiety and some people will exhibit a mixture of depressive and anxious symptoms (Lader, 1994).

In the workplace setting, people suffering with anxiety or depression are therefore likely to exhibit: tiredness, lack of motivation, poor concentration, forgetfulness, poor timekeeping and attendance. Martin et al. (1996) have demonstrated that sub-clinical depression is associated with decrements in work performance. Hence, untreated depression in the workplace is likely to lead to impaired work performance.

Failure to seek or comply with treatment may arise from the stigma that can be associated with mental ill health or, alternatively, some patients may be reluctant to take psychotropic medication because of fears they have about possible side effects and dependency.

This research collected new and in-depth data on anxiety and depression and the use of psychotropic medication among the working population. The aim was to improve understanding of the impact of mental health problems and the treatment for these conditions on performance and safety in the workplace.

1.4 RESEARCH AIMS

The aims of this research were to:

- ◆ examine the relationship between psychological morbidity, prescribed medication, and work performance, in different groups of workers
- ◆ investigate the relationship between prescribed medication and self-reported incidence of accidents and 'near miss' experiences
- ◆ explore the issue of mental health problems among employees from the employer's perspective
- ◆ review the implications that the research findings have for the advice that should be given to workers and employers

1.5 REPORT FORMAT

This report is divided into 9 sections.

Section 2 - Methodology

Section 3 - Scope of the research

Section 4 - Workers experiences of anxiety and depression

Section 5 - Effects of anxiety and depression and the medication for these conditions on safety at work

Section 6 - Relationships with colleagues and managers

Section 7 - The organisational perspective on mental health in the workplace

Section 8 - Results from the validation exercise

Section 9 - Overview of results

Section 10 - Implications for policy and practice

2. METHOD

2.1 RESEARCH APPROACH

Focus groups were used to collect detailed information on the experiences, attitudes and opinions of the group participants. This method enabled the collection of targeted data through the use of themes, sub themes and prompts within the discussion schedules (described below). A focus group is a form of group interview whereby the data obtained arise from the interaction and discourse generated by a group discussion (Morgan, 1997). Topics are supplied by the researcher who acts as ‘facilitator’ for the discussions. The facilitator ensures that certain topics are addressed and encourages participants to express their views and discuss their personal experiences.

The focus group technique was well suited to this study where the research aimed to elicit information about the personal experience of mental health problems and the impact of psychotropic drugs on work performance. Also, the focus group method allowed participants a degree of discretion as to how much personal information they revealed. The focus groups generated rich and detailed qualitative data.

2.2 RESEARCH INSTRUMENTS

Two focus group interview schedules were developed, one for employees/managers and the other for organisational representatives. The former investigated respondents’ actual experiences of mental health problems at work and the effects of medication while the latter focussed on the organisational perspectives of mental health in the workplace. Both focus group schedules were piloted and refined in the light of pilot studies. The focus group schedules for employees/managers and organisational representatives can be found in the appendices (schedule 1, page 82 and schedule 2 page 86).

2.3 INCLUSION CRITERIA FOR EMPLOYEES/MANAGERS

The criteria for participants with personal experience of anxiety or depression were that they had suffered from anxiety or depression within the two years preceding the study and had taken prescribed medication for the condition at some stage during that period.

2.4 INCLUSION CRITERIA FOR ORGANISATIONAL REPRESENTATIVES

Participants invited to take part in focus groups to discuss organisational perspectives were staff with human resources, personnel, occupational health and health and safety responsibility.

2.5 SAMPLE CATEGORIES

2.5.1 Clinical groups

Three focus groups comprised participants with anxiety and depressive disorders. These individuals were attending anxiety management courses run by clinical psychology services in the Midlands. The researchers met with people attending three separate anxiety management courses. Each group met one evening a week for six weeks. Details of the study were explained to the group members and they were invited to participate in a focus group. This extended their course by one week and this additional session was devoted to the focus group. One advantage of sampling from this source was that participants had experienced anxiety and depression problems to the extent that they had sought mental health care services. A further advantage was that the courses gave the researchers access to participants from a very a wide range of professions at different stages in their careers.

Participants were asked to discuss their personal experience of psychiatric morbidity and the psychotropic drugs used to treat these disorders; the impact of mental health problems and psychotropic drugs on work performance and safety; relationships with colleagues; support offered by colleagues and the organisation within which they worked.

2.5.2 Employee groups

The study strategically targeted employment sectors known to be high-risk groups for mental health problems such as health care, education and manufacturing (Smith et al., 2000b). The study also aimed to sample from the construction industry and transport. Despite extensive and rigorous recruitment strategies (see below), the researchers were unable to access participants from the construction industry.

Six focus groups were conducted with employees who were suffering or had suffered from anxiety and depression. The practical constraints of organising groups that participants were able to attend resulted in some groups being sector specific and other groups being of mixed sector. The researchers structured the groups so that they consisted of participants of similar occupational status. Hence there were separate groups for those with managerial responsibility (senior managers, company directors, supervisors and proprietors) and separate groups for employees with no managerial or supervisory responsibilities. It was felt that this was important to ensure that participants were not inhibited due to differences in job status.

The focus groups with employees explored: respondents' experiences of depression and anxiety; use of prescribed medication for these disorders; compliance with treatment regimens and improvement in symptoms. The focus groups examined the effects of both mental health problems and drug treatments on work performance, including effects on absenteeism and risk of accidents; effects on relationships with colleagues and the extent to which employers support employees who are experiencing mental health problems.

2.5.3 Organisational groups

Three focus groups were conducted with staff from human resources, personnel, occupational health and health and safety departments. These participants were drawn from a wide range of organisations. The focus groups with these individuals explored the organisational perspective on mental health in the workplace. Specifically, these groups discussed recruitment, support and rehabilitation of employees with mental health problems.

2.6 RECRUITMENT

A major challenge for this research was the recruitment of participants. The sensitive nature of the topics and the embarrassment and stigma associated with mental ill health were potential obstacles to successful recruitment. The study attempted to counter these obstacles through extensive recruitment strategies undertaken on a national and local level.

Table 1 details the general recruitment strategy, Table 2 outlines the methods of recruitment used for construction, manufacturing and transport. Table 3 and Table 4 show the recruitment strategies for the education and health sectors respectively. Table 5 details the recruitment strategy for organisational representatives.

Table 1
Strategy for general recruitment

PUBLICITY	UNIONS AND PROFESSIONAL ORGANISATIONS	DIRECT CONTACT
<p>Publicity Office at Loughborough University and the HSE circulated a press release to national and local newspapers, journals, radio and television.</p> <p>Researchers gave interviews to local press and radio stations.</p>	<p>The Trade Union Congress (TUC) web site published details of the study.</p>	<p>Posters were circulated to GP surgeries and health centres in the Leicestershire area.</p>
<p>Article was published in the Safety and Health Practitioner.</p>	<p>Institute of Occupational Safety and Health (IOSH) and occ-health@jiscmail.ac.uk a mail base for occupational health professionals and other interested people were used to publicise the study.</p>	<p>Researchers attended local branch meeting of IOSH to recruit and circulate information.</p>

Table 2
Recruitment strategy for construction, manufacturing and transport

PUBLICITY	UNIONS and PROFESSIONAL ORGANISATIONS	DIRECT CONTACTS
Manufacturing Organisations contacted through mail shot using the Dun and Bradstreet database.	General Municipal and Boilermakers Union (GMB) – <i>construction, engineering process and public service industries</i> Through the regional office information was circulated to stewards and branches in the region and an insert was included in the regional magazine circulated to 60,000 members.	Manufacturing Brush, Raleigh, Rolls Royce, Boots, Imperial Tobacco, Nortel, Acordis, Cussons UK.
Construction Companies on HSEU* database and from Yell.com contacted through mailshots.	Transport and General Workers Union (T&GWU) – <i>transport, manufacturing and construction</i> A summary of the research was circulated to local branches, trade networks and union journals.	Construction Companies on HSEU* database were contacted.
Transport London Underground in house magazine.	Manufacturing, Science and Finance (MSF) – <i>manufacturing</i> Summary of the study was placed on website.	Transport London Transport; Nottingham City Transport; Go North East.
	Amalgamated Engineering and Electrical Union (AEEU) – <i>construction and manufacturing</i> 1000 leaflets circulated at the national conference.	
	Institute of Occupational Safety and Health (IOSH) – <i>construction</i> The national organisation was contacted with information for relevant specialist groups.	
	Union of Construction Allied Trades and Technicians (UCATT) – <i>Construction</i> Details published in ‘Building Worker’ the union magazine.	

* The Health and Safety Ergonomics Unit, Department of Human Sciences, Loughborough University holds an extensive database of companies in the areas of construction and manufacturing.

Table 3
Recruitment strategy for education sector

UNIONS and PROFESSIONAL ORGANISATIONS	DIRECT CONTACTS
<p>Association of University Teachers (AUT) - Leicester branch with a membership of approximately 500, were circulated with information about the study via their monthly Bulletin.</p>	<p>Local education departments were contacted to recruit participants for focus groups to discuss organisational perspectives and to identify methods of disseminating the study details to employees.</p>
<p>National Association of Head Teachers (NAHT) - union contacted with information for members.</p>	<p>Local head teachers passed information on to colleagues through meetings, targeting head teachers.</p>
<p>National Association of Schoolmasters and Women Teachers (NASUWT) - Through contact with the National Chairman of the Trades Union and Education Committee (with responsibility for health and safety) who is also a member of the UK National Work-Stress network (part of the UK and European Hazards Campaigns), information was circulated to over 500 readers via newsletter and email.</p>	
<p>National Association of Teachers in Higher and Further Education (NATFHE) - Information publicised in 'Lecturer' circulation 50,000 and in Health and Safety newsletter circulated to 1000 H&S representatives.</p>	

Table 4
Recruitment strategy for the health sector

PUBLICITY	UNIONS and PROFESSIONAL ORGANISATIONS	DIRECT CONTACTS
<p>British Medical Association News - <i>membership magazine of the British Medical Association</i> Circulated to 120,000 members.</p>	<p>Institute of Occupational Safety and Health (IOSH) - Healthcare The national organisation was contacted with information for special interest groups.</p>	<p>Major health authorities were approached to recruit for both managerial and non-managerial focus groups. Occupational health and personnel departments were identified as the contact points through which to inform employees.</p>
<p>British Medical Journal Classified - circulated to 96,000 doctors in hospitals and general practice, also on website.</p>	<p>UNISON - Represents employees in the public services Through the UNISON Health Group information was circulated to the H & S and communications departments for advertisement nationally.</p> <p>The information was also passed on to the East Midlands Region and the NHS Health and Safety Risk Managers Group.</p>	<p>Nottingham and Severn Health Trusts invited to recruit employees for 'on site' focus groups.</p>
<p>Royal College of Nurses Bulletin - Carried details of the study.</p>		<p>WING - work injured nurses group Circulated details to their members.</p>

Table 5
Recruitment strategy for the organisational representatives

PUBLICITY	UNIONS and PROFESSIONAL ORGANISATIONS	DIRECT CONTACTS
PERSONNEL AND HUMAN RESOURCES		
	<p>Chartered Institute of Personnel and Development (CIPD) - Local branches contacted to identify methods of publicising the research to personnel and human resources staff. The Nottinghamshire, Derbyshire, and Lincolnshire branches, with over 2800 members included details on their website and distributed leaflets in newsletters.</p>	<p>Letters to the heads of personnel departments</p> <ul style="list-style-type: none"> - Leicester City Council - Advantica - Capital One - Leicester Mercury Group Ltd - Tesco - Greater Nottingham Co-op - London Transport - Nottingham City Transport - Derbyshire Royal Infirmary - Derby City Education Service - Nottingham Education Development Team - Nottingham City Hospital - Coventry City Council - Sainsburys - Leicester and Rutland Health Care NHS Trust
OCCUPATIONAL HEALTH AND SAFETY		
<p>EEF – Engineering Employers Federation Regional centre publicised study.</p>	<p>Occupational Health Nursing Local branch representatives in Nottinghamshire and Leicestershire were contacted to distribute leaflets to their members and at regional meetings to recruit occupational health staff for the study.</p>	<p>Occupational health departments contacted by telephone and email as above.</p>
	<p>Occupational Health mail list – Information posted to mail list occ-health@jiscmail.ac.uk</p>	

2.7 FOCUS GROUP FORMAT

The study received ethical approval from Loughborough University Ethical Advisory Committee. Consent forms were signed by all participants before the meeting started (appendices, page 96). Due to the sensitive nature of the subject under discussion, topical statements about anxiety and depression were used to encourage general discussion and generate interaction between participants. This approach provided the opportunity for the moderator to develop discussion on the themes identified in the schedules and to explore these matters in more depth.

Each focus group discussion lasted for approximately ninety minutes and the discussions were recorded on tape, with the agreement of participants. The recorded material was fully transcribed. Questionnaires were also administered to the participants. These brief, open-ended questionnaires invited participants to add any further comments and to reflect on the focus group discussion (questionnaire for employees/managers, appendices page 91 and questionnaire for organisational representatives, appendices page 94).

2.8 DATA ANALYSIS

The transcribed data was analysed by the sorting of verbatim material into emergent themes using the method described by Knodel (1993). The qualitative data were categorised using the discussion topics in the focus groups schedules and additional themes that emerged from the group discussions. Sub themes were then identified within each theme. The data are summarised under the various themes along with quotes to illustrate the themes. Also presented are a range of vignettes, or case studies describing respondents' experiences of anxiety and depression and the impact on their work.

3. SCOPE OF THE STUDY

3.1 TYPES OF FOCUS GROUPS CONDUCTED

A total of 12 focus groups were undertaken for the study. Three of these groups comprised individuals attending anxiety management courses. Six groups comprised employees and managers from various occupational sectors. Three groups were conducted with staff from health and safety, occupational health, personnel and human resources departments.

Table 6 shows the number of male and female participants in each of the three categories and Table 7 lists the work sectors represented across the three categories of focus groups.

Table 6
Summary of focus group participants

Focus Groups	Female	Male	Total
Clinical groups	14	5	19
Employee groups	22	13	35
Organisational groups	13	7	20
TOTAL	49	25	74

Table 7
Employment sectors represented in the three categories of focus groups

	Clinical groups	Employee groups	Organisational Groups
Public Sector	Further education Local authority National Health Service Research Primary education	Higher education - support staff - technical staff - lecturers Local government Police Primary and secondary education National Health Service Civil Service	Defence Local authority Local government National Health Service Social Services Education
Private Sector	Electrician Garage work SME – office work Retail Telesales Veterinary Surgery	Finance Car Leasing Food manufacturing Law Veterinary Surgery	Manufacturing Engineering Heavy industry Retail Pharmaceutical
	Unemployed	Voluntary sector	

3.2 VALIDATION EXERCISE

Finally, a validation exercise was conducted where the results were presented to an invited group of experts from relevant disciplines (including Occupational Health, Health Psychology, Health and Safety, Trade Unions, Medicine, Psychiatry and Clinical Psychology) for discussion and comment. This discussion was recorded and transcribed and group members completed a questionnaire (appendices, page 99).

3.3 RESULTS SECTIONS

The findings are presented in the following sections:

Section 5 presents the findings relating to the workers experiences of anxiety and depression. It details how the symptoms and the medication for these conditions affect people at work. The results are based on the 9 focus groups conducted with employees and managers across a broad range of occupational sectors.

Section 6 specifically explores the effects of anxiety and depression and the medication for these conditions on safety at work. It describes workers experiences of accidents and near misses related to their mental health problems and the medication they were taking to help control the symptoms. The chapter outlines the specific safety issues relating to occupations with responsibilities for others e.g. education and health care. These findings are based on the 9 focus groups conducted with employees and managers across a broad range of occupational sectors.

Section 7 presents the organisational perspective on mental health in the workplace and is based on the 3 focus groups conducted with staff from human resources, personnel, occupational health and health and safety departments.

Section 8 presents the results from the validation exercise.

Section 9 presents an overview of all of the results.

Section 10 considers the implications of the findings for occupational policy and practice.

4. EMPLOYEES' EXPERIENCE OF ANXIETY AND DEPRESSION

This section presents findings from the perspective of the employees, including the participants from the three clinical focus groups. The participants represented a wide range of work sectors.

The demographic profile of the clinical group participants is shown in Table 8 and the demographic profile of the work sector groups is listed in Table 9.

Table 8
Anxiety management group participant details

Group	Gender	Employment	Age range
Clinical group 1	Female Female Female Female Female Female Female Female	Secretarial Sales Unemployed Unemployed Photographic assistant Care assistant Sales consultant Prevocational tutor	18-55
Clinical group 2	Female Female Female Female Female Male Male	Scientific officer (NHS) Retired Administrator (SME) Veterinary Surgeon Retired Car mechanic Electrician	28-63
Clinical group 3	Male Male Female Male	Programme Area Manager/Lecturer Primary School Head Teacher Unemployed Researcher	22-55

Table 9
Profile of employees and managers groups

Group	Gender	Employment	Age range
Education	Male Male Male Female Male Male Female	Teacher University administrator Teacher in higher education Registrar in primary school Support technician – university Teacher – primary school Teacher – special school	35-60
Support workers	Female Female Female Female Female Female Female	Finance and admin in university Bank Council worker University administrator Enquiry officer – police station Public sector University administrator	29-53
Therapeutic day unit	Female Male Female Female Female Female Male	Car leasing – payroll Food manufacturing Advisory teacher Accounts department of a coach company Civil Service – Personnel Department Mental Health Social Worker Freelance Lecturer	30-56
Managers	Female Female Male Female Male Male	Front line manager – food company Personnel manager in NHS Health and safety Head teacher of a primary school Works in higher education Health and safety manager in a publishing company	33-58
Managers	Female Female Male Male	Lawyer in Civil service Veterinary Surgeon Deputy governor of a large prison Computing services at a university	45-54
Health Care	Female Female Male Female	Locum staff grade psychiatrist Consultant psychiatrist Former GP SHO in medicine	28-54

All the focus group involved lively and frank discussions. Participants spoke freely and lucidly about their experiences of anxiety and depression and the effects of medication for these conditions.

At the end of the focus groups, participants were invited to give feedback on the groups. Participants commented they found the groups very interesting and that they welcomed the opportunity to share their experiences with other people.

4.1 LACK OF KNOWLEDGE AND INSIGHT

Participants noted that in many cases they were initially unaware that they were exhibiting symptoms of anxiety and depression. It was often family, friends and colleagues who recognised the signs before the affected person. One of the participants who was a doctor had experienced symptoms for 15 months before he realised that the problem was depression.

Participants had often been unaware that they were suffering from anxiety and depression, until a crisis occurred. Vignettes 1 and 2 demonstrate typical sequences of events.

Vignette 1

A personnel manager reached crisis point when she found that she was unable to return to work after her holiday.

' when I first suffered from anxiety and depression I think I had been suffering from it for three or four months before it came to a crisis that I recognised it was only because I took some planned holiday from work and then found that I couldn't find the energy to go back to work that I realised that I really was suffering from something, but afterwards colleagues said yes you haven't looked right or you haven't been acting right for some time and we've been worried about you. I didn't recognise the signs in myself until then I wasn't aware of depression and what the signs were.'

Vingette 2

A 55 year old male Head teacher of a primary school felt unwell for months before he admitted that he was ill and went off work. A particular event triggered his acceptance of his illness:

'The thing that triggered it with me was that I found myself shouting in the face of a parent, which is something I never do because I'm a very quiet, laid-back, non confrontational manager, and I found myself shouting at this man "If you don't like it here you take your child somewhere else" and I thought "it's not me saying that" and it was as if another person was emerging. My wife has subsequently told me that I'd changed very significantly over the two years, I was becoming really difficult to live with. My colleagues, maybe I have been clever at hiding my decline from them, but certainly in the last couple of months they were aware of it, they were aware that I wasn't functioning well, and I should have seen that I wasn't working well because I got into the habit of working 7 days a week at least 10 hours a day just to try and keep on top of the paper work of my job which is fairly hefty anyway. I don't have the teaching commitment but I have enormous amounts of paper work and accountability to satisfy.'

He acknowledged that his work was 'very heavily affected' but he felt that:

'nobody was aware enough or brave enough to tell me strongly enough that I shouldn't have been there.'

People with long standing symptoms considered their feelings to be 'normal' until they were assessed and a diagnosis made. Even when respondents recognised that they were suffering with anxiety or depression, it was often very difficult to admit that there was a problem:

'I knew there was something wrong for ages. I wouldn't even acknowledge it to myself let alone anyone else - it was like if I didn't tell anybody else it wasn't real.' [33 year old manager in a large snack food company]

Those who had recurring anxiety and depression could recognise their 'relapse signatures'. During the build up to a crisis some people began to notice that their standard of work was deteriorating, often due to difficulties fulfilling their workload and criticism from their manager. A 40 year old primary school teacher illustrated how his condition affected his work:

'I mean I was making classic errors reporting, writing notes to parents and the Head would go up the wall and say, "What the bloody hell is this?" Now in normal circumstances after the twenty odd years teaching you don't make those sort of mistakes but this was happening quite regularly and I was saying, "oh I am sorry, I will go back and correct it" but the Head wouldn't be happy with that, you know she would sort of log it as some indication of failure to herself. All that stress and all that workload to a point where the Head then initiates a procedure and then that was just like a

bombshell. So the actual anxiety and depression, wasn't supported in terms of "what can we do for you" and ultimately was affecting my work over a period of time and then it got to a stage where, I wasn't capable of teaching effectively.'

4.2 SYMPTOMS OF ANXIETY AND DEPRESSION

Symptoms of anxiety and depression identified by participants included physical problems such as nausea, headaches, dizziness, trembling and lack of energy. Some people initially thought that their symptoms stemmed from a physical disorder:

'I never thought I had depression or anxiety, I thought it's a medical problem, because my arms were hurting, my shoulder's hurt, my neck used to hurt. And I used to think it's a medical problem, I had all the tests done. When I went back to my GP, he said "That's not the problem, you're depressed". And even then I didn't want to admit that I had a problem inside me. I knew there was something wrong with me mentally, I did not want to believe that this is what's happened to me.' [32 year old male assembly line worker for a confectionery manufacturer]

The physical symptoms of anxiety and depression were combined with tiredness (through disrupted sleep), lack of concentration, extremes of emotion and lack of motivation. Individuals experienced confusion and difficulties with decision-making. The terms 'vicious circle' and 'downward spiral' were often used to describe the situation. A female administrator explained how the physical symptoms affected her ability to function at work:

'I couldn't actually get out of bed in the morning and I'd frequently roll in at half nine, ten o'clock, and we're supposed to start at nine o'clock. But I just could not get out of bed. It was really, really hard. And dragging yourself into work. On a really bad day when I was really anxious I'd just be throwing up and shaking and all sorts of things and I just couldn't come into work. So then I'd stay at home.'

A male further education teacher remembered how he reached an extreme state of anxiety:

'I just couldn't leave the house I was so petrified. I had lost all my confidence. I had lost everything and I just didn't want to do anything.'

Some people, such as this 40 year old special needs teacher, experienced sudden episodes of crying:

'Looking back I feel embarrassed to say it, but I would sit and cry in staff meetings, sit in a staff meeting and tears would just stream down my face and people would just not see.'

Vignette 3 illustrates how initial physical symptoms developed into an emotional crisis.

Vignette 3

A 25 year old woman, who worked for a car leasing company experienced feelings of nausea, which she initially attributed to food poisoning:

'I thought it was food poisoning, because I just felt sick all the time. And I would drive up to work, because I would think "Well I should be better now, I'll pop into work for the afternoon", and I would pull up outside the building and I would feel physically sick. Whoever I was going to meet would have to come down to meet me, because the building was suddenly boiling hot, I couldn't step inside it, I would break out in a sweat.'

This woman was away from work on sick leave and when she returned she was unable to operate in her role in the organisation. She couldn't enter meetings rooms. She was unable to take telephone calls from customers:

'I had to go off the phones completely, and if I got a phone call I would start to feel sick again, or I used to be rude to them'

Her problems reached a crisis point when one day she was unable to move her car from the car park:

'.... And it all started when I went down to the car park, to move my car at lunchtime, and I just started to panic. And I got back in the lift, and my manager, luckily, was in the lift, and I was just crying and I couldn't move my car, and just a simple thing like that. Moving my car. It was too much. And it had all crashed down on me, and I couldn't do anything else then from that moment. And that was when I was off for a month. I just felt ill all the time, I didn't want to speak to anyone.'

4.2.1 Lack of motivation

One of the major symptoms identified by the participants was that they lacked motivation, finding everything too much to cope with. At work, routine tasks became difficult and would be avoided, such as making telephone calls. Many felt that they spent much of their time procrastinating. A 58 year old male health and safety manager had struggled for a year with his work:

'...I found myself not being able to complete a job. I find myself going down one route and then perhaps get a memo or an email from someone and go off on another tangent and nothing gets finished properly I have to force myself to finish something off that I need to do.'

A 25 year old worker in a car leasing firm described the difficulties she experienced:

'I just stare and I've got my mouse, and I just move it from left to right and left to right. And I don't care that people might be looking at me and thinking "She's not doing any work". And I'm just not doing anything. And I can sit there for ages Now I really should do some thing I'll read something, I'll read an e-mail and then I'll read it again. And I still won't do anything; I'll just keep reading it'.

At home respondents often did not feel like washing, dressing or eating, spending a lot of time sleeping or watching television. Socially people isolated themselves, avoiding friends and they found it difficult to do anything synonymous with enjoying themselves.

4.2.2 Fatigue

Feelings of extreme tiredness made people feel unable to 'get a grip on things'. Sleep patterns were generally erratic and disturbed, resulting in very little sleep or sleeping constantly. This created a cycle whereby people were tired at work and found the pressures intolerable.

A 54 year old female primary school head teacher described the sleep problems she experienced:

'mine would start at 4 in the morning with an awful anxiety attack and I would wake up there wouldn't be anything particular to worry about because there were so many things but I just would wake up feeling incredibly anxious and find it hard to get to sleep.'

Some respondents used alcohol to alleviate the insomnia. A 55 year old male primary school headteacher said:

'I found that I wasn't sleeping, I started having one drink, then another at night - to knock me out so that I could sleep but even then I'd wake up at three o'clock in the morning with my mind racing - and then crawling to work, not hung over but just exhausted.'

4.2.3 Problems with memory and concentration

People found they were unable to concentrate, they forgot things and found it difficult to absorb information, often not being able to complete work. A 48 year old health and safety manager said:

'.... you cannot concentrate, you might read something for the best part of an hour and realise you haven't taken any of it in at all and that is becoming a problem for me'

A 35 year old female locum psychiatrist described how her inability to concentrate impaired her work performance:

'You feel you can't concentrate, you feel it all piling up, it's all building up but yet, if you're like me you feel the world depends upon you in a way and so you're still keep going and you feel worse about yourself because you are sinking deeper and deeper.'

4.3 EFFECTS OF ANXIETY AND DEPRESSION ON WORK PERFORMANCE

Most respondents felt that their condition impaired their work performance. A 48 year old female lawyer who worked for the civil service explained how anxiety impacted on her ability to work:

' your productivity really goes down because of course you worry all the time you don't sleep you get up in the morning and you're worn out its just day after day you're going down gradually and the amount of work you can really do properly is getting less and less and less.'

A 43 year old female consultant psychiatrist told of how her condition prevented her from making decisions at work:

'For myself, I get very indecisive, which isn't very good when you are meant to make decisions and then I can feel myself getting pushed into making hasty and perhaps wrong decisions, I can't focus my thoughts on things and also get terribly, terribly irritable and that causes problems in relationships, not only with colleagues, but also with patients and their families which are probably more difficult to repair.'

A 51 year old male lecturer explained how his severe symptoms impaired his ability to work:

'Symptoms certainly did affect my work. There were times when I felt physically quite dreadful. I was having severe chest pains, headaches that went down my back, trembling fits when I woke up in the morning - which then led me to go into work feeling full of trepidation and anxiety about what was going to happen once I got there. On occasions I was suffering so much from the physical signs of anxiety, my staff would just put me in my office, and say "Don't come out, you're not fit to be out of your room, why have you come in to work?" and I'd say "well this has got to be done, that has got to be done" and they'd say "well just shut your door and just do paper work." So it did seriously affect my work a year ago and then I was off for seven months.'

Often individuals blamed themselves for being inefficient rather than recognising their symptoms as anxiety and depression. A 54 year old male department administrator in a university described the problem:

'The trouble is that for far too long we continue with the symptoms because we blame it on ourselves in terms of, not just the time management issue that we are not quite getting it right, or perhaps its prioritising of the workload which isn't managed efficiently or effectively. We blame ourselves and say, perhaps we are not quite efficient enough'.

People felt they were unable to cope with their usual workload, they couldn't be bothered to do things and that their work life was standing still:

'Oh I hated my job, I got nothing out of it. It was just a treadmill, go home, go to bed, get up, go to work I didn't do anything else you didn't bother going anywhere because you'd be too tired.' [female 50 administrator SME]

Participants felt they were impatient and intolerant with other people. Those who were prone to episodes of crying would leave their workplace or go for an early lunch break to avoid being seen by their colleagues. Participants admitted that they made themselves look busy at work through displacement activities but they were not managing to do their job on a day to day basis. Keeping up a calm and controlled manner at work, although that was not how they felt, was a method used by several participants, though they found it tiring. Work problems and feelings of aggression were 'saved for home' and family life suffered as a result of this. Longer term, some individuals were able to manage work better if they moved from a managerial to non-managerial role or changed from full time to part time hours.

Several group members experienced panic attacks which reduced their confidence and exacerbated further attacks creating a vicious cycle. Disrupted sleep patterns resulted in

employees constantly feeling tired. Some women felt that their symptoms of anxiety and depression were dismissed by other people as ‘hormonal’.

4.4 THE EFFECTS OF PRESCRIBED MEDICATION FOR ANXIETY AND DEPRESSION

Table 10 lists the range of psychotropic medication that the participants had been prescribed.

Table 11 shows the number and percentages of participants who had received each class of drug.

The side effects of medication were thought to be similar to the symptoms of anxiety and depression including: confusion, dizziness, nausea and difficulties with decision making. A female council worker described the following side effects:

‘... tiredness, lethargy, lack of sex drive, lack of motivation, just really lethargic. Blurred vision, dry mouth, sickness...’

A female university administrator explained how the medication affected her:

‘I just felt like I was behind a screen in my head all the time, it sounds really weird, like there was a fog behind my eyes. And I felt unsteady standing sometimes. And my colleague actually told me that I’d got a slight speech impediment as a result of taking them. And I used to pronounce my <esses> more than normal. Which made me self-conscious about it. But I did try Prozac once and it made me so ill I turned green for a week and just had to be off work.’

A woman who worked on the enquiry desk at a police station described how she felt when taking her medication:

‘... when I was on Prozac it’s like there is a wall there, you can see what you’re doing. But you just feel like you’re distant dislocated from everything, that’s going on.’

Some people experienced exaggerated symptoms of anxiety while they were taking medication, a 54 year old female head teacher commented:

‘When I had Prozac I had these horrible sensations that made me want to grit my teeth all the time a sort of charging sensation up and down my legs.’

Table 10
Summary of psychotropic medication

Drug Group	Drug	Proprietary name
Selective Serotonin Reuptake Inhibitors <i>- inhibit the re-uptake of serotonin</i> <i>- less sedative than tricyclic drugs</i>	Citalopram Fluoxetine Fluvoxamine Maleate Paroxetine Sertraline	Cipramil Prozac Faverin Seroxat Lustral
Benzodiazepines <i>- enhance the action of γ-aminobutyric-acid (GABA)</i> <i>- central nervous system depressant</i>	Diazepam Lorazepam Temazepam	Valium Ativan
Anti depressants <i>- increase levels of serotonin and noradrenaline</i>	Venlafaxine Mirtazapine Nefazodone Hydrochloride Flupentixol	Efexor Zispin Dutonin Fluanxol
Tricyclics <i>- inhibit the re-uptake of norepinephrine and serotonin</i>	Imipramine Hydrochloride Amitriptyline Hydrochloride Dothiepin Hydrochloride Doxepin	Tofranil Lentizol / Triptafen / Triptafen-M Prothiaden Sinequan
Anti manic <i>- effects on receptor transduction systems</i> <i>- increases aspects of brain serotonin</i>	Lithium Citrate Lithium Carbonate	Li-Liquid / Priadel Camcolit/Liskonum/Priadel
Beta blockers <i>- block the beta-adrenoreceptors in the heart, peripheral vasculature, bronchi, pancreas and liver</i> <i>- do not affect psychological symptoms but reduce autonomic symptoms such as fear and terror</i>	Oxprenolol Hydrochloride Pindolol	Slow-Trasicor (Modified release) Trasidrex (with diuretic) Visken Viskaldix (with diuretic)

Table 11
Number and percentage of respondents who were prescribed each class of drug

Drug Group	Number	Percentage
SSRI's	39	72%
Benzodiazepines	16	30%
Anti depressants	8	19%
Tricyclics	5	9%
Anti manic	3	6%
Beta blockers	2	4%
Not Known	12	22%
None	2	4%

note: many participants had been prescribed more than one class of drug

Another side effect of the medication was having a dry mouth. This was a particular problem for people who have to speak in public such as this 48 year female lawyer, working for the civil service:

'I was doing really well and somehow the side effects hit me again because your mouth is very dry. If I go into court I have to talk for ten minutes, fifteen minutes at a time so I thought "right I'll knock it down a bit [medication] and see what happens" big mistake I tried all the other things plenty of water, chewing gum - you can hardly chew in court can you?'

Many respondents suffered from disrupted sleep patterns while they were taking medication, as described by this 43 year old consultant psychiatrist:

'I was on a high dose of SSRI which gave me sweating episodes which meant I couldn't sleep so that made me very tired so that was a time when I couldn't sleep. Once I cut the dose down again I was alright.'

A 48 year old health and safety manager commented:

'For myself it's the sleep waking in the early hours can't get back to sleep feeling desperate and when that has gone on for a while its usually the cue to go and visit the GP. The irony is some of the stuff you are given can make you not just transiently worse but much worse. I've had Prozac, I have to say for depressive symptoms its probably helpful, but for me its just sheer hell for weeks to be honest the wakefulness is really bad.'

The side effects of medication may be apparent as soon as the treatment is started, but the symptoms may not improve for a week or two. Individuals often felt worse and discontinued the medication. Shaking and severe weight loss through loss of appetite caused several participants to stop their medication.

Some participants, such as this 56 year old male freelance lecturer, felt that drug treatments they had received in the past had caused permanent damage:

'I know there's one group of anti-depressants I used to take, the tricyclics which have terrible side effects. I've got a lesion in one of my eyes, because of damage caused by that, but when you approach doctors with this they say "Oh it's not the antidepressant, it's something else", but they just haven't got the literature. And the problem for us is

that doctors fill in few report slips a year for side effects of drugs. Where patients report thousands a year, the average doctor sends in three per year. So these things just get missed with the current system.'

This participant acknowledged that the modern drug treatments were less problematic:

' about the modern anti depressants, I've been through them all over the years, is they don't make you very much more tired and they're quite good Seroxat and that sort of thing. The older style ones, the tricyclics, they did affect your work and affected everything, you couldn't really work with them if you were on big doses, you couldn't really work with them. But these ones you can work with.'

4.5 EFFECTS OF MEDICATION ON PERFORMANCE AT WORK

Many found it difficult to disentangle the experience of symptoms as a result of the illness and the side effects of the medication. Respondents felt their medication made them unreactive to 'good or bad' events, a 'numbing down' of feelings and responses. A 22 year old female, who was recently unemployed following a warehouse job said:

'I ended up with this nothing feeling, not being happy, not being sad, being indifferent to everything.'

A 35 year old female psychiatrist explained how her treatment made her not care about her work:

'The only problem that I've had with medication affecting my work was not just my illness that affected the amount that I cared about things it was actually the medication. The anti-depressants that I was on, one of my friends told me while I was on them that apparently there is a lot of literature now that they greatly affect your motivation and you just stop caring about things after you're been on them for a long time like me. Then you've got the problem where you get to the stage where you don't know if it's the medication or just the way you are just now, you don't know what to do, the people who are looking after you aren't particularly receptive to it but you're in this situation that not only can I not concentrate on my paperwork but I don't care that my back logs building up, it just gets bigger and bigger and I'm pretty certain that that happened to me on that medication which I've now come off and it was an absolute disaster for me because at the end of the day it's not just the actual fact of the paperwork, it's the fact that people now know about that paperwork and really don't think much of me for having such an enormous back log of paperwork.'

Lack of concentration and memory loss were also mentioned as side effects of the medication. Memory loss was a particular problem to participants who were dealing face to face with customers. Two participants, a mechanic and an office worker, both working for motor companies were unable to remember people they had met earlier in the day. This was an important part of their job as the personal touch was valued by their customers. A 40 year old male mechanic explained:

'Memory loss. That's the worst thing, memory loss. I am trying to deal with, sometimes, forty customers a day. And people just walk up to you and you look at them and you think "I'm supposed to know you", I can't even remember you from this morning. And your memory loss is the worst thing. I don't know whether it's the depression or whether it's medication.'

While most participants believed that the adverse side effects of medication had a detrimental effect on their work performance, some respondents felt that if they forgot to take their medication they felt ill and had problems with their work:

'I was getting feelings of confusion, not being able to make a decision, dizziness and things like that before I started on my medication. What I notice now about medication is that if I forget to take it I feel really ill and mess up work. If I forget to take it in the morning by lunch time my head starts to be really weird and I don't feel so well and then somehow my performance can't be that good in the afternoon at work because I don't feel very well and when people ask what is the matter with you I say "well, maybe I've got flu symptoms", you have to cover it up with something else but really I am saying "god, I forgot to take that bloody tablet".' [female prevocational tutor providing training courses for unemployed people]

Four people felt that medication had enhanced their work performance as it kept them 'normal'. A female worker in the voluntary sector explained:

'Mine just makes me feel normal, I just feel so much better and I can do things. I've been on it now for six and a half years and I know I've got to, probably, think about coming off it sometime, but I don't like the prospect.'

A 54 year old, former GP commented:

'I mean I was probably lucky, apart from a brief trial of diazepam which I didn't like at all it made me feel peculiar the antidepressants I've had have been to an extent mildly sedative Dothiepin apart from the first perhaps few days or so on them or increases in dose it hasn't affected my concentration, in fact it's improved it vastly.'

4.6 NON-COMPLIANCE WITH MEDICATION

Some participants felt a sense of failure at their need for medication and stopped taking medication as soon as their symptoms showed improvement. Non-compliance with medication for anxiety and depression was common. Individuals took less than the prescribed amount of medication and often discontinued treatment because of side effects they experienced or because their symptoms had not improved. A female university administrator explained how she experienced severe side effects and had to discontinue the treatment:

'I came off Prozac, even though the Doctor told me to stick with it, because I just felt so ill my skin felt like it was alive and I was freaking out all the time. And tingles and palpitations and I just felt horrible I'd rather be depressed or anxious. Tingles, it's weird, you can't explain everything was completely exaggerated, and I was just freaking out completely, and I just couldn't eat. And not being able to eat always bothers me, so that made me more anxious. So I just thought "No, pack it in".'

A 25 year old woman, who worked for a car leasing firm, described how the medication made her feel worse:

'I found that really hard, because I felt so awful, and I thought "If I'm going to take this and it's going to make me worse", and I take it for a day, and I think "Sod that". I was bad enough to begin with. And then they give you other things, but you don't want to try it because you think "Well I want to have a good weekend, this weekend", and if this is going to make me ill, then it's going to ruin everything. And after that it just went from bad to worse really the tablets, certainly, give you some nasty side effects of nausea

.... it seems crazy that a tablet that's meant to help with those symptoms actually can make it worse to start with.'

Fear of addiction or dependency was also a major issue for participants. Although they were assured by their GPs that their medication would not cause addiction or dependency, several participants experienced different symptoms on occasions when they had forgotten to take their medication or stopped the treatment. They identified these withdrawal symptoms or discontinuation reactions, as signs of dependency. A 28 female vet described the discontinuation effects:

'The danger period is when you stop taking the medication. If you stop taking them too quickly, and I've done that it's horrendous.'

Despite being reassured by their GPs that they could not become addicted to the modern antidepressants, many people felt that they were dependent on their medication.

'They kept saying that these are really safe you won't get hooked on them. That was what I was worried about. They kept saying that you can't get hooked on them, but I am because I feel ill if I don't take them, physically ill.' [female prevocational tutor providing training courses for unemployed people]

Participants who had found their medication beneficial felt that they had developed a psychological dependency and worried about how they would cope when they had to finish taking the drugs. They saw the psychological dependency as a second hurdle to get over when the time came to discontinue treatment:

'I said "I don't want to take them because I am going to get addicted to them." He [GP] said you can't get addicted to antidepressants, and I said "but I did" I am not poo pooing the drugs because they are marvellous really. They do help, but I know when I came off my own ones I thought "how am I going to cope if I stop taking them?" That means I was dependent, addicted to them It is like another hurdle you have got to get over, you have got to get over being the way you are. So they prescribe you medicine that is hurdle number two, you have got to jump over. Why give yourself another hurdle?' [female secretary in a solicitor's office]

' you go back more, you go back further into a bigger depression.' [50 year old female administrator]

Patients who were not happy about taking medication would often stop as soon as their symptoms began to improve:

'Even though it was only me and my wife who knew I was taking these I still felt a bit of a failure and so there was a kind of incentive to stop taking them as soon as possible.' [33 year old researcher]

'Why do we mind taking them, because I don't like taking them. Is it because we're not sure what we're taking? I say to myself "If I was diabetic I would accept that I had to take insulin everyday", but I cannot accept that I need [anti-depressants] because I'm not sure what they do to your mind or your brain or whatever.' [female 61 year old – retired]

'I've had two periods where I've had time off work the first time I took the Seroxat and I did want to get off it quickly and the second time I went to the doctor and he said I think you gave up too quickly the first time round you must take it for a good period after you believe your feeling better and I don't think I've quite achieved as long as he said he

wanted me to stay on it but there is with me a desire to get off it.’ [46 year old male health and safety manager in the NHS]

4.7 PATIENT INFORMATION

The level of information given to people varied considerably. Some respondents felt their GP was extremely helpful:

‘I’m very lucky, my own GP is wonderful and he really does take time, and I often think to myself “Thank goodness, I’m blessed”, because if I had a GP who would just be fobbing me off all the time, goodness knows what might have happened to me. I’ve got so much to thank him for, pointing me in this direction for the right type of treatment. But I think that this is a pretty sad affair that sometimes people don’t get the right type of care, at the time when they really need it.’ [46 year old female accounts worker of a coach company]

‘I’ve been very well treated by all the health professionals that I’ve been in contact with, right from the beginning I was given choices of treatment initially which was interesting, as well, even though I was in a terrible state they talked about the different routes for treatment of depression, because they said the symptoms that were presenting were so obvious, and they talked about the pros and cons of each form of treatment including doing nothing and when I said that I’d prefer to go on some Prozac type, SSRI because that seemed to be the one that was going to possibly produce a good effect without too many other side effects, and because most of my stress and anxiety related solely to work, there were no other features in my life that were leading to depression and anxiety. They told me it could be 6 months so right at the start I was told I would be on them for some time. When after a month or two things weren’t improving and the doses were stepped up and still things weren’t improving and then I was referred to the hospital, the psychiatrist there was very up-front about it and said that she could increase the dose and it might tip me out of the depression and then it would be a long path to redemption and so it’s proved to be but I anticipate, and the GP has said this, that I’ll be taking this at a maintenance level for perhaps another 6 months, maybe a year. I’ve been very fortunate, I’ve not suffered any side effects, the cumulative effect has been very positive, it’s enabled me to get back into work.’ [51 year old male lecturer]

However, many felt that they were not given sufficient information from their GP regarding side effects:

‘They leave you to read the instructions, they don’t actually talk to you about it.’

Some participants felt that patient information leaflets were very comprehensive in detailing the range of possible side-effects. But the extent of the information presented in patient information leaflets could vary considerably depending on the brand of drug provided by the pharmacist. It was also suggested that the purpose of the information leaflet was as a disclaimer for the drug companies rather than information for the patient:

‘I think the patient data sheet that comes with medication now is very good almost to the point of terrifying patients because it gives so much information about things that may not happen because society is getting litigious.’ [48 year old male lawyer working for the civil service]

It was clear that many respondents would have welcomed more information from their GPs. As a 58 year old male health and safety officer put it:

'I don't think there is enough explanation. I've seen three GPs and none of them actually explained what the tablets were that they were giving me just take them they'll make you feel better after a few weeks.'

'When I went to the doctors he didn't give me much explanation and he didn't seem particularly familiar with what was available he had to look up in his book I've been on Seroxat and really don't know whether it worked or not because I still felt mussy headed. My husband says he has this impression that I'm not with him at all I'm not there he felt I was still like it when I was on medication. I've felt at the end of the day I got better because I withdrew myself from work which was causing the problem for a long enough time to get strong enough to go back so I don't know if Seroxat worked or not. I heard a radio programme a couple of weeks ago talking about that as being addictive and I'm thinking "oh I'm glad I've got off it" although at the time I was assured that none of the drugs the doctor would be prescribing would be addictive.' [46 year old female personnel manager in the NHS]

There seemed to be confusion about how long it would take for the medication to take effect. It was suggested that it took most medication four weeks to be effective; one person said that it seemed to take Prozac 2 to 3 weeks to 'kick in'. There was also discussion about the dosage of medication, many people were very concerned about becoming dependent on or addicted to the drugs and took less than prescribed. One woman was prescribed a dose of three tablets but only took one, she suggested that people could take their medication every other day.

When patients were given information about their medication they felt more able to comply with the prescribed course, they had more confidence in their treatment and valued the time that professionals had given to explain what was happening to them and how the medication was supposed to help. Many people believed they were ill prepared for their medication, such as this female 50 year old mental health social worker:

'When you start off on these tablets, the first week or so, you have exaggerated symptoms of anxiety. So you're on this tablet to help you, which initially makes you feel worse, and I didn't realize that, and I was told later on that if I kept on that tablet, like, a few months later I might have been feeling better on it, because I would have got over the initial side effects.'

Some found that their antidepressants interacted with other drugs and again they were unprepared for this:

'I took my flu tablets then they said take your antidepressants. So I took it and then I vomited for three days and I thought that's not right because they should have warned me.' [25 year old female, works part time in telesales and as a full time care assistant]

Vignette 4 illustrates how receiving accurate information about drug treatments can make a huge difference to patients.

Vignette 4

A 50 year old female administrator in an SME had repeatedly consulted her GP with regard to her symptoms of anxiety and depression. During that time she had received a wide range of drug treatments, as she put it '*They just kept dishing out drugs*'.

One morning she was due to visit her GP but she was so anxious that she couldn't drive her car the half mile to the general practice. She asked her 15 year old daughter to help her to drive the car, as she explained:

'She helped me drive the car, only a half a mile. Only just round the corner at the traffic lights and to the Medical Centre. Terrible thing to do, but I was so desperate, I thought I was going to collapse. You could see my heart beating, it was beating that hard.'

'And when I went in and he [GP] said "Have you ever thought of suicide?" I said "Yes, everyday. Everyday I wake up thinking what would it be like?" He said "Have you ever planned it?" And I said "Oh no, I've got too much to live for, too many responsibilities." He said "Oh that's alright then, have a drug".'

After many more months of battling with her condition this woman subsequently went into hospital. During this stay she had a one and a half-hour session with a psychiatrist who discussed the symptoms and explained how the drugs work:

'There was me saying "Nothing's working, look at me, nothing's working". She said "Well, it doesn't, it takes three weeks to kick in". So I said "So I might be okay this week". She said "By the end of the week you could be a lot better". But that one and a half-hour with her turned me around completely. She gave me confidence.'

When respondents were admitted to hospital they found that hospital staff were able to take the time to fully explain to them what patients should expect from the drug regimens, including the side effects that they might experience. Self help groups were also identified as a good source of information.

Individuals often sought out their own information, from books and the internet, as this 56 year old male freelance lecturer explained:

'I think the Doctors are unwilling to explain the side effects of drugs, but they ought to now, because so many people have access to the Internet, that they will get them anyway. The Royal College of Psychiatrists has a website with all the side effects of drugs and [the health profession] ought to be much more open.'

Participants acknowledged that GPs had limited time to pass on information about the drug treatments they were prescribing, as this 32 year old male assembly line worker for a confectionery manufacturer explained:

'I'd been to my GP so many times, they have never explained to me about the side effects it would have on me. And it has really affected my life completely. Well I can understand them being under pressure, they just want you go in there, they listen to you, two minutes, he goes, write your prescription out and that's it. And not talk to you or anything, about it. They never used to tell me [about side effects] until I had loads of problems. And then I bought a book and read for myself, and there are a lot.'

There was an understanding among many participants that GPs could not be expected to be specialists in mental ill health, that their understanding would be limited by their generalization and also that resources were often limited due to lack of funding, as a 33 year old male researcher put it:

'One of the factors dealing with a GP most of the time is that they understand to a certain level say you've got cancer, your GP understands that but he's not the person who treats it, he'll refer you on to a specialist. Well I found, dealing with the GPs fine, he'll prescribe you Prozac but it wasn't until I came on this course [anxiety and depression management course] and got proper psychiatric professionals in the depression field that I really felt I started to progress. It's not a criticism of GPs but it's an observation that their understanding is limited by their generalization.'

'It's just the reality of the health service, there isn't enough time to spend huge amounts of time and money on every person.'

The doctors who participated in this study found that when they consulted GPs about their anxiety or depression they were asked what treatments they wanted rather than being prescribed a treatment. They also commented that GPs didn't talk to them about possible side effects of medication as they assumed they would already have the information or could look it up. There was also a suggestion that depression was not regarded as an illness:

'I think one of the problems about GP's is that they aren't, most of them, experts, we all know a lot of them don't believe depression is an illness.' [54 year old male, ex General Practitioner]

4.8 MEDICATION REGIMENS AND PATIENT MONITORING

Many respondents felt that the selection of drug treatments involved trial and error by their GPs, as this female council worker described:

'And eventually they put me on Prozac and that did nothing. But I was never really sure what was happening. They just kept giving me different things and saying "Well we'll find one eventually".'

Most respondents had their drug regimens reviewed on a regular basis and this varied from weekly, monthly, three monthly and six monthly review. Consistency in treatment was felt to be very important, however it was often the case that the same GP could not be seen.

General practitioners did not always seem familiar with the medication or the range of services available to the patients. Some participants felt that they were being prescribed medication each time without any questioning or further exploration from their GP. It was often only when the

opportunity arose to see a specialist, i.e. psychiatrist or psychologist, that they felt treatment options were discussed and the possible causes underlying their illness were addressed.

Access to services varied considerably among participants, for example when one participant moved home his new GP was, he felt, more understanding and referred him to a clinical psychology and counselling service. Attending the course gave him the understanding to see his treatment as long term and to use it to build his confidence; he now regularly takes his medication. Another respondent who had been prescribed medication for several years eventually asked her GP about counselling:

'I took the tablets basically as prescribed I've reached the point where the doctors said "I don't think there's anything much else that we can do" I said at that stage how about counselling and he said "oh yes we could try that" and I wish in retrospect I'd asked about three years previously because I would say the counselling did me far more good than any of the tablets.' [48 year old female veterinary surgeon, who gave up her work 18 months previously]

Many participants were concerned about their future. Unless they were receiving treatment from a psychiatrist, follow up treatment depended on the individual making an appointment with the GP. As many individuals had not realised they were ill until they reached a critical point, this concerned them greatly.

A summary of themes and sub themes relating to respondents' experience of anxiety and depression and medication for these conditions are shown in Table 12.

Table 12
Summary of themes and sub themes relating to the experience of anxiety and depression
and the medication for these conditions

MAIN THEME	SUB THEMES
Lack of knowledge and insight	
Impact of anxiety and depression	<p><i>Physical problems</i></p> <ul style="list-style-type: none"> - nausea - headaches - dizziness - trembling - lack of energy <p><i>Psychological problems</i></p> <ul style="list-style-type: none"> - motivation - fatigue - problems with memory and concentration
Effects on work	<ul style="list-style-type: none"> - impaired performance - problems with decision making - inability to cope with workload - intolerance of colleagues
Effects of medication	<p>Similar to the symptoms of anxiety</p> <ul style="list-style-type: none"> - confusion - dizziness - nausea - difficulties with decision making - shaking - nausea - weight loss - sleep disturbance <p>Medication made respondents unreactive, impaired memory, concentration and work performance</p>
Compliance	<p>Side effects</p> <p>Concerns about addiction</p>
Patient information and patient monitoring	<p>Patients ill prepared for medication</p> <p>Lack of information about medication</p> <p>Trial and error with prescribing</p> <p>Variable information in patient information leaflets</p> <p>Lack of continuity of care</p> <p>Variable access to specialist health care services</p>

5. EFFECTS ON SAFETY AT WORK

5.1 EXPERIENCE OF ACCIDENTS AND NEAR MISSES

Generally employees could not distinguish between the effects of the symptoms and the effects of the medication.

Participants noted that the side effects of the medication/symptoms they experienced at work included: confusion, dizziness and lack of concentration. They believed these side effects/symptoms impaired their ability to operate at work and made them more liable to accidents. It was noted that hazards relating to anxiety and depression were difficult to measure in terms of risk assessment as, unlike physical hazards, they are not visible.

Vignette 5 illustrates a typical example of how taking short cuts can lead to injury.

Vignette 5

A 30 year old male primary school teacher, who worked in a city school was finishing off work at the end of the day:

'Well, before I actually went off sick one term, I actually had an accident in the school. It was something which I did stupidly. I was a PE co-ordinator at the school and it was a quarter past five at the end of the day and I had had enough of school so I did the planning for the next day and I was just about to go home and with the security thing in school, everything was locked and I happened to see a football outside in the playground so I thought I'd better get it and instead of going all round the school to get out and then get the ball, I opened the window, you know there was a ledge about seven metres high and I was there with my colleague who was a newly qualified teacher and I said I think we had better go and get that ball otherwise dragon will be after us. So I just stood on the ledge and jumped down. There was a grass verge and it was slightly wet and I slipped and didn't realise until several weeks later, during which time I was still going to school limping [no one] comes and says "what's the matter with you, have you got a problem?" She [Head teacher] was quite happy to fill the form in about the accident ...'

This accident resulted in the teacher having to undergo surgery on the injury.

Respondents described a range of accidents and injuries which they attributed to their condition or medication.

'I had a series of falls at the time and, in retrospect, I don't think it was the medication, I think part of my problem was the job piled up, I would go faster and faster and faster. So if I'd got a large queue, I'd try and deal with them really quickly and then, because I know they're all waiting. And I don't need to wee or have a break, because this lady's waiting here. And I go faster and faster and I'm sure I would walk faster and faster. And I had a series of falls and they actually sent me for some tests because of it.' [female working in university administration]

'I tend to make silly mistakes, some of them resulting in cuts and scratches, you know minor injuries.' [female working in the public sector]

' when I went into industry I suffered a hand injury and I didn't think a great deal of it. Actually it was a textile, a hosiery needle that went into the hand and they had to make an incision and take it out and I thought I would be back at work etc., within oh two/three days. It went from bad to worse. The pain was out of this world and I was constantly going down to the Infirmary and telling them that, you know something is not quite right here and my absence from work just kept going on.' [male university technician who previously worked in manufacturing]

5.2 ACCIDENTS AND NEAR MISSES WHILE DRIVING

Driving was an area identified as a high risk activity both at work and when travelling to and from work. A 55 year old primary school head teacher noticed that his driving was becoming more aggressive he drove faster because he felt short of time and under pressure to get to work:

'Driving is the thing that I noticed because I was always feeling short of time, under pressure. I have a 25-mile journey to work each day on fairly busy motorways driving was becoming much more aggressive. I was driving a lot faster because I felt that I had to get to work quickly to get going, you know, I couldn't waste a moment of my life even if it meant driving unsafely.'

One participant was driving students in a minibus for work and after the journey realized that his mind had not been on the job of driving the bus but he was not aware of this at the time. Some people felt they were at risk when driving to and from work, because of an inability to concentrate and as a result of tiredness:

'I had one [accident] on my way back from work where, I think because I was so highly stressed, and something happened at work, that I was quite distracted, and I don't normally have accidents, you know, known to be quite a good driver. And I just somehow, just totally misjudged the amount of space I could overtake a car, and just, it was only wing mirrors that went. We can all be distracted when we're driving, but when you're particularly in that state, and if you came across a near miss I think you just know how much more you've actually got to concentrate when you're driving. And sometimes if I felt that bad, I've just not wanted then to go out, because I actually thought about not putting myself or others at risk, because it's just too easy to do.' [48 year old female advisory teacher]

'Driving, whenever I have a relapse one of the first signs is I have a minor crash in the car, back into something and also I'll leave the keys in the car, and lock the car.' [56 year old freelance lecturer]

' realising you just don't remember the last five or ten minutes of the journey because you're thinking about something else, on autopilot and certainly I found

driving when I was depressed extremely hard because it's amazing how much concentration levels go down, you suddenly realise actually it's a difficult task.' [54 year old male former GP]

5.3 RESPONSIBILITY FOR OTHERS

Safety issues particularly concerned individuals who had responsibilities for others, e.g. staff with responsibility for health and safety in organisations, teachers, health care professionals:

'one of my responsibilities was to Health and Safety and occasionally I was so tired and fed-up with it all, you'd see something but you'd let it go and just not react because, you know, if you did you'd have another load of work' [male 51 year old lecturer]

Workers operating machinery felt they were at a particular risk. A male electrician said that he took great care when using machinery:

'It is a danger, because if you are suffering from depression or anxiety and you take medication you have to be two pairs of eyes. Careful when using machinery, things like that, very careful, like I do. Because I use a lot of machinery. I have to be very careful.'

A car mechanic checked all his work several times, aware that he could endanger someone's life:

'Because I am a foreman and a mechanic at times, and when I do servicing I don't just check the plug once, I check it five times. Then I have to check the wheel nuts five times. And everything is five times. Because you go round it, and you go round it again, "did I do that?" And then you go round it again. And it's, I know other people who don't even suffer with depression probably do that as well. But it is very difficult in our trade to be very, very efficient. And probably in a lot of other industries it's the same, you've got to do it right first time, because you're endangering somebody else's life.'

5.3.1 Health care professionals

Health professionals are a high risk occupation with regard to the impact of mental health problems on safety at work. The health care professionals who participated in this study felt that anti-depressant use was wide spread among their colleagues, as this 43 year old female consultant psychiatrist who left work for health reasons remarked:

'In the seven years I had been there all three full time female consultants had been off sick with depression, and one of the male consultants had a previous illness of depression in the past. It's happening so much and that's just among consultants let alone the managers who have been off sick with depression. In fact there was a bit of joke among my team last year all of us were on anti-depressants, myself, my staff grade we'd just sort of sit down and say "what are you taking these days?">'

Health professionals, including GPs and hospital doctors acknowledged that they sometimes put themselves and their patients at risk. In some instances, difficulties arising from their symptoms and/or medication resulted in serious consequences:

'That's the worry isn't it, that amongst all this you're going to make a clinical error The only complaint I had against me that actually got very far and actually the relatives took it to the ombudsman who found eventually for the family was during the time when I went to my GP and he said "you should take 5 weeks off sick" and I said "no I'll be alright" and that was around the time maybe slightly before that that person was under

my care. I mean the whole total systems failure that sort of contributed to that thing but I was part of that, I was the consultant in charge of that person's care and I should have made sure that things were done better. ' [43 year old consultant psychiatrist]

'My last night at work, I was having one of those days when you can't concentrate and I couldn't, I was just feeling awful, I was asking my house officer to check what I was doing, because I felt she was in a better state than me and we went to an arrest and it was one of the worst arrests I've ever been to and I made an absolute complete cock up of it and the only sensible thing I said was "lets stop because I think he's dead anyway" but then I got his haematemesis [the vomiting of blood] to my face and I think if I'd been thinking a little bit about hepatitis C and hepatitis B and I think maybe if been feeling a bit better, a little bit more awake, I might have actually run that arrest a bit better and maybe he wouldn't have vomited blood to my face, I know that night I couldn't concentrate.' [28 year old female SHO]

A particular risk was identified in relation to handling hazardous materials, e.g. blood and many doctors were concerned about administering drugs and using needles and in some cases had injured themselves:

' contact with body fluids is probably the area you are most likely to put yourself at risk apart from driving because I certainly noticed that when I'm not that great it can be very difficult to get blood out of people or get things into people without, you know, making a bit of a mess of it, the thing is if you're a psychiatrist like me and you're not doing these things every single day but you are doing them often enough to be proficient what happens is you forget the routine of having stuff handy so you don't have the cotton wool so you're standing there with a needle in somebody's arm going and blood goes everywhere, all over you, all over the floor, over the patient and your apologising and then you're realising "drug addict, oh goodness knows what they've got".' [35 year old female locum psychiatrist]

'I certainly remember when I was in general practice, just sometime after I was first ill we had a patient that was known to be aids positive and I had to take a blood sample from him at home and I mean normally I had absolutely no problem taking blood samples, it didn't bother me at all and I was quite competent, but now my hands were shaking, whether that would have happened anyway or whether it was a combination of depression and anxiety at the situation I don't know. I mean that's one of the things anxiety does, it makes you perceive things as more threatening than you would do when you're not anxious which then creates a circle.' [54 year old male former GP]

Table 13 shows the themes and sub themes relating to the impact of anxiety and depression and the medication for these conditions on safety at work.

Table 13
Themes and sub themes relating to safety at work

THEMES	SUB THEMES
Difficult to distinguish between the effects of the symptoms and the effects of the medication	Symptoms/side effects included: - confusion - dizziness - lack of concentration
Range of accidents which participants attributed to their condition or medication	- falls - minor injuries - industrial injuries
Driving was impaired due to problems with concentration and general fatigue	Impaired driving was considered a hazard: - travelling to and from work - when driving during work
Certain occupations with responsibility for others were considered high risk with respect to the impact of anxiety and depression and the medication for these conditions	High risk occupations included: - Teachers - Health care professionals - Managers - Mechanics - Electricians
The health care profession was considered to be a very high risk group with respect to the impact of anxiety and depression and the medication for these conditions	Health care professional acknowledged that they sometimes put themselves and their patients at risk. Risks highlighted included: - impaired clinical judgement - handling hazardous materials, e.g. blood - administering drugs - needle injuries

6. RELATIONSHIPS WITH COLLEAGUES AND MANAGERS

6.1 DISCLOSURE

Many respondents felt stigmatised because people did not understand the condition and there were no visible reasons for their anxiety and depression. As a result many were reluctant to tell people at work about their illness. Many participants felt a sense of guilt that others were coping when they were not. Respondents often believed they were isolated in their inability to cope. A 50 year old mental health social worker explained how she felt unable to admit that she had a problem:

'I can't help but see the irony of my situation, coming from a mental health background, and looking back, which I've been doing a lot recently, seeing some of the stresses which I probably thought I was taking my stride. And yet only now, having looked back, I think well that shouldn't have been like that, and yet I was putting up with it. And not really asking for help that much, probably, and just thinking "Get on with it", because other people are putting their heads down and getting on with it'.

Some individuals said that they were 'keeping up a front' to manage at work, which they found very tiring. Participants reported that they did not tell anyone at work that they had anxiety and depression for the following reasons:

- the stigma of mental illness
- it would be considered a sign of weakness
- they thought they would be treated differently by their colleagues and employer
- they thought that it would jeopardise their promotion and career prospects

A 48 year old bank clerk described how she views the stigma associated with mental ill-health:

'I think all this fear and stigma comes from a complete lack of understanding of what the illness is about. Somebody's got a complicated physical illness diagnosis, your employers will just accept it. They don't expect to know the whys and wherefores of it. Whereas if you've got some kind of mental thing, they don't want to know, the number of times that I've tried to feed people information. And you feel like you've got to ram it down their throat for them to take any notice'.

Some people avoided the terms 'anxiety' and 'depression' when explaining their problems to colleagues as this 48 year old female teacher advisor put it:

'I used the word stress and stressed, I'm suffering from stress. I find that a more comfortable word for people to take in as opposed to depression.'

A 51 year old male lecturer commented:

'If you've admitted to being depressed or having anxiety then it seems like you're not up to the job and sooner or later you'd be collared and moved I even had a colleague talk about one of my staff who was having severe problems, and said, "shall we push them over the edge, shall we sort her out so we actually get rid of her", I found that

appalling, unspeakable but managers, some of them, do think like that, but not only, they act on it.'

A 28 year old female vet explained how she was treated differently as a result of disclosing the fact that she had suffered from depression:

'I think it's hard to admit to it, isn't it, because you're worried they're going to use it against you. And unfortunately I've had a pretty bad experience with my first employer, but, I'd got over my depression, it just went like that, when I left college. And so I didn't feel I was suffering from it, but I did mention it to my next employers, stupidly really. And they put everything down, every little thing that went wrong they just kept saying, "Oh, you know, it's obviously a result of your depression".'

An unemployed female in her twenties believed that a history of depression severely limited the chances of gaining employment in the future:

'With depression you get signed off for long periods. If you have a stomach ache you are off for a week, but depression just goes on doesn't it and they wouldn't employ you. I know people who have got it who can't get jobs.'

Some respondents felt able to tell their immediate colleagues about their anxiety or depression but not their manager. A female senior secretary in a solicitor's office told of how she had disclosed her condition to immediate colleagues and how they had responded in a positive and helpful manner:

'My immediate colleagues, the girls that work under me they know because we have been friends for years before. Nobody managerial knows. Nobody who pays my wages knows. They are absolutely excellent. A real good back up. I am extremely fortunate because if I am having a bad day I just go in and say I am struggling and they are fine they just leave me alone in the corner and I do what I do. What I can't do they will just pick up. I don't consciously not do anything. Perhaps it would take me a bit longer than it would do normally. They are absolutely fabulous. It makes it easier for me because it tends not to last.'

Occupational health departments were often approached for counselling, individuals felt that they could speak in confidence to medical staff who were only obliged to notify managers if the employees condition created a risk in the workplace. Personnel and human resources staff were considered to be management and were approached less often for help. Some GP's would agree to sign their patients off work with non-specific diagnoses if the sufferers did not want their employers to know they had mental health problems.

6.2 SUPPORT FROM EMPLOYERS

Many people who had tried to get help at work in the early stages were disappointed. They felt that they only received support from managers and employers once they had hit a crisis and they had a diagnosis. An NHS personnel manager felt that there was nothing offered until she had been diagnosed with anxiety and depression even though she had previously told her manager that she was having problems at work:

'My family and my husband find it amazing that I work within personnel within a health service environment so you've got the best possible environment to be cared for and I have had occupational health assistance and what have you but in terms of the director of personnel, my boss, all the things that we preach to the rest of the organisation cease

to exist when it is one of your own employees within the NHS you know the pressures are such that they can't afford or they aren't able to give the same level of care as you might have thought they would do.'

One woman put her pill bottle on the desk at work every day, even when she wasn't taking them, to communicate her illness to her colleagues. Even when people felt able to notify their manager they were cautious about the information they gave. One man told his manager that he was having panic attacks to avoid a reaction from the organisation if they thought he had work related stress.

Some respondents commented on the use of the Bradford Scale (also known as the Bradford Formula, Index or Score). This is a system of scoring sickness absence, which aims to measure the disruption caused by persistent short spells of absence, which are perceived as being more costly in some circumstances than occasional longer spells of sickness. It was thought that this system particularly disadvantages people with anxiety and depression who might regularly have spells of absence due to their symptoms.

Union representatives and disability discrimination officers were praised by two group members for their assistance, support and discretion when dealing with issues arising in the workplace. A female university administrator commented:

'I have to say that my Trade Union the guy there has been superb, so supportive, and very discrete in all senses of the word if I want him to go to a meeting, he's been there, he's been smashing.'

Many respondents felt that they were forced to give up their job when they would have preferred to have carried on working. They noted that the lack of flexibility with regard to working practices meant that there was little scope for maintaining people with anxiety and depression at work. Policies were often written and in place but not implemented:

'I think there's a kind of lip service paid to it, that they're aware that to look like a modern employer, with their investors in people or whatever they are going for that they ought to have some sort of recognition and policy but I think that, certainly from my experiences, is as far as it goes. In terms of senior management being aware of the problems of anxiety and depression, knowing what to do, having mechanisms on how to deal with people to deal with staff who have these problems I don't think they exist. I think that if they do they're just not used.' [33 year old male researcher]

'Because my condition has been diagnosed as anxiety and depression due to workplace stress they just want to get rid of me as soon as possible to avoid any sort of litigation so there has been very little in terms of support.' [54 year male working in higher education]

Few managers with anxiety and depression felt that they had support mechanisms in the workplace. A 54 year old male deputy governor of a large prison explained how there was little scope in his organisation to admit to having problems:

'Well we used to have a pie chart every month at the senior management meeting and we took pride in the senior managers never having any time off. She [the governor] never had any time off and I suppose I'm the blot on the paper now because I've had a long time off if you've got anybody weak you've got to root them out and when you are working with prisoners, if there's a person that's weak, they can be manipulated you're watching the prisoners you're watching your colleagues your watching the system and therefore there can be some understanding but I think its probably survival of the fittest.'

6.2.1 Managerial support

Support from managers varied. Some participants had very supportive managers who offered work modification, reduced hours, redeployment etc to enable sufferers to keep working. But many respondents identified management methods as contributory factors in work-related anxiety and depression. Managers often did not believe staff were ill and sent them to occupational health. They were discouraged from taking sick leave or sent on time management training when they struggled with their workload. When managers and supervisors were approached about work problems they were often dismissive of the difficulties encountered because no one else in the workplace had indicated that they were having problems. A 58 year old male health and safety manager who worked for a publishing company commented:

'I don't think senior management or personnel department actually know how to deal with it they know what to do about if some body has a bad back from lifting they stop them lifting but when you're depressed and anxious and you can't do the job properly because there is no physical thing showing they don't know how to deal with it.'

Some managers criticised work constantly even though the person felt their standard of work was better than others. Colleagues were afraid to support one another due to repercussions from managers and, as a result, support networks were lost.

Some managers were thought to be unsympathetic to the demands of domestic responsibilities and inflexible in allowing staff to deal with emergencies during the day. These experiences were reflected by employees with various levels of managerial responsibility. A female special needs teacher described the lack of understanding she received from her manager:

'.... she was so inhuman. I can hardly bring myself to say it, but after six months off work the first day back was my birthday and that morning my Dad died. Well I went into school and said my Dad died and I wanted to go up to the hospital and get things sorted out and she said, oh you can't its your first day back. I said but my Dad died this morning and I need some compassionate leave because I have got to arrange his funeral and so on. And she said, "you've had your compassionate leave when your son was ill." So I had had my allotment of compassionate earlier in the year when my son was in hospital and she wasn't going to give me any time off.'

Some respondents, working in both the public and private sector, felt that their managers were sympathetic and wanted to help but in reality there was very little they could do, as this 43 female year old scientific officer working in the NHS explained:

'What I've noticed, working in the NHS is, a lot of my colleagues have got similar problems or have been off. And the care's there when you, say, cracked, as such, but it's not there before. I was saying I'd got a problem, and okay my boss was really good and kind, but there was nothing they could do. Short of me leaving the job, and doing something else. This is the job, take it or leave it. And I'm not the only one who's struggling. So that side of it does, I think, needs something doing.'

Participants returning to work on reduced hours after sickness absence were considered to be fit and well and able to deal with their usual work demands. A warehouse manager explained how her work responsibilities had grown while she had been in post, after a period of sickness absence she returned to work on reduced hours but her workload had not been modified to accommodate this temporary change:

'I had 5½ weeks off and I knew that while I was away my manager was having to do my job and I run an entire department people working for me are in three shift teams'

working 24 hours a day 7 days a week and I only do 4 days a week and my predecessor worked 5 days. Of course as soon as I came back, although I was only supposed to be in a couple of half days a week, if I set foot near my office everything was back on it took me ages to go back to being at work feeling that I was there I wouldn't go back to my office I would go to a completely different building just so that I didn't actually have to meet anyone that worked for me because they would expect that if they saw me I would start to do things.'

Some people were fortunate to receive a positive response from their employers. A 55 year old male head teacher in a primary school was pleasantly surprised by the response of his school governors:

'After I'd become ill the governing body sat down and looked at my workload and realised that it was undoable and they'd employed an ICT technician because I was trying to run all the ICT, they'd employed another secretary because there wasn't enough time for the one secretary to do all the admin work so I was doing that, they'd employed a finance assistant because I was trying to run the budget on my own so there was a recognition there that my illness was largely brought on by a workload that had just become unmanageable. I'm head of a small school and you get more and more delegation of responsibility each year with very little additional money and there are huge savings at the centre in LEA's but they don't filter out to the schools that get the delegated responsibility so in a small school where everybody else is in the classroom that's what does it, you just pick up things, and pick up things till you get to a point where nothing happens and I found the governing body at my school has been very sympathetic and understanding and have done something about it.'

A 40 year old male car mechanic explained that his employers 'a family business, a very big business, but a family business' had supported him throughout all stages of his illness, including times when he was hospitalized:

'I've been looked after very, very well by my employer. And they've done everything they can for me. We have a laugh and joke and they call me a nutter and everything else, but they're looking after me. And that's the difference, I can go to work everyday, I don't feel guilty. I haven't got a problem with it. I can still perform my job, I suppose about ninety eight percent at the moment. I've got back up to that level again, without no problem at all. And I think that's a good thing really. Because in certain trades whatever you do it is difficult to find people, we all find, it's struggling to find people to perform certain jobs. And I think they've actually learnt that as a company over the years. And they've realised that, don't kick him out straight away, try and bring him back up to health again.'

6.3 SUPPORT FROM COLLEAGUES

Close work colleagues were identified as providers of practical support on a day to day basis. Sufferers felt able to tell their co-workers they were having a bad day and they would be left to manage their work as best they could, the work they were unable to manage would often be completed by colleagues. These were also the people who would provide an opportunity for the participants to talk informally about their work problems. Indeed, sometimes it was a colleague who made the person acknowledge that they had a problem, as this female primary school teacher explained:

'it wasn't until we had a supply teacher one day who said, "what on earth are you doing here, go home" and I went home and never went back for six months my boss

pretended afterwards, "oh yes, oh yes, I suffered from depression I knew what you were going through." Yet she had watched me week after week, after week plummeting down and down and down.'

Support networks were often lost when people were absent through sickness. Colleagues were unsure whether to contact the absent person, some felt that they would fall foul of their manager if they were seen to be supporting a colleague who was away with work related illness. A female veterinary surgeon explained how she was disappointed with the lack of contact from colleagues while she was on sick leave:

'I was very, very saddened that people I considered to be more than just colleagues didn't bother to phone, call round and I know very well that if it had been a physical illness there would have been someone there almost every day, but the fact that it was classed as a mental illness as far as they were concerned they were keeping away and when challenged they said "well I didn't want to upset you" actually they upset me by ignoring me.'

Upon returning to work, respondents felt that support from colleagues had a limited timespan. A 48 year female lawyer who works for the civil service explained:

'When I first went back to work people were quite sympathetic and supportive but I think they tend to think you go back to work and you're there 5 or 6 weeks and you're perfectly alright again they don't seem to realise that its an ongoing thing I think that's really because they just don't understand the illness and you don't want to remind them every week that your not really as well as you should be.'

6.4 WORKLOAD ISSUES

Some organizations were seen to be target driven and when the general workload was increased or the number of employees reduced, the extra work had to be absorbed. Some people felt that they were given the equivalent of a second job to do when employees who left the organisation were not replaced. Changes in workload, which were not evaluated, would leave employees with unrealistic targets affecting their work performance, job satisfaction and ability to cope. Managers were 'swamped' with paperwork and had to help with the work employees couldn't manage. Most respondents believed that unmanageable workloads had contributed to the development of their mental health problems. As a 51 year old lecturer commented:

'That's the huge thing for me, the workload issue screwing as much out of people for as little money as you need to pay them I think is one of the main curses of current, industrial employment situation. My contract for the job I did have, the role I did have, the list of responsibilities was four pages long and covered literally everything except a nuclear accident, there was no way you can do it. It's this problem of, in education, perhaps it affects industry as well, too much paper work, too much red tape, too much of non productive work, it's work that creates work, you know, Ofsted and so on. I seriously think they need to look at the structure of work itself. I've spoken to head teacher colleagues and quite a few of them said "you know so many of us are on the edge" and then you subsequently find that somebody is not sitting at a meeting or is off sick and is taking early retirement. People are dropping like flies.'

Vignette 6 describes how an increased workload and unsympathetic management resulted in a worker having to leave work.

Vignette 6

A male assembly line worker in a major confectionery company had been working on a production line and over the years the number of people working on the line dwindled down in numbers. Temporary staff were brought in and as this man was the longest serving member of staff on this particular production line he was expected to take on a supervisory role.

'Like he was relying on me to be a supervisor, plus quality controller and do all the packaging. And it just built up, built up. I just carried on, carried on with it, until the bubble burst. But for the first four months I didn't believe myself I kept saying to the manager "I can't manage all this." And he goes, I can still remember his voice, he said "If you can't manage it find another job".'

The employee developed various physical problems including repetitive strain injury associated with the packing. His symptoms included pains in elbows and wrists, and his fingers went numb. He obtained a restriction note from the company doctor, stating that he could do certain jobs, but no lifting. His manager was unhappy with this situation and made things very difficult for him. Colleagues advised him to make a formal complaint but he didn't. Eventually he consulted his GP about the physical symptoms but the GP also diagnosed depression:

'That's what my GP said to me the first day I went to him about it. And I just broke up, I just broke up in tears. I never used to believe that there was depression or anxiety, myself personally, until it just broke me down. It affected me like anything, and I've been off for a while now, and I get up out of bed everyday, but when, I tried going back to work but I couldn't. I just could not face it.'

Managers in particular felt that they had to shoulder increasingly heavy workloads and responsibilities without adequate support networks. A 54 year male deputy governor of a large prison remarked:

'They don't understand or they don't care the amount of additional work that's put on people without assessing what that should be and they've done no risk assessments as far as I can see there is no facility for a senior manager to be able to talk to someone either independently or through work of a similar rank and I don't want it to sound hierarchical but there are positions where you get to where you can't start talking to people, might be a senior officer or an officer or a clerical assistant, it wouldn't be very good for the dep or the governor or someone in senior management to do that so I think there needs to be somebody from outside or from inside.'

Respondents acknowledged that their mental health problems could cause difficulties for their colleagues, as this 46 year old female personnel manager in the NHS conceded:

'You do feel guilty don't you in lots of different ways at work, I felt very guilty about the effect I was having on the people I reported to, I wanted to be strong for them and I felt dreadful when I was told to stay off work I didn't want to stay off work I wanted to be

back there helping them although I had to be told forcibly in the end “when you’re there you’re not actually helping, its better if you stay away” but I think this guilt trip comes in I feel guilty if I compare myself with other colleagues who are in a similar situation they’ve got children, they’ve got relatives and they’ve got all sorts of problems of their own but they don’t give in to depression why do I? Why am I the weak link in the chain? guilt is a big factor.’

Colleagues were often aware but did not get involved, it was thought that they were embarrassed and felt that they might make things worse by acknowledging the problems. Bullying was highlighted as a problem leading to or contributing to depression and anxiety.

6.5 SUPPORT REQUESTED

Recognition of anxiety and depression as genuine illnesses was thought to be a first step in dealing with mental health problems in the workplace. Respondents commented that *‘anxiety and depression should be as easy to talk about as a cold’*.

Participants felt that there needs to be increased awareness and understanding from managers. Many commented that manager’s attitudes toward mental health need to improve and that they should be more flexible and generally supportive. It was suggested if anxiety and depression were better understood, managers and colleagues would be more able to give support and that courses explaining the conditions might help:

‘They should go on a course of understanding. Depression in the workplace. That is all you want. You don’t want them to criticise you, you don’t want them to condemn you, you just want them to understand where you are coming from and that you are not losing the plot.’ [female working in the sales department of a welding company]

‘I think managers need some training about how to deal with people, and how to get the best out of them. Because people are just promoted and they don’t have those skills, or they are not even aware that they should have them.’ [48 year old female teacher]

However, some participants were sceptical about this idea as a male 50 year old lecturer said:

‘ but you can’t make the testosterone driven, insensitive manager into a sensitive caring manager overnight just by sending him on a training course.’

Participants believed that organisations should conduct risk assessments for mental health to:

- reduce and prevent work related illness
- enable sufferers to continue working or return to work whilst being treated for anxiety and depression
- increase awareness
- provide a written report
- inform guidelines on the management of anxiety and depression which could be added to other HSE guidelines

When asked what kind of support they would ideally want it was suggested that support services such as occupational health or a counselling service should be available, or even simply the chance to have a quiet confidential chat/discussion. They felt that there was a need to develop

both formal and informal counselling which allowed employees a choice of in house or external services. People who worked for organisations with in house counselling services (e.g. universities) were very grateful for having access to such services. Respondents also commented that they would welcome systems for confidential notification to occupational health staff without having to inform line managers.

6.5.1 Help with workload

Rehabilitation measures included phased return to work where people had been off sick and redeployment. Some people were excused 'frontline' work for a while such as meetings, presentations and customer contact. Respondents believed that it is not always necessary to go home from work, often they just needed a way to relieve the pressure of work. They noted that sometimes it is sufficient to be able to communicate that you are having a 'bad day'. As this female bank worker put it:

'All my colleagues know. And they're quite curious about it, they know when I'm having a down day, because I'm really quiet and I just sit in my little area. And they know when I'm having a good day because I'm bouncing around doing a lot of jobs.'

Many respondents mentioned that they would particularly welcome practical help, people to help with the volume of work at difficult times although it was recognised that managing someone could be an added pressure.

While people with anxiety and depression did not always require time off work, episodes of sickness absence could be long compared to absence for physical problems, this had a knock on effect as people then become anxious about returning to work after a long absence. Employment prospects were thought to be considerably reduced for individuals with anxiety and depression. Many of the participants felt that they lacked the confidence to apply for jobs. It was also thought that declaring a history of mental illness would preclude an individual from being appointed.

Table 14 shows the themes and sub themes relating the way in which participants felt that their relationships with colleagues were affected by the condition and medication.

Table 14
Themes and sub themes relating to relationships with colleagues and managers

THEMES	SUB THEMES
Reluctance to disclose condition	Keeping up a front: - stigma - sign of weakness - might be treated differently - jeopardise career prospects
Some people were willing to tell co-workers but not managers	People felt they could speak in confidence to occupational health staff They were more guarded about personnel and human resources staff Some GP's would sign patients off work with non-specific diagnoses
It was difficult to obtain support in the early stages	Organisational support came into play when a crisis situation was reached
Union representatives and disability discrimination officers offered helpful support	
People were forced to give up their job when they would have preferred to have carried on working	Lack of flexibility in working practices No scope for maintaining people with anxiety and depression at work Policies were not implemented
Wide variation in levels of support given by managers	Some managers were insensitive Colleagues were afraid to support people with mental ill health
Work colleagues provided practical support	Support networks were lost during sick leave People would have liked more contact from colleagues during sick leave
Unmanageable workloads contributed to mental ill health	Managers were particularly affected and had little support
Needs to be increased awareness and understanding from managers	Training should be provided for managers
Organisations should conduct risk assessments	
Support requested by those with anxiety and depression	Access to counselling Opportunity for informal, confidential chat Practical help with workload
Modification to work preferred over sick leave	Sick leave for mental health problems tends to be lengthy Long term job prospects impaired

7. THE ORGANISATIONAL PERSPECTIVE ON MENTAL HEALTH IN THE WORKPLACE

Three focus groups were conducted with representatives from human resources, personnel, occupational health and health and safety departments. These participants were drawn from a wide range of occupational sectors. The discussions focused on recruitment, support and rehabilitation issues for employees with anxiety and depression, from an organisational perspective. Table 15 shows the range of employment sectors covered by these focus groups. Table 16 lists the composition of the three groups, profile of job titles and responsibilities.

Table 15
Range of employment sectors covered by focus groups investigating the organisational perspective on mental health

Department	Employment sector	Number of participants	Percentage of participants
Personnel	Education	2	10%
Human Resources	Health care Local authority SME	4	20%
Occupational Health	Manufacturing Health care Pharmaceutical Retail Armed forces	10	50%
Health and Safety	Local authority Social services Engineering Construction	3	15%
Counselling and Support	Local authority	1	5%
TOTAL		20	100%

Table 16
Composition of focus groups exploring the organisational perspectives on workplace mental health

Group	Gender	Employment
Organisational group 1	Male	Occupational Health Nurse - manufacturing
	Male	Occupational Health Physician - manufacturing and retail
	Female	Occupational Health and Safety Advisor - manufacturing and construction
Organisational group 2	Male	Training Manager - Human resources development
	Male	Hospital Human Resources Manager - supporting managers and staff
	Female	Counselling and Support Unit Manager - staff welfare and consultancy service to managers on welfare issues
	Female	Human Resources Manager in SME
	Female	Senior Human Resources Advisor - healthcare, mental health and community
	Female	Personnel Officer - education, strategy and development
Organisational group 3	Female	Senior Personnel Officer - education, general support
	Male	Occupational Health Nurse - manufacturing heavy industry
	Male	Occupational Health Nurse - manufacturing heavy industry
	Male	Union Health and Safety Representative - social services
	Female	Occupational Health Nurse - manufacturing
	Female	Health and Safety Officer - borough council
	Female	Occupational Health Nurse - health care
	Female	Occupational Health Nurse - ambulance service
	Female	Nurse Specialist (Occupational Health) - healthcare
	Female	Occupational Health Nurse - health care
	Female	Occupational Health Nurse Specialist - civilian and service employees

7.1 RECRUITMENT ISSUES

7.1.1 Job specification

Participants commented that managers are very reluctant to describe a job as stressful or suggest that a particular job might cause stress. A male human resources manager in a hospital described some phrases that are typically used:

'It's a busy job, it's working under pressure and it's working to tight deadlines. There are ways around saying this job itself could cause you some stress.'

7.1.2 Recruitment

None of the organisations had a specific policy for the recruitment of employees with mental health problems. Recruitment was deemed to be based on the physical and mental ability of candidates to perform the job for which they were applying.

Candidates for posts might be screened in pre-employment questionnaires for previous histories of mental health problems or they would receive a health screening from doctors within the organisation prior to the start of their post. As this female manager of a counselling and support unit explained:

'We haven't actually got a policy about it, but everybody would be health checked before they start work. So anybody with a history of anxiety, depression it would be identified by our doctor. Most people have paper screening, but obviously if there was a problem I don't decide on paper. It would be referred through to the doctor, and then the doctor would make a medical decision as to whether the history of that problem would affect them in the work place, and then we make a recommendation accordingly. But there is no written policy to do with recruitment of employees with mental health problems.'

As part of the recruitment process, some organisations employed the use of psychometric measures to match candidates to suitable jobs. A manager of a counselling and support unit explained the rationale:

'I think it's not just the people with mental health problems, but things like personality profile, the use of questionnaires and conflict resolution questionnaires, particularly for more management positions which might be more stressful than other roles. To try and match them to look at where their strengths are what they like doing in a way trying to second guess whether that person is going to be able to cope with that role.'

Where applicants disclosed a history of anxiety and depression, they might be referred to occupational health or personnel if there was concern with regard to the work they would have to undertake. This enabled risk assessment of the work and identification of job modifications if necessary. But participants felt that this assessment was often fraught with problems, as this male human resources manager in a hospital explained:

' to get consultant opinions, and so on, is probably a three to six month process, knowing most consultants in my experience. In practical terms you need to take a decision in fairness to that applicant and in fairness to the organisation, based on what you have. And sometimes it's a bit of a wing and a prayer. And going with it because you can't see any reasons not for going with it. In fairness to that potential employee, not to drag it out over a long period. I think sometimes the information you have is very limited.'

However it was suggested that most applicants are reluctant to declare mental health problems because they think it would disadvantage their chances of employment. This was supported by the implication that some interviewers might be prejudiced towards an applicant with mental ill health. A male hospital human resources manager commented:

'It's extremely rare that they'll declare that they've got some mental health problem. They're quite happy to declare if they've got a physical problem of some sort. But my experience is that people don't declare to you a health problem, and therefore I imagine we are employing quite a lot of people who have got a variety of mental health problems, that are not known to us when they join the organisation.'

7.1.3 Disabilities Discrimination Act

The Disabilities Discrimination Act (DDA) 1995, legislates against employers discriminating against people on grounds of disability. A male head of nursing for a manufacturer in heavy industry explained:

'Well we don't have a mental health policy part of the recruitment process is the questionnaire. But people aren't supposed to be forwarded to Occupational Health until they've been they're offered the job. So it's the best person for the job, whereas previously, years ago, like all of us I'm sure are aware, that they used to use 'The Medical' as a way of filtering people out. Like I say, with the DDA you can't do that anymore. So it's the best person for the job, and then we would have to look at advising reasonable adjustments for that person if necessary.'

However it was suggested that indirect discrimination was possible through organisations requesting details of applicants' absence records in application forms or in references. Absences for mental health problems tend to be longer than for physical problems. Information relating to sickness absence could be used in the early stages of selection when drawing up a short list for interview.

It was suggested that a temporary contract could be used to the benefit of both employer and employee to establish whether people were suitable for the job and able to cope with the work.

7.2 SUPPORT FOR WORKERS WITH MENTAL HEALTH PROBLEMS

The type and extent of support offered to employees with mental ill health varied according to such things as the size and culture of the organisation and the type of work they undertook. Smaller companies without occupational health, personnel or human resources departments relied upon line managers for these services. A male training manager for a local authority commented:

'the small to medium enterprises have a lot to comply with, employers have a lot to comply with, with European Law and the way it's changing employment. And they've got a lot of pressures to keep the business going because if they don't then there are lots of people ending up without a job. And, so maybe Government should, actually, target those companies that don't even have Occupational Health support.'

Lack of flexibility in some work areas prevented people having their hours or workload reduced. This occurred where the job in question was part of a larger process. Changing jobs for people with specialist skills, for instance in the health sector, was not easy. It was considered that most jobs were demanding and that it was difficult to offer employees light duties.

Employees did not want to be treated differently from their colleagues and it was often only necessary to take them away from the most stressful parts of the job, for example, customer complaints departments or being expected to speak at meetings. Managers in other departments were reluctant to take on an employee who was ill and working reduced hours. Moving people to a 'non job' was not recommended, as employees felt undervalued and sidelined.

Larger organisations such as health trusts, local authorities and large manufacturing companies had their own personnel or human resource departments but not always occupational health or welfare services. Three organisations had their own counselling service and others offered access to independent counselling services, some through the Employees Assistance Programme (EAP). For example, there is a national EAP service for teachers. A participant from the health sector highlighted the benefits of having several options for counselling support including hospital chaplains and Community Psychiatric Nurses (CPNs). One organisation had discontinued their welfare service when financial cuts were made within the company. A psychologist had been employed by one manufacturing company to assess the counselling needs of their employees.

Even in large organisations with services in place to support workers, there was sometimes the perception that the organisation had shifted its policies away from supporting workers with mental health problems, as a male union health and safety representative working in social services explained:

'I think our organisation has moved progressively from the point of having a will to have supportive policies and types of things that deal with alcohol problems, at work, mental health problems, at work. And be flexible to support staff. And now I feel that that's, and I know a lot of colleagues do on the staff representation side, feel that's an aside, been kicked aside. As the pressure for sickness management and capability procedure comes in. Sure, it's genuine illness, but it renders you incapable of carrying out the job. And if we're not able to facilitate redeployment into some other post and a lot of employers will have a whole range of posts, but if you're not suitable for one area in a sense probably you're not really suitable in other areas. Then there's a high risk of being sacked because you're a weakness as it's perceived.'

Reduced income due to sickness absence was also discussed. It was suggested that this could be a reason why some employees do not take time off work until they are unable to manage any more. Employees were also thought to return to work prematurely due to financial pressures. Several options were identified whereby employees' income level could be maintained whilst off work, working reduced hours or having been redeployed. Therapeutic hours and protection of pay enabled full salary to be paid. Other methods were employees taking annual leave or special leave whilst on reduced hours. Some organisations paid employees their full rate during a phased return to work. Temporary injury allowance was mentioned, which operates as a financial top up for employees with an industrial injury.

The contact maintained with an absent employee varied between organisations. Early contact during the period of sickness had advantages and disadvantages. Some employees felt that they were being harassed to return to work, and in other situations early contact facilitated a return to work plan. Organisations relied upon the section manager to notify the relevant department of employee absence in order to initiate a home visit, one organisation had an automatic trigger after one month's sickness absence was recorded. There was also discussion about who should visit the absent person, it was suggested that employees identified occupational health staff with a welfare role whereas they saw managers and personnel staff as being more concerned with the effects of their absence on the workplace.

7.2.1 The role of managers in supporting workers

Management methods were identified as a possible cause or exacerbating factor for anxiety and depression in the workplace. It was commented that many managers had gained promotion through their technical skills but had not been trained in people skills. It was thought that human resources and personnel departments should help managers to identify evolving problems, for example, monitoring changes in work performance and sickness absence levels.

Although policies for bullying and harassment were in place, they were often not implemented. Male workers particularly were thought to be reluctant to report any incidence of bullying, as it was seen as a sign of weakness especially in a masculine environment. Reporting of harassment was acknowledged to be difficult for employees if the line manager was the perpetrator and also the person such incidents were reported to.

The reporting of mental ill health was seen as very problematic for many workers, particularly in male dominated work sectors such as construction and engineering:

'There's this macho image some of the people on site are there 'till seven, eight o'clock in the evening if your there in the office at nine o'clock in the evening your more likely to get promoted. Especially in construction industries, engineering, the macho thing so that mental health's just brushed under the carpet.' [female health and safety advisor for an engineering and construction firm]

'There's almost sometimes some kudos seen in getting a physical injury. Whereas the mental illness is seen as a sign of weakness, as someone who's not able to cope.' [male occupational health nurse in heavy industry]

Some workers did not wish to reveal mental health problems such as anxiety and depression to their managers, as a male occupational nurse stated:

'it's a medical problem and they're quite at liberty to withhold that information as they wish there are one or two staff, who will disclose the information to myself or the company doctor, but don't want to disclose it to their managers. As long as they're not a risk to themselves or to other staff, then we will respect that. They have the right to confidentiality. A lot of staff see stress as the kiss of death to their career they'll either be first for the redundancy or they'll look at them and say "Well, if they can't handle their present job without stress, they won't handle a promotion".'

Participants felt that the need to respect a worker's confidentiality sometimes limited the effectiveness of the support that they could provide. A male human resources manager of a hospital explained:

'I think sometimes the issues around confidentiality with individuals make it very difficult to make any real progress. Employees themselves are often reluctant to have information about themselves shared beyond, say, the confines of the Occupational Health Department. And you get a report back that you can't really work with in practical terms. You get advice that the person should be on lighter duties, or this person should be in a less stressful post. And in practical terms it doesn't actually help you to share any confidence with other managers outside of their immediate working environment, is quite difficult. They tend not to want that, they want to keep it close and share it with as few people as they can. And therefore there is a problem in achieving the sort of help that you can see they might benefit from.'

Managers were thought to be more sympathetic to stress related illness in the last ten years as many of them had personal experience of it themselves. One manager in education had given an

employee a performance target to manage her work in work hours to reduce her over working and taking work home. Participants recognised that managers were also under pressure and as a consequence were sometimes intolerant of 'invisible' illness such as anxiety or depression, it was pointed out:

'It's hard to support somebody if you're, actually, at you're wits end as well.'

Interestingly, no one could identify who supported managers with anxiety and depression in the workplace.

Support from line managers was seen as vital when modifying work for employees unable to manage their usual workload. Providing information to the manager on the plan of work, targets and reviews for the employee were important and it was thought that managers should be encouraged to conduct return to work interviews. There was a perception that managers were sometimes unaware of organisational policies available to assist workers or unwilling to use them, as a male hospital human resources manager explained:

'We've got a range of family friendly policies and term time only working. And staff can take emergency leave at short notice and special leave under certain domestic circumstances. And those policies are all there, sometimes the issue is getting managers to recognise that they're there and to use them. They tend to be quite mean with them, and we encourage them to be a bit more liberal. And say well if this helps somebody to actually manage that part between work and their other issues well then use them. But there's a bit of a stick in the mud approach to this.'

7.3 REHABILITATION

Various methods of rehabilitation were identified from the wide range of organisations represented. Phased returns to work involved therapeutic hours over 4 to 6 weeks starting with as little as 2 hours a day. Involvement of managers and colleagues in the rehabilitation plan helped them to know how long support would be required. A manufacturing company allowed a longer rehabilitation period for more skilled workers.

Flexibility in rehabilitation was considered to be important for both the individual and the organisation, and it was stressed that the worker had to feel valued. Difficulties arose where the cause of the problem was management methods and returning employees to the same work area would be difficult. Small firms were thought to be less able to accommodate rehabilitation measures.

Participants felt that occupational health staff should identify the implications for work of any medication taken by the person returning to work:

'I think this is one of the important aspects of the Occupational Health role that we identify the medication that people are on and relate that to the job that they are doing. Obviously, if people are operating machinery, driving, that sort of thing, that is one of the main reasons why we see them from a Health and Safety point of view. And our company has a policy that people who're on medicines which may effect their abilities to do the job, they have to notify Occupational Health. So it is a policy, it is a company requirement people should notify Occupational Health. So, it's another way of flagging up that somebody may be suffering with their occupation. That, there is an important Health and Safety aspect to it, because psychotropic drugs do affect people's ability to do machinery type jobs.' [male head of nursing from a heavy industry manufacturing company]

'where a person has a problem because of the medication coming at certain times of the day, they've made the hours more flexible to, to help them. That was successful I think.'
[male occupational physician in a pharmaceutical company]

One participant thought that sick notes were given by the GPs in the light of the condition and not in relation to their patient's occupation e.g. hernia six weeks, depression three months. It was believed that medical practitioners were concerned about people returning to work too early. Liaison between employers and GP's about rehabilitation programmes would enable some workers to make a phased return to work earlier. As a male head of nursing in a manufacturing company explained:

'GPs are, justifiably, anxious about whether they can let someone come back to work. Because unless they know the employer, and the support they're going to give, then they tend to say 'Well it's all or nothing', you're either better or you're not. We daren't risk letting you go back to work. And I think Occupational Health plays a part there, in developing a relationship with local GPs and just giving them the confidence to let their patients come back to work sooner rather than later.'

A female occupational health nurse specialist working for the civilian and armed forces commented:

'We're trying to get away from somebody being off sick away from work for a very long time before they get offered help. Having said that once they're offered help, and they've been pinpointed, there's a problem, then they are very well supported within the Ministry of Defence, I think, with regards to support. We feel that, if they feel they can come back to work, the GP feels that they can come back to work for a short while then they can be brought back to work. It doesn't happen very often with depression, but it is happening. And there is support, if they stay off sick for a long time, but again that's not always the best way.'

The HSE leaflet *'What your doctor needs to know'* is given to employees by one occupational health department. Employees returning to work on reduced hours should be 'extra' to the staff needed, to avoid other workers being put under pressure through having to cover the shortfall. While co-workers might initially show empathy and understanding to those in reduced hours, this feeling may diminish as they continue to carry the extra burden of supporting someone with mental health problems. Employees on reduced hours sometimes returned to full duties too early in order to relieve the pressure on their co-workers. As a male union health and safety representative working for the social services put it:

' a lot of problems would be solved if there was that extra bit of resource that gave what you might term as old fashioned slack in the system.'

7.4 POTENTIAL SOLUTIONS

Participants believed that it is important to be clear about the demands of the job from the start and to assess the candidate's ability to cope with the stresses of the work. They made a range of suggestions for raising the profile of mental health in the workplace, these included:

- inclusion of mental health issues in health and safety training
- appraising managers of the causes and consequences of employee stress

- ensuring managers are skilled in managing people and have effective communication skills
- consulting staff about how stress in the workplace might be reduced
- conducting risk assessments for stress

A male head of nursing in a manufacturing company described some of the training they offered to managers:

'We have an education program for managers called Managing Mental Health in the Workplace. Managers go on a one day course, running in parallel to that is one called Occupational Health for People Managers, and that's just a half day course. And that's how to work in partnership and relate and refer to Occupational Health. So that they're then on the course about managing mental health and the signs to look for etc. and what they can do about it. Historically other areas around the UK haven't enjoyed that luxury. And so we are looking at expanding that around the country. And we started it about, what, eighteen months ago. And we've got another eighteen months to go because we've got five thousand managers to get through it.'

Most participants agreed that they were not confident to assess risk for stress related conditions in the workplace. One local authority had commissioned a questionnaire which was circulated to 800 employees to gather data to help identify a baseline level of stress in the workforce from which they could monitor changes and identify areas of risk. A human resources advisor in the health sector talked about their pilot study of risk assessments for people returning to work after absence due to stress.

It was widely agreed that assessing risk relating to mental health in the workplace was a difficult and subjective process. Participants made a range of practical suggestions to facilitate this process:

- there is a need to develop valid measurement tools to measure stress and feedback to managers any changes which may indicate problem areas in the workforce
- information should be gathered from a range of sources: questionnaires, appraisals, comments from staff at department meetings, exit interviews and sickness absence figures
- information collected by organisations should be stored in a retrievable form and in a way that would flag up potential areas of risk

It was suggested that exit interviews can provide useful information but are often not conducted with people leaving due to ill health or those who have left due to dissatisfaction. Participants felt that there should be greater use of exit interviews in organisations with a high turnover. As a female human resources advisor in health care explained:

'Oh I've had a lot of exit interviews a fair proportion have been with staff who've had something definite to say about discrimination, or harassment or couldn't get on with that person So I think you can get some useful stuff.'

A major problem identified in many organisations was that it is difficult to draw together the various sources of information relating to stress in the workplace. A female occupational health nurse outlined the problem:

'I just discussed this with personnel, if we could get indicators of where stress was in the workplace from these sorts of indicators. And it is very difficult, because, it's a difficult procedure in a way, because a lot of the information is kept by one department or in one database and you can't really cross reference it. Then that was particularly true of sickness records and things like that. So the information might be there in the workplace, but drawing it out to find out what, actually, is stress related and what the effect of that is, is quite difficult.'

Participants believed that it was important to identify the cost effectiveness of managing mental health problems at an early stage. It was commented, for example, that there is a very long waiting list for counselling services from the NHS and it may be more cost effective in the long term to have this service provided by the employer.

It was recognised that managers needed support from human resources and occupational health departments when rehabilitating and managing employees with anxiety and depression. Respondents felt that it is important to keep managers informed about rehabilitation and work modification plans, and to set targets and reviews so that progress can be measured. It was argued that organisations need to build networks for listening and communicating about problems relating to work and mental health.

Table 17 details the themes and sub themes resulting from discussions with organisational representatives.

Table 17
Themes and sub themes relating to the organisational perspective on mental health

THEMES	SUB THEMES
No specific policies on recruiting employees with mental health problems	
Pre-employment screening questionnaires and medical assessments used to assess candidates suitability for job	Risk assessment fraught with difficulties Candidates unlikely to disclose mental health problems Significant undetected psychiatric morbidity in working population
The Disabilities Discrimination Act (DDA) 1995, legislates against employers discriminating against people on grounds of disability	Applicants with a history of anxiety and depression likely to have notable sickness absences which may lead to discrimination in the selection procedure
Extent of support offered to employees with mental ill health varied according to company size, culture and type of work	Large organisations have in-house services SMEs have little in the way of provision Redeployment limited by lack of flexibility in the workplace Employees off sick return to work prematurely
Contact with employees off sick can be advantageous	Some people felt harassed about returning to work
Management methods thought to contribute to mental health problems	Workers (especially males) unlikely to report cases of bullying Workers reluctant to report mental health problems Managers themselves under pressure and sometimes intolerant of 'invisible' illnesses such as anxiety and depression Managers unaware of policies available to assist workers or unwilling to use them
Rehabilitation methods	Phased returns SMEs less able to accommodate staff Need to assess risk from medication Liaison between GPs and employers important
Need to raise the profile of mental health in the workplace	Methods include: - mental health issues in H&S training - managers trained in communication skills - consult staff on how stress might be reduced - conduct risk assessments for stress
Assessing risk relating to mental health difficult and subjective	Practical suggestions: - valid measurement tools - information taken from: questionnaires, appraisals, staff comments, exit interviews, sickness absence figures - information to be stored in retrievable form - need to build communication networks

8. THE VALIDATION EXERCISE

A validation exercise was conducted where the results were presented to an invited group of experts from relevant disciplines. Table 18 lists the areas of expertise of members of the validation group. The names and affiliations of the participants are listed in the appendices (Table 20, appendices page 103).

Table 17
Range of disciplines covered by the expert panel

Validation group panel of experts
Union representative - MSF Psychiatrist and academic researcher Health Safety and Environment Advisor Occupational Physician Professor of Occupational Health Psychology General Practitioner Senior lecturer and researcher in mental health in the workplace Union representative - UNISON Clinical Psychologist who runs anxiety and depression management courses

The invited experts were very interested in the results gathered by this study and felt that the work made a significant contribution to understanding of mental health in the workplace. There was a lively discussion relating all aspects of the findings.

8.1 CAUSES OF WORKPLACE MENTAL HEALTH PROBLEMS

Identifying causes of mental health problems in the workplace was thought to be of paramount importance. Pressure of work could be a cause or a symptom of the problem, with some people being asked to do additional work and others finding it hard to cope with their usual level of work. It was suggested that managers and employers need to be aware of changes in an employee's work performance or behaviour as this is often a key factor in the early identification of problems. People suffering with anxiety and depression may perceive that they are producing a high standard of work even when their work performance has changed. A health care practitioner commented:

'... their work may not be up to scratch despite them thinking it is. They put a lot of time and effort into it but it's actually not good, and the criticism may be valid. You may not be terribly supportive, but it may be valid and even if it is done supportively, if they are very depressed they may not see it as supportive. Because people who are depressed see things in a very black and white way. I think they're already criticizing themselves and already feeling guilty about feeling ill, they try to pull themselves together and can't and are feeling frustrated about that. They are going to perceive things that set them in a very different light to those who are fairly upbeat and reasonably happy about life. It's trials and tribulations.'

Anxiety and depression were also thought to be related to human relationships in the workplace. Redeployment alone may not be a sufficient solution. To maintain employees with mental health problems in the workplace there needs to be a degree of understanding from managers. It was suggested that some people were unwilling to complain when there was a problem in the workplace. Therefore investigating a department where people were regularly off ill or that was performing differently to a similar department may help to identify 'hot spots' of stress.

It was felt that mental health in the workplace should be given a higher profile in organisations and that general awareness of the issue needs to be increased, a union representative remarked:

'There's a real problem as far as social taboos are concerned. It's changing the issue of bullying at work is now more broadly recognised and I wonder whether there isn't a similar sort of exercise, a similar process that needs to be gone through in terms of anxiety and depression at work, and the relationship between that and poor work performance. Having personnel managers who are willing to listen, and recognise that someone with a problem of depression is not simply a whinger or a trouble-maker or a milksop but actually a person with a genuine problem that needs to be considered. That is actually quite a difficult thing to do, you're talking about probably several years before that level of awareness can be raised, but if you think about what has happened, with bullying there is now much personnel management literature, human resource management literature, containing articles about the extent of it and what can we do about it and so that it's become quite a respectable area for personnel.'

The validation group commented that staff promoted to management positions on technical ability should be fully trained in management skills including people management, as outlined by an occupational health expert:

'The general advice we give to managers about stress management is that good management is stress management. If you have sound management policies, HR policies, appraisal systems and feedback systems and if all those things are in place and if your managers are trained how to manage (rather than just being promoted on technical ability and assuming that they would be able to manage people) then you'll be getting somewhere.'

In general it was felt that employees benefit from being valued and treated with respect, as a union representative explained:

'Having an organisation that treats people with respect, that gives them a sense of being valued, a sense that they are not just stuck in a particular part of the organisation and there they stay until they die. They've actually got some prospects in the organisation. They are being developed, all those things add to the feel good factor. It isn't just the pay that makes the difference between working for an organisation that you're proud to say you work for and an organisation that you groan to go to work for on a Monday morning. That's all part of the difference between working for a good outfit and having a miserable job you want to move on from as quickly as you can and of course that links in with high turn over and all the problems that employers are continually aware of and try to deal with. I deal with organisations having a turnover of 25% on average per year and you wonder how those organisations can cope with that.'

The advantages of maintaining employees with anxiety and depression at work were discussed. Remaining at work maintains a person's social support network. Hence prolonged absence from work due to anxiety and depression is not always beneficial, as noted by a union representative:

'This is a Catch 22 situation. If someone is on medication and they step down from work you take them away from the problem but you take them away from the social networks.'

Validation group respondents described rehabilitation programmes that they had encountered in some organisations that involved a gradual reintroduction of the person back into the organisation. This maintained contact between the person and their colleagues without putting too much pressure on the individual, allowing them to slowly regain their full role in the workplace.

8.2 INFORMATION FOR ORGANISATIONS AND MANAGERS

While it was acknowledged that information already exists on mental health in the workplace, it was felt that such resources could be further developed. In particular, it was suggested that more information was needed on:

- the prevalence of anxiety and depression in the working population
- an indication of how many people organisations should expect to have anxiety and depression in their workforce
- how mental ill-health among employees affects employees and organizations

A mental health care practitioner felt that managers generally lacked knowledge regarding these issues:

'People have a lack of knowledge when presented with someone with mental health problems. I imagine the initial reaction is panic, they don't know what to do. There's often a sense of hopelessness around as well, particularly with things like depression which is a real shame because actually there is hope with depression. It's a very treatable problem and there's an awful lot of things that people can do.'

Guidance provided for managers on the management of anxiety and depression in the workplace should be easy to 'pick up and use' and include: preventative measures, management in the early stages and longer term management. An occupational health expert suggested:

'We could easily have leaflets available on common illnesses, effects, medication and so on. Current HSE information leaflets are much more about work related rather than health related issues.'

Some members of the validation group had experience using stress questionnaires in the workplace, and there were mixed views on their benefits. Doubts were raised about the validity of information given by the respondents and the reports developed from the data. It was felt that analysis and interpretation of the data should be undertaken by a skilled person. It was also recognised that there was little point in using questionnaires if the findings were not acted upon both at the employee and organizational level.

8.3 PREVENTION OF MENTAL HEALTH PROBLEMS

It was suggested that useful measures to prevent or identify problems would include:

- good management and human resources policies which are implemented
- an appraisal system to identify potential problems and respond to the changes in the limitations of the individual
- feedback systems relating to important indicators such as the rate of staff turnover

Employers should ensure that the employee is capable of doing the job they are appointed to and establish an appraisal system which identifies employees who are being affected by work related anxiety and depression.

8.4 ORGANISATIONAL RESPONSIBILITY

Organisations should identify the root cause of the problem, acknowledge the cause and address the problem at both an individual and organisational level. As a mental health care practitioner explained:

'One of the cautions in therapy is that while the individual may be identified as the sick person, their reaction may well be quite a normal understandable reaction, and it's the organisation that's actually sick and not the individual.'

Large organizations were thought to have better communications networks for circulation of information to employees and facilities to provide people with support. It was commented that a greater proportion of the public work sector employees, over 90%, have access to occupational health services than the private sector, which was estimated to be in the region of 40%.

Provision of psychotherapeutic treatment by the employer should be considered as it is unlikely to be available to employees through the NHS. It was commented that the waiting list for cognitive behaviour therapy on the NHS was 2 years. It was felt that provision of such services or the organization facilitating access to a service may be a cost effective measure in the long term. A skilled assessor is needed to establish who would benefit from treatment and provide information on the cost and the estimated duration of treatment.

It was felt that health issues were better dealt with by occupational health or personnel departments. It was suggested that line managers should not be dealing with confidential medical information. SME's particularly need guidance on services and support for mental health problems. Industrial relations were thought to be closely related to mental health problems in the workplace and that union and welfare representatives have a crucial role to play. It was acknowledged that managers often have a difficult task of balancing the needs of their staff with their responsibility to the organisation. A union representative commented:

'It is absolutely necessary that we understand that there are two sides to this relationship you know there's the manager who is tearing his or her hair out because of resource problems and the difficulties of running the organisation and there is the employee with their problems.'

8.5 MEDICATION

The issue was raised that workers were at risk of accidents and near misses when they were depressed and not treated possibly more so than when being treated with effective medication, as a mental health care practitioner remarked:

'In terms of safety there is more risk involved in being depressed and not treated than in being treated effectively on a drug.'

The validation group noted that employment sectors vary in terms of their policies relating to medication. Occupations such as train operation and off shore working have strict policy relating to psychotropic drugs including alcohol. It was commented that this may deter some operators from notifying their employers that they are taking medication due to the risk of losing their job. As an occupational health expert commented:

'Individuals don't tell managers because they know their job may be at risk but there are also other reasons - maybe more to do with personal privacy or the stigma.'

It was suggested that measuring the effects of prescribed medication on work performance might avoid operators having to automatically stand down.

8.6 HEALTHCARE AND PATIENT INFORMATION

It was argued that GP's need to 'sell' the benefits of medication to their patients, giving full and detailed information about the condition and its symptoms and the effect of the medication prescribed. A health care practitioner stated:

'It's very hard when I'm starting someone on antidepressants to tell them they will probably feel worse for the next couple of weeks. It's going to take a couple of weeks for them to work and if that hasn't been sold they will get tangled up they'll think "oh the tablets are making me more tired I feel worse." The important thing is the way it is sold. It is important to give information very early on in the process so people are aware of what those tablets are going to do to them and what they are not going to do to them.'

Regular follow up in the initial stages of treatment was recommended to explain to patients that the benefits of the medication would not be seen immediately. In the case of some drugs, such as Prozac, patients may experience heightened anxiety initially and they should be prepared for this possibility.

Compliance with medication was recognised as an important issue but this was thought to be less of a problem with the more recent drugs which have fewer side effects. Lack of compliance was associated with the early stages of treatment, when patients may feel worse and also later when patients start to feel better and decide they no longer need the medication. A health care practitioner remarked:

'In the early stages that's the time when they are still feeling rotten and they've got the side effects of the drugs. In my practice I see people one to two weeks after they have started the medication and then at 4 weeks. An issue for us is keeping people on their medication after they feel better. Keeping them on the medication after they feel better for 4 to 6 months will reduce the risk of their relapse for up to 2 years.'

It was also noted general practice patients normally retain only 30% of the information given to them in a consultation and patients suffering with depression or anxiety would probably retain less than this. Hence it was believed to be important that GPs took time to explain to patients what they should expect from their medication.

The validation group acknowledged that patients are concerned about long term management, duration of treatment and discontinuation effects.

'There's also an issue about psychological dependency and people do certainly feel a psychological dependency on the drug if that's what they feel has got them better. The thought of coming off is actually very frightening because people are very, very anxious about getting back to how they've been. Once you're out of the quagmire, you really don't want to go back, so that can fill you with a huge amount of trepidation. So there can be a psychological dependency.' [mental health care practitioner]

'The modern anti-depressants, SSRI's and so on, do have a discontinuation reaction, which will come on if you miss the odd dose. I can see why people think that they've got a dependency on it.' [health care practitioner]

It was noted that patients sought information from a wide range of sources. Patient information leaflets provided with the medication were considered unhelpful to patients. They were described as *'not really an information leaflet. It's a cover my back leaflet for the manufacturer'* and thought to be of limited use to patients. There were doubts about the accuracy and reliability of information on medication gathered from the internet, as a mental health care practitioner remarked:

'people come with all sorts of things from the internet, some of which is very accurate and very useful, some of which is very inaccurate and very unhelpful.'

Information on psychotropic drugs and their actions provided by the Royal College of Psychiatrists was widely regarded as helpful. A health care practitioner remarked:

'The Royal College of Psychiatry leaflet is brilliant, it's short, it's snappy, it covers all the issues and I've given it to lots of patients and they all come back saying, "I'm so glad I had that leaflet because I could show it to my family and it explains to them how I was feeling. I didn't have to do the explaining." It covers medication, and alternatives to medication.'

It was felt that many people are strongly influenced by information given by friends and family. This information often related to earlier generations of psychotropic medication and was not strictly relevant to current treatments on offer.

8.7 SELF MEDICATION

The risks associated with self-medication such as alcohol, herbal products and caffeine were discussed. The use of alcohol was identified as a particular work hazard. People with anxiety and depression use alcohol to help them cope. This can make depression worse and has associated safety risks. As this health care practitioner commented:

'Alcohol is often used as a self medication. It's not a very effective self medication. It contributes to the problem. If we don't look for it we are going to be less effective in treating a depression.'

It was suggested that it was important to ascertain how much people were drinking, normalizing the use of alcohol to alleviate problems enabled people to talk about it and give a truer picture of the amount they drink.

Self-medication with herbal products such as St Johns Wort and Rescue Remedy may be used in larger doses than prescribed. Caffeine was also considered to be a problem when used in excess.

Table 19 details the themes and sub themes resulting from discussions with the validation group.

Table 19
Themes and sub themes from the validation exercise

THEMES	SUB THEMES
Important to identify causes of mental health problems in the workplace	Inability to cope with work could be a cause of anxiety and depression or a symptom Managers and employers need to be aware of changes in performance, often a key to early identification of problems People with anxiety and depression may have inaccurate perceptions of their work
Mental health related to relationships in the workplace	Redeployment may not be sufficient People may be unwilling to complain when there is a problem Investigating a department where people were off ill or that was performing atypically may identify 'hot spots' of stress
Mental health in the workplace should be given a higher profile in organisations	Managers need: - training in people management - information relating to mental health problems, their impact on work and effects of medication
Prevention of mental health problems should be addressed	Measures to prevent or identify problems: - management and HR policies - appraisal system - feedback systems
Organisations have a responsibility to the mental health of their employees	Large organisations have better communication and support networks Provision of counselling services may be cost effective for some employers
Industrial relations closely related to mental health problems	Union and welfare representatives have an important role Managers have a difficult task of balancing the needs of staff with organisational needs
Untreated depression and anxiety may be greater safety risk than medication	Policies relating to medication may deter employees from reporting that they are taking medication
Patients need accurate information about their condition and effects of medication	Problems with compliance can be countered with information and reassurance by GPs Patient information leaflets issued with medication of limited use Patients seek information via the internet, family and friends
Self medication with alcohol, alternative remedies and caffeine may pose a safety risk at work	

9. OVERVIEW OF FINDINGS

9.1 EFFECTS OF ANXIETY AND DEPRESSION

Many people stated that they were initially unaware that they were suffering from anxiety and depression and it was typically family or colleagues who first recognised the problem. Sometimes it took a crisis at work to make them acknowledge that they were unwell.

Anxiety and depression were associated with a wide range of physical and psychological symptoms. Physical symptoms included: nausea, headaches, dizziness, trembling, insomnia and lack of energy. Psychological symptoms involved: inability to concentrate, extreme emotional distress and lack of motivation. These symptoms impaired work performance and respondents felt that they were unable to cope with the demands of their work. Respondents tried to hide their emotions and maintain a calm appearance while at work but this was very difficult and they felt their home life suffered as a result.

9.2 EFFECTS OF MEDICATION

The side effects of medication were reported to be similar to the symptoms of anxiety and depression including: confusion, dizziness, shaking, nausea, weight loss, sleep disturbance, difficulties with decision making. Respondents felt their medication made them unreactive to events and they no longer cared about things, including their work. Concentration and memory were thought to be particularly affected to the extent that performance at work was considerably impaired. Impaired work performance was reported across all the employment sectors represented by the study participants.

9.3 COMPLIANCE WITH MEDICATION

Non-compliance with medication for anxiety and depression was very common. Individuals took less than the prescribed amount of medication and they often discontinued treatment due to side effects, or because their symptoms had not initially improved or because they felt worse. Demyttenaere (2001) has argued that poor compliance with antidepressant medication is widespread, and is a major obstacle to the effective management of depression, even with the newer well-tolerated antidepressants. This author suggests that prescribing physicians should ensure that they choose an effective antidepressant with minimal side-effects and actively explore the patient's beliefs and attitudes at the time of treatment. Addressing common misconceptions about antidepressant medications, and undertaking a structured follow-up, have been shown to enhance compliance and improve treatment outcomes.

9.3.1 Side effects

Participants in this study reported a range of unpleasant side effects that they experienced when taking medication. This concurs with a growing body of evidence which suggests that even newer generation antidepressants are by no means free of side effects. Glenmullen (2000) documented the side effects associated with Prozac and other serotonin-boosting medications. These include neurological disorders, such as facial and whole-body tics; sexual dysfunction; debilitating withdrawal symptoms, including visual hallucinations, electric shock-like sensations in the brain, dizziness, nausea, and anxiety.

9.3.2 Addiction

In addition to compliance problems at the start of treatment, respondents further on in their course of treatment tended to cease medication as soon as they started to feel better, often due to concerns about addiction. Many respondents were convinced that they had become dependent on their medication despite being assured by their GPs that the newer antidepressants are non-addictive.

Recently, a discontinuation syndrome has been identified for SSRIs and other new antidepressants. After abrupt and even gradual withdrawal from these agents, the syndrome presents with somatic symptoms of disequilibrium, gastrointestinal symptoms, flu-like symptoms, disrupted sleep, and sensory disturbances as well as psychological symptoms of irritability, crying spells, and anxiety or agitation (Rivas-Vazquez et al., 2000). A characteristic selective serotonin reuptake inhibitor (SSRI) discontinuation syndrome exists which commences within 1 week of stopping treatment and consists of dizziness, nausea, lethargy and headache (Haddad, 1998). Some of the symptoms seen on SSRI discontinuation, such as nausea, lethargy, insomnia, and headache, are similar to those reported with tricyclic discontinuation. However, SSRI discontinuation is also associated with novel symptom clusters, including problems with balance, sensory abnormalities, and possibly aggressive and impulsive behaviour (Haddad, 1997).

The dependency effects described by the respondents in this study were confirmed by the health professionals that took part in the validation panel. They acknowledged that patients do experience both a psychological dependency and a physical discontinuation reaction with SSRIs and other modern anti-depressants.

9.4 PATIENT INFORMATION AND PATIENT MONITORING

While a few respondents felt well informed about their medication, most people believed that they were not given sufficient information from their GP regarding mechanisms by which the medication works and the possible side effects they might experience. Many people were unprepared for the fact that their medication could make them feel worse initially. Respondents said that when they were given accurate information about their medication they were more likely to comply with the treatment regimen. This result was supported by health professionals that took part in the validation group who felt that GPs need to 'sell' the benefits of medication to their patients and that poor compliance can be countered by giving patients adequate information as to what they should expect from their medication. Careful patient monitoring and information provision was believed to be important at the start of treatment, when the medication may not initially improve their symptoms, or indeed may make them feel worse, and later on when patients feel better and are tempted to prematurely discontinue their medication.

The patient information leaflets issued with medication were considered to be comprehensive in detailing side-effects, but the extent of the information presented in leaflets could vary considerably depending on the brand of drug provided by the pharmacist. It was also felt that the purpose of these information leaflets was as a disclaimer for drug companies rather than information for the patient. Members of the expert panel noted that patients are influenced by information gathered from the internet, official information sources (e.g. Royal College of Psychiatry leaflet) and family and friends. Information from family and friends often related to older generations of psychotropic drugs and thus gave patients inaccurate perceptions and expectations.

Participants felt that there was a good deal of trial and error in the medication treatments they received. Most respondents had their drug regimens reviewed on a regular basis, however it was

often the case that the same GP could not be seen. Respondents felt there was a lack of continuity in the care and that GPs were not always familiar with the medication or the range of services available to the patients. Some participants felt that they were being prescribed medication each time without any questioning or further exploration from their GP. It was often only when they were referred to a specialist, i.e. psychiatrist or clinical psychologist, that they felt treatment options were fully discussed and underlying causes of their illness were addressed. Access to such services varied considerably among the participants in the study.

9.5 SAFETY AT WORK

Employees found it difficult to distinguish between the effects of the symptoms and the effects of the medication. They felt that the side effects of the medication/symptoms they experienced resulted in: confusion, dizziness and lack of concentration. They believed this impaired their ability to operate at work and made them more liable to accidents. Participants described a range of accidents, which they attributed to their condition or medication, including falls, minor injuries and industrial injuries. Driving was thought to be particularly badly affected, due to poor concentration and fatigue.

Respondents with occupations with responsibility for others (teachers, health care professionals, mechanics and electricians) felt they were at particular risk with respect to the impact of anxiety and depression and the medication for these conditions on their work. Health care professionals acknowledged that they sometimes put themselves and their patients at risk. The risks highlighted by health care workers related to impaired clinical judgement and making clinical errors, handling hazardous materials such as blood, administering drugs and needle injuries.

The validation group noted that occupations vary in terms of policies relating to medication. Some organisations e.g. public transport have very strict policies relating to psychotropic drugs and it was felt that this may deter employees from notifying their employers that they are taking medication. It was suggested that conducting risk assessments relating to medication could avoid workers having to stand down from their job. Untreated anxiety and depression was also considered to be a safety risk. Self treatment for anxiety and depression, including the use of alcohol, herbal products and caffeine were also identified as potential safety risks in the workplace.

9.6 RELATIONSHIPS WITH COLLEAGUES AND MANAGERS

Many respondents felt that anxiety and depression were stigmatised and so were reluctant to tell people at work about their illness. Respondents often felt isolated in their inability to cope. They thought that if they disclosed their condition they would be treated differently and that their career prospects would be impaired. They perceived a lack of understanding about the nature of anxiety and depression among their colleagues and managers. Some participants felt able to tell their colleagues but not their managers. Employees felt they could speak in confidence to occupational health staff but were more guarded about personnel and human resources staff. It was commented by some that their GP would sign them off work with non-specific diagnoses.

9.6.1 Support for employees with anxiety and depression

Employees found it difficult to get help in the early stages of developing anxiety or depression. It often took a crisis situation before they received support. Many respondents felt that they were forced to give up their job. Lack of flexibility in the workplace meant that there was little scope for maintaining people with anxiety and depression at work. Support from managers

varied. While some participants had very supportive managers, many workers felt that their managers were dismissive and offered little help. Participants commented that colleagues often provided practical support and the opportunity to talk about problems. These important networks were often lost when people were on sick leave.

Most respondents in this study believed that unmanageable workloads contributed to the development of their anxiety and depression. Managers, in particular, felt that they had to cope with ever increasing workloads and responsibilities without adequate resources. The validation group acknowledged that managers have a difficult task in managing people with anxiety and depression, and that such employees may have inaccurate perceptions about the standard of their work. Maintaining employees with mental health problems at work necessitates a degree of understanding and sensitivity from managers.

Participants said that they would welcome practical help with workload, support services from occupational health departments, counselling services or just a quiet confidential chat/discussion. While people with anxiety and depression did not always require time off work, periods of sickness absence were thought to be detrimental to work relationships and longer term career progression.

Workers with anxiety and depression were concerned about the impact of their illness on their long term job prospects. A study by Glozier (1998) suggests that their concerns are well founded. Glozier conducted a survey of HR directors in UK companies to determine whether attitudes prejudice employment opportunities for applicants with mental health problems. Participants were presented with vignettes of job applicants identical except for diagnosis. It was found that a label of depression significantly reduced the chance of employment compared with diabetes.

9.6.2 Awareness of mental health issues in the workplace

Participants felt that there needs to be greater awareness of mental health issues in the workplace and that training should be provided to help managers understand the conditions and offer appropriate support to workers. They also felt that organisations should conduct risk assessments for mental health. This view was fully endorsed by members of the validation group. They felt that mental health should be an integral part of the health and safety training managers receive and that managers should be fully trained in people management and communication skills. It was acknowledged that information already exists on mental health in the workplace, but it was felt that this could be further developed to provide information on the prevalence of mental health problems and to explain how these problems impact on employees and organisations.

The stigma and lack of understanding about mental health issues in the workplace highlighted in this study concurs with research in the community which shows that people do hold negative beliefs about depression. Knowledge and beliefs about mental illness show that the general population recognise social environment factors and traumatic events to be likely causes of depression, however they also associate depression with weakness of character, generating the stigma associated with mental illness (Jorm et al., 1997). Among employers, lack of knowledge of mental illness was seen to affect their readiness to believe sick-notes declaring a physical illness rather than a mental illness (Manning and White, 1995). Hence, there is clearly a need to provide managers and organisations with accurate information about anxiety and depression and how these conditions impact on the working life of employees.

9.7 THE ORGANISATIONAL PERSPECTIVE ON MENTAL HEALTH IN THE WORKPLACE

Representatives from human resources, personnel, occupational health and health and safety departments drawn from a wide range of private and public organisations stated that they had no specific policy for the recruitment of employees with mental health problems. Candidates for posts might be screened in pre-employment questionnaires for previous histories of mental health problems or they would receive a health screening from doctors within the organisation prior to starting work. Where candidates disclose a history of mental health problems, a risk assessment may be conducted, but it was felt that candidates were unlikely to disclose such information and that there is probably a high level of unreported psychiatric morbidity in the working population. The Disabilities Discrimination Act (DDA) legislates against discriminating on grounds of disability. However it was commented that candidates with mental health problems may have lengthy sickness absences on their records and that this could disadvantage them in applying for new positions.

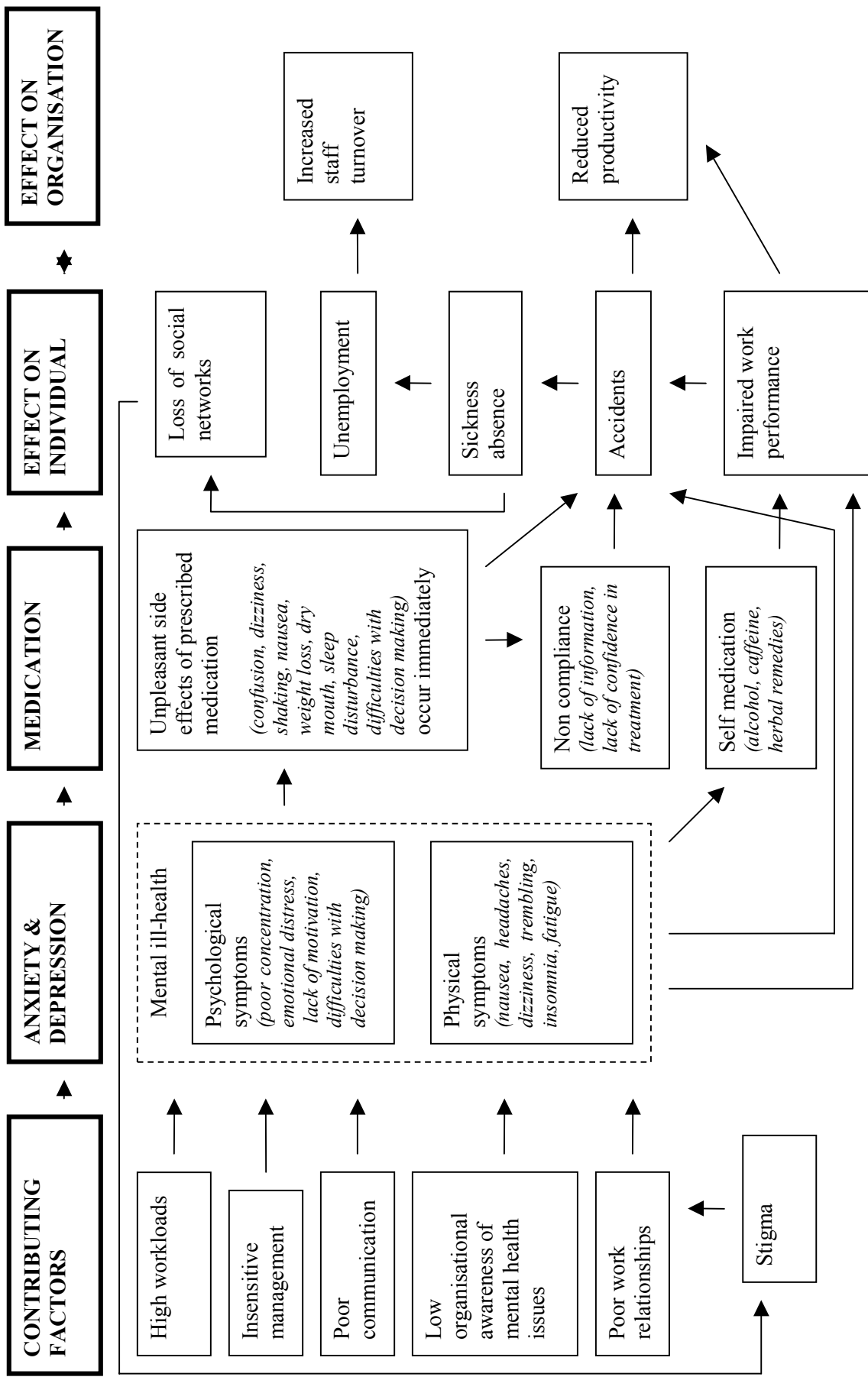
The type and extent of support offered to employees with mental ill health varied according to size and culture of the organisation and the type of work undertaken. SMEs generally have little to offer their staff in terms of mental health provision. Lack of flexibility in the workplace made it difficult to accommodate changes in jobs to assist staff with anxiety and depression. When staff are off sick it was thought to be important to remain in contact, however it was commented that this could make some employees feel pressured about returning to work. Rehabilitation may involve phased returns to work. It was felt that there is a need to assess any risk associated with medication and there should be liaison between the GP and the organisation.

Anxiety and depression in the workplace are linked to management methods and managers are often unaware of, or unwilling to use, organisational policies that exist to assist workers experiencing problems. Managers themselves may be under considerable pressures and so may find it difficult to support their staff. It was thought that there is a need to raise the profile of mental health issues in the workplace. Mental health should be included in health and safety training for managers and managers should be trained in both management and communication skills. Risk assessments should be conducted, where staff asked about how stress might be reduced in the workplace. Risk assessments are fraught with problems and organisations need valid tools to measure workplace stress. Information should be gathered from a range of sources (questionnaires, appraisals, staff comments in meetings, sickness absences, exit interviews). This data should be stored in an easily retrievable form and regularly reviewed. Finally organisations need to build effective communication networks.

9.8 SUMMARY

The discussion above demonstrates that anxiety and depression and the medication prescribed for these conditions significantly impact on health and safety at work. At the individual employee level the conditions and medication are associated with impaired work performance, accidents and poor job satisfaction. At the organisational level there are likely to be effects on productivity, staff morale, accidents, sickness absences and increased rates of staff turnover. The following diagram represents these inter-relationships as a schematic model.

FIGURE 1 SCHEMATIC MODEL OF THE FACTORS CONTRIBUTING TO ANXIETY AND DEPRESSION AND THE IMPACT OF THESE CONDITIONS ON SAFETY AT WORK



10. IMPLICATIONS OF FINDINGS

10.1 IMPLICATIONS FOR EMPLOYEES

The accounts from workers in this study indicate that they initially lacked insight into their condition and attributed their symptoms to physical illness. Since early recognition of anxiety and depression is important in effective treatment, it seems appropriate to recommend that resources be developed to help employees become more aware of mental health issues. Jorm et al. (1997) have used the term ‘mental health literacy’ to describe components for the recognition, management and prevention of mental illness:

- ability to recognise specific disorders
- knowledge of how to seek mental health information
- knowledge of risk factors and causes
- knowledge of treatments and of professional help available
- attitudes that promote recognition and appropriate help seeking

Information relating to mental health in the workplace could be an integral part of health and safety information supplied to employees and managers by their organisations. This would help to reduce the stigma associated with anxiety and depression, which was widely reported by workers in this study. It would promote the early recognition of problems and active seeking of help in the initial stages of the conditions. An important aspect of this information provision should be an explanation that workers suffering with anxiety and depression are potentially at risk of accidents and injury due to impaired concentration, decision making, memory and physical symptoms such as dizziness, trembling, nausea, headaches and fatigue.

10.2 HIGH RISK OCCUPATIONS FOR ANXIETY AND DEPRESSION

The personal experiences described in this study suggest that workers with responsibilities for others (health care workers, teachers and managers) are particularly at risk of developing anxiety and depression. Moreover, these groups, by virtue of their responsibilities, represent an important health and safety risk in the workplace.

The experiences described by teachers, managers and health care workers in this study are in line with other research. A number of studies have indicated that teachers have a high prevalence of anxiety, worry, and fatigue compared to other occupations (Travers and Cooper, 1996; Cropley et al., 1999). A recent survey of a random population sample, has shown that 20% reported very high or extremely high levels of stress at work (Smith, 2000; Smith et al., 2000a) and stress is highest among teachers, nurses and managers (Smith et al., 2000b).

It would seem there is a strong case for focusing on the mental health of these particular groups of workers, both in terms of future research and policy formation. More research is needed to focus on the occupational health of employees with responsibilities for others including: workers in health and social care, managers and teachers. This work should explore the particular aspects of these ‘high risk’ occupations that contribute to psychological ill health and determine what organisational factors mediate against the development of mental health problems.

10.3 IMPLICATIONS FOR HEALTH CARE

A major finding of this study is that people were unprepared for their medication. Non-compliance with medication was very common. In the earlier stages of treatment this was due to: unpleasant side effects, lack of symptom improvement or the medication making people feel worse. Further on in the treatment, patients often ceased their medication as soon as they started to feel better because they were concerned about becoming dependent on the medication. Respondents felt there was a good deal of trial and error in their treatment regimens and they lacked confidence in their treatment.

People sought information from the internet, books, friends and family. Information from family and friends tended to relate to older generations of drugs and was not relevant to current medication. Information from the internet was of variable accuracy. Information leaflets provided with medication were very limited in their usefulness to patients, tending to focus on side effects and offer little in the way of practical advice. While some good sources of information do exist (leaflet from the Royal College of Psychiatrists is a notable example) there is clearly a need to develop accessible and accurate information. This information should describe the range of drugs available, their actions, side effects, implications for performance and safety at work and what patients should expect in terms of symptom improvement.

General practitioners and others involved in the health care of people with anxiety and depression need to engage their patients in the treatment process. Patients require explanation of: the chosen course of treatment, what to expect from the medication and potential safety risks. Patients concerns about dependency also need to be discussed. Health care professionals, and GPs in particular, have very limited consultation time, so effective patient information leaflets that can be handed to patients during the consultation would be a valuable tool for doctors. Careful initial preparation and regular monitoring of patients at the start of treatment is likely to improve compliance, patient satisfaction and long term prognosis.

10.4 IMPLICATIONS FOR EMPLOYERS

All the participants in this study (workers, staff from human resources, personnel, occupational health and health and safety and departments and validation group members) believed that there is a need for greater awareness of mental health issues in the workplace.

10.4.1 Managers

Mental health should be an integral part of the health and safety training that managers receive. Training needs to be provided for managers to help them:

- ◆ understand the nature of anxiety and depression
- ◆ understand factors in the workplace that contribute to the development of these disorders
- ◆ become aware of the safety risks associated with these conditions
- ◆ become aware of the effects of medication on work performance and safety
- ◆ offer appropriate support to workers

Adequate training would enable managers to look for early warning signs such as changes in behaviour or work performance which may signal problems. Where a member of staff has been diagnosed with anxiety and depression, managers need to know that work performance may be

impaired and that there is a potential safety risk associated with both the symptoms and any medication. In particular, managers should appreciate that a member of staff prescribed medication for anxiety and depression may actually feel worse when they commence their medication and so they should be carefully monitored in the early stages of treatment.

It was widely acknowledged that managers face a difficult task trying to reconcile the needs of their staff with the requirements of the organisation and indeed managers are themselves at high risk of stress related disorders. Hence managers will require support in managing staff with anxiety and depression and this can be provided from occupational health, health and safety, human resources and personnel departments. To maintain workers with anxiety and depression in the workplace and rehabilitate people returning to work, managers should be acquainted with policies in the organisation and services available to help their staff.

Information and guidance for managers on mental health in the workplace already exists (e.g. *Tackling work-related stress: a guide to improving and maintaining health and well-being*, HSE, 2001b). This could be further developed to focus on specific mental health problems such as anxiety and depression. Such information would outline the nature of these conditions, prevalence of these disorders and, in particular, how these problems affect employees performance and safety at work, prognoses of these conditions and treatment options available.

Managers may require guidance on maintaining people with anxiety and depression in the workplace, which may involve modifying workloads or the range of tasks staff undertake and providing workers with access to formal and informal counselling services. Managers need support from occupational health, health and safety, human resources and personnel staff in the rehabilitation of workers following sick leave for anxiety and depression. Rehabilitation might involve phased return to work, being excused front line duties such as meetings or dealing with the public until the worker feels able to regain their full role in the organisation. Occupational health staff may need to conduct an assessment of risk relating to medication when the employee returns to work and this should involve liaison with the GP or other health care professionals involved in the treatment of the employee.

10.4.2 Organisations

There was a widespread view that organisations should conduct risk assessments relating to mental health in the workplace. Staff should be asked about how stress might be reduced in the workplace. However such risk assessments are fraught with problems. Organisations need valid tools to measure workplace stress and expertise within the organisation (or access to external agencies) to administer, analyse and interpret the findings of surveys. An alternative technique, might involve the use of focus groups, which as this study shows, can generate detailed information on workers experiences.

Information can be gathered from a range of sources: questionnaires, appraisals, staff comments in meetings, sickness absences, productivity data, staff turnover and exit interviews. It is very important that such data is stored in an easily retrievable form. The data needs to be analysed, interpreted, regularly reviewed and the findings acted upon.

The workers in this study, organisational representatives and validation group felt that anxiety and depression are associated with:

- ◆ impaired job performance
- ◆ risk of accidents
- ◆ poor job satisfaction

- ◆ high levels of staff turnover

Addressing the issue of anxiety and depression in the workforce and assessing the needs of employees may help to reduce organisational costs. The validation group felt that given the long waiting list for counselling services in the NHS, providing in-house services or facilitating access to outside services may well be cost effective for many organisations.

The findings of this report and the recommendations outlined relate directly to the Government's occupational health strategy (Health and Safety Commission, 2000) to stop people being made ill by work; help people who are ill return to work; and improve opportunities for people not currently in employment due to ill health. This strategy has set a number of targets to be achieved by 2010 and the recommendations pertain to 3 of these targets:

- ◆ 20% reduction in work-related illness
- ◆ 30% reduction in the number of working days lost due to work-related ill health
- ◆ everyone currently in employment but off work due to ill health or disability is, where necessary and appropriate, made aware of opportunities for rehabilitation back into work as soon as possible

Prevention of mental health problems, such as anxiety and depression, should be an important goal for organisations both large and small. Early detection and management of mental health problems in the workplace can be achieved through good management and human resource policies being implemented, and through effective communication networks and feedback systems in the organisation. These measures, combined with the careful rehabilitation of workers with anxiety and depression, may offer significant benefits to organisations in terms of reducing accidents, sickness absence and staff turnover and enhancing staff morale and productivity.

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APPENDIX 1

FOCUS GROUP SCHEDULE FOR EMPLOYEES AND

MANAGERS

Anxiety and depression and use of prescribed medication: effects on working life

Schedule – 1 – individuals with anxiety and depression

Arrival & refreshments - set the scene informally

Introduction – introduce ourselves - briefly

Thank you very much for agreeing to take part in this focus group. Your help is much appreciated. As you know, we are interested in the ways that anxiety and depression may influence working life and how medication prescribed to treat these symptoms may influence performance at work and relationships with colleagues. The findings from these discussions will help with future guidelines for employees and employers.

What is a Focus Group?

A focus group is a group discussion with moderators. We are moderators, and our role is to provide you with topics to discuss among yourselves. There are no right or wrong answers to any of the questions we might ask you today so please talk freely, we very much want to hear your opinions and experiences. At times we may guide you with regards to time, or to introduce another theme for discussion. The discussions should be fairly informal and, although we will tape the conversation these tapes will be destroyed and all the information from them will be confidential to the research team and will be collected together and reported upon anonymously.

(REITERATE – we are here to listen to and guide the conversation topics, so please talk among yourselves as you would with any similar discussion).

Themes – ON FLIP CHART/WALL FOR REFERENCE

These are the four themes/topics we would like you to discuss today

- 1. Do your symptoms of anxiety or depression affect your work?**
- 2. Does the medication you are prescribed affect your work performance?**
- 3. Have you ever decided not to take your medication because of concerns about side effects?**
- 4. Are your colleagues, supervisors and managers understanding and helpful with regard to your anxiety/depression?**

Introductions

**Perhaps we could start the discussion by everyone introducing themselves
START WITH MORE DETAILS OF OUR ROLES**

Experience of anxiety and depression

As an introduction to the discussion we have a couple of quotes from newspaper articles which we would like your comments upon.

- *October 12, 2000* –
‘Depression in the workplace is the second most disabling illness for workers after heart disease.’ (UN report)
- *January 30, 2000* –
‘It is difficult to know when you are dangerously stressed because....symptoms are so diverse and the build up to crisis is gradual. Often it is other people who first notice that something is wrong’ (Dr Cosmo Hallstrom, Charter Clinic, Chelsea)

Topic 1

Do your symptoms of anxiety/depression affect your work?

(prompt: performance, ability to cope, satisfaction with work, relationship with colleagues)

CAN YOU GIVE EXAMPLES?

Have your symptoms ever caused you to have accidents or near misses (where you narrowly avoided an accident) at work?

CAN YOU GIVE EXAMPLES?

Experience of drugs used to alleviate anxiety and depression

Topic 2

Does the medication you are prescribed affect your work performance?

(prompt: tiredness, dizziness, memory, reaction time, inability to concentrate)

CAN YOU GIVE EXAMPLES?

When you first started taking your medication, what effect did it have on:

- your symptoms
- your work performance?

Have you ever had an accident or near miss in your workplace that you feel was connected with taking this medication?

CAN YOU GIVE EXAMPLES?

Were you given enough information by health care professionals (e.g. general practitioner, hospital doctor, pharmacist) when the medication was prescribed?
Is your medication reviewed on a regular basis? HOW OFTEN?

Topic 3

Have you ever decided not to take your medication because of concerns about side effects?

Topic 4

Relationships with colleagues

Are your colleagues/supervisors/managers understanding and helpful with regard to your anxiety/depression?

(prompt: do they know you have anxiety/depression, are they helpful, are they unhelpful)

CAN YOU GIVE EXAMPLES?

Do your colleagues/supervisors/managers understand your needs?

What practical help or support has been offered to you by your employers?

What kind of help/support would you ideally like to receive from employers/managers?

Final comments

Are there any other comments or experiences that you would like to discuss in relation to the impact of anxiety and depression on your working life?

We would like to thank you for taking part in the group this afternoon, the information you have given us will be extremely useful for the study. Could you spend a couple of minutes filling in this short questionnaire to give us a few further details and some feedback on today's discussion.

APPENDIX 2

**FOCUS GROUP SCHEDULE FOR ORGANISATIONAL
REPRESENTATIVES**

Performance effects of Psychotropic drugs – workers view

Schedule 2 – Organisational Perspectives

Arrival & refreshments - set the scene informally

Thank you very much for agreeing to take part in this focus group. Your help is much appreciated. As you know, we are interested in the way organisations manage mental health issues in the workplace. All of you this evening have been invited as you work in the areas of occupational health or health and safety. The findings from these focus groups will inform future guidelines for employees and employers. It is equally important for the research to know what isn't provided as well as what is provided.

Introduction – introduce ourselves fully

As we are unlikely to remember the names of the whole group would you fill in a name card for the table, your first name is sufficient if you are happy for us to use that.

What is a Focus Group – A focus group is a 'moderator' led discussion. This means that we provide you with topics to discuss among yourselves. We very much want to hear your opinions and experiences, there are no right or wrong answers to any of the questions we might ask you today so please talk freely. We may at times guide you with regards to time or to introduce another theme for discussion. The discussions

should be fairly informal and, although we will tape the conversation (for later transcription), these tapes will be destroyed and all data will be confidential to the research team and will be collated and reported upon anonymously.

(**REITERATE** – we are here to listen and guide the conversation, so please talk among yourselves as you would with any similar discussion).

THEMES – ON FLIP CHART FOR REFERENCE

What policies or practices does your organisation have with regard to recruitment of employees with mental health problems?

What support is offered by your organisation to employees experiencing anxiety and depression?

What rehabilitation measures does your organisation provide for employees returning to work following absence due to mental health problems?

Opening

Perhaps we could start with everyone introducing themselves. Please tell us your job title and a brief summary of your role at work.

Introduction to the subject

Use newspaper quotes to initiate discussion in general and for the tape.

- *January 30, 2000.*

‘It is difficult to know when you are dangerously stressed because....symptoms are so diverse and the build up to crisis is gradual. Often it is other people who first notice that something is wrong.’ (Dr Cosmo Hallstrom Charter Clinic, Chelsea, London)

- *October 12, 2000*

‘Depression in the workplace is the second most disabling illness for workers after heart disease.’ (UN Report)

- *January 30, 2000*

‘Definition of work related stress “A feeling that you are having demands put on you which you can’t meet. You’re chasing your own tail, trying to do more and more in a shorter space of time, until you can’t function”.’ (Martin Deahl, Consultant Psychologist, St Bartholemews Hospital London)

Recruitment

- | |
|---|
| 1. What policies or practices do the organisation you work for have with regard to recruitment of employees with mental health problems? |
|---|

(prompt: previous sickness absence records; GP reports; probationary periods)

- can you give examples?

Support in the workplace

- | |
|---|
| 2. What support is offered by your organisation to employees in the workplace experiencing anxiety and depression? |
|---|

(prompt: counselling; practical assistance e.g. designated support; ‘buddy scheme’; ‘time out’; private space)

- can you give examples?

2a Are there designated people to contact for support, when are they available?

2b Can tasks be delegated to relieve pressure of work?

2c Are there opportunities to communicate problems between employee and supervisor/manager?

Return to work

3. What rehabilitation measures does your organisation provide for employees returning to work following absence due to mental health problems?

(prompt: part time hours, modified work load, counselling)

4. What help do you feel organisations need in supporting employees with anxiety and depression at work?

Final comments

- 5. What do you think have been the most important elements of this discussion?**
- 6. Are there any other comments or experiences that you would like to discuss in relation to the management of anxiety and depression in the work place?**

We would like to thank you for taking part in the group, the information you have given us will be extremely useful for the study. Could you spend a couple of minutes filling in this short questionnaire to give us a few further details and some feedback on today's discussion.

APPENDIX 3
QUESTIONNAIRE FOR EMPLOYEE AND MANAGERIAL GROUP
PARTICIPANTS

Anxiety and depression in the workplace

Focus Group Discussion

Many thanks for taking part in today's discussion; before you go we would be grateful if you could answer a few questions.

1. What do you think was the most important point arising from today's discussion?

2. Were there any aspects of today's discussion you found particularly interesting?

3. Can you please tell us which medication you have taken to alleviate symptoms of anxiety the dosage you are taking and how long you have been taking this medication?

4. Can you please tell us which medication you have taken to alleviate symptoms of depression the dosage you are taking and how long you have been taking this medication?

5. Can you please tell us your age (for background information)

6. Is there anything further you would like to add?

Please return the completed questionnaire before you leave. Many thanks

APPENDIX 4

QUESTIONNAIRE FOR ORGANISATIONAL

RESPRESENTATIVES

Performance effects of psychotropic drugs

Organisational representatives

Many thanks for taking part in today's discussion; before you go we would be grateful if you could answer a few questions.

Which employment sector do you work in?

YOUR AREA OF WORK

Occupational health

Occupational Health and Safety

HR/Personnel

Other (please state)

1. **What do you think was the most important point arising from today's discussion?**

2. **Were there any aspects of today's discussion you found particularly interesting?**

3. **Is there anything further you would like to add?**

APPENDIX 5
INFORMED CONSENT FORM

Information for participants

Anxiety and depression and use of prescribed medication: effects on working life

The Department of Human Sciences at Loughborough University is conducting a study into the impact of anxiety and depression on working life. We are interested in the ways that anxiety and depression influence working life and how the medication used to treat these symptoms may influence performance at work and relationships with colleagues.

We aim to gather the information by conducting focus groups with employees in various employment sectors. The focus group will last approximately one and a half hours, it will cover issues such as: impact on work performance and safety; relationships with colleagues; support offered by colleagues and employers.

The purpose of this project is to understand the impact of anxiety and depression and to develop guidelines for employers and employees to help them manage the anxiety and depression in the workplace.

You are under no obligation to take part in this study and you may decide to withdraw at any time without giving a reason. Any information that is collected will be kept confidential and no names or identifying details will be disclosed.

If you would like any further information or if there is anything you do not understand, please do not hesitate to contact Sue Brown tel: 01509 228482 or Sarah Hastings tel: 01509 228481 Department of Human Sciences, Loughborough University.

Anxiety and depression and use of prescribed medication: effects on working life

Reply sheet and consent form

Please tick

I **agree** to take part in the study

I **do not** wish to take part in the study and understand that I do not have to give a reason.

If you agree to take part, please delete the following as necessary:

I understand that all the information obtained will be kept confidential
Yes/No

I understand that I am free to withdraw from the study at any time and without having to give a reason
Yes/No

Signature..... Date.....

Name (block capitals).....

APPENDIX 6
VALIDATION GROUP QUESTIONNAIRE

Anxiety and Depression in the Workplace

Validation group questionnaire

We would like you to take this questionnaire away with you to give you the opportunity to add further points which were not addressed in the meeting or which have occurred to you on reflection since the discussion.

The questions relate to the implications identified at the end of the presentation.

Implications for the workplace

What do you think could be done to improve identification and understanding of mental health problems in the workplace?

Do you have any further suggestions with regard to managing anxiety and depression among employees?

Do you have any suggestions for the development of effective reporting systems for mental health in the workplace?

Implications for healthcare

In what ways do you think patient information on the effects of anxiety and depression and prescribed medication could be improved?

How could patients be better supported during their treatment?

Thank you for taking the time to consider these issues further, please return completed questionnaires in the envelope provided.

APPENDIX 7

NAMES AND AFFILIATIONS OF EXPERT PANEL MEMBERS

Table 20
Expert panel members

Validation group members
Mr Chris Ball, National Secretary, Non-Profit Sector and Working Environment, MSF
Professor Traolach Brugha, Professor of Psychiatry, Brandon Mental Health Unit, Leicester General Hospital
Mr Neil Budworth, Principal Safety Advisor, Severn Trent Water Ltd
Dr Olivia Charlton, Occupational Physician, London Underground
Professor Amanda Griffiths, Professor of Occupational Health Psychology, Institute of Work, Health and Organisations, Nottingham University
Dr Bevis Heap, General Practitioner, The Surgery, Mill Lane, Belton
Mr Kevin Maguire, Senior Lecturer, Nottingham Trent University
Mr Doug Walker, Officer with Unison Health and Social Services, UNISON Branch Office, Nottingham
Dr Gary Willington, Clinical Psychologist, Stratford Mental Health Resource Centre



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