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Symptoms of depression and their effects on employment

Summary Report

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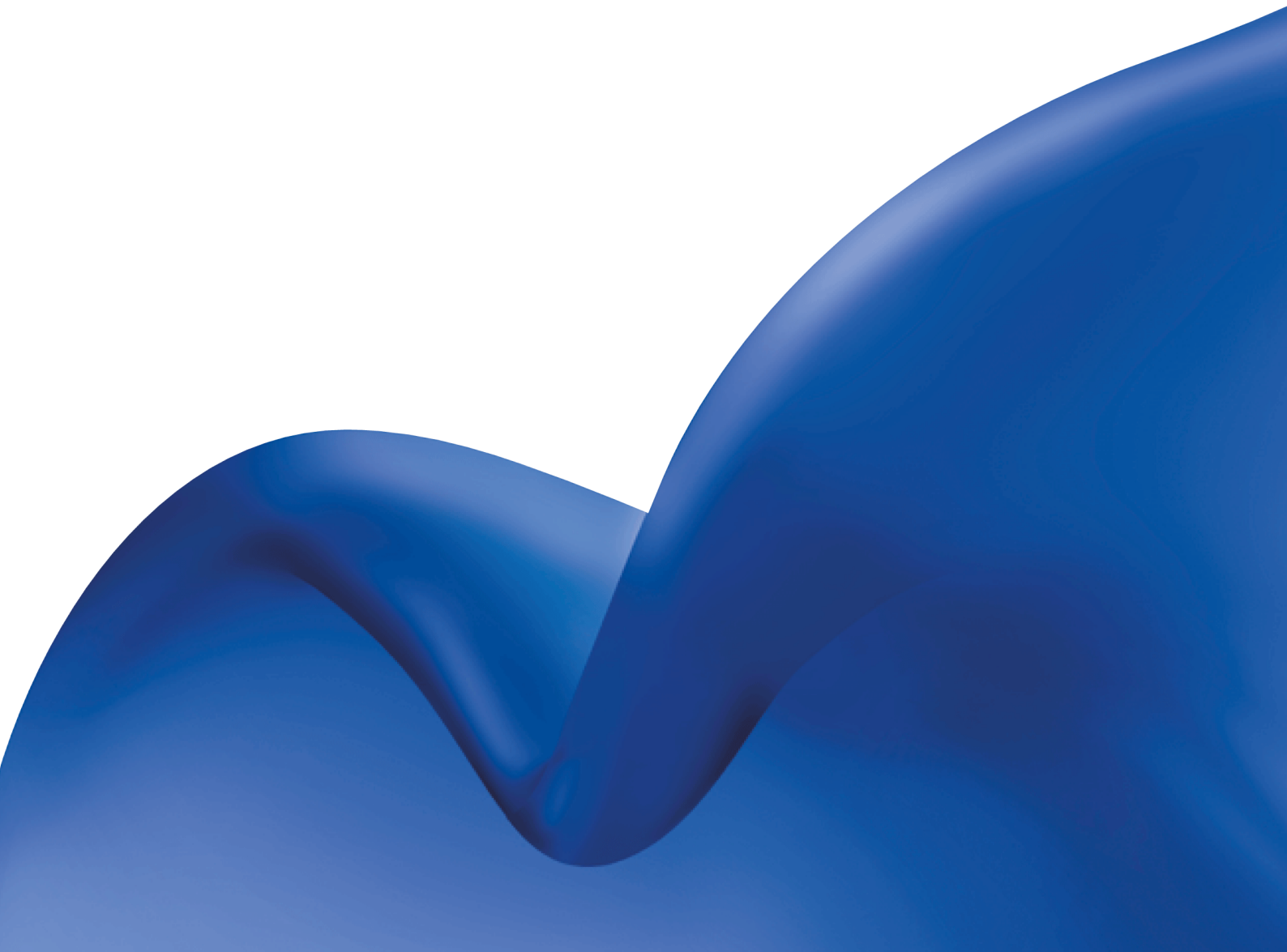

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Summary Report

Symptoms of depression can have a significant effect on employment outcomes, creating barriers in terms of retaining and obtaining employment. In this paper we consider both of these and the range of interventions and services which have an important role in improving employment outcomes for people with the condition – including health and employment services, both nationally and locally commissioned. **The authors argue that many of the working age people in the UK who experience symptoms of depression could be better supported to retain their jobs, as well as in finding employment, through changing the way treatment and vocational rehabilitation support is provided.**

In order to gain an in-depth understanding of how the symptoms of depression influence employment outcomes, and which interventions may improve outcomes, we reviewed the academic literature and conducted interviews with a number of experts including healthcare and vocational rehabilitation professionals from a range of settings in the UK.

Symptoms of depression as a barrier to employment

Mental health conditions affect 1 in 6 people of working age, with depression being one of the most common conditions. Depression is a heterogeneous condition, presenting differently in different people and is associated with a wide range of symptoms. It is characterised by persistent low mood and/or loss of pleasure or interest in most activities, as well as a number of associated emotional, physical, behavioural and cognitive symptoms.

The questionnaire studies included in the literature review (involving 46,513 individuals of working age with depression[1]) identified strong and mainly consistent evidence that poor cognitive dysfunction and other symptoms of depression have a negative impact on employment outcomes. There is also moderate and mixed evidence that older age and co-morbidity, and moderate but consistent evidence that higher symptom severity and lower educational level, act as barriers to employment in people experiencing depression.

Experts agreed that symptoms of depression were highly significant in terms of impact on employment. The symptoms most often seen as problematic were low mood, lack of motivation or interest, difficulty concentrating, being easily distracted and negative thinking. These were seen as potentially difficult for both job retention (e.g. difficultly getting to work, completing work tasks and engaging with colleagues) as well as creating barriers to seeking employment (e.g. lack of motivation and self confidence to try).

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

[1] Approximately 80 per cent of whom had a diagnosis of unipolar depression.

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

Where symptoms negatively affect an individual's work performance, e.g. poor concentration might lead to mistakes; this might exacerbate low self-esteem and self-confidence, further influencing ability to work. Where employers are unaware of such symptoms, they may see a change in an employee's work performance as a performance management issue rather than a result of a health condition. This was suggested as particularly problematic where symptoms of depression become chronic and remain a long time after a period of treatment.

This cycle of negativity is also a factor in unemployment, where being unemployed may be felt to give more weight to an individual's negative view of themselves and possibly worsen their symptoms.

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

All experts highlighted, however, that the experience of depression and the consequences it might have for employment are entirely personal and may be experienced very differently by different people despite having the same diagnosis.

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

Interventions to support employment for those experiencing symptoms of depression

A range of interventions are seen as having an important role in improving employment outcomes for people experiencing symptoms associated with depression. Evidence for these can be found in both the academic literature as well as anecdotally through the expert interviews.

The questionnaire studies included in the literature review involved 6,435 individuals, approximately 95 per cent of whom had diagnosis of unipolar depression. The review identified positive, moderate quality evidence that psychological interventions, especially those using Cognitive Behavioural Therapy (CBT) approach combined with either antidepressant medication or work-focused psychological approaches, are effective in improving employment-related outcomes of people with depression. Inconsistent evidence exists, however, that clinical interventions (using drug therapies alone) are effective in improving employment related outcomes in people with depression.

The experts reflected the findings of the literature review, expressing a consensus of opinion

that psychological and occupational therapies have the greatest impact in terms of employment outcomes for people experiencing symptoms of depression, particularly when used alongside medication.

The commitment of Occupational Therapists to identifying and understanding the goals of the individual was seen as complementary to the treatment of symptoms. The experts felt they were often an important addition to multi-disciplinary care teams, though it was suggested that there was insufficient appreciation of the role of occupational therapy in supporting people with depression.

In addition, the experts called for improved recognition of the value of other therapies (e.g. behavioural activation), greater rigour in treatment and also for improved recognition and treatment of ongoing symptoms which can affect work as well as other aspects of an individual's life. Improving understanding about mental health among clinicians was also important – both in terms of improving awareness of the broad range of symptoms and in its relationship to employment.

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

"Keeping people in work it's so much better than them losing jobs and having to find them again" – Back to work support and job retention

Experts recommended that enhancing employment outcomes required more than treatment alone; specific vocational rehabilitation and support was discussed.

The integration of health and employment support – from Jobcentres to GP surgeries – was considered crucial in improving employment outcomes. Most importantly, integrated services were seen as very important for patients.

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

Experts were wary, however, of the ability of Jobcentre programmes to support people with depression back to work. Their role was often seen as having too narrow a focus on outcomes and being too impersonal in its approach to really be able to help people with depression.

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

In terms of job retention, several experts discussed the importance of the workplace for

offering support to someone with depression. Workplace adjustments can play an important role in managing symptoms and the effect they have on work, for example, by changing work tasks, allowing flexible working or providing additional support (e.g. a mentor or work coach). Such workplace adjustments are, however, underused for people with mental health conditions mainly because of a lack of understanding among employers about what they could do to support the employees experiencing symptoms of depression.

That's been one of the most difficult areas because it's easier often to think of making reasonable adjustments for people with physical disorders than mental health ones.

An important message for clinicians and employers, identified throughout the interviews, was that people do not have to be one hundred per cent well to return to work and for many people with depression return to work before full symptom remission can be very helpful. The Fit Note was designed to support this message; however the task of completing this for people with complex mental health conditions is likely to be too great for many GPs given their lack of specialist knowledge in occupational mental health. Thus they are not always well placed to identify needs and refer patients to specialised services.

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

Along with the Fit Note, the new Fit for Work[2] was suggested to have a potential role in retention support for those with depression. Some of the experts raised concerns that there would not be sufficient specialist knowledge among service providers and that it would not address fundamental issues such as waiting lists for NHS interventions in cases where an employer does not have its own occupational health or private health insurance provision.

It's not clear to me how detailed an assessment is going to be and the extent of psychiatric knowledge that any of the occupational physicians who are going to be part of this will have. This is quite fine grained stuff.

Effective back-to-work support for people who have experienced severe mental ill health is provided through the Individual Placement and Support (IPS) model of vocational rehabilitation. IPS services are locally commissioned in the UK (and therefore very variable) and involve the integration of employment support with mental health services. Locally commissioned retention services are rarer and are often described as being an add-on to back-to-work IPS rather than a specialist service in its own right. More evidence might be needed to ascertain what works for retention as separate from a back-to-work service, so quality services can be encouraged and developed locally.

IPS is not job retention, that's a different thing…. So I think there's probably a need to look more closely at what is job retention, what does it mean, and what kind of models work well?

[2] http://www.fitforwork.org/

Recommendations

This report makes recommendations about the ways in which employment outcomes for people with depression might be improved. Several of the recommendations made reflect those in other recent reports broaching the topic of mental health conditions and employment – these include reports from the OECD (2014), Mind (2014), the Taskforce on Mental Health in Society (2015), the Chief Medical Officer (Davies, 2014) and the think tank 2020 Health (Manning & Paxton, 2015).

1. Working better together

We need to improve the way that different stakeholders work together across the health and employment landscape – and actively encourage them to work together – to enhance support for people experiencing symptoms of depression. Better working with and between all stakeholders be they government, voluntary sector or employers should be fundamental to policy in this area.

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

We need to provide individuals with well-rounded, personalised treatment and support which reflects their life goals. However, often we see government health and employment services not working together, nor even in some cases sharing information and knowledge, likely negatively affecting their understanding or knowledge of an individual's needs.

It is recommended that:

- ***The DH and DWP jointly take action to improve access for people with mental health conditions to evidence-based employment support services across the UK. One way this might be achieved is through engaging with and encouraging local commissioners and key local bodies – including Clinical Commissioning Group, local authorities, NHS Trusts and the Jobcentre – to develop joint strategies to achieve shared outcomes around population health and employment. This might be accomplished by:***
    - ***Issuing joint commissioning guidance to encourage and support the pooling of resources to achieve shared local outcomes; or,***
    - ***Revising and aligning applicable outcomes frameworks to ensure that mental health and employment is a priority for all local stakeholders.***
- ***It should be mandatory for employment specialists to be introduced to NHS***

IAPT[3] teams in England, reflecting the original IAPT brief. Steps to incorporate employment specialist support into NHS psychological support provision in Scotland, Wales and Northern Ireland should also be undertaken. This might be achieved through a national model, led by DH and DWP in partnership, or as suggested in the OECD report this might also be achieved through joined-up local commissioning.

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

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

It is recommended that:

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

1.3 Improving capacity for knowledge-sharing between employers, individuals and clinicians. Enhancing employer knowledge about the needs of their employees is beneficial in terms of addressing stigma and the many implications that it has for workplace culture, as well as to improve their ability to make workplace adjustments which better support employees with depression to remain in work.

It is recommended that:

- ***A template for an employee-owned 'health at work' record is developed, to provide employees with a personalised and authoritative record on how their condition affects their work. This would highlight ongoing symptoms, what employers need to be aware of and what an employer can do to help them to stay in work. This should be piloted to ensure it is valuable for all***

[3] Improving Access to Psychological Therapy

stakeholders involved – employers, employees, GPs and other clinicians and occupational health.

2. Promoting the concept of employment as a health outcome

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

2.1 Employment as a health outcome and treatment goal for people with depression. According to experts, GPs signing an individual with depression off work sick for a long period of time could harm employment outcomes. Getting work on the agenda during primary care consultations might be a way of improving understanding about work and developing treatment plans which reflect this.

To this end, we recommend that:

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

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

Further it is recommended that:

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

- ***Medical Colleges continue to encourage clinicians (in particular GPs) to undertake training and CPD on the therapeutic benefits of vocational rehabilitation and employment for people living with mental health conditions.***

- ***The role of employment and its relationship to mental health are included in NHS psychological therapist training.***

3. Enhancing understanding and recognition of the symptoms of depression

In many cases depression goes unrecognised by individuals themselves, by their clinicians or by their employers meaning many people don't receive any treatment or intervention for their condition. Even where depression is diagnosed, some symptoms, including cognitive symptoms such as difficulty concentrating, may be missed. Any ongoing symptoms of depression missed in treatment (particularly if access to treatment is limited) can provide an ongoing barrier to work.

In order to improve employment outcomes for people with depression, we need to get better at recognising symptoms of the illness so we can provide the best support.

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

It is recommended that:

- ***Measures to increase awareness of mental health conditions are introduced into GP surgeries, for example, considering the reintroduction of the Patient Health Questionnaire 9 (PHQ-9)[4] as a Quality and Outcomes Framework (QOF) measure.***

- ***Training and guidance for clinicians involved in mental healthcare (in particular GPs and psychiatrists) emphasises the nature, role and likelihood of mood, cognitive and physical symptoms of depression and provides guidance on how to identify and treat them. A period of specific mental health training could be included within GP training as recommended in the Chief Medical Officer's report.***

- ***In some cases NHS-funded psychological therapy services should be provided on a long term basis, to improve the capacity to treat ongoing symptoms.***

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

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

It is recommended that:

- ***Mental health awareness and management training is provided to managers to enhance their understanding of employee needs. Training needs to be of a high quality, and evidence-based where possible – techniques such as psycho-education may be useful. As suggested in the recent report of the Taskforce on Mental Health in Society (2015), this might be incentivised through inclusion in professional management standards and employer accreditation schemes. Alternatively, tax breaks may provide an incentive.***

- ***As a minimum, employers are encouraged to know about local mental health support and services to which they might refer employees when there are concerns (e.g. the local IAPT).***

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

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

3.3 Recognising the barriers intrinsic to depression. The symptoms of depression (e.g. poor motivation, lack of interest and negative thinking) can in themselves provide barriers to accessing services. IAPT services may not always be easy for people to access. It requires proactivity from the individual who may have already waited weeks or months to be contacted by the service only then to be unable to engage due to poor health, be branded as a 'did not attend' and sent to the back of the queue. Though the pressure on NHS psychological therapies is acknowledged, more needs to be done to break down these barriers to access and to engage patients with the available services and support.

It is recommended that:

- ***A form of low-level Assertive Outreach[5] is developed and trialled to identify whether it can be used to improve engagement of patients with depression in treatment, in particular psychological therapy.***

3.4 Ensure the complexities of depression are a focus of Fit for Work. The service will need to be monitored to see how well it is reaching people with depression and how successful it is with supporting their long-term return to work. Fit for Work assessors will also need to recognise ongoing symptoms associated with depression, which might remain a long time after remission of other symptoms and continue to cause problems at work, possibly affecting the long term sustainability of the return to work.

[5] Currently used for people with a severe and enduring mental illness.

It is recommended that:

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

- ***Evaluation of Fit for Work should include specific attention to the management of depression in the longer term.***

4. Improving access to job retention support

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

4.1 Increasing focus on retention. External support for job retention was seen as limited – especially access to specific locally-appropriate, retention-related information (e.g. employment law and employee rights guidance) and advocacy and direct support with employers (e.g. attending meetings and explaining needs).

It is recommended that:

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

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

4.2 NHS as an exemplar of good practice. Positive role models can be used to drive change and improve practice. The NHS, as the provider of health services to the UK, should (as suggested in the NHS Five Year Forward View[6]) strive to be an exemplar of good practice in supporting employees with depression to remain in work and to drive positive change elsewhere.

It is recommended that:

- ***A requirement is placed on each NHS employer to provide:***
    - ***A Health and Wellbeing strategy which includes provision for interventions which focus on job retention and return to work for staff with mental illness.***
    - ***Minimum referral times for access to Occupational Health for people***

[6] http://www.england.nhs.uk/ourwork/futurenhs/

with mental health-related absence.

- ***Compulsory return to work plans for staff with depression after four weeks of absence.***

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

It is recommended that:

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

4.4 Improve access to treatment services for people in employment. Limited access to health services outside of working hours creates a further barrier to treatment for those in work who are seeking to remain in work. GP services are increasingly acknowledging this and there has been an (albeit slow) expansion of out of hours GP access. This has not thus far extended to the IAPT service in England.

It is recommended that:

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

5. Improving access to evidence-based interventions

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

5.1 Building the evidence-base on supported employment for people with depression. The better the quality of evidence, the better chances there are that we can

provide effective, quality services which improve employment outcomes. This is true at local and national level. In order to commission services, commissioners need to know 'what works'.

It is recommended that:

- ***Gaps in evidence around what works in terms of employment support for people with depression are identified and addressed to enhance the case for commissioners seeking to commission local services.***

- ***Long term pilots are established to more thoroughly test the IPS in IAPT model of employment support with attention paid to employment (and progress towards employment outcomes) for people with common mental health conditions. It should consider the different outcomes for people with different symptoms and diagnosis, to improve understanding of who this approach works for and what the potential financial savings are.***

- ***Recent budget announcements, i.e. on the integration of IAPT in Jobcentres, and the provision of online Computerised Behavioural Therapy (CBT) for users of Fit for Work as well as welfare claimants, are thoroughly evaluated. This is required to build the evidence base around these approaches, in terms of both employment and wellbeing outcomes and***

- ***Evaluation of 'recovery colleges' is commissioned to improve understanding of how well they achieve employment outcomes for people with depression.***

- ***Investment is put into testing how innovative solutions like Vocational Rehabilitation prescriptions (developed by Macmillan Cancer Support for people with cancer) might be adapted for people with depression. These provide a simple way for Clinical Commissioning Groups to refer patients to case managed, tailored, multi-disciplinary vocational rehabilitation support (Gilbert & Marwaha, 2013).***

5.2 Building the evidence base around the relationship between health interventions and employment outcomes. We need a clearer understanding of what is effective in terms of psychological interventions and employment outcomes. Much of the academic evidence is around CBT and its effect on employment outcomes among people with depression.

It is recommended that:

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

through NHS psychological services.

5.3 Promote effective services which are already available. Even where services exist, many people in the community with depression may not be aware of them. There is poor awareness of the Access to Work Mental Health Support Service, as well as other local employment support – including IPS back to work services.

It is recommended that:

- ***The DWP explore and assess the role of local Work and Learning Coordinators to see whether there would be value in expanding this role across the UK.***

- ***Methods to enhance the role of GP surgeries as places of information on employment support are considered – including encouraging the addition of employment advisors in primary care settings to provide support or 'signpost' to other services.***

6. Developing a welfare system that supports individuals with depression

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

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

It is recommended that:

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

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

It is recommended that:

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

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