

Workplace Experiences of Mental Ill Health in Northern Ireland

By

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2006

Mr Gregory Black was on placement with the Commission from October 2002 to July 2005. During his placement, Gregory completed a project entitled "Workplace experiences of Mental Ill Health in Northern Ireland". The Commission provided him with office space, computer access and advice on conducting research. The project is the work of Gregory Black and as such the Commission takes no responsibility for any errors or omissions in the project.

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Executive Summary

1. The current research looks at the area of mental health in the Northern Ireland workplace. The aims of this study are:
 - To identify existing studies in this area, within and beyond Northern Ireland.
 - To uncover the experiences of Northern Ireland workers with mental ill health in relation to their employment, both positive and negative.
 - To find potential changes which could improve these experiences.
 - And, to note examples of 'best practice' – practices or procedures in the workplace which have proved beneficial to people with mental ill health.
 - To identify policy and practice recommendations for dealing with mental ill health disability in the workplace.

2. This was achieved by carrying out a literature review of existing studies of employment experience, and making contact with Northern Ireland-based mental health bodies and related individuals. These contacts included the Shadow Programme, LAMP, STEER, the Voices Forum, Action Mental Health, RETHINK and others. From this initial piece of research, a questionnaire was drawn up. The questionnaire examined the workplace experiences and related ideas/attitudes of Northern Ireland people with mental ill health. Thirty three people took part in the questionnaire – these volunteers were drawn from the afore-mentioned mental health bodies.

3. From the results of this questionnaire, and among a smaller group of respondents from the original bodies (LAMP, STEER etc), a more in-depth interview was carried out. There were 12 people in the volunteer group.

4. Overall, the results of the study were that:
 - Work can be a very positive and rewarding activity for those with mental ill health.
 - People experiencing mental ill health at work can bring many positive qualities to work precisely due to their mental ill health and/or how they have dealt with it.

- Perhaps more often it can be a source of negativity due to stigma and lack of awareness of mental health issues, or proper structures/procedures to deal with mental ill health at work.

5. It was concluded that:

- There is not enough awareness amongst employers of the positive aspects that those with experience of mental ill health can bring to work.
- Work needs to be done to educate the public (including schools) and workplaces & managers in particular of mental health issues at work.
- A general set of procedures and structures to deal with mental health issues at work should be drawn up and promoted in Northern Ireland workplaces.

Chapter 1. Introduction and Background

- 1.1. The current study looks at the area of mental ill health (as well as the more extreme 'condition' of mental illness) in relation to the world of work, in Northern Ireland. There is a significant body of existing research in this subject area, however this has mostly been conducted outside Northern Ireland.
- 1.2. In the current section, the complexities of mental health issues will be addressed through examination of the following issues:
 1. Definitions of mental health
 2. Causes of mental ill health
 3. Stereotyping and stigma
 4. Myths and misconceptions about mental health
 5. The Disability Discrimination Act and Experience of mental illness
 6. The costs of mental ill health
 7. The positives aspects of work for mental health
 8. The positive aspects of mental ill health at work
 9. Empowerment: Survivors, not Users

Definitions of mental health

- 1.3. Mental health is a complex issue, and needs some introduction. The major definitions of mental health (outlined by Mackey 1996) are as follows:
 - *Mental health* – should be used to describe more than the absence of illness in an individual, rather more the state of coping with and being in control of their life circumstances.
 - *Mental ill health* – should be seen as a challenge to one's mental health, associated with short-term feelings of dissatisfaction with one's life situation,

and/or sadness, anxiety. Such difficulties may require and be alleviated by professional help – such as treatment by a psychiatrist. Examples include stress and anxiety.

- *Mental illness* – more serious than mental ill health, when the difficulty may be termed as ‘clinical’, and need more professional help/treatment. Examples of mental illness include depression, schizophrenia, and obsessive-compulsive disorder (OCD).
- *Stress* – has many definitions. Kaminoff (1982) described stress as “that pattern of ... response of the individual to demands of the physical and social environment that exceed his ability to cope effectively, that is, to carry out activities, realise goals and experience satisfaction.” In addition, Mackey (1996) describes the nature of stress for a person as being in “the meaning of the situation for that person.”

Causes of Mental Ill Health

- 1.4. The causes and cure of different forms of mental ill health is a controversial and complex issue. There may be different causes, such as genetic and biochemical, and/or environmental ‘triggers’, such as stress, which could cause or exacerbate existing mental ill health.
- 1.5. In the past, treatment for mental ill health included some very controversial procedures such as surgery (including lobotomy), ECT – Electro Convulsive Therapy, and internment within an institution. In these now much more enlightened times, mental health users are now far more integrated into the community, being treated by medication and therapy.
- 1.6. This report focuses on the effect of work on mental health, and vice versa, in Northern Ireland.

Stereotyping and stigma

- 1.7. Mental ill health is experienced by as many as 1 in 4 people in the UK in the course of a year (Goldberg 1980, 1990), yet it still has a negative stigma attached to it. Being labelled even with “mental illness” has been shown to provoke negative stereotyping, especially with disorders such as schizophrenia. Stereotyping reinforces negative stigma – often all those seen to have mental ill health are ‘tarred with the same brush’.
- 1.8. This stigma can have an extremely detrimental effect on a person’s life, both at work and beyond. More serious forms of mental ill health, such as bipolar disorder (“manic depression”) and especially schizophrenia, have been ‘demonised’ by much of the UK media, especially the tabloid press. Fortunately, 60-80% of people with serious mental illness can be substantially helped with the right medication, management and support programme (Mental health and work).
- 1.9. The best media ‘coverage’ that a person with mental ill health can expect at times is to be tagged by the label of their doctor or psychiatrist’s diagnosis – instead of their worth and abilities, occupation, or relationship within a family. To experience mental ill health/distress can be at once terrifying, confusing, depressing and alienating. Thus, to have your experiences mocked in the press, to have people abuse you in the street, in your home or family, would distress any person immensely.
- 1.10. This and many other types of harassment and victimisation are what commonly happen to some that experience mental distress (Kelly 1997). When this happens at work, it must follow that this is also a very negative experience.

Myths and misconceptions about mental health

- 1.11. Negative stereotyping of mental ill health disability occurs because many aspects of mental ill health are misunderstood – some of these myths and misconceptions are dealt with here.
- 1.12. One large area that people worry about is the idea of ‘dangerousness’ and mental ill health. However, very few people who experience mental ill health are dangerous to others. Mentally ill patients are **6 times more likely** to be murdered than the general population (BBC Online, 21/12/2001). Further, the public are far more at risk of violence from young men under the influence of alcohol than they are from people with a mental health problem (Pepper, MIND 1997).
- 1.13. There are a few myths (Mental Health and Work, p29) about mental illness, and the workplace, which should be noted and challenged by the facts:
- Recovery from mental illness doesn’t happen:
 - **False.** The development of new treatments has allowed people with mental illness to show genuine improvement over time and lead “stable, productive” lives.
 - Employees who are or have been mentally ill are “second rate” workers:
 - **False.** Employers who have hired this “category” of worker have reported an equal or higher than average attendance and punctuality record, as well as superior motivation and quality of work.
 - People with psychiatric disabilities cannot stand job stress:
 - A **generalisation** that doesn’t always hold. Different people will find different things stressful, such as perhaps an unstructured working day. Productivity is achieved when the work conditions match the employee’s needs and strengths.

- Mental disability/illness/distress is not the same as, nor does it lead to, mental handicap or learning disability:
 - This **false** notion still persists, and seems to be very popular. It needs to be challenged vigorously.

1.14. These and other misconceptions about mental ill health, especially about users' fitness to work, serve only to heighten the barriers against them receiving a fair deal at work, or indeed work at all. The repetition of these notions without challenge reinforces negative stereotyping, and promotes discrimination – especially in the workplace.

The Disability Discrimination Act and Experience of mental illness

1.15. There is sufficient law in place in the Disability Discrimination Act (1995) to protect the rights of those with mental ill health, at work and beyond. However, more needs to be done to educate the public - both about the rights enshrined in this law, and furthermore that all people (including those with mental ill health) deserve and should have equal rights in all areas, including employment. While school education is an important part of the answer it would not be an immediate solution, and should be seen as the 'long game'.

1.16. Under the Disability Discrimination Act (1995), a person may be termed as having a mental/psychiatric disability if they have experienced 'debilitating' mental distress, which would affect their carrying out of day-to-day activities for at least 12 months (or if their experience of such is likely to last that long). This also applies if the person's condition is alleviated by treatment, and would be debilitating if that treatment was suspended – for example, if the person was on a course of anti-depressants and would experience the aforesaid 'debilitating mental distress' without them.

- 1.17. The DDA is based on the **social model** of disability. This says that people who are disabled are “disabled people” – that they are **people** who have **been disabled by society**, and the way it is organised. An ILO publication (World Employment Report 1998:35) supports this model, saying, “There is a growing awareness that disability is not so much an impairment of the individual as a product of the environment in which he or she lives.”
- 1.18. This is illustrated with humour by Vik Finklestein (Finklestein (1981), “To Deny or Not to Deny Disability”). In this, he relates the story of a hypothetical community of wheelchair users, whose physical environment is designed according to their needs – part of which is low, wide doors to accommodate their wheelchairs, rather than the tall, narrow doors preferred in communities of non-wheelchair users. In Finklestein’s hypothetical community, all is well until people from an outside community come in, and have trouble with the doors. They have to stoop to fit under the door, and often end up hurting their heads on the top of the doorways. The community natives term them as being “disabled” and give them crash-helmets to stop them hurting themselves, rather than changing the environment to suit all. In short, the designers of the environment (the “able”) see the crouching “helmet-heads” as being different merely because the environment was not designed with the needs of all the community in mind.
- 1.19. The social model may also be applied to mental disabilities. At first glance, it may seem that “people with a mental disability” is a better descriptive term than “disabled people” – as it emphasises the humanity of people by ‘putting **people** first’. However, it would seem to be that the social model and its associated term, “disabled people” is more empowering and likely therefore to be the best term to use for the purposes of this introduction.

The costs of mental ill health

- 1.20. Mental ill health and its treatment have a great impact on people’s lives – and not just those who experience it first-hand. Its effects may be seen in all aspects of life. For example, people with mental ill health might be marginalised and bullied in their

own home, workplace and in public. Research in Northern Ireland (Kelly, 1997) has shown that people with mental ill health are sometimes bullied and abused in the street, in their home, financially and in other ways. UK research (Warner 2002) has shown that such treatment also happens in the workplace.

- 1.21. Mental ill health and the treatment of those who experience it also have a cost to industry. Compared to other forms of illness, by 2020 depression will be second only to chronic heart disease as an international health burden (Hartley, May 1998). The *Working Minds Toolkit* states that stress-related work absence in the UK costs an annual £4 billion. Further, almost 3 in every 10 employees will have some mental health problem to manage in any one year (Office for National Statistics, 1995). In Northern Ireland, certified absences due to anxiety and depression alone cost £2 billion a year (Mackey 1996). Also in Northern Ireland, 30 times more days are lost to stress/mental illnesses than are due to industrial disputes (Banham 2001). It is estimated that 30-40% of all sickness absence from work is due to mental or emotional disturbance (Mental Health at Work, p594).
- 1.22. More subtle than the above effects on the workers and workplace are what might be described as the **human** costs of mental ill health. These costs include the waste of human potential – that is, the loss of talent and skills of workers developed over years of hard work and financial investment (Working Minds toolkit), and, it seems to follow, the loss of good relations between workers and the “networked” relations between contacts and companies.
- 1.23. Compared to the disabled community as a whole, those with mental ill health have a significantly higher rate of unemployment (Office for National Statistics 1995). It would seem that mental ill health might carry a greater stigma than other disabilities. This may be because it is not understood, and/or because it is “hidden”, unlike many physical disabilities. There are many costs to those who experience mental ill health first hand. Careers may be stunted and attitudes towards them hardened. As an illustration, the following case studies are taken from the *Working Minds Toolkit*:

ALISON'S CASE STUDY

"When I decided to go public about my mental health problems at work, I felt my previous achievements were wiped out."

Alison found that some managers' attitudes were:

"I'd never employ her again now I know the truth", and that she was "deemed unreliable and unable to cope."

Alison now works for herself and finds this arrangement much better, now that she has control over her work.

DEBRA'S CASE STUDY

*Debra worked as a teacher when her mental health problems began, one of the triggers being having children of her own. Her school wasn't at all supportive, and she worried about how she'd manage. The head teacher kept putting pressure on her about plans for maternity leave. She changed jobs after her child was born, finding support at her new school. There, she worked providing full-time support for a child with autism. Her employers gave her "**praise and positive feedback**". However, her contract ended and when she found a new job she had to leave it to look after her health more.*

Debra sees that the most useful support she's had in work is with planning her workload – so she can break it into bits so it can be more easily dealt with. She says that managers shouldn't assume that a return to work means that the employee is fully recovered from mental ill health.

Positives aspects of work for mental health

1.24. Employment can and should be a positive and therapeutic part of life. With the right environment and management, a job can bring back a person's self esteem and positive outlook. The following categorise some positive results of employment on a worker's mental health:

- Time structure of the working day, rather than one hour/day/week blending into one.
- Social contact – with one's fellow workers.
- Collective effort and purpose – pulling together as a team.
- Social identity – it's important to define yourself an identity, such as 'a worker at Company X'.
- Regular activity – one's life is more organized with work.

1.25. There are reasons for both employers and employees to work towards a positive working environment, or work-life balance. The idea of work-life balance is that life inside and outside work should be balanced against each other, with a degree of flexibility and control for the worker over their working day and conditions. The *Essential Guide to work-life balance* states that **“for some people with health problems or disabilities, having a flexible arrangement ... may enable them to find or continue in paid employment”**, and goes on to suggest in-house benefits such as healthcare and financial/time off help with training.

1.26. The Working Minds Toolkit suggests further steps towards a balanced, healthy working environment, such as education for staff leading to acceptance of difference & diversity, and signing up to an “Employee Assistance Program” provider to help employees with off-site help for their problems.

Positives aspects of mental ill health at work

- 1.27. The above are some of the reasons why work can be good for employees with mental ill health. However, it is also true that employees with mental ill health can be good workers.
- 1.28. Many people with mental health difficulties may well have developed extra skills and traits to get on in work and life as a whole, such as (from Working Minds Toolkit):
- A positive work ethic (going that “extra mile” for a project).
 - Empathy with others (they have “been there” themselves).
 - Coping strategies, developed to “get along” with life and work (Working Minds Toolkit).
- 1.29. There are many positive outcomes for an organisation working towards work-life balance, many of which are listed in the *Working Minds Toolkit*. For example:
- The workforce would become more motivated.
 - The workforce may be less likely to be absent or to leave, meaning.
 - They would retain relationships/contacts (within the company and ‘networked’ relationships with others beyond the organisation).
 - Skills and knowledge would be maintained.
 - Productivity levels would be maintained or even enhanced.
- 1.30. These “positives” are in stark opposition to the challenges in the workplace due to mental health difficulties (*Stress at work: a guide to employers, 1995*). The above, interlinked results would mean an all-round healthier workplace, and would go a long way towards compliance with the Disability Discrimination Act (1995).

Empowerment: Survivors, not Users

- 1.31. Empowerment and its language are vital in disabled politics. The disabled Community is becoming more empowered, vocal and active, and has taken on new descriptive terms for its membership.
- 1.32. Terms to describe people with experience of mental ill health might be 'people with a mental disability', or 'disabled people'. Both terms seem adequate, but care should be taken with them as language shapes both our perceptions and treatment of the people and things it describes. One could view things this way: "people with a mental disability" describes people in the same way as "people with blue eyes". It emphasises their humanity, as "people" comes before "disability". Another view is that "people with a mental disability" is a loaded phrase – you say "people" and then you **qualify** it with the term "mental disability", thereby reducing their humanity. It also implies that they are responsible for this "impairment", and so also for the way they are treated by society. Research has shown that even the label 'mental illness' can provoke negative stereotyping, whereby people are 'pigeonholed' into a negative category. The present section explores the area of self-identity. The term that a 'user' chooses to describe themselves may influence their experience at work.
- 1.33. 'Survivor' is the new term for individual members of the disabled community who have experienced mental distress. They view that they have survived their own mental distress and/or the mental health service system.
- 1.34. Along with such groups as the Gay and Black communities, the disabled community is using former terms of abuse as terms of 'Pride'. The 'Mad Pride' celebration was in London on 20/6/1999, and 'World Mad Pride Week' was in July 2000. Both were very open and positive celebrations of survivors and their experiences, an active counter to the negative press that many survivors have had for so many years.
- 1.35. There are different terms which could be used to describe the section of the disabled who experience mental ill health. At this point, it would seem best to use

the least emotive term, 'User', rather than perhaps 'Survivor'. However, it would be most useful and interesting what consensus may be found among users/survivors, as to what terms to use. It is quite likely that a totally separate term will be found most suitable and popular. It would be important to find out how many people in Northern Ireland who have experienced mental ill health would also describe themselves as 'survivors'. It might well be that many would not have heard of the term (with that meaning), or indeed of the 'survivor movement' at all.

Rationale

- 1.36. From the background above, it may be seen that social exclusion, victimisation and bullying of all types are prevalent in the experience of mental ill health. In the 'Out at work' research/questionnaire (Warner, 2002), it is seen that this is also just as true when one focuses on the world of work – work for which users, as it is, may quite well be difficult enough to enter and cope with.
- 1.37. The current project will examine the challenges and rewards of employment for users in Northern Ireland. Using this, recommendations will be made as to what 'reasonable adjustments' may bring about positive change within the workplace in Northern Ireland for mental ill health users.

Chapter 2. Methods

Aim

2.0. The extent of negative/challenging experiences in the Northern Ireland workplace has not as yet been quantified by research.

2.1. This project has the following aims:

- i. To gather information to create a picture of both the **challenges** and **rewards** within the Northern Ireland workplace for mental ill health users.
- ii. To make **recommendations** as to what can and/or should be done to bring about positive change within the workplace, which should result in a healthier, more empathetic (as opposed to simply sympathetic), better informed and more efficient workforce.

Objectives

2.2. The specific objectives of the project are:

- i. To carry out a literature review of past and current research (on the subject of mental ill health and the workplace), to determine the extent and breadth of knowledge in this area.
- ii. To determine the attitudes and experiences of those with mental ill health.
- iii. To make recommendations, based on the findings of the project, for positive change.

Methodology

- 2.3. A Literature review was conducted to establish what work has been done in this area – internationally, in UK/Europe and locally within Northern Ireland.
- 2.4. Contacts were made with groups and individuals willing to share their knowledge, views and resources, and to take part in further research.
- 2.5. Drawing on the literature search and others' input, a questionnaire-based information gathering exercise was initiated. This was a questionnaire, intended for mental health 'users', preferably those who have been in work. The questionnaire looked at people with experience of mental illness and of mental ill health – it was not asked of the respondent which category they would put themselves in. The questionnaire looked at the respondents' work details (past and present), how they feel work impacted on their mental health and vice versa, the idea of 'disclosure' of mental ill health, their self-identity (as a 'user', for example) and what changes they would like to make for a better work life for people with mental ill health.
- 2.6. The questionnaires were sent out to several groups. The target population was workers/ex workers in Northern Ireland with experience of mental illness (preferably) or mental ill health. Opportunity sampling was used to recruit 33 individuals (N=33), through mental health groups/bodies in Northern Ireland.
- 2.7. 12 interviews were held with people from the initial target population ('users').
- 2.8. From the existing research, questionnaires and interviews, all the information was processed to result in the write-up of:
 - i. An overview of the challenges of mental ill health in the workplace.
 - ii. A description of the potential rewards of a workplace where the (above) challenges are met head-on, in a well-informed and empathetic (rather than merely sympathetic) way.

- iii. How these challenges could and should be met – make recommendations for positive change.

Outline

- 2.9. Information was gathered by survey (mainly for **quantitative** analysis) followed by one-to-one **interviews** (for **qualitative** analysis). The questionnaires and interview questions are listed in Appendices 1 and 2 respectively.
- 2.10. The 15-question **questionnaire**/survey (see Appendix 1) was carried out with the aid of the users/staff of some mental health bodies, including voluntary bodies. It looked broadly at the areas of:
 - Mental health status.
 - Impact of work on mental health.
 - Impact of mental ill health on work.
 - Impact of disclosure of mental health status at work.
 - The area of disclosure; how different scenarios might affect willingness to disclose.
 - Changes respondents might like for an improved work-life for users/employees.
- 2.11. The **questionnaires** were filled in without the presence or aid of the researcher, and returned by post. It consists of 15 questions, many with sub-questions and multiple choices, with room for additional comment. Answers to some multiple choice questions were graded on the answer and the type of question ('positive' or 'negative'). The answers were analysed with the help of an Excel spreadsheet to tot up the overall response to questions. This approach is explained in more detail later on.
- 2.12. Note was also taken of users' extra comments to some answers, for some qualitative analysis.

2.13. The **interviews** were carried out with the volunteers on a 1-to-1 basis. Consisting of 2 main sections, it looked at the areas of:

- Job details/circumstances and consequences of mental ill health at work.

And, if the interviewee has left employment:

- Details on life after that job, focussing on support, employment and mental health.

2.14. With permission from individual interviewees, their interviews were recorded on audio tape and later transcribed. Following this, the tapes were destroyed. Names were assigned to individual interview transcripts for ease of reading; however, they are not connected in any way to the interviewees' real names. Where an interviewee mentions a particular body or group, these are not included in the actual transcript. These measures ensure that **confidentiality** was maintained.

2.15. Thematic analysis was used to analyse the interviews. The approach was to look for common or conflicting experiences or viewpoints between different interviews, and search for connections between the experiences. In addition, discrepancies or connections with results of the survey or literature search were also sought.

Survey Analysis

2.16. The questionnaire (see Appendix 1) was carried out with 33 respondents, with only one reply rejected due to lack of information (N=32).

2.17. From the questionnaire, it was seen that there are a few things that can/did happen in a person's work-life because others at their work knew of their history of mental ill health. These may be positive (for example, people could be accepting), negative (e.g. one could be patronised) or things could remain unchanged.

2.18. The results were analysed *depending on the type of question*. For a straightforward question, such as ‘what term would you choose to describe yourself’, the total number of replies to each individual **category** (e.g. “Person with a mental disability” with 5 replies) was divided by the sum of responses to that **question** as a whole (in this case, 96), to get a percentage figure for each category (see Figure 3).

2.19. Other questions such as ‘in the following situation, how happy would you be to reveal a history of mental ill health...’, with the options *Always, Often, Sometimes, Seldom, Never, and Depends*, would be analysed in the following way. For each scenario (e.g. ‘To a HR manager if you felt well’, answers other than *Depends* were summed as follows:

All *Always* answers + All *Often* answers

All *Sometimes* answers

All *Seldom* answers + all *Never* answers

so to give a measure of how likely the respondent is to reveal a history of mental ill health under specific conditions. Note that *Depends* answers are ignored for the quantitative analysis. Figure 2 shows the results of such analysis.

2.20. Another type of question allows much the same responses (*Always, Often, Sometimes, Seldom, Never, and N/A* – for ‘not applicable’). The question may be ‘positive’ or ‘negative’. For example, looking at the effects of others at work knowing one’s history of mental ill health:

- “People are very accepting” **or** “It makes no difference” would be positive, as answering *Always* or *Often* would show a good experience, while,
- “Management are patronising” would be negative, as answering *Always* or *Often* would show a bad experience.

2.21. From this system, a measure of the respondent’s experiences was found by summing the ‘Poor-Bad’ experiences, the ‘Fair’ experiences, and the ‘Good-OK’ experiences, and assigning a percentage value to each.

For example, for the question about ‘People are very accepting’, the *Always* and *Often* answers are summed to give the number of ‘Good-OK’ experience; the *Sometimes* answers are summed to give the number of ‘Fair’ experience; the *Seldom* and *Never* summed to give the number of Poor-Bad experiences. *N/A* (for not applicable) answers are **ignored**. These numbers are summed to allow a percentage value to be generated for each answer (e.g. “People very accepting” - 72% Poor-Bad, 22% Fair, and 6% Good-OK).

This general rating system is summarised in Table 1, below:

Table 1: Rating for questionnaire answers

Answer	Effect	Rating
ALWAYS	POSITIVE	GOOD-OK
	NEGATIVE	POOR-BAD
OFTEN	POSITIVE	GOOD-OK
	NEGATIVE	POOR-BAD
SOMETIMES	POSITIVE	FAIR
	NEGATIVE	FAIR
SELDOM	POSITIVE	POOR-BAD
	NEGATIVE	GOOD-OK
NEVER	POSITIVE	POOR-BAD
	NEGATIVE	GOOD-OK
N/A	POSITIVE	ANSWER IGNORED
	NEGATIVE	ANSWER IGNORED

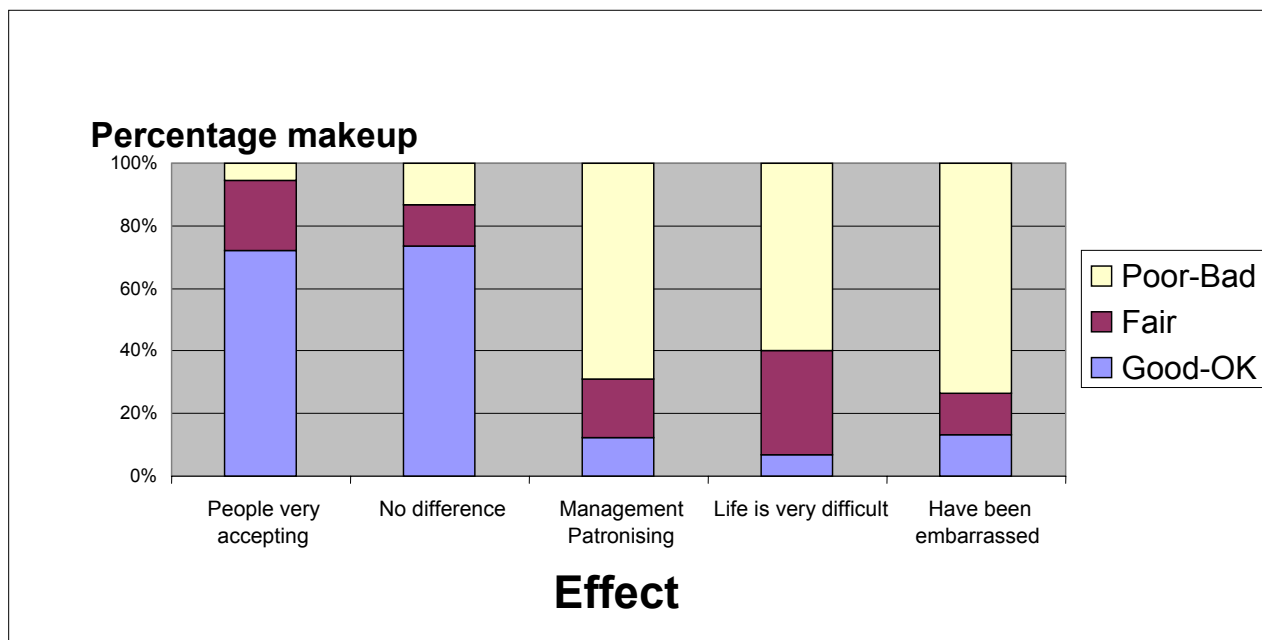
Qualitative Analysis of Interviews

2.22. Following on from the questionnaires, 12 one-to-one interviews were undertaken, with nine (9) deemed useful for the study. The other 3 were excluded from the analysis as they had too little information in them, or did not fit in with the criteria of being employed and having mental illness/mental ill health. Comprising of 15 questions, the interview took both content and format largely from the questionnaires and results of the literature review (see Appendix 2 for the questions of the interview).

Chapter 3. Survey Results

- 3.0. Working with different bodies and individuals within Northern Ireland, the experiences and viewpoints of many people were gathered together using questionnaires and face-to-face interviews.
- 3.1. One of the main areas in the quantitative analysis of the questionnaires was the extent to which others at work having knowledge of a person's history of mental ill health affects their work-life.
- 3.2. Figure 1, below, shows some of the effects (and their extent) caused by others at work knowing of a person's history of mental ill health. The data is taken from the questionnaire results, where the person's experience (N=32) is rated as Poor-Bad, Fair, or Good-OK., as discussed in **Quantitative Analysis**, above.
- 3.3. It was found that the most common bad effect was being patronised by management (69%), followed quickly by the general feeling that life was so difficult that one thought of leaving (60% chose Poor-Bad for this, only 7% chose Good-OK). However, it was also found that there were some positive aspects of work. 72% of those who responded on the subject said that people were very accepting at work, while 73% said that it made no difference – which, as an absence of negative, may be seen as a positive. See Figure 1 for more details.

Figure 1: How other people’s knowledge of mental illness has affected person’s work-life



Disclosure - questionnaire

3.4. It can be seen from the above figure that employers’ knowledge of a worker’s history of mental ill health may have a detrimental effect on work life, and it follows that the idea of disclosure should be investigated. A significant part of the questionnaire dealt with this topic.

3.5. One of the questions (see Figure 2) asked whether the respondent would be happy or willing to reveal a history of mental ill health in the following situations:

- On a job application form, in general.
- On a job application form, one you thought a person you knew might see.
- To a manager, if in good health.
- To a manager, if unwell.

- To HR (Human Resources) people, if in good health.
- To HR (Human Resources) people, if unwell.
- To insurance people.
- To close family.

The respondent was given the following 6 options to answer with:
Always, Often, Sometimes, Seldom, Never, Depends.

- 3.6. In addition, the respondents were invited to give a reason for a 'Depends' answer. From the questions above, a significant amount (about one third) of the answers were 'Depends', or left blank. Many comments were given to explain the 'Depends' answers.

Some reasons for 'Depends' answers were:

(Q11.1: Reveal mental ill health history on a job application form)

“(It depends) on employer’s policies.” (of treatment of recovered mentally ill)
(Respondent A’s questionnaire)

(Q11.2: Reveal mental ill health history on a job application form, including one you thought someone you knew might see)

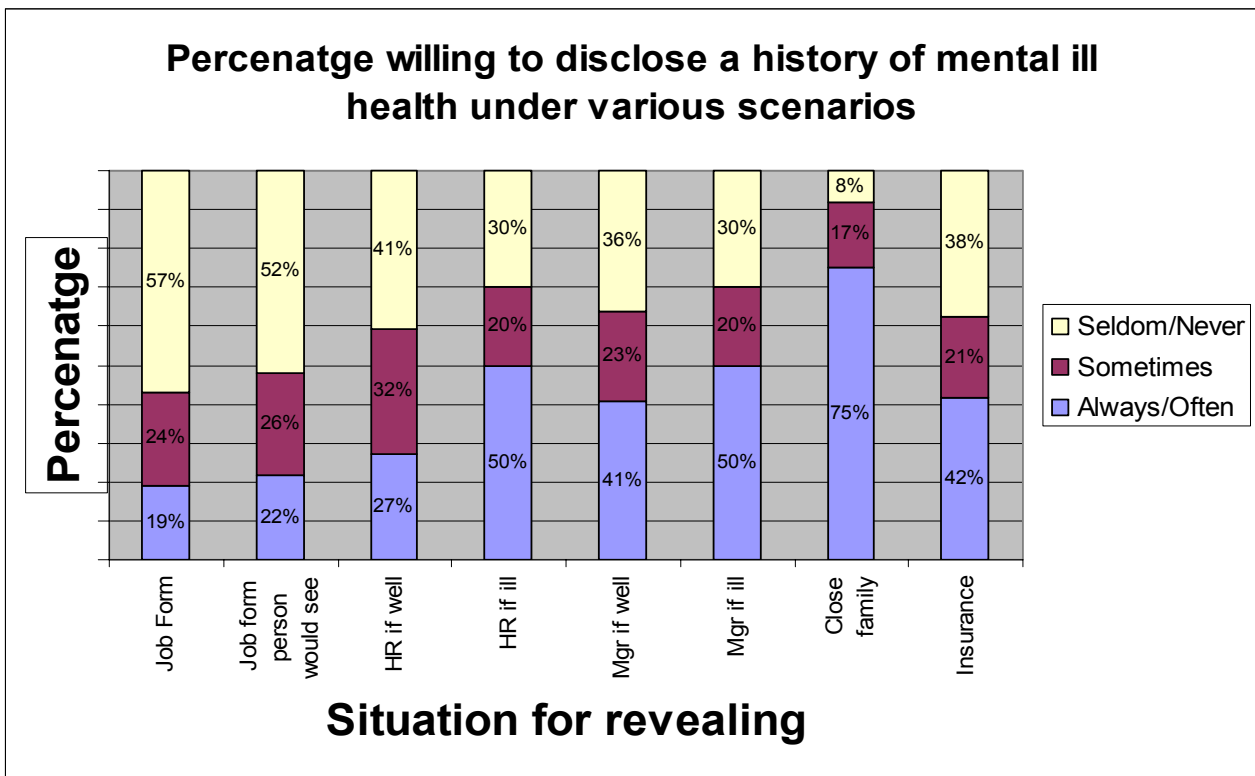
“(It depends) on perceived sympathies, or lack of them, of prospective employer.”
(Respondent G’s questionnaire)

While **Respondent J** said they **would** disclose their history of mental ill health on an application form...

“... if it was work related to my personal experience.” (of mental ill health)

The results of these questions are plotted in Figure 2, below:

Figure 2: Percentage willing to disclose a history of mental ill health



3.7. From the results, it stands out that - of those who replied - fewer respondents would always/often disclose a history of mental ill health on a job application form in general (19%) than on one someone they knew might see (22%). One interpretation of these responses might be that, if a person that the respondent knew might see their application form, they may also know of their history of mental ill health. If that was the case, they may think they should disclose, as their prospective employer would know anyway and not disclosing may count against their application or future prospects with that employer. However, these differences may be an artefact of the small number of respondents for each of these two sub-questions with only 4 and 5 people answering “Always/Often” to questions 11.1 (‘on a job application form in general’) and 11.2 (‘on a job application you thought someone you knew might see’) of the questionnaire respectively.

3.8. It is enlightening to look at the changing attitudes as regards disclosure to managers/HR personnel in good health or unwell. 59% of respondents (27%

always or often) said they would disclose to HR personnel if well, rising sharply to 70% (with 50% always or often) if unwell. There is a similar trend for disclosure to management – 65% (with 23% always or often) if well, rising to 70% (with 50% always or often) if unwell. This final figure is exactly the same for disclosure to HR if unwell.

- 3.9. From the figures, it would seem that employers find their managers more 'approachable' than HR personnel. Perhaps this is because managers would be seen more often than HR, or even (more negatively) that HR personnel are more associated with disciplinary procedures and redundancy.
- 3.10. One very positive point that comes across from the figures is not to do with work, but from life outside of work. From the areas covered here, the highest portion of positive answers (75%) came from disclosure to close family, significantly higher than the highest (50%) from the other categories.
- 3.11. The answers concerning disclosure to Insurance officials are split rather evenly between Always/Often (42%) and Seldom/Never (38%). This is obviously an issue of importance, especially when one looks at some of the related comments from the respondents. Questionnaire respondent C noted that they disclose their history of mental ill health as:

"They (insurance people) check up anyway"

While Questionnaire respondent G said that it depends on what kind of insurance:

"Not car insurance"

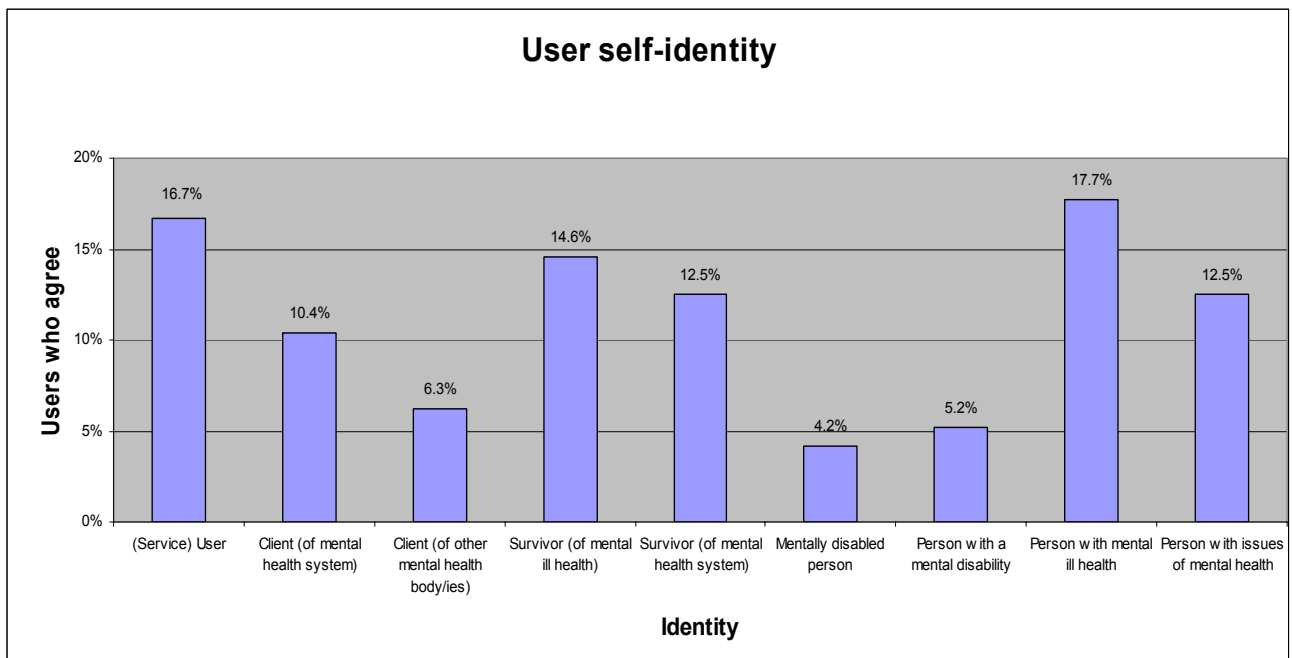
and Questionnaire respondent H noted that they always disclosed their history, but the negative aspect was/is:

"I feel I'm penalised by motor car insurers... cost of insurance is higher because of my declaration (of mental ill health)"

Identity

- 3.12. On a general note, the respondents were asked about their 'self-identity', i.e. what term(s) would they use to describe themselves as regards their experiences of mental ill health, etc. The results are plotted below, in Figure 3.
- 3.13. Note that the most popular descriptions are the more positive: 'Person with mental ill health' (17.7 %), followed by '(Service) User' (16.7 %); and the most unpopular are the potentially demeaning 'Mentally disabled person' (4.2 %) and 'Person with a mental disability' (5.2 %). One of the terms the respondents were invited to consider was 'Person with Issues of Mental Health', or 'PIMH'. This was created for the purposes of the study, and was quite popular (12.5 %), showing that there is room for change in the terms used by users for their identity.

Figure 3: Preferred identity of People with Mental Ill Health



Chapter 4: Interviews

4.1. Four broad themes with associated subthemes arose from the interview. These were as follows:

1. Positive experiences in the workplace
2. Negative experiences in the workplace
3. Disclosure
4. Employer's and Colleagues' Attitudes

Theme 1: Positive experiences:

4.2. Three general positives were seen to arise from the respondents' answers:

1. An increase in self-knowledge, or realising one's own limits
2. Work as empowerment
3. Work as a supportive environment

4.3. Out of all (9) interviews, Luke, Matthew, Annette, Phillip said that there were no positive experiences in their work arising from experiencing mental ill health at work. Of these, Annette and Phillip said that there were some positive experiences regarding mental ill health. However, these were outside work.

An increase in self-knowledge, or realising one's own limits

4.4. Two of the nine had 'personal insights' into their mental ill health, as shown below.

Louise, who had a high-pressure job in a caring profession, said of her work that:

'the only good thing was that my GP said it was 'either you or your job' – I ended up having a total nervous breakdown, and so gave up my job. These

experiences were positive in that I came to know my limits, and know that I'd never get into that (work) situation again."

While health service worker Phoebe said that she:

'... gained insight into my illness, and how to spot triggers for it.'

Work as empowerment

4.5. In some ways, Phoebe's experience must be one of the most positive from the interviews, and shows that work can be a positive, empowering part of life. She said that in fact her life wasn't stopped by her illness:

"I showed I could work while ill"

Mental health worker Danielle stated that work can be a positive experience, a buffer against other more challenging parts of life:

"Work helps take your mind off other things..."

Work as a supportive environment

4.6. As well as being broadly positive, work can provide a supportive environment with the right treatment.

Julia states that:

"My consultant in Occupational Health was very good, sympathetic, and wanted to take a case against my boss for his treatment of me..."

My boss was ok about me attending appointments, and was aware that I was attending weekly mental health appointments.”

Mental health worker Danielle stated that work can be supportive, with the right working environment:

“The employers understand (my needs related to mental ill health). I have a pretty supportive work environment.”

Julia, an NHS worker, stated that she had some good or mixed experiences at work from different people, as part of a supportive environment:

“Colleagues were generally sympathetic...

“They (people I supervised) just accepted it (my mental ill health).”

Theme 2: Negative Experiences:

4.7. The majority of respondents replied that there was a lack of understanding, knowledge, policies, procedures and/or positive actions regarding mental ill health at work. Respondents might categorise their experiences as ranging from indifference to the more serious direct discrimination.

4.8. There were two broad areas of negative experiences mentioned by the respondents:

1. Lack of understanding,
2. Lack of structures/action to deal with mental ill health in the workplace.

Lack of Understanding

4.9. Even though she worked in the area of mental health, with the positives of much of her workplace mentioned before, Danielle noted that:

“My supervisor doesn’t understand mental ill health as well as they (sic) should”

Phillip talked passionately about his work situation in the civil service:

“I believe that there should be much better understanding of mental ill health in the workplace – the general attitude is ‘*Get on with it ... pull yourself together*’ ...

They (*the employers*) don’t seem to have any basic understanding, and you’re going through hell.”

Julia talked about the lack of action/intervention to help her at work when she felt under stress in her job at an NHS hospital:

“Nothing was done to alleviate my stress”

Louise, working in a high-pressure caring profession, was critical of how her superiors lacked both understanding and policies to help her and others like her in managerial positions.

“I found that they (the employers) used ‘pressure tactics’ to pressure you back into work before you were ready...”

The job was too much (for one person)...

Employer had no idea of stress on managers, and had no healthy policies.”

- these show a trend towards employers' lack of knowledge/understanding.

Lack of Structures

4.10. Engineer Luke noted the lack of structures to deal with certain negative situations at his work:

(There were) “no policy or procedures on harassment, (I was) told I was being too sensitive”

Similarly, Accountant Annette saw a lack of action at her workplace, in that (there was) “no discussion about mental ill health at work, except the use of the word ‘Stress’ as a catch-all”

Theme 3: Disclosure

4.11. Another key theme within the interviews was that of disclosure – telling someone at work that one has experience of mental ill health.

4.12. All but Luke said that their ‘boss’ knew of their mental ill health. Luke said that ‘personnel and senior management’ knew. This is a very large majority, and seems to differ from the general trend evident in replies to the initial, earlier questionnaire. The replies to the earlier questionnaires suggest that the majority would only disclose a history of mental ill health to employers if they were ill (and so needed to disclose).

4.13. Perhaps this difference is due to the fact that most people who took part in the final questionnaires had been through more stages in their ‘employment story/ history’. That is to say, the majority had left their employment for one reason or another, in some way.

4.14. But, is their disclosure directly related to their leaving work? Only engineer Matthew and mental health worker Danielle are still working in the same job. Furthermore, Danielle states that the mental health body she works for had a very positive approach and did not discriminate against anyone with a disability. Indeed, mental ill health was considered to be a positive benefit as outlined in the following quote:

“experience of mental ill health is a prerequisite (of my job)”

- so that it would be unlikely for her to be discriminated against due to her mental health status.

Theme 4: Employer’s and Colleagues Attitudes

4.15. Another key theme was the general ‘atmosphere’, or attitudes in the workplace, and the treatment of the user by others at work, in connection to mental ill health.

4.16. Of the 9 interviewees, Louise, Annette, Julia and Danielle said that the attitudes of and treatment by their boss/bosses were either indifferent or negative.

4.17. Of these 4, all but Accountant Annette worked in what were arguably “caring professions”.

4.18. The most positive attitudes and treatment were experienced by Danielle, characterised by the ethos of her employers:

“Their attitude is total equality, and they don’t treat you any differently from others.”

4.19. NHS worker Julia’s experiences were those of indifference. She spoke of her treatment by her employers, and their attitudes towards her, as regards them knowing she had mental ill health:

“I don’t know if they (the employers) treated me any differently. They weren’t specifically sympathetic and didn’t do much to alleviate stress in the department; some of their actions **contributed to** extra stress.

I can’t say that they looked down on me (as regards mental ill health), but they didn’t make life any easier.”

- 4.20. Louise’s experiences are negative, due not to indifference but outright discrimination by her employers. She talked of how her employer’s attitudes hardened towards her when they realised the extent of her ill health:

“Initially, the employers’ attitudes were okay. But, when they realised it wouldn’t be a short-term illness (my own GP indicated it could take several months to recover), they were irritated and quite threatening – not understanding.”

- 4.21. Accountant Annette’s story is of her negative experiences at work due to a lack of understanding. She talks of changing attitudes at work, among different people, and of how her employer and even Annette herself lacked understanding of her illness:

“My employer was keen to know what was wrong, but I couldn’t tell them as I didn’t know/understand it myself..... I had little contact with my employers (while off work sick), mainly just the occasional phone call. My immediate boss treated me well, and visited me when unwell, was very understanding. My immediate boss left, and he was the only one I felt comfortable with. Therefore, I felt I couldn’t return, I had no support from anyone else. The next manager in line ... was a ‘bit hairy’; they allowed the work to pile up when I was away, and didn’t get a replacement in. My employer’s attitudes towards me were that they didn’t know how to treat me, were nervous of me.....

(Earlier...) my employer wanted to know when I was coming back, and kept pressurising my CPN (Community Psychiatric Nurse) who was non-committal about the time factor, and this was scary.”

- 4.22. From this work, therefore, it could be taken that 'caring' professionals can expect a less sympathetic treatment at work when experiencing mental ill health. This view is supported by previous research which has indicated that those working in the Medical Profession (and perhaps in caring professions as a whole) could expect to be treated rather unfairly as relates to experiences of mental ill health at work.
- 4.23. The interviews provided a rich and in-depth exploration of employment experiences and mental ill health. How this relates to the overall picture of experiences of employment and mental ill health in Northern Ireland is unclear, due to small sample size. Further work needs to be done to establish how these experiences relate to a larger and more representative sample of mental ill health users in Northern Ireland.

Chapter 5. Recommendations of Users

- 5.1. Many of the respondents to both questionnaires and interviews were very passionate and eloquent in giving their stories, as well as their recommendations for changes to promote better understanding of mental ill health, and better workplaces etc for those who experience mental ill health. Overall, the respondents wanted more action and awareness in the area of mental ill health at work, with the view that work can be positive and therapeutic.
- 5.2. Individuals' recommendations, from interviews and open-ended questions from questionnaires were seen to fall into 3 broad themes. These themes and related recommendations were as follows.

Raising Awareness of Mental Ill Health Issues

- 5.3. Raising awareness of mental ill health (and the options available to those with mental ill health), especially in the workplace:

“Better awareness in the workplace ... I would like doctors to have more information on places like (named training/support body).” (**Respondent L's questionnaire**)

“More awareness. Empathy as opposed to sympathy.” (**Respondent I's questionnaire**)

“More honesty and openness between people in general regarding their own mental health problems.” (**Respondent A's questionnaire**)

“Better recognition of mental health issues by employers.” (**Respondent E's questionnaire**)

“I believe there should be much better understanding of mental ill health in the workplace.” (**Phillip’s interview**)

Support

5.4. Provision of support and support networks:

“Support networks in the workplace for ALL to create greater awareness, acceptance, prevention, etc. ...

“Crisis Houses, support programmes (are important) ...

“I was never, over a 10 year period, given information on my illness or how to manage it effectively. Support group, training programs were never recommended and I remained at sea in ignorance and pain for that length of time until I joined (named training/support body).” (**Respondent M’s questionnaire**)

Tackling discrimination

5.5. Ending discrimination against people with mental ill health.

“An end to discrimination in services and employment. A move to a system based on Human Rights and equality.” (**Respondent J’s questionnaire**)

Benefits of Work

5.5. Highlighting the benefits of work for mental ill health:

“I would say that work has helped me become more well. I really enjoy my current job and believe it is good for me.” (**Respondent H’s questionnaire**)

"Work has played a key part in my rehabilitation. I could not cope with conventional employment. Volunteer work has meant I could rediscover myself through the work with support encouragement and constant psychological reinforcement."

(Respondent J's questionnaire)

"(Work) gave a sense of reality." **(Respondent G's questionnaire)**

"Work has played a key part in my rehabilitation." **(Respondent J's questionnaire)**

Education

5.6. Improving education about mental ill health issues:

(we should teach)... "Mental Health Issues as part of curriculum in 'Training for Life' to eliminate discrimination and open the door to early detection, prevention/management." **(Respondent J's questionnaire)**

Work-life Balance

5.7. Flexible working and flexible clinics for those with mental ill health:

"More support should be given by psychiatrists to User workers – such as making appointments flexible to fit in with work commitments (even a Saturday morning clinic)..."

Time off work to go to psychiatric appointments could be viewed very negatively by some employers."

Chapter 6. Findings and Conclusions

The key themes from the quantitative and qualitative data are:

Survey findings:

- 6.1. Disclosure of mental ill health is a big issue, and it may affect different aspects of life, at work and beyond.
- 6.2. At work, a user's experiences may depend on others knowing of their mental health status. For example, your overall treatment by others, how well you 'fit in' and are accepted, and your general comfort at work. Therefore, it is not surprising that willingness to disclose at work depends on the situation (e.g. to HR/manager, if well or ill, etc).
- 6.3. It was also found that willingness to disclose a history of mental ill health to any person depends on the situation even beyond work – for example, to close or broader family.
- 6.4. Self-identity was also an important issue. When invited to choose terms with which describe themselves regarding their experiences related to mental ill health, there was no overall consensus between respondents, and many chose multiple terms. Indeed, one term (PIMH, "Person with Issues of Mental Health") was created for the purposes of the study and was chosen by a significant number, 12.5% of the respondents. The 'upbeat', empowering terms were, understandably, most popular.

Interviews:

- 6.5. Overall, quite a few positive experiences related to mental health were revealed in the interviews. General positive experiences include an increase in self-knowledge, viewing work as a positive experience, and as a positive environment.

- 6.6. Experiencing mental ill health can lead to a greater knowledge of oneself, including one's abilities and limits - due to them being tested by experience related to mental ill health.
- 6.7. Work may well be seen as a positive part of life, something extra to the rest of life to perhaps bolster self-esteem or take one's mind off other aspects of one's life. Further to work being a positive experience, it can be a supportive place to be in, with the right support from other people in the workplace.
- 6.8. As well as positive experiences, respondents related a number of negative ones. Overall, these experiences may be due to lack of understanding of mental health issues and/or lack of appropriate positive structures/procedures in place at work to deal with situations and people involving mental health issues.
- 6.9. Disclosing a history of mental ill health was seen to be a contentious issue, with many respondents distrustful of groups or individuals, including people at work and insurance companies.
- 6.10. It was seen from the results that, after disclosing a history of mental ill health at work, at most about 1/3 of cases noted positive treatment there, and the rest experienced poor or mixed treatment. This generally unsympathetic treatment was seen to be due to both employers and workmates. It would be more helpful and most interesting to repeat this analysis with a larger sample size.
- 6.11. Treatment of user-workers in caring professions is seen to be less sympathetic than that experienced by user-workers outside of this profession.
- 6.12. Proper action, education and policies at work can make the difference for employers and employee between positive, rewarding experiences and negative ones. This may apply for any person, whatever their position - although it perhaps applies to people who experience mental health more than most other groups.
- 6.13. Workers who have experience of mental ill health have a lot to give in the workplace. There are many rewards for those workplaces that have the right

procedures and education in place to meet the challenges that an employee with experience of mental ill health can bring.

- 6.14. This particular study showed that such ‘empathetic’ workplaces do exist in Northern Ireland, although many respondents indicated there was definite room for improvement as regards their workplace experiences.

Recommendations

- 6.15. The current research has uncovered the need for change in the public, schools, and workplace to create better experiences for users in the Northern Ireland workforce.

- 6.16. Based on the current research, 4 broad areas for improvement are recommended.

Promoting the positives of employing mental health users in the workplace

- 6.17. As mentioned in the Findings and Conclusions:

“Workers who have mental ill health have a lot to give in the workplace”
- with potentially little or no need for ‘reasonable adjustments’.

This idea must be reinforced in the workplace, especially to employers.
If it were better accepted, perhaps more users would be employed and treated more positively.

Policies and structures for fair treatment

- 6.18. To ensure that workers with experience of mental ill health are treated fairly, employers need **more than** education. A set of general structures and procedures for workplaces should be drawn up, as a firm guide of ‘how things should be done’

in relation to mental health issues at work to ensure fairness in relation to the experience of user-workers in Northern Ireland.

Promoting positives of work to mental health

6.19. From the Findings and Conclusions, it is seen that work can be a positive aspect of a user's life. This idea should be promoted among users and mental health groups to increase the number of user-workers. That would, ideally, improve the **positive profile** of user-workers, which in turn could increase the **number** of user-workers, and so-on in a snowball effect.

Equality Awareness among users

6.20. Users need to know their rights as the law stands (notably the Disability Discrimination Act 1995), to make sure that they are not treated unlawfully by discrimination at work (and beyond). Without knowing their rights, they are disempowered and open to mistreatment, such as the bullying behaviour noted earlier in Kelly (1997).

Raising awareness of mental health issues amongst the general public

6.21. The final part of the population of Northern Ireland who should be targeted for education is the public in general, including schools. The appropriate education programme(s) would take longer to have effect (at least for schools). While this part of the recommendations is the last and most long-term, it is still vital to cause lasting positive change for the Workplace Experiences of mental ill health in Northern Ireland.

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Appendix 1: Questionnaire Details

- The following 9 pages make up the initial questionnaire used for the research

The following questionnaire asks 15 questions about the experience of mental distress and its relation to the workplace. Please read the following questions and answer as many as you wish.

This form is entirely voluntary and confidential

Thank you for taking the time to complete this short questionnaire. The results will help us to build a greater understanding of the issues and challenges surrounding Issues of Mental Health. All replies will be treated confidentially, and if you would like to answer in more detail, please feel free to use additional sheets of paper where necessary.

1. Do you have experience of mental distress, (mental ill health, mental health difficulties, etc)?

Yes

No

If you wish, can you categorise how you would communicate your experience to others, by answering the following?

2. Were you diagnosed by your doctor?

Yes

No

If 'No', please go to question 5

3. What was his/her diagnosis?

.....
.....
.....

4. Did you accept this diagnosis?

Yes

No

5. What would be your own diagnosis of your experiences?

.....
.....
.....

6. Are you currently working? (please tick one box only)

Yes - full time paid work .

Yes - part time paid work

Yes - voluntary work .

Yes - self-employed

No - student .

No

Other (please specify).....

7. If you are currently working please indicate your contract type.

Temporary .

Permanent

CURRENT EXPERIENCE OF WORK

8. If employed, who at work (if anyone) knows that you have experience of mental distress?

My manager

People I supervise

My workmates

My clients

Personnel/HR Dept

No-one

Other (please specify)... ..

9. If you have experience of employment, do you feel your work has had impact on your mental health (choose one only): -

It helped make an existing ailment better

It helped hold off ill health

It had little impact

It was a major factor in existing mental ill health

It made existing mental ill health worse

It caused mental ill health

Please comment on your given answer (e.g. why did the work help/hinder you?)

.....

.....

.....

.....

.....

.....

10. If someone at work DOES know about your mental distress, has it had any effect on your work-life? Please tick one box in each row. If the effect given does not apply, please tick 'N/A', for 'not applicable'.

	Always	Often	Sometimes	Seldom	Never	N/A
People are very accepting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It makes no difference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My workplace values my personal experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have had no support when or where I needed it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management is patronising because of my experience of mental ill health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel just as closely supervised as other colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others attribute mistakes to my mental distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues make snide/sarcastic remarks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am encouraged to take on exciting projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues include me in social and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

work events

Life is very difficult and I'm thinking of leaving

I believe I have been promoted because of my experience of mental ill health

I believe I have been put onto mental health 'user'-related projects only

I have been made to feel embarrassed because of my experiences

11. Would you be happy/willing to reveal a history of mental ill health under the following conditions? Please tick all that apply.

	Always	Often	Sometimes	Seldom	Never	Depends
On a job application form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

.....
.....
.....

On a job application form you thought someone you knew would, or might see	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

.....
.....
.....
On a monitoring form you thought
someone you knew would, or
might see

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.....
.....
On a general questionnaire you
thought someone you knew
would, or might see

.....
.....
.....
On a company questionnaire you
thought someone you knew
would, or might see

.....
.....
.....
To a HR manager, if you felt well

.....
Always Often Sometimes Seldom Never Depends

To a HR manager, if you became ill

.....
.....
.....
To a line manager, if you felt well

.....
.....
.....
To a line manager, if you became ill

.....
.....
.....
To a work colleague you feel would be less sympathetic

.....

.....

To a partner

.....

.....

.....

To your children

.....

.....

.....

Always Often Sometimes Seldom Never Depends

To family

(brothers/sisters/parents)

.....

.....

.....

To broader family

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.....
.....

To a friend

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.....

To a doctor

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.....
.....

To insurance people

.....
.....
.....

12. Which term would you use to describe yourself, in relation to experiencing mental ill health? (Tick all that apply)

(Service) User

Client (of mental health system)

Client (of other mental health body/bodies)

Survivor (of mental ill health)

Survivor (of mental health system)

Mentally disabled person

Person with a mental disability

Person with mental ill health

Person with Issues of Mental Health (PIMH)

13. What changes you would like to see made (for a better work life for people who have mental ill health), and where? Please give details. For example, recommendations to employers, the public (people in general), support agencies etc.

Better education and awareness of mental health, in schools

Better education, for the public in general

More sympathetic coverage of mental health issues in the media

Other(s) - please specify.....

.....
.....

14. Are there any issues, ideas or experiences you would like to share or discuss further?

Yes

No

If YES, please give details

.....
.....
.....
.....
.....
.....

15. Would you be willing to take part in a further informal talk/interview, or focus group

(talking in a group)? All your personal details will be held confidentially, and you have the right to withdraw your comments at any time.

I am willing to talk further about my experiences, confidentially Yes
No

If YES, I would prefer to do this in a (choose one only): One-to one chat
Group talk/focus group

Thank you for your time and co-operation.

Note that you may read and change any reports prepared using the results of this questionnaire. You may also ask anything you want, at any time, about this project and questionnaire.

This questionnaire remains totally confidential, and your details will not be released to anyone else.

- *End of Questionnaire*

Appendix 2: Interview Details

The following 3 pages make up the general line of questioning for the final questionnaires

*Interviewer's comments/questions are in **Bold**. The Interviewee's responses are between "inverted commas"*

Permission to tape record interview:

Section 1: EMPLOYMENT EXPERIENCE

Job Title: “”

Industry: “”

Company Size: “”

Working: “”

Job conditions: “”

When did you notice you became ill (e.g. before/during work)?

Did others know you weren't well?

How did mental ill health affect your work?

As a consequence of them knowing about your mental ill health, what were your employers' attitudes towards you?

As a consequence of them knowing about your mental ill health, did your employers treat you any differently?

As a consequence of them knowing about your mental ill health, what were your colleagues' attitudes towards you?

and

As a consequence of them knowing about your mental ill health, did your colleagues treat you any differently?

Did you supervise/manage people?

As a consequence of them (your 'subs') knowing about your mental ill health, what were their attitudes towards you?

and

As a consequence of them knowing about your mental ill health, did your 'subs' treat you any differently?

How did you and your life change as a result of this one experience of mental ill health in work?

Specifically, was there anything positive in your experiences? Was there anything negative?

What way did things end up for you regarding your work and mental ill health?

SECTION 2: OUT OF EMPLOYMENT

How did you leave your company?

Directly after you were let go, what were you doing, and did you try to regain employment?

What support did you receive during this time between jobs, in finding further employment?

What support did you receive to help improve or stabilise your mental health?

What support did you receive in doing day-to-day things, such as being confident, motivated and housekeeping?

What help might you have liked when between jobs, but may not have got?

- *End of interview*