The development of an intervention to support job retention and return to work for individuals with a diagnosis of bipolar disorder

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Abstract

This research explores the links between bipolar disorder and work. It focuses on the factors that impact an individual's ability to work and explores whether a simple intervention to support all the key stakeholders (employees with bipolar disorder, line managers and occupational health professionals) involved in the process can be effective. This thesis involved three distinct parts.

In the first part a qualitative focus group study explored the views and experiences of the employee, line manager and occupational health professional (OH) participants with respect to the management of bipolar disorder and work. Consensus was reached across the three groups on the main challenges to managing work and bipolar disorder and the solutions to overcome these. The three groups were in agreement on the key areas to be addressed in the intervention to meet the needs of each stakeholder group.

In the second part, a qualitative questionnaire study explored the employment patterns and the impact of clinical and demographic variables on the employment outcome across a large sample of participants with a diagnosis of bipolar disorder. This study identified that individuals with bipolar disorder can obtain and sustain employment for prolonged periods, with some reporting sickness absence levels that match those without a mood disorder. It also identified the key clinical and demographical variables best associated with employment outcome, which included educational attainment, age of onset of contact with psychiatric services and length of longest psychiatric hospital admission.

In the third part, informed by the literature review and focus group findings, the intervention 'Working With Bipolar' was developed that aimed to improve the interactions and conversations between the three key stakeholders in regard to the management of bipolar disorder and work. This intervention was well regarded among the target users and allowed positive and constructive ideas for change.

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List of my contributions to the work described in this thesis

Work presented in chapter 2: Qualitative focus groups with employees with bipolar disorder, line managers and occupational health professionals: I contributed to the design of the study and the running of the focus group meetings. I prepared the application and obtained ethical approval for this qualitative study. I contributed to the recruitment of participants by contacting organizations and Bipolar UK via email and telephone. I set up the focus group meetings, consented participants and co-facilitated the meetings. I conducted the analysis and interpreted the results.

Work presented in chapter 3: The samples utilized for the questionnaire study as outlined in chapter 3 are part of the large Bipolar Disorder Research Network (BDRN) dataset of patients with a mood disorder diagnosis. I did not contribute to the recruitment or initial assessment of these participants, but I did design the work specific measure that was distributed to the sample. I designed the analytic plan and cleaned the dataset, and I conducted the statistical analyses and interpreted the results.

Work presented in chapter 4: 'Working with Bipolar' intervention development: I contributed to the design and written content and participated in all review meetings throughout the development process. I did not contribute to the content build as this was carried out by a specialist software design company. I contributed to the design and delivery of the pilot study. I contributed to the design of pilot study measures and recruitment of participants and I coordinated data collection. I contributed to the analysis plan, and I conducted the analysis and interpreted the results.

List of Abbreviations

Abbreviation	Definition
APA	American Psychiatric Association
BDRN	Bipolar Disorder Research Network
BEPC	Bipolar Education Programme Cymru
BPI	Bipolar disorder I
BPII	Bipolar disorder II
BT	British Telecom
CSO/CSOs	Clinical studies officer/officers
DSM	Diagnostic and Statistical Manual of Mental Disorders
F	Focus group facilitator
FG1	Data extracted from first set of focus groups
FG2	Data extracted from second set of focus groups
GE	General Electric
HLC	Healthcare Learning Company
HR	Human resources
ICD	International Classification of Disorders
LM/LMs	Line manager/managers
MDD	Major depressive disorder
MI	Motivational interviewing
MRC	Medical Research Centre
NICE	National Institute for Health and Care Excellence (formerly National Institute for Health and Clinical Excellence)
OH	Occupational health
OHP/OHPs	Occupational health professional/professionals
ONS	Office for National Statistics
P	Participant
RCT/RCTs	Randomized controlled trial/trials
RTW	Return to work
SCAN	Schedules for clinical assessment in neuropsychiatry
SPSS	Statistical Procedures for the Social Sciences
WHO	World Health Organization

Introduction

Bipolar disorder is a chronic mood disorder characterised by recurrent mood episodes and high levels of psychosocial impairment (Kessler et al. 2006; Michalak et al. 2007). Bipolar disorder is recognized as the second greatest cause of lost workdays and is reported as one of the top five most disabling conditions (Alonso et al. 2010). The condition is associated with high rates of sustained unemployment, absenteeism and poor work performance (Dean et al. 2004). The symptoms and side effects of this condition can make it very difficult for individuals to function in the workplace environment and occupational impairment is profound among this group.

Ultimately more is known and researched about how to treat the condition than about the promotion of occupational wellbeing among this group of individuals. The process of return to work and job retention for those with bipolar disorder is complex and poorly understood. Earlier return to the workplace and functional recovery among those with bipolar disorder is a key consideration, not only for the individual but also at an organizational and health professional level. To date, no studies have specifically focused on the workplace environment, to explore the challenges experienced across all the key stakeholder groups involved in the job retention and return to work process. This PhD thesis seeks to address this gap by exploring the challenges to job retention and return to work for individuals with bipolar disorder and for the line managers (LMs) and occupational health professionals (OHPs) supporting them, and then to use the findings to inform the development of an intervention that will increase the user's level of knowledge and confidence to engage in complex conversations about bipolar disorder and work.

The PhD project was organized in three parts, which are reflected in the core structure of this thesis.

- In the first part, three focus groups involving participants from three stakeholder groups: employees with a diagnosis of bipolar disorder, LMs and OHPs (3x3 design) were conducted. The participants within each of the three stakeholder groups stayed the same for the duration of the study. The aim of the qualitative study was to explore the views and experiences of the employee, LM and occupational health professional (OHP) participants with respect to the management of bipolar disorder and work. The focus group meetings explored: i) the challenges to job retention and return to work, ii) the solutions to overcome the identified challenges, and iii) what an intervention should look like to meet the needs of the key stakeholder groups.

- In the second part, a quantitative questionnaire study was conducted with a large sample of patients with a bipolar disorder diagnosis. The aim of the questionnaire study was to explore the employment patterns and the impact of clinical and demographic variables on the employment outcome across a large sample of participants with a lifetime diagnosis of bipolar disorder. It tested the main findings from the employee focus groups and further explored the clinical and demographic issues associated with employment for individuals with bipolar disorder.

- In the third part, the intervention 'Working With Bipolar' was developed. The aim was to develop an intervention informed by the literature review and focus group findings, to improve the interactions and conversations between the three key stakeholders in regard to the management of bipolar disorder and work. On completion of the intervention a small-scale pilot study was undertaken to test the face validity and usability of the programme.

Thesis Outline

Chapter 1 – Background

This thesis explores the links between bipolar disorder and work. It focuses on the factors that impact an individual's ability to work and explores whether a simple intervention to support all the key stakeholders involved in the process can be effective. To meet the aims set out in this study, an understanding of a broad range of research areas was required. The research areas and the order in which they are covered are outlined below and reflect the core structure of the background chapter.

Part 1 – Mood disorders

The first section of this chapter is dedicated to the broad subject of mood disorders and the controversies in the classification of conditions.

Part 2 – Work and health

The second section of this chapter is focused on the literature in regard to mental health and work. This chapter explores the cultural shift that has emerged with the drive for functional recovery among those with mental health conditions, and the implications for all key stakeholders in the delivery and investment of workplace support.

Part 3 – Severe mental health conditions and work

The third section of this chapter is focused on the more severe and enduring mental health conditions and the associated work impairment. This section explores the main clinical and non-clinical factors that, to date, have been found to be associated with difficulties in remaining in and returning to work among this group of individuals.

Part 4 – Work and health interventions and behaviour change

In the final section of this chapter I provide an overview of the interventions currently developed in the field of work and mental health. I describe the behaviour change model (motivational interviewing) and the key principles that have informed interventions to assist in the management of health and work.

Chapter 2 – Qualitative focus group study

The methodology and findings of the focus group study will be reported in chapter 2 of this thesis. The key themes identified from each of the stakeholder groups will be reported in turn, starting with the employee results followed by the LM and finally the OHP findings. The chapter will conclude with a discussion on the key findings, exploring the similarities and differences in views across the stakeholder groups. This will be followed by a summary of the strengths and limitations of the methodology and a discussion on future research in this field.

Chapter 3 – Quantitative Questionnaire Study

The questionnaire study methodology and findings will be reported in chapter 3 of this thesis. I will describe how I collaborated with the Mood Disorder Research Team (a joint collaboration between Cardiff University and the University of Birmingham) to recruit a large sample of participants with bipolar disorder. I will then describe the process I followed to develop and distribute a work specific questionnaire to this sample and how I combined this data with secondary clinical data. This will be followed by a summary of the analysis process and a comprehensive overview of the questionnaire results. The results will be separated into two sections: section one will describe the employment patterns of the sample and section two will report the clinical and demographic factors associated with employment outcome. The chapter will conclude with an overview of the key findings, followed by a summary of the strengths and limitations of the methodology and a discussion on the direction of future research in this field.

Chapter 4 – Development of the 'Working with Bipolar' intervention

In chapter 4 I will describe the framework and research activities that informed the content and the build of the intervention. I will then provide a step-by-step overview of the intervention, describing how the user is taken through the programme. This will be followed by an overview of the pilot study methodology and a summary of the findings. The chapter will conclude with a discussion on the key findings from the intervention development process and the small-scale pilot study. This will be followed by a summary of the strengths and limitations of the intervention and pilot study methodology and a discussion on the implications for policy and practice and future research.

Chapter 5 – Discussion

An overall discussion will be presented in chapter 5 of this thesis. This chapter will discuss the overall key findings from across the three studies in the context of current literature. This will be followed by a discussion of the findings in terms of the implications for policy and practice, and suggestions for future research to take the study findings forward in this field. The thesis will finish with a formal conclusion.

Chapter 1

Background

1.1 Database and search terms

To meet the aims set out in this study, an understanding of a broad range of research areas was required which included; mood disorders, work and health, severe mental health conditions and work, work and health interventions and behaviour change. A systematic search strategy was adopted to identify relevant papers.

Medline, PsychInfo, EMBASE and Web of Science databases were searched to identify papers published between 1993 – current, in the English language. Search terms were used in groups and subsequently results were amalgamated. The search terms used were Bipolar disorder, manic depression, affective disorders/psychosis, mental health; employment, work; vocational rehabilitation, return to work; occupational functioning, job termination and job retention. The reference sections of key papers were also reviewed to identify any further key studies that were not identified during the literature search. The paper title and abstracts were reviewed to identify papers for full text retrieval. The literature search aimed to address the following questions:

1. What impact does living with a diagnosis of bipolar disorder or a mental health condition have on an individual's ability to retain employment?
2. What predicts successful employment outcomes for an individual with bipolar disorder or a mental health condition?
3. What interventions have been successful in helping individuals remain in or return to work with a diagnosis of bipolar disorder or a mental health condition?
4. What evidence is there on the role of the line manager and occupational health professional in supporting employees with bipolar disorder or a mental health conditions to return to/retain employment?

The literature identified from this review will now be discussed in the following order:

Part 1 – Mood disorders

Part 2- Work and health

Part 3 – Severe mental health conditions and work

Part 4 – Work and health interventions

Part I – Mood disorders

1.2 Mood disorders

Bipolar disorder is a mood disorder characterised by symptoms of low mood (depression), high mood (mania or hypomania) or sometimes a combination of both states at the same time (Michalak et al. 2007). It is a lifelong remitting condition that affects the individual's emotions and behaviour. In the diagnostic classification systems, 'mood disorder' (also referred to as affective disorder) is a term used to describe a set of psychiatric conditions where disturbance in a person's mood (ranging from severe elation to severe depression), thinking and behaviour are the characteristic features. It is common to experience changes in mood; however, to be diagnosed with a mood disorder the changes must be of a more severe and disabling nature.

1.2.1 Diagnosis

To be diagnosed with a mood disorder (or other mental illnesses), a patient's symptoms are compared against classification systems that provide diagnostic criteria to establish the presence of psychiatric disorders. The two key diagnostic systems most widely used are the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5), authored by the American Psychiatric Association (APA) (APA 2013), and the International Classification of Disorders version 10 (ICD-10) authored by the World Health Organization (WHO) (WHO 1993). The DSM is the diagnostic system most commonly used in the USA for the investigation and treatment of mental disorders. It is also the classification system most widely used for research purposes and in publications, due to its international recognition. The ICD is the most standardly used diagnostic tool in the UK and internationally outside the USA. Both classification systems systematize symptoms and disorders into discrete diagnostic categories and provide a common language among clinicians and researchers to define diagnostic groups. Diagnostic systems classify mood disorders

as either unipolar or bipolar in nature, where the main clinical distinction between them is the requirement of at least one episode of mania for a bipolar disorder diagnosis.

1.2.2 Unipolar depression

Unipolar depression, or major depressive disorder (MDD) as it is also termed, is characterised by periods of sadness, worthlessness, withdrawal, loss of sleep, loss of appetite and loss of pleasure in activities that persist for two weeks or more. To receive a diagnosis of MDD according to the DSM-5, patients must have at least five or more of the nine symptoms listed below at a level that causes significant impairment to social and occupational functioning (APA 2013):

1. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful)
2. Decreased interest or pleasure in most activities, most of each day
3. Significant weight change (5%) or change in appetite
4. Change in sleep: insomnia or hypersomnia
5. Change in activity: psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Guilt/worthlessness: feelings of worthlessness or excessive or inappropriate guilt
8. Concentration: diminished ability to think or concentrate, or more indecisiveness
9. Suicidality: thoughts of death or suicide, or has a suicide plan

MDD is the most prevalent of the mood disorder diagnoses. It is considered the third leading cause of global disease burden and it is estimated that by 2030 MDD will become the leading cause. The estimated lifetime prevalence of MDD based on the DSM classification is 16% of the population (Kessler et al. 2005).

1.2.3 Bipolar disorder

Bipolar disorder differs from major depression due to the presence of manic or hypomanic symptoms. Although both conditions are associated with episodes of depression, evidence suggests that the profile of the depressive symptom may differ across the two conditions (Forty et al. 2008). The symptoms of depression often differ in length, frequency and intensity from those experienced by patients with MDD. Patients with bipolar disorder often experience a greater number of depressive episodes but of a shorter duration, combined with periods of hypersomnia, mood variations and psychosis (Forty et al. 2008). Bipolar disorder is sometimes considered a more severe condition than MDD, due to the greater lifelong recurrence and higher level of comorbidity (Angst 2007).

1.2.4 Symptoms

According to the DSM-5 diagnostic system (APA 2013), bipolar disorder can be classified as either bipolar I or bipolar II disorder. To be diagnosed with bipolar I disorder patients must experience manic or mixed episodes (combination of manic and depressive symptoms at the same time) that last at least seven days at a level that causes significant impairment to work, social and personal functioning. A manic episode is defined as a distinct period of abnormal and persistent elevated, expansive or irritable mood. These episodes can lead to the individual feeling overly happy and outgoing, cause racing thoughts, increased activity, unrealistic beliefs in one's ability, a decreased need for sleep, impulsivity and engagement in high risk behaviours. Manic episodes are often severe and can result in patients being hospitalized. Bipolar II disorder is considered the less severe form of the condition and is defined by recurrent depression accompanied by hypomanic episodes that last at least four days. Hypomania is a milder form of mania (described above) where symptoms cause less impairment for the individual and do not require hospitalization. In the population, the estimated lifetime prevalence of bipolar I disorder is estimated at 1% and up to 6% for bipolar II disorder (Pinia et al. 2005).

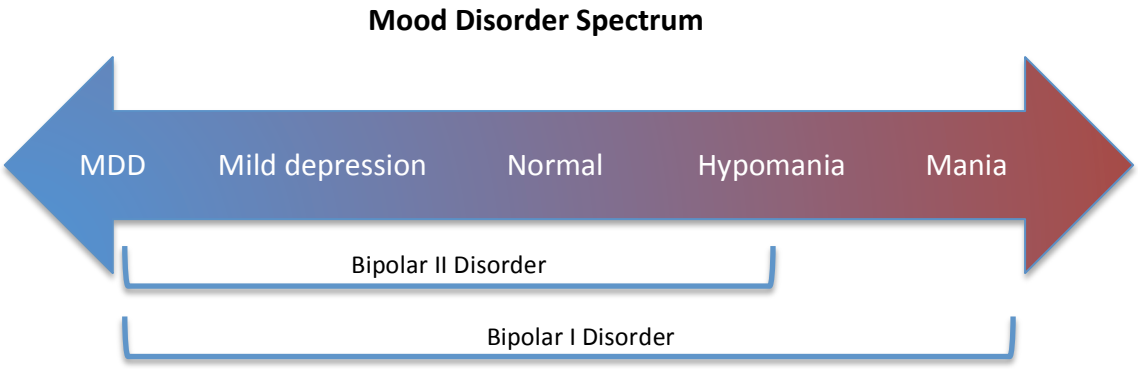
A small proportion of patients are diagnosed with a third form of bipolar disorder known as schizoaffective bipolar disorder, where patients experience a combination of psychotic and bipolar symptoms. However, this diagnosis is less common than bipolar I and bipolar II disorder.

The symptoms experienced during episodes of depression, mania and hypomania are outlined in table 1 and illustrated in figure 1.

Table 1: Symptoms of depressions and hypomania (APA 2013)

Depression	**Mania –** *The mood episode **is sufficient** to cause marked impairment to occupation functioning or social functioning, or to necessitate hospitalization to prevent harm.*	**Hypomania –** *The mood episode **is not severe enough** to cause marked impairment to social and occupational functioning, or to necessitate hospitalization.*
▪ Depressed most of the day ▪ Insomnia or sleeping too much ▪ Diminished interest or pleasure in most activities ▪ Significant unintentional weight loss or gain ▪ Agitation or psychomotor retardation noticed by others ▪ Fatigue or loss of energy ▪ Feeling of worthlessness and guilt ▪ Diminished ability to think or concentrate, or indecisiveness ▪ Recurrent thoughts of death	▪ Inflated self-esteem or grandiosity ▪ Decreased need for sleep ▪ More talkative than usual ▪ Flight of ideas or subjective experience that thoughts are racing ▪ Distractibility ▪ Increase in goal- directed activity or psychomotor agitation ▪ Excessive involvement in pleasurable activities that have a high potential for painful consequences	▪ Inflated self-esteem or grandiosity ▪ Decreased need for sleep ▪ More talkative than usual ▪ Flight of ideas or subjective experience that thoughts are racing ▪ Distractibility ▪ Increase in goal- directed activity or psychomotor agitation ▪ Excessive involvement in pleasurable activities that have a high potential for painful consequences

Figure 1: Diagram illustrating the mood disorder spectrum



Even during periods of remission (euthymic state), up to 50% of individuals with bipolar disorder still experience high levels of impairment as a result of sub-syndromal symptoms (Sanchez-Moreno et al. 2009; Waghorn et al. 2007). These are symptoms that are not of a severity or of a frequency to constitute a mood episode; however, they are still associated with disruption to everyday wellbeing.

1.2.5 Diagnosis

Obtaining a diagnosis of bipolar disorder can be a long and drawn-out process, with some studies reporting a gap of 5 to 10 years between the onset of symptoms and receiving a diagnosis (Pinia et al. 2005; Stimmel 2004). There are several reasons that could account for this delay. There can often be long periods of remission between bipolar disorder symptoms, therefore medical treatment is not sought and the condition is not identified. Additionally, hypomanic spells are often under-reported as patients mistake these symptoms as periods of wellbeing following depressive episodes (Sharma et al. 2005). Underreporting of these high moods to health professionals can contribute to a delayed bipolar diagnosis.

A delayed diagnosis can also be attributed to environmental and social factors. Feeling fearful of the stigma and discrimination associated with a mental health condition can discourage individuals from seeking support from health professionals

following the onset of symptoms (Laxman et al. 2008; Thornicroft et al. 2008). However, following a drive to increase awareness of mental illness through television and radio campaigns, and with an increase in 'high profile figures' (e.g. actor Stephen Fry and actress Catherine Zeta-Jones) disclosing their bipolar illness, there is a greater awareness and acceptance of the diagnosis. As a consequence, health professionals have reported an increase in patients presenting with a self-diagnosis of bipolar disorder (Chan and Sireling 2010). This suggests that people are either identifying the pattern of symptoms earlier or are over-medicalizing behaviour that is personality driven and not a symptom of a mental illness (Chan and Sireling 2010).

Issues with the diagnostic systems also need to be considered, and may account for some of the problems associated with obtaining a diagnosis of bipolar disorder. The diagnostic system for bipolar disorder and other mental illnesses is reliant on descriptive data elicited from clinical observation being compared against the diagnostic criteria in the DSM (APA 2013) or ICD (WHO 1993), rather than measurements that relate directly to brain function or pathology (Craddock and Mynors-Wallis 2014). The categorical approach used in these classification systems suggests that each mental health disorder is a discrete condition with no overlap. However, in reality the boundary between disorders is far less discrete and could be considered somewhat 'fuzzy'. When considering bipolar disorder on a spectrum, the condition shares boundaries with unipolar depression at one end and psychosis at the other end. It is not uncommon for an individual with unipolar depression to experience bipolar type symptoms or for a patient with a bipolar illness to experience episodes of psychosis; however, the original diagnosis would still stand. There is also the additional risk of recall bias within this diagnostic system, with patients overpathologizing 'normal' periods of sadness which could lead to the overdiagnosis of mental illnesses. Therefore, caution and critical appraisal of methodology are needed when interpreting data on prevalence figures of bipolar disorder, and on mental health populations more generally.

Thus far this chapter has provided an overview of bipolar disorder and unipolar depression, to describe how these conditions fit into the 'mood disorder' classification system. I provided an overview of bipolar disorder and its associated symptoms. I then described the diagnostic classification system and explored the issues associated with it. The next section of this chapter will focus on the literature in relation to mental health and work, to identify the impact these conditions can have on employment outcome.

Part II – Work and health

1.3 Mental health and work

Mental disorders are considered highly burdensome due to their high prevalence, chronicity and early age of onset and impairment (WHO 2000). They differ from chronic physical disorders as they have the strongest foothold in youth, with older age ranges being at a lesser risk (Kessler et al. 2005). The average age of onset of mental illness is early adulthood and for bipolar disorder is reported at between 20 and 30 years (Pinia et al. 2005). This is an important time, where individuals are most productive in developing the education and work skills (Stimmel 2004) that form the grounding for their future engagement in the work environment. This early age of onset of bipolar disorder often results in low levels of educational attainment and high levels of work impairment (Reed et al. 2010).

Approximately 450 million people worldwide are living with a mental health condition that impacts their daily life, including the capacity to maintain employment (WHO 2001). A large employment gap has been identified between those with psychiatric disorders and the general population. It is estimated that those with a serious mental health condition are six to seven times more likely to be unemployed compared to the general population (OECD 2012). Mental illness is also considered costly to the UK economy with a reported associated cost of 70 billion pounds a year (OECD 2012).

1.3.1 Sustaining and remaining in work

The literature suggests that sustaining employment can often be particularly difficult for those with a mental health condition. Fossey and Harvey. (2010) conducted a qualitative meta synthesis to explore the difficulties associated with obtaining and sustaining employment for those with mental illness. The authors reported that the difficulties were partly due to the work environment and its associated demands,

which can be a source of stress and problematic to those individuals returning to work after a period of mental illness.

The remitting and relapsing nature of mental health conditions is often associated with frequent and extended periods of sickness absence. Returning to work after extended periods of leave can be difficult and is influenced by several environmental and social factors. Dekkers-Sanchez et al. (2010) conducted a study to explore the perpetuating factors for long-term sick leave and the promoting factors for return to work among chronically work disabled patients. The authors identified several important non-illness related factors that contributed to long-term absence within this sample. These included poor working relationships, poor degree of control over work conditions and adjustments not being put in place to accommodate the individual. The main promoting factors included employees having some influence over their work conditions and support being provided by the employer.

Similar findings on the perpetuating factors to sustaining employment have even been identified among the less severe, common mental illnesses. Fossey and Harvey (2010) reported that following a period of absence a gradual return to work was preferred, and support from supervisors and colleagues was considered essential. The authors stated that employees desired an understanding and acknowledgment of their condition, and a feeling of respect. Their study also explored the role of other key stakeholders in this process and the associated challenges. The role of the occupational health professionals (OHPs) in offering strategies and support to the individual and negotiating with the employer on the part of the employee was described as particularly important and useful. However, health professionals were identified as a challenge in some circumstances due to being associated with reinforcing the illness status by focusing on the condition instead of on the resources needed to return to work (Bevan et al. 2013).

In a study exploring job termination among a sample of patients with severe mental illness similar findings were identified (Becker et al. 1998). Maintaining a job was reported as more difficult than obtaining employment, and job termination was

reported as more frequent among this group than among those without a mental health condition. The authors reported job termination was frequently a result of poor work performance and interpersonal skills.

The studies explored in this section of the chapter highlight how the symptoms and clinical aspects of the mental health condition ('common' or 'severe') are not the only factors to consider when thinking about retaining work among this group of individuals. Managing a mental health condition within a workplace setting is complex and requires a more holistic approach. In addition to the clinical symptoms, non-illness related factors such as interpersonal skills, workplace support, adjustment and an understanding of the condition and respect for the individual are also important and require careful consideration. Additionally, considering the role of the other key stakeholders within the process, particularly the employer and OHP, was highlighted as a factor that could promote return to work among those with a mental health condition.

Thus far, this chapter has provided an overview of the literature on mental illness and work, exploring issues around gaining and remaining in work among this group of individuals. I will now move on to explore the cultural shift that has emerged with the drive for functional recovery among those with mental health conditions, and the implications for all key stakeholders involved in the delivery and investment of workplace support.

1.3.2 Evidence on the benefits of work

There is now evidence to suggest that work is generally good for mental health and wellbeing, with the beneficial effects of work outweighing the risks (Waddell and Burton 2006). Being out of work has been linked to physical and mental deterioration, poor health, social exclusion and poverty (Waddell and Burton 2006), whereas employment is associated with increased social contact, confidence, self-esteem, financial independence and a sense of identity and status (Dunn et al. 2008; Leufstadius et al. 2009; Shepherd et al. 2009; Warr 1987). Engagement in

employment provides a structure and routine of meaningful activity (Leufstadius et al. 2009), reducing the likelihood of social exclusion and isolation that is commonly associated with mental illness. Better quality of life (Medard et al. 2010), reduced use of mental health services and higher rates of independent living (McHugo et al. 2012) have been reported among those in work with mental illness in comparison to a non-working group.

In a study by Elinson et al. (2007) that explored the service use of those with mental illness, the authors reported the majority of the 'working' sample were typically managed by a primary care practitioner, in comparison to the 'non-working' sample who were under the care of a secondary care practitioner. This suggested that those in work had better control over their condition, were less symptomatic and therefore required less specialist support. This was supported in findings by Glozier (2002), who reported unemployment as being associated with twice the psychiatric morbidity of any employed group.

1.3.3 Worklessness and the family unit

Prolonged worklessness has also been shown to impact negatively on the family unit. Children in workless households have a higher prevalence of recurrent health conditions and lower wellbeing, suffer higher rates of psychiatric disorders and are more likely to experience worklessness themselves during adult life (Edwards et al. 2006). There is also the associated economic cost of worklessness to consider. Worklessness and sickness absence are estimated to cost the UK over 100 billion pounds, with 2006 figures reporting 175 working days being lost to illness (Black 2008).

1.3.4 Type and nature of workplace environment

The evidence on the benefits of work is compelling in regard to bipolar disorder, and to mental health more generally. Being engaged in employment and retaining a job are often considered steps in the recovery process and they form an important part of the rehabilitation plan (Boardman 2003). However, it is important to consider the type of work and nature of the workplace environment. Waddell and Burton (2006) included an important caveat in their findings, reporting that it is 'good' work that is the key to better health and wellbeing. They defined 'good work' as an environment that offers safety, security, control and fulfilment (Waddell and Burton 2006), as opposed to a monotonous unskilled work environment that is unlikely to offer the flexibility and accommodations needed for those with psychiatric illness. Evidence suggests the latter type of work environments are associated with lowered levels of confidence and self-esteem among workers (Provencher et al. 2002; Tse and Walsh 2001). Stansfeld and Candy (2006) conducted a meta-analysis to explore the psychosocial work environment and the associated incidence of common mental health disorders. The authors reported high psychosocial demand and low decision making, and a combination of high work effort and low reward was consistently associated with an increased risk of common mental disorders. These findings were found to be consistent across studies that were both cross-sectional and longitudinal in nature.

Studies have also explored the negative impact that work could have on mental illness. Burns et al. (2009) described how the impact of work demands and increased social interactions that occur in workplaces could be detrimental, and could lead to increasing anxiety and to destabilising individuals with mental illness. It is important to note that for some individuals there may be periods where their illness is too disabling to make them suitable for open employment or involvement in any form of meaningful activity.

1.3.5 Directional relationship between work and health

A further issue to consider when reviewing work and health literature is the question of whether being engaged in work leads to better mental health, or whether those who are in employment are able to work because they are less symptomatic and have better management of their condition. Is it the participation and engagement in work that directly contribute to better mental health, or are those in work able to sustain employment because they have better mental health in the first instance? Based on the current literature it is difficult to answer this question with complete certainty as a statistically sound causal relationship is yet to be reported. However, clinical severity is not a conclusive predictor of work impairment (Hammen et al. 2000; Medard et al. 2010; Waghorn et al. 2007). Even those with a severe mental illness such as schizophrenia (Bevan et al. 2013) and those experiencing bipolar symptoms at a severity that requires hospitalization (Medard et al. 2010) do gain and sustain employment. This would suggest that those in work are not just reflective of those with a less severe or more manageable course of illness. However, this does need to be considered with some caution due to the complexity of the issue and the methodological issues discussed above

1.3.6 Promotion of functional recovery

In recent years, the UK government has recommended that health and social care services have a stronger focus on maintaining and promoting employment for individuals with mental health problems (Black, 2008). This has resulted in a major shift in society's perceptions of work and health, with the messages about sickness absence now focusing on promotion of functional recovery. Traditionally the mental health system endorsed the concept of psychiatric conditions being chronic and debilitating despite studies showing otherwise (Krueger and Casey 2000). The chronicity of the condition often led to a dismal prognosis and poor expectations for functional recovery. However, extended periods of absence are no longer considered the best course of action for physical and mental health problems. It is now considered appropriate to return to work before being considered fully fit, as

this is unlikely to impede recovery. The focus is now on what a patient/employee 'can do' when recovering from a health condition and not what they 'can't do'. The introduction of the 'fit note' in 2010 demonstrated this shift in focus, as until this time the 'sick note' had not changed since its introduction into the NHS.

1.3.7 Fit note

In a government approach to reduce sickness absence and work disability, and to improve the health and wellbeing of working populations, the 'fit note' was introduced into general practice (Black and Frost 2011). The aim of the fit note is to build closer collaboration between the healthcare and employment sectors to promote an earlier return to the workplace. It provides GPs with an opportunity to make recommendations on the circumstances in which a patient may be able to return to work. However, if the employer is unable to accommodate the recommendations suggested by the GP the patient would then be considered not fit for work.

The government approach to improve engagement with the fit note and the fit for work guidance has been associated with some difficulties in its implementation (Coole et al. 2015). In a review by Coole et al. (2015) the authors identified that more than three years after its implementation the fit note is of limited use in helping employees return to and remain in work. Some GPs have reported having inadequate time and experience to broach the return to work conversation with patients. Employers have also reported difficulties with the new process, in particular in accommodating the GPs' recommendations. Although employers are in a key position to support employees on sickness absence to return to work, they often report a lack of adequate knowledge, skills and confidence to do so (Black and Frost 2011). This is particularly true for employers in smaller organizations (Black 2008) where training and support to manage employees with mental health conditions may not be available. In a study by the Mental Health Foundation (2015), 7 out of 10 managers reported having experience of managing employees with

mental health problems; however, only a quarter felt they had the adequate knowledge to do so.

1.3.8 Occupational health support

Occupational support and adopting good management practices have been cited as the most effective ways to tackle long-term absence and can have a powerful effect on returning employees to the workplace quickly (Black and Frost 2011). Occupational physicians and nurses have the skills and knowledge to evaluate an employee's health and an in-depth understanding of the workplace environment. They are therefore ideally placed to provide impartial advice to facilitate a supportive return to work that meets the needs of both parties. However, it has been reported that 40% of organizations do not have any sickness absence policies in place (Black 2008) and less than 30% have access to OH support (Faculty of Occupational Medicine [FOM] 2010). A lack of support and advice for the employers, who play a pivotal role in maintaining staff welfare, is identified as the most common barrier to investing in the health and wellbeing of their employees.

1.3.9 Return to work, workplace adjustments and support

Earlier return to the workplace and functional recovery among those with mental illness is a key consideration at an individual, organizational and health professional level. Waddell et al. (2009) identified a window of opportunity between one and six months where rehabilitation is most likely to be successful. Several factors have been identified in the literature that facilitate return to work following a period of sickness absence. Regular and ongoing contact between the line manager (LM) and employee has been associated with a more rapid return to work (Black 2008). This is supported by findings by Waddell et al. (2009), who identified good communication between stakeholders as key if rehabilitation is to be successful.

Implementation of workplace adjustments is also often key to assisting employees to return to the workplace. These may include alterations to working hours, allowing

flexibility for the employee to attend medical appointments and offering supervision (Glozier 2002). Ultimately, it is in the employer's interest to invest in developing workplace cultures and environments that proactively manage an individual's health condition to boost productivity and benefit from lower levels of sickness absence (EEF 2015). Links have been identified between high levels of employee engagement and lower levels of sickness absence, therefore managers need to be willing to acknowledge the problem and take action (Black and Frost 2011). Organizations often invest a substantial amount of time and money in training employees to develop the skill base and knowledge specific to their job role. Therefore, not supporting an employee's wellbeing is costly in the long term due to the extra investment that is required to cover or replace staff on long-term sickness absence (Boorman 2009).

1.3.10 Employee role and disclosure

The role of the employee within the job retention and return to work scenario is also important to consider. The employer/LM/health professional can only provide adequate support and accommodate the employee if they have been informed of the condition. In a survey by the Mental Health Foundation (2015) only 61% of respondents had disclosed their mental health problem to their manager. The remaining 39% reported feeling fearful of disclosing their mental health condition due to a fear of stigma and discrimination. This further highlights the complexity of the issue. Disclosure of the condition could enable greater access to support within the workplace; however, withholding this information could provide a means of sustaining control and reducing the likelihood of being defined by the condition.

In summary, this section of the chapter has provided an overview of the literature on work and mental health. I explored the evidence on the benefits of work for those with mental health conditions and the cultural shift that has emerged with the drive for functional recovery. The literature highlighted the potential benefits of work for individuals with mental health conditions, even those of a severe and enduring nature. Returning to and engagement in work is becoming an accepted goal in the

recovery process for those with mental health conditions, which is clearly reinforced through the introduction of the fit note. However, in practice, this chapter clearly identified implications for all key stakeholders in the delivery of workplace support for those with mental health conditions. An earlier return to the workplace has clear benefits for the individual, organization, health professional and economy. However, the implementation of training, support and resources are clearly required to assist employers in adopting workplace cultures that actively promote employee wellbeing. Additionally, employees need to understand their role within the process and feel reassured that if they choose to disclose their condition it will not lead to stigma and discriminatory behaviour.

Part III – Severe mental health conditions and work

1.4 Schizophrenia

Schizophrenia is a psychotic illness. The term 'psychotic illness' describes a set of symptoms where patients are unable to distinguish between their own thoughts and ideas and reality. Symptoms of schizophrenia are grouped in two categories and are defined as 'positive' and 'negative' symptoms. Positive symptoms refer to active symptoms that include delusions, hallucinations and disorganized behaviour. Negative symptoms refer to a loss of normal function that can include a lack of motivation, lack of emotion, low energy and social isolation (APA 2013). Schizophrenia exists on a continuum from mild to severe and it can sometimes be difficult to distinguish it from bipolar disorder due to the similarity in symptoms, particularly for those with a schizoaffective disorder where individuals experience a combination of both psychotic and bipolar disorder symptoms.

Schizophrenia affects around 1% of the UK population (National Institute for Health and Clinical Excellence [NICE] 2009), with an average age of onset of between 16 and 30 years. Consistent with bipolar disorder, schizophrenia is associated with profound impairment, including academic failure, unemployment, isolation and physical illness (National Alliance on Mental Illness [NAMI] 2008). In a review of literature on schizophrenia and employment, Marwaha and Johnson (2004) noted that most studies reported an employment rate among those with schizophrenia of between 10% and 20%. This is substantially lower than the employment rate in the UK population (74%) (Office for National Statistics [ONS] 2016) and among those with a bipolar disorder diagnosis (40-60%) (Marwaha et al. 2013).

1.4.1 Schizophrenia and work impairment

Due to lack of space, a full review of the literature on schizophrenia and work cannot be given. However, a recent wide-ranging review conducted by Bevan and Guilford (2013) that explored the links between employment and schizophrenia will be

discussed. The review specifically explored the barriers to employment and the pathways to work for individuals with schizophrenia. The report identified some of the challenges for this group and the support mechanisms required to facilitate integration into employment and sustained employment. The authors reported high levels of disability and unemployment among this group; however, among those of working age there was a willingness and ability to undertake some form of work.

Bevan and Guilford (2013) identified the benefits of regular work, where those in employment were five times more likely to be in functional remission than their unemployed counterparts. The report described work as invaluable to those with schizophrenia, with individuals reporting that work provided a sense of purpose and structure to their day. Consistent with findings from the general mental health literature, the clinical symptoms of schizophrenia were not always the main barrier to work. The report highlighted the importance of considering non-illness related issues such as the workplace environment and the key stakeholders involved in the work process. A supportive workplace environment was identified as key to enabling employees with schizophrenia to remain in work. Bevan and Guilford (2013) also described the need for a coordinated approach between the key stakeholders (employee, LM and health professional) in the management of the condition, with a focus on increasing the understanding of the condition and the work environment. The report highlighted the importance of not only an understanding and supportive LM but also the responsibilities of the employee in managing their own health condition. Finally, the authors identified the role of the health professional and the need for work to be considered as a priority in the recovery and rehabilitation process.

1.4.2 Comparisons between bipolar disorder and schizophrenia

A detailed review such as the one conducted by Bevan and Guilford (2013) is yet to be carried out for individuals with bipolar disorder. This is surprising as bipolar disorder is recognized as a condition with one of the highest levels of disability (Alonso et al. 2010), and the spectrum diagnosis of bipolar disorder accounts for up

to 6% of the population and possibly more if the evidence relating to under diagnosis is found to be true. Comparable with schizophrenia, bipolar disorder is also considered one of the leading disorders associated with losing significant years of healthy life, attributable to significant states of less than full health. A detailed understanding of the barriers to sustained employment for those with bipolar disorder from the perspective of all stakeholders could have substantial economic and personal benefits. Such an understanding would be required to inform interventions and policies to support this population. Although no major reviews have been undertaken, a number of studies have been conducted that will now be discussed.

1.5 Bipolar disorder and work

1.5.1 Employment rates

An international study by WHO explored the days out of work role lost due to common physical and mental health conditions. Bipolar disorder was recognized as the second greatest cause of work days lost and was reported as one of the top five most disabling conditions (Alonso et al. 2010). The National Depressive and Manic-Depressive Association reported that approximately 60% of individuals with bipolar disorder are unemployed (Hirschfeld et al. 2003). Those affected by bipolar disorder are often young to middle aged and are therefore at a point in their lives where they would be expected to be economically active (Gilbert and Marwaha 2012). Bipolar disorder, although less prevalent than MDD, is associated with an overall higher economic burden in terms of the costs associated with high levels of unemployment, sickness absence and treatment, which are attributed to the severity of symptoms (Laxman et al. 2008). This is consistent with findings from the USA that also reported a significantly lower proportion of patients with bipolar disorder in work (43%), in comparison to those with a unipolar diagnosis (63%) or to a non-mood disorder population (81%) (Shippee et al. 2011).

1.5.2 Occupational outcome among those with bipolar disorder

Although high levels of unemployment are reported among those with a psychiatric disability, evidence does suggest that a large majority want to be engaged in some form of meaningful activity (Boardman 2003). Employment is now recognized as a key treatment outcome (Black and Frost 2011), and evidence suggests that those with bipolar disorder do gain and sustain employment (Gilbert and Marwaha 2012). Medard et al. (2010) explored the occupational outcome of bipolar disorder patients three years after hospitalization. At baseline 58.1% of participants were in work following an episode of hospitalization, and at the 3-year follow-up just over half the of the 'in work' participants were still in employment. This supports findings that individuals with bipolar disorder can sustain employment even with symptoms of a severity that requires hospitalization. In addition, clear benefits to being in work were identified among the 'in work' group. Significantly higher levels of quality of life were reported among the 'in work' group in comparison to the non-working group, with no clinical or occupational differences identified across the two groups to account for this difference. One could therefore propose that the difference in quality of life between the working and non-working groups may have been a result of the benefits to be gained from being engaged in work. Findings by Zimmerman et al. (2010) further support this assumption, with authors reporting an association between prolonged unemployment and increased episodes of depression and an increased likelihood of hospitalization. However, due to the design of the two studies it is not possible to make an assumption on causality and directionality.

1.5.3 Sickness absence and productivity

Although individuals with bipolar disorder do gain and sustain employment, similarly to findings in the field for common mental health conditions, high levels of sickness absence and poor productivity are reported among this group of individuals. Zimmerman et al. (2010) explored the amount of time missed from work due to psychiatric reasons among a sample of patients with bipolar disorder, and reported that 34.5% of the sample missed up to two years or more of work. Evidence suggests

those with bipolar disorder frequently report difficulty with maintaining employment (Becker et al. 1998), which is often due to functional problems such as inconsistent performance and interpersonal difficulties (Tse and Walsh 2001).

1.5.4 Clinical symptoms and workplace impairment

Several studies have attempted to identify a relationship between the clinical symptoms of bipolar disorder and the level of workplace impairment. A consistent finding in this area is the association between work disability and depressive symptoms. In a 15-year prospective follow-up study comparing work disability between a bipolar and a unipolar sample, depression symptoms even at a sub-syndromal level were significantly associated with poor work outcome among those with bipolar disorder. A greater level of work disability was attributed to the depressive pole of the disorder rather than mania related symptoms (Goldberg and Harrow 2011). In an earlier study, Kessler and Frank (1997) also reported a higher rate of absence among those with bipolar disorder as a result of the persistence and severity of depressive symptoms. Simon et al. (2008) reported that those with depressive episodes missed three times as many days of work compared to those in remission and were 15% more likely to become unemployed. The authors assumed a causal relationship as the data showed a stepwise increase in functional impairment as the severity of depressive symptoms increased.

Depressive symptoms are associated with decreased confidence, inability to concentrate, social withdrawal and decreased energy and enthusiasm (Dickerson et al. 2008; Goldberg and Harrow 2011; Kessler et al. 2006; Provencher et al. 2002; Simon et al. 2008; Wilkins 2004). These are all well recognized symptoms that impact on performance in work. It is therefore unsurprising that these symptoms are related to high levels of work impairment in this group of individuals.

1.5.5 Mania and work impairment

Mania and its impact on performance and work have also been explored. Symptoms of hypomania have been associated with positive influences on the work environment in terms of increased productivity, higher levels of problem solving ability, increased enthusiasm, creativity and confidence (Angst 2007). However, during periods of hypomania individuals may also have the tendency to take on unmanageable workloads, lack insight and experience high levels of irritability that could lead to work impairment. Kessler et al. (2006) reported that manic and hypomanic symptoms can cause the same level of impairment and lost work performance as depressive symptoms.

The studies discussed above clearly demonstrate the increased level of workplace impairment experienced among those with bipolar disorder, and the complexity of the condition due to the two poles of the illness. The literature suggests that the management of the depressive and manic symptoms, even at a subclinical level, is particularly important in assisting both those who want to work and those who are in work to retain employment. However, consistent with the data for common mental health conditions discussed earlier, clinical symptoms are not the only factor that should be considered in regard to work, as will now be discussed.

1.5.6 Non-clinical factors and work impairment

It has been argued that clinical symptoms alone cannot explain or predict the level of impairment experienced by those with bipolar disorder (Medard et al. 2010; Waghorn et al. 2007). Hammen et al. (2000) stated that psychosocial factors are a stronger predictor of work outcome than psychiatric factors such as hospitalization and symptomology. Tse and Yates (2002) conducted a qualitative study to explore the internal and workplace factors that influenced an individual's ability to maintain employment. The internal factors identified included personal factors (determination to succeed) and internal attribution factors (being considered a 'good worker'). The workplace factors identified were job satisfaction, workplace

structure and support from health professionals, family and colleagues (Tse and Yates 2002).

1.5.7 Management of mood symptoms

There are also additional personal factors to consider, such as the management of mood. Inability to control mood states has been recognized as a major barrier to remaining in or returning to work for individuals with bipolar disorder (Michalak et al. 2007). The authors stated that ideally individuals should be tuned into the condition and have insight into their personal strengths and limitations (Michalak et al. 2007; Sanchez et al. 2010; Tse and Yates 2002). This would ensure that individuals have realistic goals and expectations in terms of their capabilities to remain in and return to work during symptomatic periods.

Studies have reported the coping strategies often used by individuals to manage their symptoms of bipolar disorder in the workplace. These include individuals removing themselves from the workplace or changing the environment or workload when symptoms become problematic (Laxman et al. 2008). Additionally, some choose to change to less pressured and less demanding job roles to help manage symptoms and sustain employment (Marwaha et al. 2013). These strategies appear to reduce the chances of the excessive stress that individuals perceive may trigger a bipolar disorder episode. Some studies have suggested that older workers are more likely to sustain employment than younger workers (Waghorn et al. 2007) due to the coping mechanisms they have developed to manage their condition in the workplace. It is important to understand the coping strategies that are effective among this sample to inform future practice and strategies in the workplace, and to assist those with bipolar to maintain employment and return to work following a spell of absence. However, it is important to be mindful of the healthier worker survivor effect which may account for older workers being more likely to sustain employment. This effect relates to the out-selection of less healthy workers (Virtanen 2005) as there is a tendency for those with disease to leave the workforce.

1.5.8 Methodological issues

There is a large body of evidence on the clinical and psychosocial characteristics of bipolar disorder and mental illness in relation to occupational functioning; however, there are important methodological issues to consider when interpreting these studies. Some studies on work impairment include a more inclusive 'serious mental health' sample; therefore bipolar disorder only accounts for a small proportion of the overall sample. Inclusion of several conditions is beneficial in recruiting a large sample where comparisons across the condition can be made; however, only a small proportion of the overall sample is therefore representative of each distinct diagnostic group. This could result in important implications unique to those with a bipolar disorder diagnosis being missed. However, understanding the differences and similarities across differing mental conditions can be useful, especially when developing interventions and workplace polices to support the management of mental health.

As with research more generally, adequate sample size is also an issue in this field of research. The majority of studies cited in this chapter reported a small sample size as a major limitation of their study. However, it was encouraging to discover that findings were frequently consistent across the literature, suggesting the studies are often representative of the population under investigation. For example, the demographic distribution of the sample in the study by Medard et al. (2010) was comparable with population literature, and the reported findings were consistent with other studies irrespective of the small sample size.

Several studies adopted a longitudinal type design which offered the researcher the opportunity to capture periods of symptom improvement or deterioration that may have been lost using a cross-sectional design. However, cross-sectional studies often do capture the disruptive nature of the condition. A main concern identified on reviewing the literature was the use of a retrospective design, where researchers are reliant on participants accurately recalling previous episodes of illness and years of absence. It was not possible to find any studies that collected data directly from the

workplace, therefore sickness absence and work productivity figures were solely based on the participant's recall of the events. Even longitudinal studies often collected follow-up data at specific time points throughout the study. Therefore, unless a period of absence occurred during that data collection point, the study was still reliant on participants providing accurate information. There is a high probability that estimations of this sort are likely to be inaccurate, particularly due to the nature of the condition. If an individual is experiencing a high mood they may underestimate the impact of the condition and, equally, if they are experiencing a low mood episode they may overestimate their level of work impairment.

It is difficult to report any causal or directional relationships between bipolar disorder and work due to the methodological limitations identified above. To report a statistically robust causal relationship would require a study design that adopted a prospective longitudinal approach with an adequately powered sample size. A high quality study of this type would be costly and time intensive.

In summary, in this section of the chapter I have provided an overview of the literature in relation to bipolar disorder and work. The literature clearly highlighted the high level of work impairment reported among those with bipolar disorder due to the complex nature of the condition. However, sustained employment is reported among this group of individuals, even among those experiencing symptoms of a severity that requires hospitalization. This chapter identified the main clinical and non-clinical factors associated with difficulties in remaining in and returning to work among those with a bipolar disorder diagnosis. Consistent with the findings discussed earlier in this chapter in regard to common mental health conditions, there was also no single exclusive factor that accounted for work impairment among this group of individuals. The depressive pole of the condition was described as being particularly problematic; however, there was also strong evidence identifying the role of other psychological and social factors in perpetuating job retention and return to work among this group. This literature review has highlighted the need to consider all clinical and non-clinical psychosocial factors when considering future practice and intervention development.

Part IV – Work and health interventions and behaviour change

1.6 Workplace interventions

1.6.1 Evidence on workplace interventions

Interventions developed specifically to support employees to return to work have been shown to play a positive role following a period of sickness absence (McHugh 2002). Michie and Williams (2003) stated that interventions that use training to increase participation in decision-making and problem solving are effective at reducing work-related psychological ill health and sickness absence. This was further supported by the findings of Black (2008), who highlighted the importance of interventions that focus on the interaction between the employer and employee to facilitate communication and shared decision-making.

1.6.2 Individual Placement and Support

In regard to reintegrating employees back into the workplace, Individual Placement and Support (IPS) is the model currently recommended by the Department of Health and NICE. Where existing vocational interventions provide training and preparation prior to reintegration into work, IPS is based on rapid job placement, and then training and support whilst the individual is in the workplace. IPS employment specialists work closely with the individual to match them with their preferred choice of job role. A key aspect of this model is the links established between the employment specialist and all key stakeholders, namely the treatment teams, to ensure employment is integrated into the individual's treatment plan. This model is based on the concept that rehabilitation into the workplace should be an integral component of medical care and not a separate service (Boardman 2003), thereby overcoming the issue of separating mental health and rehabilitation services (Drake et al. 1999) which can often lead to conflicting advice being given to the consumer. Research has shown that in comparison to other interventions, individuals that

entered employment via IPS were more likely to be in employment 18 months later, had worked more hours and had earned a higher wage (Drake et al. 1999) than those who accessed other standard rehabilitation services. Studies have shown that for those with long-term mental health problems, high fidelity IPS can have a significant effect on employment outcome (Rinaldi et al. 2011), independent of general employment rates.

There has, however, been some conflicting findings in regard to the effectiveness of the IPS model. In a UK randomized controlled trial (RCT) of IPS versus standard care, no significant difference was found between rates of competitive employment (Howard et al. 2010), which contradicts the superior outcomes that have been identified in the USA where IPS originated. The author stated the insignificant findings were a result of the implementation of the intervention, as the IPS model had not been fully integrated into the mental health teams. This highlighted that one of the main 'active' components of the model is engagement with health care teams. IPS is an accepted and evidenced-based model that is widely used to reintegrate those with long-term illness back into the workplace. However, this model does not support employees in the long term to assist them in retaining employment with conditions such as bipolar disorder that are lifelong and relapsing in nature.

1.6.3 Psychoeducation

Psychoeducation interventions aimed at the long-term ongoing management of conditions such as bipolar disorder have also proven very effective. Psychoeducation is a means of providing accurate information about diagnosis, prognosis and treatment to support individuals to keep themselves well. In an RCT of psychoeducation in a group setting, patients in the intervention arm experienced significantly fewer relapses (Colom et al. 2004) than those in the control group. At the 5-year follow up the treatment group had a significantly longer time before a mood episode, fewer recurrences and a lower median number of days in hospital compared to the control arm (Colom 2009). This study was conducted in Barcelona and was based on a psychoeducation programme for bipolar patients that consisted

of twenty-one 90-minute group sessions, covering four main areas: illness awareness; treatment compliance; early detection of prodromal symptoms; and lifestyle regularity.

In a Cardiff study Smith et al. (2011) adapted the Barcelona model to develop an online psychoeducation programme to improve the long-term outcome for patients with bipolar disorder by educating the patients and their families on the management of the condition. Teaching individuals to identify early symptoms of relapse has also been reported to improve employment outcome (Perry et al. 1999). The online programme 'Beating Bipolar', developed by Smith et al., provided information to the users via a blend of delivery models to maximize the impact of the content, for example, video clips, voice over and interactive activities. It was developed in collaboration with the user group to ensure the information offered was rich, detailed and grounded in real lived experiences. Developing the intervention online was deemed cost-effective, as it did not need to incorporate therapeutic time, training and travel costs. This programme showed a positive impact on self-management among the user groups (Poole et al. 2012).

1.6.4 Internet-based learning

Online computer-based programmes such as 'Beating Bipolar' are becoming increasingly popular as quick access to information is now an expectation. There are several benefits associated with computer-based interventions. They include:

- Uniformity in how the intervention is delivered
- Accessibility in a range of settings (group or individual)
- Ease of use
- Inexpensive delivery method

Programmes adopting this delivery method have been linked to improved access and engagement in interventions (Coyle et al. 2007). Utilizing IT and the Internet offers an opportunity to provide interventions to a large number of people in a cost-effective, quick and accessible way.

The Internet is now accessed by 39.3 million adults (78% of adults) in Great Britain (ONS 2015) and has become an accepted health information resource. The Internet is becoming increasingly used in the health care setting as the result of a government push for the NHS to use IT to improve communication between professionals and patients (Atherton and Majeed 2011). The government set an information revolution target which aims for people to have access to the information they need to make decisions and stay healthy (Department of Health 2010). Adopting this mode of delivery is therefore not only cost-effective but also consistent with the government agenda on how health information should be shared in the future.

1.6.5 Work intervention for bipolar disorder

The Cardiff group noted that an issue raised by the user group in regard to the 'Beating Bipolar' programme was the lack of information on work issues. Suggestions on what an intervention should look like to assist those with mental health conditions have been made by authors across several studies. The need for an intervention that integrates and collaborates with all key stakeholders is clearly evidenced (Black 2008; Boardman 2003; Waddell et al. 2009). This approach is further supported by study findings looking specifically at the bipolar disorder population. In a systematic review on the impact of bipolar disorder on the working population the authors described the need for an intervention that engaged with the employer, employee and healthcare providers, and provided information about the condition and treatment (Laxman et al. 2008).

1.6.6 Interventions targeted at line managers

There has also been research looking specifically at the role of the LM in the return to work process, with a focus on the skill and training requirements among this group. Yarker et al. (2010) developed a competency framework for LMs to support the return to work process. The framework suggested that effective communication

and sensitivity to and understanding of the individual were the most valuable skills for a LM when supporting an employee to return to work. However, the authors noted that skilful conversations about these complex issues are not easy and LMs often report they lack the confidence to engage in these interactions.

1.6.7 Interventions targeted at healthcare professionals

Studies have reported that GPs have also described a lack of confidence, knowledge and skill to engage in complex work and health consultations with patients (Cohen et al. 2009). To address this issue, Cohen (2007) developed an online programme underpinned by motivational interviewing (MI), the behaviour change model, that provided skills training and information to increase GPs' confidence in managing these interactions, and to increase the level of importance they assigned to these conversations. Interventions and training grounded in models such as MI, targeted at developing skills, have been shown to be effective in improving the return to work consultations among GPs (Chang and Irving 2008; Cohen 2008) and LMs (Cohen et al. 2012).

In summary this section of the chapter has provided an overview of the interventions currently developed and researched in the field of work and health. As stated previously, the evidence clearly highlights the need for an intervention that integrates all stakeholders involved in the process, which for the purpose of this study would include the employee (with bipolar disorder), the LM and the OHP/health professional. To assist users groups to engage in more skilful interactions would require skills training, and information to address any gaps in knowledge. Encouraging a user group to engage in more skilful interactions requires a change in behaviour from their 'current' practice to 'better' more skilful practice. The intervention by Cohen (Cohen 2007) discussed above adopted the principles of MI to facilitate this change in behaviour. The underlying principles of this model provided a solid grounding for intervention development in this area. I will therefore now provide an overview of MI, to describe the principles of this model and how they can be utilized to inform an intervention in this field of research.

1.7 Behaviour Change model

1.7.1 Principles of motivational interviewing

MI is a counselling style that explores a client's ambivalence to change. It promotes behaviour change by strengthening a client's motivation and commitment to change. Simply telling individuals to change their behaviour often proves unrewarding (Rollnick et al. 2010) and can elicit resistance. Therefore, MI explores the client's reason for change, using a guiding style of communication to evoke motivation to change. MI has been used in various health care settings and has shown potential in enhancing clients' intention and confidence to change and engage in treatment (Lundahl et al. 2010).

Rollnick et al. (2010) defined three ways in which to learn MI:

1. Adopt a guiding rather than directing style to communicate with the client. This involves shifting communication style from director to well informed guide. Work alongside the client to help them identify solutions and inform their decision. This can be done through 'asking, listening and informing'.
2. Develop strategies to elicit the client's own motivation to change. Work with the strengths of the client rather than focusing on the challenges.
3. Refine listening skills and respond by encouraging change talk. Eliciting change talk will enhance motivation to change.

MI interventions are a collaborative process between the practitioner and client. The approach is person-centred, with the practitioners adopting a non-judgemental approach. In healthcare settings an MI style of communication has been considered a constructive and time efficient method (Rollnick et al. 2008).

To assist the practitioner in focusing the conversation it is important to ascertain the client's level of 'confidence' in their ability to change behaviour and the level of 'importance' they assign to the change. This is based on the assumption that if the client is confident in their ability to change and they perceive the change as

important they are more likely to be ready to change their behaviour, as illustrated below.

IMPORTANCE + CONFIDENCE = READINESS TO CHANGE

Adopting the principles of MI described above suggests that an intervention would need to focus on a guiding style of training rather than simply telling the user to change. The intervention content would need to highlight the importance of engaging in more skilful interactions, and provide the skills training to encourage and give confidence to the users to do so. Finally, the intervention would need content that would elicit the users own motivation to use the new skills being presented. The intervention would move beyond an educational model, which simply relies on the didactic learning style of providing information and skills, to a model that contains psychological components, including feedback, assessment, information and advice.

Chapter 2

Qualitative Focus Group Study

2.0 Chapter 2 – Qualitative Focus Group Study

In this chapter I cover the qualitative work I conducted through a series of focus groups to explore the complex interactions between the employee, LM and OHPs in relation to bipolar disorder, job retention, and the return to work process. I will first present the rationale for this aspect of the study, then provide a comprehensive overview of the methodology and results. I will conclude this chapter with a discussion on the focus group findings.

2.1 Rationale

The overall aim of this thesis was to explore the return to work and job retention process from the perspective of the three groups (LMs, employees and OHPs) and to use the findings to inform the development of an intervention. The purpose of the qualitative aspect of the study was to define the content and structure of the intervention by exploring the perspectives and experiences of all stakeholders responsible for the management of bipolar disorder in the workplace. Qualitative methodology was used as it allows an in-depth exploration of respondents' views and experiences, including topics that it is not possible to predict in advance.

2.2 Focus group methodology

Data collection was undertaken through a series of focus groups with each of the three stakeholder groups (employees, LMs and OHPs) to facilitate discussion on the challenges they face in managing bipolar disorder and return to work. Focus group methodology allows a user-led approach to understanding the topic of interest (Baker 2001) so that informed choices can be made when developing an appropriate intervention (Krueger and Casey 2000). Focus groups promote discussion of the clearly defined topic areas in a permissive and non-judgemental environment, allowing the researchers to gain an understanding of how participants think and feel about the topic area under discussion. This methodology favours open questioning to stimulate a response about attitudes and behaviours, which would not be possible

if a direct questioning approach through interviews was used. The researcher within a focus group has the flexibility to refocus the conversation to address unexpected issues or topics of importance that may arise. A longitudinal type approach was adopted, as engaging with the groups over an extended time frame assisted in building a rapport with the participants. It also allowed participants time to reflect on conversations that occurred during the focus groups and to explore solutions to the topics under investigation. The three groups met separately to eliminate the possibility of power differences that may have made participants feel reluctant to talk (Krueger and Casey 2000).

2.3 Aim of the qualitative study

The aim of the qualitative study was to explore the challenges, views and experiences of the employees, LMs and OHPs sample in relation to bipolar disorder, job retention and return to work. These findings informed the development of the intervention, helping to build content with high face validity to support each of the three stakeholder groups in the management of bipolar disorder in the workplace.

2.4 Design

The qualitative study included a series of focus groups with employees with a diagnosis of bipolar disorder, LMs and OHPs. A longitudinal type approach was adopted, with each stakeholder group attending three focus group meetings over a 6-month period (3x3 design). Stakeholder groups met separately, and the participants within each of the three groups stayed the same for the duration of the study, as shown below:

- An unchanging group of employees attended three employee focus groups
- An unchanging group of LMs attended three LM focus groups
- An unchanging group of OHPs attended three OHP focus groups

2.5 Method

2.5.1 Participant recruitment

A purposeful sampling strategy was adopted when recruiting employees, OHPs and LMs. This method allowed a group to be sought where the interactions and issues being studied were most likely to occur (Silverman 2005).

2.5.1.1 Inclusion criteria – Employee sample

Employees were considered eligible to take part in the focus groups if they met the following inclusion criteria:

- Formal diagnosis of bipolar disorder
- Either in work or out of work for six weeks or less
- English speaking
- In a euthymic state (not experiencing an episode of depression or mania) at the point of recruitment
- Able to give informed consent
- Able to attend a series of focus groups in the Cardiff area over a 6-month period

2.5.1.2 Inclusion criteria – Line manager and occupational health professional sample

LMs and OHPs were considered eligible to take part in the focus groups if they met the following inclusion criteria:

- Managers with line management responsibilities
- OHPs (physicians and nurses)
- The LM and OHP samples were required to have experience of managing employees with bipolar disorder and/or severe mental illness
- Able to attend a series of focus groups over a six-month period

2.5.1.3 Recruitment of employees

The employee sample was recruited via the charity Bipolar UK and the Bipolar Education Programme Cymru (BEPC).

Bipolar UK is a charity that supports and provides information to individuals with bipolar disorder. The Welsh branch of the charity informed participants of the study via a newsletter and the Cardiff-based self-help group.

BEPC is a 10-week psychoeducation programme funded by the Big Lottery Fund, delivered across Wales via Cardiff University. The course facilitator disseminated study information to local (Cardiff and Vale of Glamorgan) groups.

Employees that met the inclusion criteria and were interested in taking part in the focus groups were instructed to contact the research team. In total, 12 employees volunteered via the BEPC programme. No participants volunteered via Bipolar UK. Traditionally focus groups comprise seven to ten participants (Leung 2009); however, due to the longitudinal nature of the study all twelve employees were recruited in anticipation that some might drop out due to the relapsing and remitting nature of bipolar disorder. The purpose of the focus group meetings was discussed with employees who had expressed an interest over the phone, and an information sheet and consent form were sent via email or post. Employees were contacted via phone or email prior to the group with details on the time and date of the meeting and to discuss the structure of the group and address any questions that had arisen. Signed consent forms for each participant were collected at the first meeting.

2.5.1.4 Recruitment of line managers

Existing contacts of the co-supervisor (DC) within organizations across the UK were contacted. DC has developed relationships with BT, E.ON, General Electric (GE) and

Capital Law through her role as an OH physician and via other project collaborations. Key contacts within each organization were asked to disseminate a study invitation to LMs and OHPs within their organization. The invitation provided an overview of the study and inclusion criteria.

GE and E.ON withdrew their interest in the study due to high work demands and restructuring within the organizations. One LM from Capital Law and nine LMs from BT volunteered to take part in the focus groups. Having a sample in which BT LMs were overrepresented was not ideal, but recruiting further organizations was not possible without causing significant project delays. A strategy was put into place to limit bias where possible, where LMs were recruited from across a diverse business and geographical area within the organization. The BT business areas included Retail (call centre, office based), Openreach (engineers, outdoor based), Fleet (vehicle maintenance and accident management, garage based) and Global Services (IT services, office based). The LMs recruited from BT were therefore not known to each other prior to the first group meeting.

LMs interested in taking part in the study consented to their contact details being passed on to the researcher. They were then contacted to discuss the focus groups and sent an information sheet and consent form via email. LMs and OHPs were contacted via email prior to the group with information on the time and location of the meeting and to address any queries that had arisen. Signed consent forms for each participant were collected at the first meeting.

2.5.1.5Recruitment of occupational health professionals

Existing contacts of the co-supervisor (DC) in OH departments within BT, E.ON, ATOS, GE, Capital Law and South Wales Fire and Rescue were approached about the study. The key contacts within each organization were asked to disseminate an invitation to OHPs working within their organization. Organizations that outsourced OH services invited their external provider to attend. OHPs that volunteered to take part in the study consented to their contact details being passed on to the researcher. They

were contacted to discuss the focus groups and sent an information sheet and consent form. Ten OHPs volunteered to take part; all were recruited to the study.

2.6 Location of focus groups

It was envisaged that the LM and OHP focus groups would be held in Cardiff and London to ensure ease of travel for all participants. However, when asked, participants stated Cardiff as their preferred location. All groups were therefore held at Cardiff University. The timing of the meetings was agreed in response to the groups' preferences. Employees requested an evening group, LMs and OHPs opted for daytime meetings. The daytime group meetings lasted three hours, with a 20-minute break, and the evening group lasted two hours with no break, to accommodate participants' working hours.

2.7 Ethical approval

Ethical approval from Cardiff University School of Medicine Ethics Committee was sought. An application was written that outlined the study procedure and ethical implications. Two ethical concerns were identified that related to the participating employees:

1. An 'employee' participant could attend the group whilst unwell (low mood or high mood)
2. The employee group may find it distressing to discuss challenges they have experienced in work

Ethical concerns were addressed in the following ways:

1. The main supervisor (IJ), a consultant psychiatrist, attended the employee focus groups to be available should any participant become unwell or distressed

2. The information sheet provided a comprehensive outline of the focus groups to ensure participants were fully informed before consenting to take part. All

participants were made aware that they were free to withdraw at any point. Contact information of the research team and support organizations was included in the information sheet.

Cardiff University School of Medicine Ethics Committee gave ethical approval (SMREC ref: 11/51) for the study in December 2011. All respondents were provided with an information sheet and signed a consent form immediately prior to starting the focus groups.

2.8 Consent

Participants were provided with further verbal information about the study at the beginning of the first set of focus groups. Participants indicated their agreement to take part by signing a consent form. Verbal consent was also obtained at each group to audio record the session

2.9 Facilitation

Focus group meetings were jointly facilitated by the co-supervisor (DC) and me. The facilitators' role was to ask questions, listen and ensure all participants had the opportunity to contribute (Krueger and Casey 2000). A colleague (SW) observed the focus groups and kept field notes. IJ (main supervisor) attended the employee groups to support the facilitators should any participants become unwell.

2.10 Data collection

A topic guide informed by the literature review and research aims defined the main topics to be explored, whilst allowing flexibility to pursue issues in more depth as they emerged from the groups. The broad subject areas to be explored included the views of each stakeholder group on the main challenges to managing bipolar disorder and work, and the solutions to overcome these. At the end of each set of

focus groups the content of the sessions was reviewed to inform the outline and content of the next set of meetings. Table 2 illustrates the topics that were explored in each of the focus group meetings.

Table 2: Table illustrating the content of each focus group meeting

Focus group	Content of focus group
Focus Group 1	• Employee group: What are the challenges to returning to work or remaining in work with a diagnosis of bipolar disorder? • LM group: What are the challenges in managing an employee with a diagnosis of bipolar disorder on returning to work or remaining in work. • OHP group: What are the challenges in managing an employee with a diagnosis of bipolar disorder on returning to work or remaining in work.
Focus Group 2	The three groups were asked to explore the question: • How can communication between the LM, employee and OHP be improved to provide more effective rehabilitation and support for individuals with a diagnosis of bipolar disorder?
Focus Group 3	The three groups were asked to explore three questions: • What key messages would support an earlier and more effective return to work? • What might an intervention to support employees, LMs and OHPs look like? • How should an intervention be delivered?

A variety of techniques were used throughout the focus group meetings to help engage the participants in the topics under investigation. These included: use of scenarios, partner work, group work and ranking exercises.

2.11 Debriefing

A de-briefing session took place between the supervision team and me at the end of each meeting. The field notes and transcriptions were reviewed to inform the content and structure of the next set of focus group meetings. This allowed identification of tasks that had worked well so that consequent groups could be adjusted accordingly. It also helped identify key areas of interest that could be followed up in the subsequent meetings.

2.12 Focus group procedure

2.12.1 Focus group 1 – What are the challenges?

An 'ice breaker' task was initially set to introduce group members to one another. The meeting was then divided into two parts, each focusing on a specific question:

Part 1 (employee group) – Thinking about a time when you have been off work due to your bipolar disorder symptoms, what were the key challenges you experienced in trying to return to work?

Part 1 (LM and OHP group) – What are the challenges you face in managing an employee returning to work following a bipolar disorder/serious mental illness related absence?

Participants worked in pairs for this first task. As one participant explained their experiences, the other identified the key issues and noted them on a piece of paper. Participants were then asked to re-join the group to discuss the issues identified.

Participants were given a break between part 1 and part 2. The second part of the session focused on the following questions:

Part 2 (employees) – What are the key challenges in retaining employment?

Part 2 (LMs):

- What are the challenges you face in supporting an employee with a diagnosis of bipolar disorder to retain employment?
- What challenges do OHPs face when managing an employee with a diagnosis of bipolar disorder?

Part 2 (OHPs):

- What are the challenges you face in supporting an individual with a diagnosis of bipolar disorder to retain employment?
- What challenges do LMs face when managing an individual with a diagnosis of bipolar disorder?

During this session participants were given time to consider the questions individually and note down the challenges identified. Participants were then asked to share and discuss their thoughts with the group. At the end of the session the facilitators summarized the key issues that had been identified by the group and checked for consensus.

2.12.2 Focus group 2 – How can communication be improved?

At the beginning of the second set of focus group meetings participants were given an overview of the structure of the meeting and a summary of the findings from the first set of all three previous group meetings. The groups were encouraged to comment and feedback on these summaries.

To encourage participants to think about solutions that involved the three stakeholder groups (employees, LMs and OHPs), a scenario was developed based on a fictitious character. The aim was to move participants from thinking about challenges to exploring solutions and best practice. The character presented to the group was Billy:

Billy is a 33 year old man who has worked for a medium-sized company for several years. He works in a logistics role in a small team, and has a good working relationship with his colleagues and his manager. Three months ago, Billy received a diagnosis of bipolar disorder after a manic episode during which he was admitted to a psychiatric ward for the first time. The company that Billy works for has an Occupational Health Physician and Nurse.

The structure of the meetings was the same for the LM, OHP and employee focus groups. Following the summaries and introduction of the character Billy, the content of the focus group was split into two parts:

Part 1

In the first part of the session participants were informed that Billy was well enough to return to work. The group was split into pairs to consider the following questions:

1. How could Billy get the most out of OH?
2. How could Billy get the most out of his LM?
3. What should happen between Billy, his LM and the OHP to support him in returning to work following a bipolar related absence?

Participants then re-joined the group and discussed their responses.

Part 2

In the second part of the session participants were informed Billy was in work and his condition was stable. Working in partners participants were asked to again consider the above questions. Participants then shared their responses with the whole group. At the end of the session the facilitators summarized the key solutions identified and checked for agreement among the group.

2.12.3 Focus group 3 – Intervention development

The final set of focus groups were shortened to two hours, as the content of the group meeting adopted a more descriptive methodology. At the beginning,

participants were given an overview of the structure of the meeting and an overall summary of the findings from all focus groups.

A broad outline of the aims of the proposed online intervention was provided. It included the perceived model of delivery, and the budget and timeline for development. During the session participants were asked to consider the following questions individually:

1. What key messages should be included in the programme?
2. How would you like to access the programme?
3. How could we make the programme user friendly?
4. What would attract you to using such a programme?

Participants were then asked to share their thoughts with the group. The written responses to these questions were collected at the end of the group. Participants were asked to contact the research team if they had any further thoughts or ideas about the intervention after leaving the group. Permission was sought to contact group members throughout the building of the intervention for feedback on content and development.

2.13 Data recording

The nine focus group meetings were recorded using an Olympus digital recorder. The recorder was switched on at the beginning of the meeting following consent from all participants. The recorder was paused during the breaks. The content was downloaded onto a password protected Cardiff University computer at the end of each group.

2.14 Data transcription

The focus group recordings were uploaded via digital media files on to a computer, labelled with a recording number and transcribed verbatim. The media files and

anonymised transcripts were stored securely on a Cardiff University password protected computer. Anonymised transcripts were uploaded onto QSR NVivo 10 qualitative software for coding.

2.15 Data analysis

Data was analysed using thematic analysis with an inductive approach (themes strongly linked to data). This method involves searching across a data set to find repeated patterns of meaning to provide rich and detailed accounts of participants' perceptions and experiences (Braun and Clarke 2006). The themes and categories reflect original accounts and are grounded by the summaries and experiences shared by the participants. It is a methodical approach that follows a clear and documented process. Analysis was carried out in line with Braun and Clarke's (2006) five interconnected steps, described in table 3, using NVivo 10 to develop and manage the codes and themes. Themes were reviewed by the research team to ensure agreement was achieved.

Table 3: Braun and Clarke's five phases of thematic analysis (Braun and Clarke 2006)

Phase	Description of process
Familiarising yourself with your data	Transcribing data, reading and rereading the data, noting initial ideas.
Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
Searching for themes	Coding interesting features of the data in a systematic fashion across the entire data set.
Reviewing themes	Checking the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2).

Defining and naming themes	Ongoing analysis to refine the specifics of each theme. Generating clear definitions and names for each theme.

The first two sets of focus groups were explorative in nature whereas the third set focused on closed questions directly related to intervention content and development. Therefore, the data from the first (FG1) and second (FG2) sets of focus groups for the employees, LMs and OHPs was analysed separately to the third (FG3) set of data. In addition, data from the LM, employee and OHP focus groups were analysed separately to ensure the specific perspectives of each individual stakeholder group were identified.

The focus of the first set of focus groups was on challenges and the second on solutions to overcome these. The second set of focus groups built on the findings from the first groups to further explore the areas identified. Therefore the data from FG1 and FG2 for each user group was combined for analysis, as illustrated in table 4. The analysis focused on identifying the areas explored by the groups and identifying the challenges and solutions in relation to these.

Table 4: Table illustrating the data collection and analysis process

Line Manager focus groups			**Employee focus groups**			**Occupational Health Professional focus groups**		
FG1	**FG2**	**FG3**	**FG1**	**FG2**	**FG3**	**FG1**	**FG2**	**FG3**
Data combined			**Data combined**			**Data combined**		
Thematic analysis		**Descriptive summary**	**Thematic analysis**		**Descriptive summary**	**Thematic analysis**		**Descriptive summary**

The third set of focus groups focused on defined questions, therefore the results are more descriptive in nature. A summary of the LM, OHP and employee responses to the set questions will be described at the end of the results section, separately from the findings for FG1 and FG2.

Thus far this chapter has provided an overview of the rationale and methodology of the qualitative study. The focus group results for the employees, LMs and OHP group will now be presented separately, as outlined below:

- First, I will provide a summary of the major themes that emerged from the first and second employee focus group meetings.
- Second, I will provide a summary of the major themes that emerged from the first and second LM focus group meetings.
- Third, I will provide a summary of the major themes that emerged from the first and second OHP focus group meetings.

At the end of this chapter a summary of the employee, LM and OHP responses to the questions in the third set of focus groups will be provided.

Data extracts from FG1 and FG2 will be used to evidence the themes. These extracts will be referenced as (FG1) or (FG2) to illustrate the source of the data. As the themes emerged from the combined FG1 and FG2 data, some of the themes describe the challenges, and other relate to solutions identified by the sample. The challenges and solutions are interlinked, and therefore are discussed together throughout the results section of this chapter.

The abbreviations shown in table 5 are used throughout the results section of this chapter.

Table 5: Abbreviation

Abbreviation	Definition
FG1	Data extracted from first set of focus groups
FG2	Data extracted from second set of focus groups
OHP	Occupational health professional
OH	Occupational health
F	Focus group facilitator
P	Participant

2.16 Results

2.16.1 Overview of recruitment

A total of 33 people expressed an interest in participating in the focus group meetings and 26 were finally recruited: 8 employees with a diagnosis of bipolar disorder, 8 LMs and 10 OHPs. Attendance numbers across each focus group meeting are shown in table 6.

Table 6: Attendance rate for focus groups

Focus group (FG)	**Employee attendance figures per group** (N=13)	**Line manager attendance figures per group** (N=10)	**OHP attendance figures per group** (N= 10)
FG1	8	8	10
FG2	5	4	7
FG3	5	4	7

2.17 Employee focus group results

The findings from focus groups meeting one and two for the employee sample will now be presented. Thirteen employees were recruited to the focus group study. The entire employee sample were in employment at the time of the study, on either a full-time or part-time basis. The employee group worked in a variety of roles and had been diagnosed with bipolar disorder for between two and twenty five years.

Six major themes and six subthemes were identified through the analysis of data from the two (FG1 and FG2) employee focus group meetings. The six themes that

illustrate the job retention and return to work challenges that employees face, along with the solutions identified, are outlined below and illustrated in figure 2:

Theme 1: Employee's openness about their diagnosis of bipolar disorder

Subthemes:

- *Perceived forced dishonesty*
- *Openness and communication*
- *Stigma*

Theme 2: Knowledge and understanding of bipolar disorder

Subtheme:

- *Inappropriate comparisons*

Theme 3: Managing symptoms of bipolar disorder

Theme 4: Employee's level of control

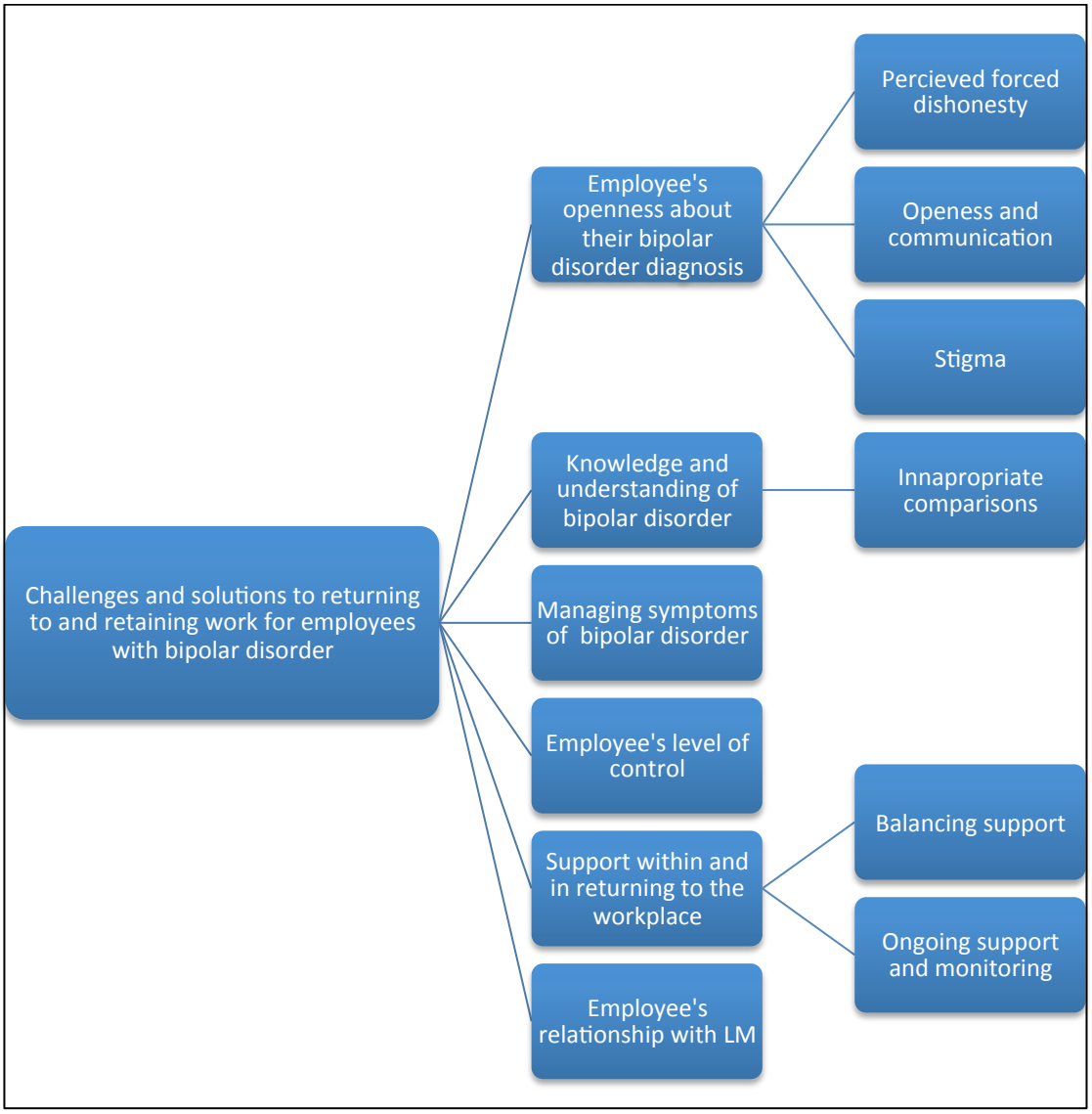
Theme 5: Support within and on returning to the workplace

Subthemes:

- *Balancing support*
- *Ongoing support and monitoring*

Theme 6: Employee's relationship with the LM

Figure 2: The challenges and solutions to job retention and returning to work for employees with bipolar disorder as identified by the employee sample - overview of themes and subthemes



2.17.1 Employees' openness about their bipolar disorder diagnosis

This theme highlights the uncertainty and unease that employees felt about being open and transparent about their bipolar disorder condition. This theme describes how employees controlled the amount of information they disclosed to LMs and OHPs in order to protect themselves against any perceived negative outcome.

The subthemes that were identified within this theme will be discussed in turn:

- Perceived forced dishonesty
- Openness and communication
- Stigma

2.17.1.1 Perceived forced dishonesty

When discussing the challenges to returning to work, the group discussed the unease that some members felt in disclosing a mental health condition to their employer. One participant described hiding the true nature of his sickness absence from his employer through fear that disclosure would result in termination of his contract. The employee believed his organization would deem him unsuitable for the job if they were aware of his condition, due to the 'risky' nature of his role. The group described the need for forced dishonesty in some circumstances to retain employment and the impact this can have on the individual:

P: Also when he is unwell he has to tell his employer he is ill with less problematic things, like he has the flu or something less problematic wrong. Can't be upfront and tell them

P: It would be nice to be honest and turn around and tell them this is what is wrong, can you help. Rather than I am not going to be in work today, I have this and this today, tomorrow. When you are hiding things you are worried it's going to go wrong, are they going to catch me out, why should I have to hide it.

F: There are two things: why should I have to hide it and what will happen if they find out?

P: It is potentially quite serious if they find out you have been hiding it.

P: Yes, it adds extra stress into everything else that goes with it. Rather than saying, look, I am bipolar, I am having a problem at the moment, please can you help, I have to lie, cheat and steal to keep my job and it shouldn't have to be that way.

(FG1)

The employee described the 'risky' nature of being untruthful to employers, through fear of being caught out and the consequences this could have.

2.17.1.2 Openness and communication

When employees did disclose their condition to the employer or OHP, some were still cautious about the amount of information they offered. The group discussed how the amount of information they divulge is dependent on the person they are talking to and their role within the organization. One employee described how they were more open and transparent with OHPs as they perceived them as independent of the organization. Therefore, the information they disclose is less likely to jeopardise their career. Another employee explained how they would advise the OHP about the level of information they were prepared to share with their LM.

P: You can be quite open with OH but when it comes to talking to the line manager you can tell OH what you want put in the reports.

(FG2)

P: I am open with my OH but haven't got the same openness with my line manager and that works.

(FG2)

The group described feeling confident that anything disclosed to OH would be kept confidential and not impact on their work. Employees were less confident of the LM's discretion and were concerned that information may be passed on to other managers and colleagues. One employee described how this could result in them being stigmatized and branded 'crazy' due to the misconceptions that surround mental health.

P: Confidentiality, the last thing you want is your work colleagues and the entire company knowing that you have an issue. Anything that gets mentioned is between OH and nurses and that is it. Nothing goes to the line manager or anywhere else unless it is specifically required for a specific reason or you say yes, he can know that information. Otherwise once you are branded crazy you are crazy forever

(FG2)

P: OH would be best because they are apparently separate so anyone who isn't involved in the company or who doesn't have a stake in the company. The last thing you want to do is go to them and say blah blah blah and then they go to the company and say blah blah blah. Then it all erupts into a giant nightmare.

(FG2)

2.17.1.3 Stigma

The anxiety associated with disclosure was triggered by employees' fear of stigmatization. The groups discussed examples of perceived and experienced stigma, as a result of peoples' negative misconceptions about mental illness. One employee provided an example that illustrated a change in the LM's attitude towards them following disclosure of their condition. The employee described herself as functioning well in the workplace with the condition; however, she was instructed to take time off work following disclosure of her illness to the LM:

P: It was when I was working, I had been there for 2/3 years and suddenly went, just to let you know they are changing my meds, and they said why, and what

medication are you on. At this point they thought I was depressed. As soon as I said 'that' word they said ohhh, you can't work for us anymore, you have to go to OH. I was like I have been working for you fine for three years. Even OH said why are you here if you have been working for so long without a problem.

F: One of the problems of what occ health is there for…

P: Yeah, they kind of panicked as soon as employment found out, said I couldn't work until it was said I was fit for work when they had employed me. It wasn't like a new thing.

(FG1)

Another employee described how on disclosing their condition, the LM had made an inappropriate comparison to a previous employee with a mental health condition. The LM assumed the employee would perform poorly in their role based on the performance of a previous employee with a mental health condition. The LM did not consider this individual's abilities, skill set and productivity to date:

P: Discrimination at workplace and line manager not being sympathetic and understanding. When I started the job I informed them I had bipolar and tried to give the line manager information of what it was and told him he would need to monitor my behaviour from time to time because I may not be aware of any changes. He showed complete lack of interest. He said the last person he had employed with a mental disease he had to sack because they were crap at the job.

(FG1)

2.17.2 Knowledge and understanding of bipolar disorder

This theme highlights how employees perceived LMs to lack a level of knowledge and understanding of mental illness.

The group discussed how mental illness is often incorrectly viewed as fundamentally different to physical illness. They described a degree of stigma associated with mental illness that is not apparent for enduring physical conditions.

P: Awareness of mental health, it is no different to breaking your leg.

P: You say it's not different but it is.

P: Or they don't understand that bipolar is another name for manic depressive, don't understand, not going to be moping around or in the middle of work suddenly stand up and put your knickers on your head and run around. They think as soon as you say bipolar, what the heck is that and then suddenly you are going to become some complete nutter.

(FG1)

P: Make them aware you are a person, it's like epilepsy. If it's managed you will still have up and down days. Need to be aware of certain things that can trigger episodes. Don't go to EastEnders for reference.

(FG1)

The group described a desire for employers to be more informed about mental illness and not to use inappropriate comparisons as the point of reference. Employees explained how they would like to be judged on their merit and not on preconceived beliefs and perceptions about mental illness.

2.17.2.1 Inappropriate comparisons

Two members of the group described occasions where LMs had drawn upon personal experiences with mental illness to understand and manage the employee. One employee provided the example of being compared to the LM's friend who had experienced a different set and intensity of symptoms:

P: My employer has a friend of hers who is bipolar but suffers from manic highs, who gets sectioned, it's the second time this year that he's been sectioned;

they pulled me into the office to say 'we're concerned about you and your health'. Do they think I'm going to get sectioned now and not be back for months.

P: Misinterpreting how your disease works for you.

(FG1)

The group described how LMs are often fearful of employees being sectioned when this is unlikely to be a common occurrence, especially for employees that have been functioning well in the workplace.

The group also discussed the inappropriateness of being compared to colleagues and the stress associated with this:

P: I was being compared to the person who did my job a lot because I work differently, because everyone works differently. My boss really liked this girl so took an immediate dislike to me so was really narky and stern and would blow hot and cold, which was quite stressful to deal with. When I was down I thought she was out to get me completely, which made it even worse really.

(FG1)

2.17.3 Managing symptoms of bipolar disorder

The employees discussed how the symptoms associated with bipolar disorder can often make it difficult to function at full capacity in the workplace. One employee provided an example of the difficulty they face in managing symptoms of paranoia in the workplace:

P: I get really paranoid which doesn't help. I suffer from paranoia so it doesn't help. Before Christmas I thought my boss was against me, was going to kick me out.

(FG1)

The group also discussed the impact a working 'routine' can have on supporting and managing the condition. Some described a routine as a facilitator in helping them manage the condition, whereas another employee felt a less structured routine was more beneficial.

P: Find it difficulty getting to sleep and then find it difficult getting up. Because I have set days off like half terms and holidays. Because I had half term two weeks ago I am finding it a bit, I can't get settled back in because I have had a whole week off where I can do what I want and have had no structure to very structured days. Other job I could choose my days off.

(FG1)

P: Being self-employed, so you are worrying about turning down work. Feel have to go back to work before you are ready. Not having the support network behind you when you are self-employed. The lack of routine in particular job was a trigger point.

(FG1)

The group also discussed the impact medication can have on one's ability to function at full capacity within the workplace. One employee described experiencing poor concentration following a change in medication:

P: Effects of medication when come back to workplace. With my line of work anything that acts as a break on my cognition is a hindrance.

(FG1)

The two poles of the condition were also discussed in the focus group, with one employee describing the impact a hypomanic state can have on one's productivity and wellbeing within the workplace. This employee described a tendency to take on unachievable workloads during periods of hypomania. In the short term they are highly productive; however, this often leads to instability and deterioration in

wellbeing. The group discussed the need for LMs to intervene during periods of hypomania to assist employees in managing workloads appropriately.

P: If you are in an open plan environment then the problem are reduced ability to filter out things you would otherwise. If you are hypomanic you think that is interesting and start to go off on tangents, as your attention diverges so does your capacity to complete any one task decreases. So you end up coming to a point where you are at a complete standstill. That can be controlled to a degree by the working environment.

(FG1)

The group also discussed the complexity of bipolar disorder and the importance of managing the condition on an individual basis. They described how the definition of 'stable' could vary greatly depending on the individual.

P: Depends on your definition of stable; one person's stable is another person's…

(FG2)

2.17.4 Employees' level of control

The group discussed the control they hold over their employment situation when off work and on returning to work. One employee described an occasion where all control had been taken away on becoming unwell. The company car and tools were taken away, leaving the employee to feel as if the organization had no confidence in his ability to return to the role. The group discussed the distress caused by such actions by an LM and the organization:

P: Been sectioned a couple of times and the first job I was sectioned in it was the speed and reaction to me being ill. Someone coming down, collecting my company car, expecting, taking away all my tools and equipment. Suddenly being returned as if there was no hope.

F: Over reactive response to the condition, not understanding.

P: Speed of reaction, was very quick and harsh…

F: Yes, there was a lack of control over what was happening to you.

P: Taking control rather than speaking to me, communication with me or speaking with my doctor. Various people round me including family members. All of a sudden everything is in their hands and everything is being taken away from me.

P: One job gave tremendous amount of support and other gave nothing and almost didn't want you back and did everything not for you to come back.

F: What did good place do right? What helped?

P: It little things, one company left the company car with me so I could use the car and go to appointments with the car. I was still able to do things and function properly, whereas the other company wanted all the gear, testing equipment and car back in their own possession because they had no support and confidence in me. The two were like chalk and cheese. One was there to nurture me, the other just cut the ribbon.

(FG1)

The group also discussed an occasion where one of the employees had received a great deal of support from the organization whilst off work. The way in which one aspect of work (leaving the company car or taking it away) is handled can have a substantial impact on how the employee feels, and their perception of the organization.

2.17.5 Support within and on returning to the workplace

This theme highlights the employee's need for support in retaining employment and in returning to the workplace following periods of bipolar related absence. The employees described their experiences in relation to periods where they had received either 'good' or 'bad' support and discussed how it impacted on their perceptions of the LM and workplace.

2.17.5.1 Balancing support

The employees described the importance of support being put in place to assist them in retaining work and returning to work. However, the support had to be provided at an appropriate level. Excess levels of support and monitoring made employees feel 'watched' and scrutinized. One employee described how getting the support at the right level was a balancing act on the part of the employer:

P: Balancing act between everyone checking everything is going as it should. It's a fine balance as it's nice to have people checking in on you but you don't want to feel you are being watched and having someone constantly asking how are you, as this can be a pressure.

(FG2)

P: You could have too much communication where he could feel smothered; it's like finding the balance

P: Might come down to someone saying how are you doing at the moment, and if they say ok and manager can see everything is ok they won't need to pursue it any further. If there are indications that something isn't quite right.

(FG2)

The group highlighted a need for dialogue between the LM and employee to negotiate an appropriate level of support.

2.17.5.2 Ongoing support and monitoring

The group discussed the importance of ongoing monitoring and support in helping employees manage their condition and remain in the workplace. The group discussed their experiences, with one employee describing how meeting regularly with the LM and OHP had been hugely beneficial. The employee felt supported and

confident in returning to his role, and the LM and OHP gained an understanding of the condition, and the adjustments required for reintegration back into the workplace. The group described how the LM's actions of setting aside time to meet and discuss the employee's conditions would make them feel supported by the organization and management:

P: When I was first off when I was diagnosed I was off for a year. I was having monthly reviews from my line manager and HR. They were actually coming to my house so in that respect they could see the progression I was going through in regard to changes in medication, and yes or yeah he is bad, oh he is better and then bad again.

F: So they got a real picture of what was happening, they could understand you.

P: Yeah they were really good and with OH as well they reinforced that and sent it back to them. Communication was excellent as it was across the board from clinical psychologists through to OH, whoever I was seeing was being relayed and being taken on board.

P: Monitored at all stages not left to fend for self.

(FG1)

One employee described how routinely the structured OH support provided to assist employees to return to work often stops at the point of reintegration. They described how continuation of support from OH would be beneficial in assisting employees to manage their changing needs to sustain employment:

P: Taking it from my personal experience with OH. Point of contact I continue to have, regular meeting with OT and that gets fed back to HR and my line manager. It will stop as they will say here is your phased return to work and at that point OT will drop off and won't keep going. Be good to continue contact just in case something needs to be tweaked.

(FG1)

The group required reassurance that support was always available should they need

it, due to the enduring and relapsing nature of the condition. The point of reintegration back into the workplace was a sign of recovery from the episode that had destabilised them and not recovery from the condition. Therefore, future episodes were highly likely.

One employee described their experience of returning to work in an unsupportive environment. On returning the employee felt pressured to instantly return to 100% productivity. What they actually required was a phased return to work allowing adequate time for a full recovery.

One employee highlighted that support in returning to work can be particularly poor if the employee has been untruthful about the true nature of the absence. The employee described an example where they had not told the truth, and had informed their employer they were returning following an episode of flu, therefore adequate support had not been put into place.

P: He feels for a big company they could be a lot better than they are.

P: When I do eventually go back to work it is literally straight, 8am, expected to be in work with your tools and that is it. You are expected to do exactly what you have done beforehand. There is no phased return and that causes a great amount of stress again. This can trigger you back off and back to square one.

F: Is it stressful that you have to go back and have to get back full time, have to be 100%.

P: If it's not 100% they are watching me like a hawk because I have been off and if its 99% they are down on my case. They are like you have only done 99% of your work, why?

P: Especially if you say you have been off with the flu, they are like you are back now and ok then. It cleared up now, take a couple of Lemsip. That's more stress. If you are having a bad day thinking I shouldn't be back at work, what do you do?

(FG1)

There was some contradiction in the employees' accounts. One employee described not disclosing their condition, but still expecting the LM to be supportive and accommodating due to the nature of their absence. This lack of dialogue caused resentment and frustration towards the LM and organization.

Another employee described an occasion where they had felt supported in returning to the workplace. They described how the LM had listened to their concerns and implemented flexible working hours to allow the employee to return on a phased basis. These actions allowed the employee to ease back into a working routine at a more manageable pace and made them feel supported and valued.

P: Job was positive, he had a phased return to work. There was a lot of support. He had a lot of people to speak to say this is wrong and that is wrong, then come up with solution like change position, change hours.

F: Saying flexibility really helped as rigidity was too hard

(FG1)

P: Yeah, the entire period I was off and even now. Because I have gone back to a different role because it was too stressful. I explained to them if I do a role that is stressful it is going to make me worse, so they said ok we will change your role and put you into something different. They have noticed I am not getting on in that role so now there is going to have discussion about where else I can go.

P: You must be a real asset to the company, I think that is part of it

(FG1)

The employees described the need for reassurance from the LM that they were sympathetic too, and had considered their difficulties in returning to work. One employee described how returning to work can be a time of vulnerability and fear, therefore support is required to help overcome these insecurities.

P: *Physical working environment. Very little understanding that goes across the board. If you are on a short-term contract, they employ you for a period of two years. If during that time you are unlucky enough to get ill and need to be away to recover. Provided with right support and amended duties you should be able to return to work environment. It falls down at the stage where you have to speak to line manager and they say we can't accommodate these within the timeframe of the project. Then you don't have or show any interest in managing your condition or any support in you. You don't feel valued. When you return to workplace you have enough doubts anyway from your horrendous experience. You are in a very vulnerable state.*

(FG1)

P: *If possible for the line manager to show you that you are part of their team. Understand that the person has bipolar but as part of a team show that you, they missed him. Anything they can do such as discussions with OH, show that you will go along with it.*

F: *Is that something about feeling a valued member of the team?*

P: *Yes, that is incredibly important. I think it is a fundamental human requirement that people feel needed. If you feel needed you are more likely to have a satisfactory working…*

F: *Is that something to talk about?*

P: *One of the other things that would be part of that would be that they don't need to prove they can do the job, head off any thoughts an individual may have about that.*

(FG2)

The group then highlighted ways in which the organization can assist in addressing the employee's insecurities in returning to or retaining work. One employee described the importance of joint decision making in place of a more dictatorial approach. The group described how each stakeholder has a role within the decision making process. The employee is the 'expert' in regard to the condition and how it affects them in the workplace, therefore they should be a key contributor to the

decision making process. The LM has the greatest level of understanding of the workplace and absence policy therefore is best placed to contribute to decisions about organizational resources and the work environment. The OHP provides the independent professional opinion in the decision making process. It is therefore important for the three stakeholders to work collaboratively to make informed decisions.

P: One way in which employee can feel valued is through joint decision making. Need to feel like they are part of the process. The decisions have an impact on them and ultimately they have an insight in what does and doesn't work for them, therefore need to be part of the process.

P: One thing that may help with that situation is a less dictatorial approach by whoever is doing OH. More of a joint decision making process as that may make you feel less told what to do, other than deciding with the person what is the best thing for you.

(FG2)

P: OH involvement and line manager needs to be part of that, needs to take place over several sessions. Line manager needs to be part of that at least for several sessions. They are going to be in the best place for knowing what resources they have available to put individual in quieter part of the building for example.

P: If he is work and stable why does he need help?

P: To maintain stability.

(FG2)

The groups described how combining the expertise of the three key players could assist the employee in maintaining their 'stability', therefore reducing the possibility of further absence.

2.17.6 Employees' relationship with the line manager

The employees discussed the importance of the 'relationship' between the employee and LM. The group discussed how processes such as joint decision-making are only likely to be successful if there is a positive working relationship between the employee and LM. Employees within the group that had a 'good relationship' with their LM described the ease with which they could discuss work and health issues whenever necessary, whereas employees that had a 'poor relationship' with their LM described how interactions were often hostile and they felt unable to discuss difficulties they were experiencing in the workplace.

P: I think that depends on his relationship with the line manager.

P: If it was mine there is no way in hell I could phone him and say that.

P: If it was mine, he is really easy going.

P: You could say this and he would say no problem. Whereas with mine they would come down on me like a ton of brick and I would have the manager on the phone saying why this, why that, why the other, so I would have to find someone to go between. So I would end up having to use OH then as I would be stuck.

(FG2)

The group described a 'good' LM as one that had good listening skills, and was approachable and empathic.

The group discussed ways to overcome a poor relationship between an employee and LM. They described how the employee and LM would need to be objective, focusing on the shared goal (employee returning to work) and the current situation, disregarding previous poor interactions.

P: Depends whether the line manager is prepared to listen and act upon it. In my experience of good and bad line manager, an example of a good line manager is someone who will sit down with me, go through my, what has to

be done for that week and decide some kind of time allocation. If I have any problems I can go back to them.

(FG2)

P: It has to be done in a way that is as objective as possible. If I'm sitting down with me line manager and I have an issue with them because of the intensity of my feeling and past history it is going to be very difficult to negotiate.

P: Need to have someone to speak to and who will listen. If you have no one you can tell then you are in the same position. Getting everyone together to talk and informal.

(FG2)

The group also discussed the important role OH can play an when there is a breakdown in the relationship between the LM and employee. They described how OH can provide an independent and objective opinion and negotiate the required outcome that best suits both the employee and LM. Some employees recognized the value of this role; however, they highlighted that many organizations do not have OH departments.

2.18 Line manager results

Eight LMs took part in the focus group meetings: seven employed by BT and one by Capital Law. The LMs were based in areas ranging from South Wales and the Midlands to the South East. All had experience of working with employees with bipolar disorder or serious mental health conditions.

Four major themes and eight subthemes were identified from the first two focus group meetings with the LMs that illustrate the challenges they face in supporting an employee with bipolar disorder, and the solutions to overcome these. The main themes and subthemes are listed below and are illustrated in figure 3. Each theme will be discussed in turn.

Theme 1: The LM's fear and uncertainty of mental health conditions

Theme 2: The LM's role within the organization

Subthemes:

- Business demands
- Boundaries

Theme 3: Support

Subthemes:

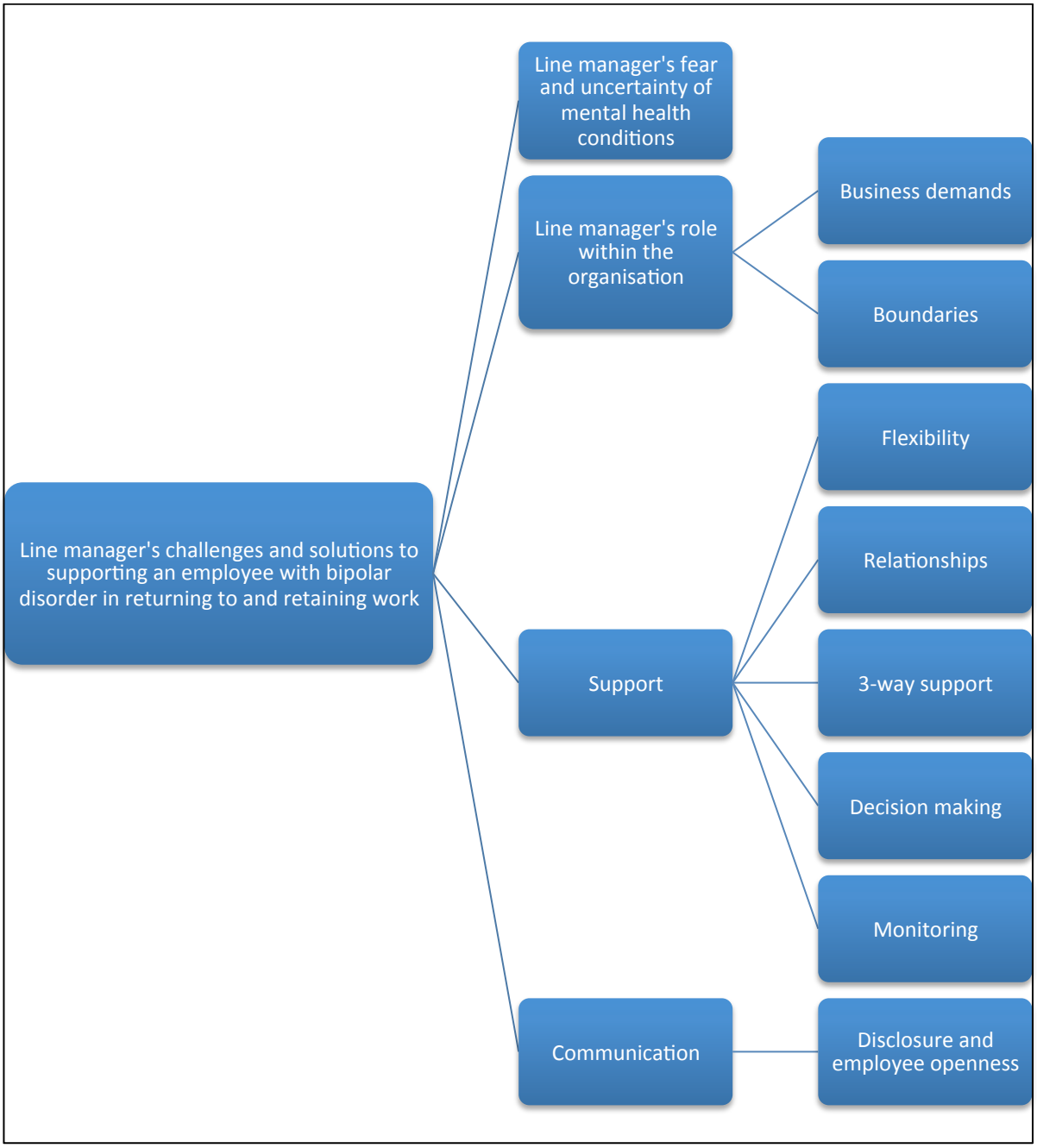
- Flexibility
- Relationships
- Three-way support
- Decision making
- Monitoring

Theme 4: Communication

Subthemes:

- Disclosure and employee openness

Figure 3: The challenges and solutions identified by the LM group to supporting an employee in the workplace with a bipolar disorder condition - overview of themes and subthemes



2.18.1 Line manager's fear and uncertainty of mental health conditions

This theme highlights the LM's uncertainty around supporting employees with mental health conditions to return to work. One LM described times where he has felt unsure as to whether the support being provided to the employee was helping or hindering their recovery.

P: No the issue is not between you and the individual. Between you and the individual you will try and do your best. But always ticking away in the back of your head is 'is my best what is needed'. Am I doing the right thing or am I actually causing more problems by doing what I am doing?

(FG1)

The group described feeling that they were not equipped with the level of knowledge and experience required to support employees with mental health conditions. One LM described how this fear and uncertainty added additional pressure and stress to their role.

P: At that point you are worrying, am I the right person to be dealing with this? I still need to keep contact; he is one of my managers so I need to maintain that contact. You need to find some way of balancing that off so you are not going to…

P: Add pressure that is not already there

(FG1)

The group described the lack of guidance available for LMs on supporting employees with mental health conditions. A few members of the group discussed how mental illness was fundamentally different to physical health conditions. They described how workplace sickness absence processes and policies are tailored to physical health conditions and are therefore unsuitable for employees with mental illnesses such as bipolar disorder.

P: *It's a real balance. All trigger points for sickness absence and having to speak to people and support is based around physical illnesses. We work out whether to have a discussion with someone based on this simple equation but it doesn't work for people off with depression and things like that. It doesn't fit like someone who has flu twice a year or a diabetic who is off a couple of time a year because something has happened to them. It is a different kettle of fish and I don't feel like I have got any sort of support in place for a different route.*

(FG1)

2.18.2 Line manager role within the organization

This theme highlights the complex functions and part played by the LM in the return to work scenario. The group described how LMs have a duty to meet the demands of the business and the needs of the employee, which can often conflict. They described the challenges they face in fulfilling their role and the impact this can have on the organization and employees.

2.18.2.1 Business demands

The LMs described the responsibility they hold in delivering company policy to the employee during periods of sickness absence. One LM described the anxiety he felt when informing an employee their wages were due to stop through fear that this may "push them over the edge". Although LMs described having limited control over company policy, they still felt responsible for the impact it has on the employee.

P: *You are maintaining that level of contact but sometimes you may have to deliver company policy. How do you deliver that thinking this could turn over the edge here? Your pay is going to stop in a few months.*

(FG1)

P: All the time he is worrying about his job, he has financial worries and all of this. You are the one that directly influences that.

P: So you feel really responsible.

(FG1)

2.18.2.2 Boundaries

The group discussed the time and emotional investment involved in supporting an employee to return to work. This level of investment can become a source of stress and upset to the LM if the employee is not meeting their expectations in terms of recovery. One LM described the need for boundaries to be set to ensure they are not becoming too emotionally invested in the process.

P: One thing I have learnt and coming here today is not to build up your expectations; you should try and step back. It is very hard for the person. You actually have to step back a bit in terms of your own expectations. You can end up dragging yourself in. I have seen one of my managers do it. I have 10 managers and one of them is managing a stress case. I actually watched him go downhill as it went on and I had to drag him out.

P: Because he was starting to take it personally?

P: Too personally. If you have known a person for 20-25 years, how can you not get involved? There is a balance – you can still be involved but you have to at that point think I am here as the business side.

(FG1)

One LM described how difficult it can be not to invest emotionally in a return to work case when there is a long-standing and established relationship with the employee.

P: I have junior managers that are just about to start with these issues. Very easy to give advice, but do I follow my own advice? I still don't. I tell them not

to get too involved, not to take it personally then they see me doing exactly the thing I told them not to do.

(FG1)

2.18.3 Support

This theme highlights the role of the LM in supporting employees to return to work and the challenges they face in doing so. This theme was spilt into several subthemes that covered several different areas of support.

2.18.3.1 Flexibility

The group described the difficulties they face in supporting employees to reintegrate into the workplace following a period of absence. On returning, the employee may not be well enough to return to full duties. One LM described the need for a flexible approach, adjusting the employee's role accordingly to support them in returning to full health and productivity.

P: *I think it's the steady build up to them returning to their normal targets and things like that as well, so they're not the odd one out on the team, from their point of view as well.*

P: *So keep them in the fold.*

P: *Yeah, because what happens too often is that – you know, this is with any OH thing if their targets have been adjusted – they'll be adjusted and then they'll just remain in place with these adjusted targets, and the end goal should be, they've returned to work, over a period of time, and then they need to return to normal working practice*

(FG2)

The group described how supporting an employee to reintegrate back into the workplace at an early stage on a gradual basis can ensure they do not become too isolated from the workplace and colleagues.

The group also discussed the challenges they face when the employee is unable to return to their original role on returning from a period of absence. One LM described an example where an employee had requested a less stressful role to minimize the risk of relapse. The LM described the feeling of pressure in trying to meet the needs of the employee within the constraints of the organization.

P: So when it became obvious that he didn't want to go back to his normal role…

P: Yeah, he wanted to go back to the shop floor

P: There was a conversation saying don't give up yet. Maybe we can find something different. Almost creating a position for him. We didn't want him to think that he had failed.

P: Needed negotiation really.

P: Yeah, negotiation is the word. It was almost like we don't want to give up on you so what about this option. What about that option. We can do it this way.

(FG1)

2.18.3.2 Relationships

The group described how developing a trusting relationship with the employee was key in facilitating successful support strategies. A trusting relationship between the LM and employee led to open conversations about the condition. The LM therefore had an understanding of the employee's condition and was able to recognize signs of deterioration and intervene early to offer support. Another LM described how taking the time to build this relationship demonstrates to the employee they are a valued member of the team.

P: It's knowing when to, because I know this individual really, really well so I know what are her trigger points, so I know when she is going to go really high and when she is going to go really low. That has taken a long time to get to that point in our relationship.

(FG1)

P: Getting to know your team, that helps gain respect.

(FG1)

Developing a relationship with an employee assisted the LMs in establishing the boundaries when discussing work and health issues. One LM described how knowing the employee informs the conversation, establishing the boundaries to ensure the discussion is not considered too intrusive.

P: Yeah, need to know the individual really to know where that boundary is before becoming too intrusive in asking questions and knowing when to back off.

F: So it's something about knowing that individual to be able to know your boundaries. Is that one of the main issues – knowing boundaries with that individual?

P: Yeah, because you have to build rapport with the person and the rapport you may have had before this mental issue was made known might have been slightly different to what it is now.

(FG1)

The group also discussed the importance of OH in supporting an employee back to work. However, the groups described the need to feel assured of the OH professional's competence and authority to make decisions. They described the frustration the LM and employee feel when working with junior OHPs that are unable to make decisions on the employee's management.

P: They may not be able to make the decision that is key.

P: They're not empowered to make…

P: They have to go away and find out, which with the time it takes, the momentum…

P: You want instant decisions.

P: Exactly.

P: And for the individual, they don't feel that the person they're talking to knows what they're talking about, so it puts them on edge.

(FG2)

There appeared to be a lack of value for the advice provided by the OHP if they lacked expertise and the authority to make informed decisions.

2.18.3.3 Three-way support

The group discussed the need for the LM, employee and OHP to be engaged in and contributing to the return to work process. One LM described how OHPs can provide a third perspective to assist in the negotiation process and resolve conflict should it arise.

P: I think there needs to be a third person that's perhaps not directly involved, maybe; somebody who's compassionate, can listen to both sides and perhaps act as a bit of an arbitrator, maybe.

F: So some kind of mentor or arbitrator.

P: I think two is always a dodgy number, because if there's any conflict then it's not going to get cleared up easy. But somebody, a third party there, that can at least contribute, build up the rapport in the same way, the confidence, and understand the background, then they can help. Especially if one's off on leave, and they're not available, they're still there as a second line of contact.

(FG2)

There was consensus among the group that the third person in the support process should be independent and impartial to the employee and employer. One LM described how OHPs can assist in negotiating what the employee needs and what is achievable within organizational constraints.

P: What do you think should happen between… ah, so I think this session we've got should be a three-way thing, so everyone's invited along.

P: You need to find out what will help, without conflicting with the business…

P: Say, in short, gets his chance to provide a solution as well. It's quite often you go away and think 'this is what we should do for them', and actually, it's the wrong thing.

P: If you find out what their expectations are, sort of guide them, you can come up with a compromise between what you want and what they want.

(FG2)

2.18.3.4 Decision making

There was discussion among the LM sample on how decisions regarding the employee's reintegration into the workplace should be made. One LM highlighted that the employee is the expert on their condition, therefore they should lead the conversation on what they require to return to the workplace. Conversations between management can take place in isolation but ultimately the employee's input is imperative to ensure the support is tailored to their specific needs.

P: We've said about isolating appropriate activity to try and help, so he should be looking, actively, for ways back into work, potentially. So maybe easier work, less stressful work than he's used to, or whatever caused the trigger. Maybe they should sort of be coming up with solutions himself. 'Cause we can go offline and have a discussion about things, but obviously they know what's best suited for him, and what potentially…

(FG2)

There was discussion among the group about the LM's role within the decision making process. The group described how the LM's role was to offer suggestions on what adjustments were achievable whilst letting the employee lead the conversation.

P: Yeah, you're right, I think the manager, the line manager still has to control things but the employee has to be given the opportunity to drive things. If he's not, then it's just stagnating. Then I think the manager should take

control. But usually, usually the person is the expert and good at saying what's wrong with them.

F: *And what about…it's a negotiation really?*

P: *I would say that at the initial stage I wouldn't say it was stepping back and letting drive it, almost certainly you're going to have to drive Billy, to drive it, because they could be nervous about the whole process.*

(FG2)

2.18.3.5 Monitoring

There was discussion among the group about the remitting and relapsing nature of bipolar disorder. The group discussed the need for continued monitoring to identify signs of relapse, allowing the LM to intervene early before the employee became too unwell. One LM recalled an incident as an example where the employee had advised him to monitor the structure of emails for signs of relapse. When the emails became a block of text it was agreed the LM would intervene and make adjustments (e.g. cancel meetings) to support the employee.

P: *Discuss with the individual what to look out for. With my employee his emails go into big blocks of text. When I see that, any conference call he has scheduled I cancel, any work commitments I make sure those expecting him to achieve are aware. That should take into account his performance as you are taking into account his complexity*

(FG1)

One LM highlighted the need to balance the level of support provided to the employee. Intensive monitoring could leave the employee feeling scrutinized; however, too little could result in signs of relapse being missed. One LM described how he organized a weekly meeting with one employee to ensure support was easily accessible if needed, but it was the employee's decision as to whether they needed to attend each week.

P: *I have a weekly hour slot in my calendar that is always booked with HR and the individual. Most weeks he declines and says he doesn't need it but if he ever does I am there and ready. I have joined the call and more often than not no one ever joins so I send a text saying are you not coming on today. It is a crutch for me and him.*

2.18.4 Communication

The LMs discussed some of the challenges they face when communicating with employees. One LM described how they often experience difficulty in maintaining contact with employees when they are out of work and are therefore unsure of the reason for the absence.

P: *There was no communication about why he was off.*

(FG1)

Another LM described feeling unsure about how and when to contact employees off work due to sickness absence.

P: *Knowing how to retain contact, home visits, the telephone. When is appropriate to do that…*

(FG1)

One LM described the difficulties associated with discussing workplace issues with employees off work. There was a concern among the group that contacting the employee at home would be perceived as pressure to return to work and not as a facilitator to offer support.

P: No, when he wants to talk about work, he does like to talk about work. One of the things I found early on is you need to talk to him about something else other than the reason you are there. Initially when you are talking to him he know you are from work and know you are going to talk to him.

(FG1)

2.18.4.1 Disclosure and employee openness

The LMs discussed the need for employees to be open and honest about their condition if support is to be tailored to their needs.

P: Yes, because at the end of the day this is to support him when he comes back to his role, so therefore he needs to say…

F: So be open and honest…

P: …this is what I want…

(FG2)

One LM identified how the employee needs a level of insight into their condition to recognize the support they require and when.

P: It's about insight, it's about being honest and open and frank.

(FG2)

The group also identified the difficulties they face in managing the perceptions of the employee's colleagues. The group described how colleagues would need to be informed of the employee's condition to gain an understanding into why workplace adjustments had been put into place. There was uncertainty among the group whether colleagues would be sympathetic of the employee, particularly when they had incurred an increased workload to accommodate the employee's adjustments.

P: Do your teams understand? Do the other people in the team understand? I guess they do if you've got ten people.

P: They all understand; whether they all accept is a different kettle of fish.

P: Obviously that's part of it, if you're integrating the person, people need to understand what they're going through.

P: You'll always have the people who acknowledge that there's an issue and the person is trying, but don't like the fact that other people have to make accommodations for them. You will always have those people.

(FG2)

2.19 Occupational health focus group results

Ten OHPs, all with previous experience of supporting employees with bipolar disorder, took part in the focus group meetings. The group included a range of OH specialties including OH physicians, nurses and a clinical psychologist. The group worked in OH departments covering a broad geographic area including Wales, the Midlands, Northern Ireland and London.

Five major themes and ten subthemes emerged from the first two focus group meetings that illustrate the challenges OHPs face in supporting an employee with bipolar disorder and the solutions to overcome these. The themes and subthemes are listed below and are illustrated in figure 4. Each theme will be discussed in turn.

Theme 1: Complexity of the condition

Subthemes:

- LMs' knowledge and understanding of the condition
- OH confidence to manage the condition

Theme 2: OH role within the management of bipolar disorder in work

Subthemes:

- Organization expectation of OH

Theme 3: Working relationships between key stakeholders

Subthemes:

- OH relationship with the organization
- LM's relationship with the employee

Theme 4: Support

Subthemes:

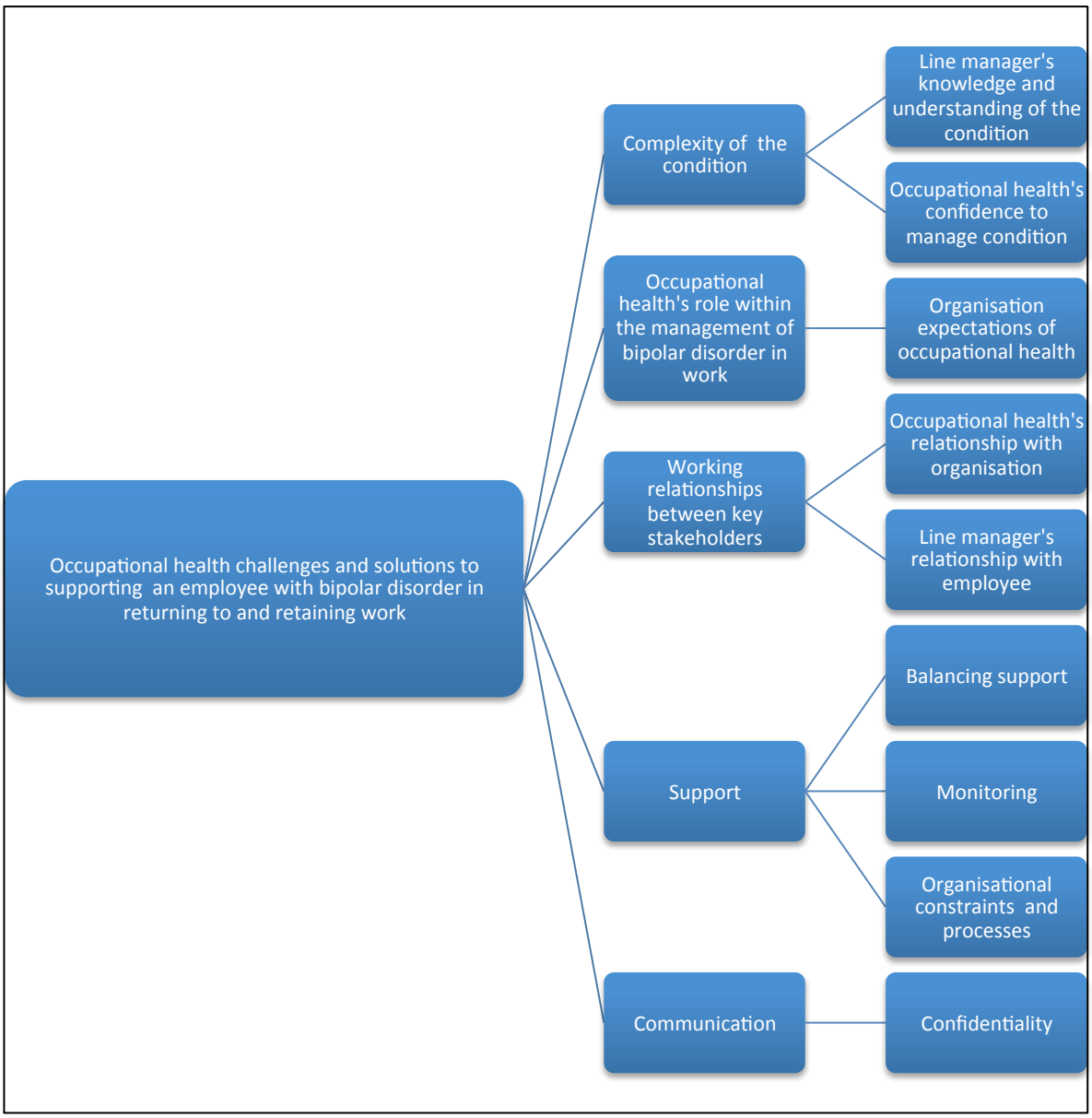
- Balancing support
- Monitoring
- Organizational constraints and processes

Theme 6: Communication

Subthemes:

- Confidentiality

Figure 4: OH challenges and solutions in supporting employees returning to work with bipolar disorder - overview of themes



2.19.1 Complexity of the condition

This theme describes the complexity of managing a condition such as bipolar disorder due to the lifelong and relapsing nature of the condition. In addition to managing the employee, OH is also responsible for guiding and informing the LM on how to manage the changing needs of an individual with this condition. The group explored the difficulties OHPs and LMs face in managing employees with this condition.

2.19.1.1 The line manager's knowledge and understanding of the condition

The group described the difficulties LMs face in supporting an employee with a relapsing condition to sustain work. The level of intervention required to integrate an employee back into the workplace and sustain them there is likely to be of long duration and complex. One OHP described how employers often struggle to manage common mental health problems, let alone severe and enduring conditions. The group discussed how an LM's lack of knowledge and understanding of bipolar disorder can often make it very difficult for them to support and manage the employee.

P: This person had a relapsing recurrent nature to their illness so for a retention point of view that made it increasingly difficult for employer to retain them in work. Because of complexity and length of time, then the intervention required to be stretched over a long period of time so individual was required to be away from work for increasingly longer, longer and longer periods of time. Most recent being 18 months. The longer you are away, chances of you getting back are pretty slim.

F: One of challenges is complexity…

P: So assessment became longer to get all the details required. Assessment was longer and included more kind of people, advocacy. More people were involved in the assessment.

F: *There is the complexity that impacts on assessment, if you have complex disorder and comorbidity.*

P: *Employers in the workplace sometime struggle to manage common mental health problems and then you have got severe and enduring mental health problems. It just adds another layer.*

(FG1)

The group discussed how they are always mindful of the LM's level of knowledge and understanding of bipolar disorder. Limited knowledge can cause poor uninformed decisions over the employee's management. One OHP provided an example where an LM had altered an employee's working environment, based on the assumption that the workplace was the main source of stress. However, the LM's assumption was wrong and they had caused a greater level of stress for the individual by changing their working environment.

P: *Assumptions about what the nature of the work was, felt job was stressful, they thought that by giving him stressful work made his condition worse. Actually he liked the job, he enjoyed it and it wasn't stressful at all. It was them who made it stressful by making him move out of it. It was their assumptions rather than fact.*

The group explained how OH has a role to play in educating the LM and organization about complex conditions such as bipolar disorder. They described how LMs often distinguish the management of physical health conditions as fundamentally different to mental illness. However, the management of enduring conditions is often similar regardless of whether they are physical or mental health illnesses.

P: *I worry that people say mental health is different because you could say the same for musculoskeletal. They need reassuring and most of the time it's not that different. Most of the time when you see them they have a mental health problem anyway, whatever they started with. It is about the OH service being evidence-based and honest.*

(FG1)

One OHP explained how they often used physical analogies to help LMs understand how to support the employee with an enduring mental health condition:

P: *Yes, there are so many things that will be affecting it and if you can get them to understand, using a physical analogy, but they can't get their heads around it if it is hidden.*

(FG1)

2.19.1.2 Occupational health professionals' confidence to manage bipolar disorder

The group described how OHPs can also lack confidence in managing complex mental health conditions. They described how irrespective of their medical background and training some OHPs still feel insufficiently skilled and experienced to manage complex mental health conditions:

P: *A lot of people say they don't feel comfortable addressing psychological issues. They feel they are not trained enough and background doesn't cover that.*

P: *It's in general, a large number of OH nurses complain. There is an issue and it's not due to experience. A lot of people go into OH and have been doing health screening. If you come in from nursing you will find yourself doing mostly sickness absence consultations which can be quite challenging. Some doctors might find it a problem.*

P: During training there wasn't much teaching in psychiatry/ psychology. My gut feel is that is the main problem. We get it through experience over time. That's what trainees find most difficult. They are ok at first but get bitten once or twice and then get very scared.

F: Do you think this is about knowledge, skills or both?

P: Confidence.

P: They have the knowledge to know this is what I do or this is out of my skill set and I need to do something else.

(FG1)

There was some agreement among the group that confidence can develop over time through experience and continued exposure to managing mental health conditions in the workplace.

2.19.2 Occupational health role within the management of bipolar disorder and work

This theme highlights the role of the OHP in the return to work process and how this can be misinterpreted by the employer and employee. The group described how their blend of medical expertise and understanding of work environments make them best placed to provide impartial expert advice that meets the needs of both the employee and LM/organization. However, the group described the confusion that is sometimes present between the employer and employee about who takes ultimate responsibility for workplace decisions based on the employee's health. The group defined the role of the OHP as providing expertise to enable the employer to make informed management decisions.

P: Lack of clarity on who takes responsibility for the sickness. Lot of variation across the occupation of OH. Some people think you are the doctor, you are OH: make the decision. I see it as more of a management decision. Us giving info and them giving the balance. How do you balance all these things to decide whether they are fit?

(FG1)

The group highlighted the importance of being perceived by the LM/organization and employee as a source of independent impartial advice. They described occasions where either the employer or employee had perceived the OHP as an advocate, causing their opinion to be considered no longer independent and therefore not of value.

P: Advocacy, people advocating on behalf of the individual whether it be family member, employer or doctor. That's a challenge because they think that advice is no longer independent.

F: Advocacy moves to lack of independence.

P: In my case I ended up being the person's advocate which meant the employers became resistant to my advice.

F: Perceptions of who you are and how you provide that. Who they see you as, in terms of advocacy. Not just being that advocate.

P: When you become an advocate you lose independence and your opinion becomes less valid; in terms of someone standing back and saying I no longer value your opinion.

(FG1)

The group described a need for employers and employees to have an understanding of the role of OHP upfront to ensure their expectations of the service being provided are both accurate and realistic.

2.19.2.1 Organization expectations of occupational health

The group also discussed the unrealistic expectations sometimes placed on OH by the organization. One OHP described how employee referrals to OH services can be very late in the return to work process, leaving them with unrealistic timeframes to support the employee before the organizational absence policy penalises the individual.

P: Length of time to be seen by OH so if they have been out of work for 11 months, sick pay finishes in a month's time, let's get them into OH and what 'miracle' cure they can do. You say I want to see them within at least four weeks. Sooner if possible.

(FG1)

P: OH first before he comes back. Some cases you don't see them until they have already come back. Should have liaisons with HR, ring every week, let them know what is happening. HR will make appointment to see OH to start talking about coming back.

(FG2)

One OHP described how organizations sometimes delay referral in an attempt to limit costs, especially if services are outsourced.

The group described how employees should be referred to OH at a much earlier time point. This would allow sufficient time for OH to liaise with the employee and employer to negotiate a plan to ensure the best outcome for all concerned.

2.19.3 Working relationships between key stakeholders

This theme highlights the need for a positive working relationship between OH, the organization/LM and the employee. 'Good' relationships between the employee, LM and OH can be key to facilitating a successful return to work and a positive outcome

for all. The group described two main relationship dynamics: the relationship between OH and the organization, and between the LM and employee. These will be discussed in turn.

2.19.3.1 Occupational health relationship with the organization

The group described the importance of having a 'good' working relationship with the organization. This appeared particularly important if the OH service was sourced externally. One group member described how those organizations outsourcing OH support need to feel reassured they are getting value for money and are satisfied with the service being provided. They described how the organization is more accommodating of their advice on the type and intensity of support required if a trusting relationship between OH and the organization has been established.

P: A relationship where the organization was confident in the service being provided by the OHP. They described how there is a need for organizations to have confidence and value the service being provided and not feel that they are being unnecessarily charged for the service.

P: That's about the way OH provider is behaving, I could claim I have a close relationship with big customers and speak to people where HR ring me every day about cases. If I say I want to see this person in five weeks or two months, then that's fine.

(FG1)

P: A good relationship with the organization where they don't think you are ripping them off when you say you want to see them again or saying I want to deal with a doctor this time or a nurse this time and they don't challenge me because I am the specialist.

(FG1)

2.19.3.2 Line manager's relationship with the employee

The group also discussed the relationship between the LM and employee and the need for OH to monitor this dynamic. They described how the LM's attitude and behaviour towards the employee could change following an episode of illness. The LM may lack an understanding of the condition and treat the employee in a stigmatizing manner following the disclosure of a mental health condition. The group described how they monitor the dynamic of the relationship to ensure the employee is being treated fairly and receiving the support required.

P: The expectations and general close monitoring with new introduction of treatment, close monitoring of treatment. The longer term you would expect it to stabilise out, and explaining that to the individual that they are not going to be scrutinized. Trying to assess the relationship between the employee and line manager to see if that has changed. Has their working relationship changed? Is there any element of stigma which could commonly arise? Is the manager less comfortable with employee as he has perceptions that he is mad?

F: That is what OH needs to do. Be aware as OH, watch out for these kind of things. Being aware of that and seeing how the relationship is between the two.

P: The info you get in the referral, if it say can I dismiss this person, you soon realize the relationship has changed.

F: Keeping independent eye and relationship with LM.

P: Want a nice open supportive relationship, but life isn't always like that. That is the reality, that is.

(FG2)

The group described the ways in which they monitor the relationship between the employee and LM. One OHP described how a scrutinizing report from the LM can be a sign that the relationship has changed and OH may need to intervene.

2.19.4 Support

This theme highlighted the key role of the OHP in providing support to the employee, LM and organization. The group described the type of support they provide to each group and the challenges they often face in doing so.

To meet the requirements of the employee and to provide the best possible support, the OHP requires an in-depth understanding of the employee's needs and expectations. This involves exploring their fear about returning to work and exploring solutions to overcome these. The group described using these solutions as a basis to form a plan, to assist the employee in reintegrating back into the workplace.

P: Formulate ideas what he can do for himself, think about things about the job that he has considered to be aspects that he may struggle with. Give some degree of insight but to see if he has any fears or expectations. It might be that he feels that his colleagues are all scared of him because of what has happened in work so is worried about the reception he will have so it is important to explore his own concerns of going back to work. Willing to take a look at point of contact should his condition deteriorate. Setting up a plan before he come back.

(FG2)

2.19.4.1 Balancing support

The group discussed the need for support to be provided by the LMs at an appropriate level. There is a fine balance; too much support can leave the employees feeling scrutinized, too little can leave them feeling unsupported.

P: Up to line manager how he treats individual but should be treated the same as any individual as much as possible. Don't want him to feel he has been subject to undue scrutiny by his LM. That may be difficult as LMs have different styles and I am not there to tell them, I am there to give them…

F: We need to think about what is best, there is a fine balance between scrutiny and support, that for OH that would be tailored on disease progress, is that what you are saying?

P: The expectations and general close monitoring on with new introduction of treatment, close monitoring of treatment. The longer term you would expect it to stabilise out and explaining that to the individual, that they are not going to be scrutinized.

(FG2)

The group described how OH could provide guidance for the LM on the level and type of support required. Due to the complexity of the condition the employee's needs are likely to change and the level of support required may need continuous review and refinement. They described the need for a close working relationship with the LM to address these changing needs.

2.19.4.2 Monitoring

As bipolar disorder is a relapsing condition the group identified the need for ongoing and regular monitoring. The group described the need to work closely with the employee to gain an understanding of the illness, recognizing potential stressors and signs of relapse. Having this level of knowledge would enable OH to intervene early if the employee showed signs of relapse.

P: Reason it worked out was because the guy ended up working quite closely with OH department. I could recognize when he was going off the rails in addition to any management. Some were slow to spot it but because he worked close with our department.

F: So the challenge is managing the poles of the disease.

P: Recognizing when things are going out of control. Therefore monitoring is important.

(FG2)

However, in order to achieve this level of planning the employee would need to be open and honest with the OHP about the condition. If the employee lacked insight into the condition or did not disclose an adequate level of information it would be difficult for OHP to tailor their support, and put together proactive plans that pre-empt an episode of illness.

The group then described how ongoing monitoring could be difficult as OH support frequently stops at the point the employee returns to the workplace. They described how maintaining contact with the employee is particularly difficult if the OH service is outsourced, unless the employee is re-referred. One OHP described how they advise LMs to re-refer the employee at an early stage, acting proactively, instead of contacting OH when the employee is already out of work.

P: Ask line manager to re-refer at an early stage if they have any concerns or… Cut cord a bit for OH. Emphasize manager should continue to have, manager see him working, sees how he is. He has to have continuing freedom to tackle employee if he is going off rails.

F: Keep in contact and if concerned refer back.

(FG2)

The group described how ongoing monitoring by the LM is important to identify when the employee is becoming unwell.

2.19.4.3 Organizational constraints and processes

The group discussed the conflict that can occur between company policies and the employee's needs and expectations. They described how the role of the OHP is to negotiate a level of flexibility for the employee around the organization's rigid policies and procedures. The workplace can be a process driven and unaccommodating environment, making it very difficult to provide the support required for an individual with an enduring and relapsing condition.

P: *For large organizations we are talking process driven.*

F: *I am just trying to see to get it right…*

P: *Because we are very process driven to try and apply that individual discretion is a struggle. Sometimes it's about the application of common sense which seems to go out the window when process comes into play.*

(FG1)

The OHP has the delicate task of meeting the demands of the organization whilst ensuring the employee is satisfied with the level of support and workplace adjustments implemented.

The group also discussed the difficulty of reintegrating an employee back into the workplace when there are aspects of the job that cannot be adjusted. The group described how adapting the role to avoid stressors is the most favoured course of action. When this is not possible, it can leave all parties in a difficult situation that cannot be easily resolved.

P: *Way organization is configured acts as an environmental stressor to make relapse more likely to happen. Thinking about is the individual's stressors. Pace of change can make the environment a trigger that can impact on the person.*

P: *Jobs can become very different so by the time you return the individual the job might not exist at all. It may be that the job may not exist anymore.*

P: *Organizations going through change can mean that their role changes, so what is expected of them. Having the flexibility to shift is where some of them do struggle.*

(FG1)

This highlights the complex nature of the OHPs' role as they are required to meet the needs of the employee within the confines and constraints of organizational policies and processes.

2.19.5 Communication

This theme illustrates the importance of open and honest communication across all the key stakeholders, to enable the OHP to provide tailored and relevant support.

2.19.5.1 Confidentiality

There was agreement among the group that confidentiality should be broached and discussed with employees from the outset, to agree what information should be disclosed, to whom and when. The group described how the information employees disclose to the OHP may be different to what they want shared with the LM and organization.

P: Confidentiality and disclosure. Who says what? It should be on the agenda between all three to talk about.

P: Information, what LMs needs to know to be discussed between all three.

(FG2)

The group described how it is important to assure the employee of confidentiality, setting an environment where they feel confident sharing personal information about their condition.

One OHP also described the need to ensure the employee is being truthful about their readiness to return to the workplace. They described the importance of ongoing communication and monitoring of the employee to assist OH in making an assessment of the employee's readiness and suitability to be integrated back into the workplace.

P: Reliability of client information. By the time you see them sometimes they are itching to get back and you are not sure how reliable the information is and how serious it was. You need to have a consultation before they go back, to

ensure everything you have been told is correct. It delays the case a bit longer which put pressure on them.

(FG1)

2.20 Focus group three – Intervention development

Thus far, this chapter has provided an overview of the methodology and results from the first two qualitative focus groups. The themes that emerged from the employee, LM and OH focus groups were discussed in turn. The results of the third set of focus groups will now be presented. Four questions relating to the content and design of the intervention were asked of each group. The employee, LM and OHP responses to these questions will now be discussed.

2.20.1 Key content

The first question asked participants to consider the key content and messages that should be included in the intervention being developed as part of this study. Table 7 illustrates each of the three stakeholder groups' responses to this question.

Table 7: Table illustrating responses to question one - What do you think should be included in the intervention and what are the key messages?

Employee focus group	Line manager focus group	Occupational health focus group
• Guidance for LM on how to manage employees with bipolar disorder • Guidance on making workplace decision • Highlight employee's role in decision making process • Highlight importance of support for employee when returning to work • Information on bipolar disorder and triggers within workplace • Information on the role of the LM and OH • Information on workplace adjustments • Suggestion if there is a break down in relationship between employee and LM • Scenarios where employee has had a positive outcome following a return to work • Demonstrate that it is 'normal' for employees to experience difficulties in the workplace	• Information on bipolar disorder o What is bipolar? o Treatment o Signs and symptoms o Medication • Information on the role of the employee and OH • Video scenarios for LM, employee and OH, highlighting the outcomes and benefits • Examples of good and bad practice • Information on sickness absence policy • Information on the importance of confidentiality • Guidance on setting realistic expectations • Mechanisms for early support/referral/ re-referral • Demonstrate the importance of cooperation and trust	• An overview of the illness (signs of high, signs of low) • Links to documentation specific to the remit • Links to other websites • Information on medication and side effects • Example of a performance management conversation when an individual is on a high or a low so that people can see the difference • Guidance on what can be done differently to make a management conversation more productive • Examples of good practice that can be used in real life • Information on what employees can do to manage their condition • Information on what employers can do to support employees e.g. adjustments • Prevention – early detection, information on what can be done at each stage

All three groups identified the need for an intervention that included information and an overview of the disorder. The employee and LM groups felt it was important to include information on the role of each key player in the return to work process. All groups suggested information on the decision making process, with the LM and OHP groups requesting this via video scenarios. The LM and OH groups also requested examples of 'good' and 'bad' practice, and practical information on how to make management conversations more productive. The employee group also stated that information on workplace adjustments would be key content for the intervention.

2.20.2 Accessing the intervention

The second question asked each group to consider how they would prefer to access an intervention targeted at the management of bipolar disorder and work. The responses to this question from each of the stakeholder groups are summarized in table 8.

Table 8: Table illustrating responses to question two - How would you like to access the intervention?

Employee focus group	Line manager focus group	Occupational health focus group
• Internet • CD (for home use) • Intranet (in work provided it is in a private area) • Needs to be available in different formats, e.g. for visually impaired, hard of hearing • Various locations, e.g. doctor's, at work, at local library • Mobile app • Link via mental health/government website • Workplace e-learning • GP surgeries/clinics	• Via the Internet • Linked to organization's HR website • Organization's online training and development • Via Intranet • CD Rom • Linked to mental health websites • Via iPad and phone	• Online • DVD-ROM • Printed booklet • Training – as part of work/group workshop • App • Via HR website • Intranet

All groups stated that the Internet would be their preferred method to access an intervention such as this. The groups also listed other ways in which the intervention could be accessed, which included DVD/CDs, workplace intranet, mobile apps and mental health websites.

2.20.3 Intervention – user friendly

The third question asked each group to comment on how the intervention could be developed to make it 'user friendly'. The responses to this question from each stakeholder group are summarized in table 9.

Table 9: Table illustrating responses to question three - How could we make the intervention user friendly?

Employee focus group	Line manager focus group	Occupational health focus group
• Interactive (computer media) • Predominantly visual (action) rather than being talked at for 20 minutes • Provide links to useful websites/support organizations • Pages not too cluttered • Videos that act out scenes/instructions • Easy to navigate around intervention	• Easy to use regardless of computer experience • Not too long • Ensure it is stimulating and individuals can navigate with simple mouse clicks • Where possible have an interactive component, e.g. confirmation questions • Must be simple with ability not to short cut any important content • Attractive visually • Straightforward language, not 'medical' or 'business' speak • Informative and not patronising	• Succinct but educational/helpful • Interactive, where user can choose how to watch the programme • Good production value • Plain English/reading age median 11 • Helpful links to other areas (websites/information, GP/HR, LM/individual) • Offer practical/sensible suggestions • Simple instructions • Illustration and animation • Small bites of information • Use good actors and ensure scenarios are realistic and laid out in a way that will be found convincing • Minimal clicks (3 max) to get what you want; quick access • Real life stories – engage people • Structured, engaging

All three groups were in agreement that the intervention should be interactive where possible, and stimulating, with information that is easy to access. The OHP and LM groups stated the intervention content should use straightforward language and not 'business' or 'medical' terminology. All groups agreed that the intervention should be attractive visually, informative and of an appropriate length.

2.20.4 Attract user to access intervention

The fourth question asked each group to consider what would attract them to using an intervention targeted at bipolar disorder and work. The responses to this question from each stakeholder group are summarized in table 10.

Table 10: Table illustrating responses to question four - What would attract you to using such an intervention?

Employee focus group	Line manager focus group	Occupational health focus group
• Using real people and situations • Solution based • Evidence-based • Informative • Information on how to stay well in work • Information on preparing to go back to work • Endorsements from Bipolar UK and NHS • Endorsed by celebrity figure	• Endorsed by an individual that has bipolar, e.g. Stephen Fry • Recommended by organization, HR or Bipolar UK • Provide accreditation (CPD)	• Informative and easy to use • Endorsed by major bodies and institutions • Interesting • Relevant • Up to date/reliable • Recommended by colleagues • Easy to access • Evidence-based – supported by The Royal College of General Practitioners, Faculty of Occupational Health

All groups suggested that endorsement or recommendations from organizations such as Bipolar UK, the Royal College of General Practitioners or the NHS would attract them to using such an intervention. The groups also stated that the intervention needed to demonstrate that it was evidence-based with reliable and up-to-date information. The employee group stated the intervention should be based on real life case studies that are solution based.

Thus far this chapter has provided an overview of the findings that emerged from the qualitative focus groups. The findings from each of the three stakeholder groups have been discussed in turn. The key findings from across the three focus groups will now be

discussed and compared to current literature in the field of bipolar disorder and work. This will be followed by a discussion on the methodological limitations and the chapter will close with a conclusion on the findings.

2.21 Focus group discussion

This study employed qualitative methodology to explore the challenges to job retention and return to work, and the solutions to overcome these, from the perspectives of the three stakeholder groups (employees with bipolar disorder, LMs and OHPs). To our knowledge, this is the first study to explore the interconnectivity in perspectives across all key stakeholder groups involved in the job retention and return to work scenario, specifically in relation to the management of bipolar disorder.

2.21.1 Key findings where consensus was met across the three focus groups

2.21.1.1 Key finding – Line manager knowledge

The level of an LM's knowledge and understanding of bipolar disorder was identified as a challenge across all three stakeholder groups. In identifying solutions to overcome this challenge, the LM participants described the need for accessible information on the condition to assist them in the management of employees with bipolar disorder. Better communication between the OHP and LM was also identified as key. This would allow LMs the opportunity to utilize the expert knowledge of the OHP to assist in managing an employee with bipolar disorder in the workplace. The employee sample also described how the LM can utilize their expertise to inform management decisions.

The employees described how misunderstandings about mental illness can lead to poor management decisions on the part of the LM. These findings are consistent with current literature that states that although LMs are in a key position to support employees on

sickness absence to return to work, they often report a lack of adequate knowledge, skills and confidence to do so (Black and Frost 2011). It is therefore difficult for LMs to invest in the health and the wellbeing of their staff if they are not equipped with the necessary knowledge, support and skill.

2.21.1.2 Key finding – Disclosure

Extending beyond the current literature, this study explored the challenges associated with disclosure of the condition from the perspective of the three stakeholder groups. Disclosure and openness about the condition were challenges for each stakeholder group but in different ways. The employees described the dilemma that is often associated with disclosure. To ensure adjustments and support in the workplace, the employee must disclose their illness at work. However, a level of anxiety was associated with disclosure due to fear of workplace discrimination or, worse, job loss. This 'fear' was not necessarily grounded in past experience or tangible evidence but was based on a perception they held of how the employer would react to such information. This is consistent with current findings where disclosure of mental illness in the workplace has been recognized as a dilemma and source of anxiety, with some hiding their illness (Fossey and Harvey 2010) due to concerns about how the employer will react (Tse and Walsh 2001).

The LMs and OHPs both acknowledged the anxiety associated with disclosure on the part of the employee. However, both highlighted that without knowledge of the illness they would not be able to implement workplace accommodations and offer support to the employee. This is consistent with findings by Glozier (2002), who reported that adjustments can only be made and implemented if employers are made aware of the disability.

Moving beyond the current literature, the three stakeholder groups identified ways to overcome the issue of disclosure and the associated anxiety. The LMs and OHPs all identified the need for open and clear statements about confidentiality to create an environment where employees felt comfortable and safe to talk openly about their condition. This would ensure employees felt assured that anything disclosed would be kept confidential and handled professionally. The employees endorsed this view and described the need for clear assurance from LMs and OHPs that anything discussed would be kept confidential.

2.21.1.3 Key finding – Stakeholder roles

Defining the role of each stakeholder group within the work and health scenario was discussed extensively across the three groups. The LMs described the complexity associated with their role within the organization, and how this is often not recognized by employees and OHPs. In addition to supporting their team of employees, LMs also hold responsibility for managing workplace demands, meeting organizational targets and adhering to and imposing workplace policy and procedure. They described the difficulties that can occur when trying to meet the needs of an employee returning to work within the organizational constraints. Therefore it is important for employees and OHPs to be clear of the LM role to ensure realistic expectations are set.

The OHPs described a need for their role to be defined, due to the common misconception that they are an advocate for either the organization or employee. When viewed in this manner they are no longer viewed as the independent intermediary, and their opinion and advice are no longer valued. An understanding of the role of the OHP on the part of the employees and the organization will ensure they are perceived and utilized suitably.

Extending beyond the current literature, these finding highlight that an action as simple

as clear statements about each stakeholder's role can ensure realistic expectations are set and groups are utilized appropriately.

2.21.1.4 Key finding – Relationships, shared decision making and communication

The focus group results supported current findings that the relationship between the LM and employee in the workplace is crucial (Dekkers-Sanchez et al. 2010; Tremblay 2011). To demonstrate a supportive relationship the employee needed to feel listened too, valued and supported by their LM. Consistent with the current body of literature employees sought an understanding and acknowledgment of their condition (Fossey and Harvey 2010) and were more likely to work in partnership if they felt understood and as if their concerns were taken seriously (Tse and Walsh 2001). The LMs described how employees were more accepting of company policy if a 'good' relationship had been established. Consensus on this finding was also reached among the employees.

When relationships were not established all three stakeholder groups described the importance of the OHP in facilitating interactions. Consistent with current literature, the OHPs described how they are ideally placed to offer strategies and support and to negotiate with the employer on the part of the employee (Fossey and Harvey 2010).

A key finding that emerged across the three stakeholder groups was the importance of joint decision-making. Consistent with findings by Anderson et al. (2006) joint decision making between the employee, OHP and workplace was key, and reduced the doubt and uncertainty associated with this process. Engaging in a joint decision making process allowed the employee the opportunity to offer information on their illness, their difficulties within the workplace and the solutions to overcome these. In addition, it allowed the LM the opportunity to discuss these, and to offer solutions within organizational constraints.

Extending beyond the current literature, ongoing communication and support were identified as key among this group due to the lifelong remitting nature of the condition. The support required for such a condition was described as a continuum and not a 'one-time' process. To assist employees to sustain employment ongoing communication was required to ensure their changing needs were being identified and addressed. Consistent with the findings of Fossey and Harvey (2010), ongoing support was identified as crucial to help employees sustain employment.

The study findings highlighted an important caveat in regard to the literature on communication and support between the LM and the employee. The timing of the communication and the amount of support offered to an employee with bipolar disorder require careful consideration. The employees described feeling smothered and watched if communication with the LM was too frequent, and if too many support processes were put into place. However, at the other end of the spectrum too little support and communication left employees feeling unvalued and unsupported. There was consensus across all groups that defining and implementing the appropriate level of support could only be achieved through open communication and shared decision-making across all stakeholders. Due to the relapsing nature of bipolar disorder the amount and timing of the support will change, therefore regular review and discussion are required. Employees may need minimal input from the LM and OHP during periods of remission and increased support during the onset of symptoms, or during periods of high work demand, or following a period of absence.

2.21.1.5 Key finding – Adjustments

Consistent with the current literature, consensus was reached across the three stakeholder groups that adapting the workplace environment and a gradual return to the workplace were preferred, and were described as the most commonly offered adjustments (Fossey and Harvey 2010). In agreement with the findings of Glozier (2002),

the LMs identified that adjustments should be considered on an individual basis, in the context of organizational constraints, cost, disruption and the associated beneficial outcome. Again setting adjustments required open communication and joint decision-making across all stakeholder groups to reach agreement on what was required, necessary and achievable.

2.21.2 Key findings where consensus was met within groups but not across the three stakeholder groups

2.21.2.1 Key finding – Perception of mental health

The results of the focus group study suggest that a number of LMs perceived mental health conditions as considerably more difficult to manage than physical health conditions. However, the OHPs disagreed with this view and stated the management skills are the same, regardless of whether the illness is related to a physical or a mental health condition. Consistent with the findings of Glozier (2002), the OHPs identified that mental illness should be treated the same as any enduring condition such as diabetes or asthma. If LMs feel confident of their skills to manage those with physical health conditions, they should have no difficulty in managing employees with a mental health condition. This highlights the need for information to be disseminated to dispel some of the myths and misconceptions held in regard to mental illness.

2.21.3 Implication for intervention development

Consensus was reached across the three groups on the main challenges to managing work and bipolar disorder and the solutions to overcome these. The three groups were in agreement on the key areas to be addressed in the intervention to meet the needs of each stakeholder group. The consensus reached across groups suggested one intervention could be relevant to and targeted at all three stakeholder groups. Therefore, based on the focus group findings an intervention targeted at the

management of bipolar disorder and work across the three stakeholder groups needed to:

- provide information on bipolar disorder to increase LMs understanding of the condition.
- demonstrate to the LM the uncertainty associated with disclosure from the perspective of the employee.
- demonstrate to the employee the benefits of disclosure to obtain support within the workplace.
- highlight the importance of confidentiality and ways in which to create an environment where employees feel safe to disclose their condition.
- highlight the role of each stakeholder within the process and the associated complexities.
- demonstrate the importance of building a rapport and relationship between stakeholder groups and the associated benefits.
- highlight the importance of open communication and joint decision making, and illustrate the behaviours to demonstrate they are engaging in these processes.
- demonstrate the complexity associated with negotiating adjustments and setting up the process of support when dealing with a remitting condition such as bipolar disorder.

The focus group results highlighted how the intervention being developed for this study would need to differ from current established programmes such as IPS. Vocational rehabilitation interventions such as IPS adopt the collaborative approach of engaging all stakeholders in the process, but primarily focus on reintegrating individuals back into the workplace. However, this study demonstrated that in addition to needing assistance to re-enter the workplace following a period of absence, employees with bipolar disorder also require ongoing support to sustain employment. Therefore the intervention being developed would need to highlight the importance of, and provide

the skills training to engage in, the proactive long-term management of bipolar disorder and work.

In order to achieve this, skilful communication and management practices are required across the key stakeholder groups. Best practice in terms of absence management and communications skills, and the need for a supportive and collaborative relationship between the stakeholders, is clearly documented in the literature. However, there are few resources and little training available to demonstrate how to achieve this. Simply telling the individuals the skills needed to engage in complex interactions is rarely enough. Many participants in this study were from large organizations with established sickness absence management policies and practices. However, participants still described feeling unsure and inadequately skilled to manage sickness absence and job retention in regard to a complex mental health condition such as bipolar disorder.

To my knowledge, this is the first to study to explore the complexity of bipolar disorder and work from the perspective of all stakeholders involved in the work and health process, and then to use this information to develop an intervention to provide information and skill training to promote skilful communication and interactions between the stakeholder groups.

2.21.4 Limitations of the qualitative study

The focus group results need to be interpreted in light of several limitations.

2.21.4.1 Sample drop out

Focus group attendance rates dropped throughout the study across all three stakeholder groups. A larger sample than required had been recruited initially in anticipation of this; however, the dropout rate was still higher than expected. As the

study adopted a longitudinal type design with the same participants attending three focus groups over a 6-month period it was not possible to recruit further participants during the study. The longitudinal nature of this study could account for participants not attending all focus group meetings. Participants' enthusiasm and commitment to the study may have decreased over the course of the six-month period. The highest dropout rate was among the employee group, which in some cases was due to participants becoming unwell and feeling unable to attend further meetings. This issue is unavoidable when working with participants with a remitting condition such as bipolar disorder. However, this longitudinal type design was a key strength of the focus group study. Meeting with the groups over an extended period allowed time for reflection between meetings, capacity to build upon findings from previous groups and the opportunity to share findings across stakeholder groups. The inclusion criteria for the study ensured all focus group participants had lived experience of the topic under investigation, therefore they were able to provide detailed accounts and examples that were grounded in lived experiences.

2.21.4.2 Recruiting via organizations

Recruiting the LM sample to the study was particularly problematic. Several companies were approached who had expressed an interest in taking part in the study; however, apart from BT and one LM from Capital Law, all withdrew due to the time commitment associated with participation. This is not surprising, as recruiting participants via organizations is commonly identified as being problematic. Organizations do not exist to be participants in studies (Cox et al. 2007). Asking companies to allow LMs the time to travel to and attend three focus group meetings during working hours could have been considered an impractical and unrealistic request. A consideration for future studies would be to offer some financial compensation to encourage organizations to engage in such research. However, for those who did take part, some participants travelled a

considerable distance to attend the groups, suggesting there is a high level of interest and importance invested in this area of research.

The LM sample was primarily recruited from one organization – BT. This is a large organization with established absence policies, training and in-house OH support. Therefore, the key findings identified may not be representative of LMs from smaller less resourced organizations. To limit bias where possible, LMs were recruited from across a diverse business and large geographical area within the organization.

Preferably the LM sample would have been recruited from across a more diverse range of organizational settings (e.g. small organizations, medium organizations, public sector, voluntary sector, etc.). However, due to study time constraints and the lack of engagement from other organizations it was not possible to recruit additional companies. Despite the lack of diversity across the LM sample the findings from this group corroborate and extend previous research findings. Challenges in regard to the management of bipolar disorder and work were clearly identified by this group. Therefore, if LMs in a large organization such as BT require information and skills training, the demand for an intervention developed as part of this study is likely to be in even greater demand in smaller and less resourced work settings.

The lack of engagement from other organizations may reflect the lack of importance given to the issue of mental health and work. Alternatively, it may reveal the high level of workplace demand and lack of resources at organizations that would make it difficult for LMs to have the time to engage in such research activities. Organizations are not a common exploratory setting, therefore this unfamiliarity with research may have discouraged companies from taking part. An important consideration for further research would be to collect information on the reasons why organizations choose not to engage in research studies such as this. This information would inform future

recruitment strategies that could be utilized when setting up studies with a similar target population.

2.21.4.3 Recruitment – employee sample

A further sampling issue to consider is the recruitment of the employee sample. All employee participants were recruited from the Cardiff area via the BEPC groups. This could limit any broad interpretation being made from the results because of differences in employment rates and healthcare systems across the country. The sample had all attended the BEPC course, which aims to support individuals to develop skills to manage their condition more effectively. Therefore, it could be argued that the sample was only representative of a group functioning well in the workplace. However, the retrospective nature of the focus groups addresses this issue, as this design allowed an insight into how the condition had impacted them across their working life history and not just at the time of the study. The sample described both extremes, from periods where they had functioned well in the workplace to periods where they had been hospitalized, therefore reflecting a diverse range of experiences.

It was anticipated the three stakeholder groups would be difficult to recruit, especially to a study that required a substantial time commitment (three, two-hour meetings) over a six-month period, therefore a pragmatic approach to recruitment was required. This form of recruitment method is typical and commonly accepted for qualitative research, especially when exploring complex issues over an extended time period. A consideration for future research using this method would be to include some form of incentive to encourage more participants to take part. In RCTs hospitals are often given a payment for a complete set of data, therefore a similar incentive approach could be utilized to encourage organizations to engage in research.

2.21.4.4 Focus group methodology

The qualitative focus group methodology was a key strength of this study. Existing literature has recognized that qualitative studies are particularly suited to capturing data on the complex processes that are associated with return to work (Anderson et al. 2006; Dekkers-Sanchez et al. 2010). This type of methodology allowed investigation of complex issues throughout the study, instead of focusing on a small number of variables (Tse and Yates 2002) that could have resulted in important findings being missed if a quantitative method had been used. Focus group methodology is particularly beneficial as the group dynamic can help participants to explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger 1995). Meeting with the same group of participants over a 6-month period allowed sufficient time to develop a rapport between participants and the research team, and to summarize and discuss the key findings at subsequent groups to ensure accurate interpretations of the data had been made. Developing a rapport with, and among the group was crucial to developing a trusting relationship where participants felt confident to talk openly about potentially sensitive work and health challenges which may have been considered more suited to a one-to-one interview setting.

Focus group methodology is associated with several limitations, particularly if the group dynamic make it less likely that individuals will discuss issues or voice options that are sensitive or not considered socially desirable. There was a particular concern that the line manager and OHP sample would not feel comfortable disclosing the challenges associated with the management of bipolar disorder and work as it may have been perceived as a means to identifying their own weaknesses in terms of their communication skills and management practices. However, this did not appear to be an issue for the line manager participants who discussed the challenges associated with their role and were forthcoming in providing real life examples that highlighted weaknesses in their own practice. The employee participants also discussed, without

hesitation, the challenges they had experienced and their views in regard to the topics under investigation. The OHP samples were very open about discussing issues associated with the line manager and employee, but were initially more reserved when voicing opinion on their own role and challenges. Steps were taken when designing the focus group study to encourage open and honest discussion from all participants. The use of paired; individual and group tasks, and a fictitious character were key in promoting active discussion and engagement from all group members, particularly among the OHP sample. The more openly spoken and less inhibited members of the group, who openly discussed the topics under investigation, also encouraged the quieter participants to engage. Additionally, the mutual support that was given across the group for the challenges being voiced by participants encouraged group members to express their views openly even if they deviated from a socially desirable response (Kitzinger 1995).

The focus group methodology encouraged participants to explore subjects of importance in their own words, and to pursue the issues they perceived as priority. This methodology utilized a group dynamic to provide a rich and detailed account of the topic under investigation. It facilitated the expression of criticism and the investigation of different types of solutions that is invaluable when the study aims to build an intervention to improve communication skills and management practices among its user groups. The observational and longitudinal type methodology allowed movement of the research back and forth between data collection, analysis and conceptualisation, which led to an in-depth understanding of the data.

2.22 Conclusion

This study has provided a unique contribution to the literature. The unique methodology gave ‘a voice’ to all three stakeholder groups individually (employee, LM and OHP) whilst allowing dialogue and feedback to the group as a whole. To my

knowledge, this is the first study to investigate the interaction and interconnectivity between all three stakeholder groups together to inform the development of an intervention to provide synergistic messages and common strategies applicable to all target users.

Chapter 3

Quantitative Questionnaire Study

3.0 Chapter 3 – Quantitative Questionnaire Study

Moving beyond the qualitative focus group findings, a quantitative questionnaire study was conducted with a large sample of patients with a bipolar disorder diagnosis. This questionnaire study sought to explore the clinical and occupational challenges that individuals with bipolar disorder face in relation to work. In this chapter I describe how I collaborated with the Mood Disorders Research Team to design and distribute a questionnaire to a large sample of participants. Utilizing the Bipolar Disorder Research Network (BDRN) database also provided me with access to a unipolar sample where comparisons across diagnosis could be made. I describe the recruitment and assessment process for this sample, the development and distribution of the 'Cardiff Mood Disorder and Work Questionnaire' and the statistical analysis process, followed by a comprehensive overview of the results. I conclude this chapter with a discussion of the main findings and summary of the study limitations.

3.1 Rationale

In this questionnaire study I sought to further explore the clinical and occupational challenges that individuals with bipolar disorder face in relation to work, across a much larger sample. Adopting a quantitative type methodology allows information to be gathered from a larger sample of the population in question, in a quick and cost-effective manner. Collecting data on such a large sample via other methodologies such as focus groups or interviews would have been time intensive, expensive and impractical.

To assist in recruiting a large sample of participants with bipolar disorder, I collaborated with the Mood Disorder Research Team, who are a joint collaboration between Cardiff University and the University of Birmingham (recently moved to the University of Worcester). The team have developed the BDRN, a programme of work that has

collected data on over 6000 individuals with unipolar and bipolar disorder over a 20-year period. This sample was initially and primarily recruited for genetic research purposes; however, the data collected also allows for a range of research questions to be addressed. The BDRN collects set data on recruited patients, and participants sign up to further contact, and an annual newsletter. The newsletter is accompanied by further questionnaires allowing additional measures on the sample to be collected. As part of this annual data collection, the BDRN provided agreement for a work specific measure to be included in the questionnaire pack. This allowed me to collect work specific data on a sample where clinical and demographic data were already available. Using the unique participant numbers I combined the demographic and clinical data already collected with my work questionnaire data. Utilizing the BDRN database also provided me with access to a unipolar sample where comparisons across diagnosis could be made. This allowed me to look at the MDD sample to identify if there are any specific influences of having a bipolar disorder diagnosis that impact work over and above having a mood disorder more generally.

Having access to such a large sample of participants provided the opportunity to test the main findings from the employee focus groups, and to explore further the clinical, demographic and occupational variables associated more broadly with employment for individuals with a bipolar disorder diagnosis. This questionnaire study was explorative in nature, adopting an open approach to maximize insight into the data. Exploratory data analysis such this can reveal unsuspected insights into data and can be used as a method to formulate hypotheses for future data collection and studies.

3.2 Design

The retrospective cohort design included distribution of a work-related questionnaire to all participants on the BDRN database that had consented to being contacted for future research.

3.3 Aim

The aim of the questionnaire study was to explore the employment patterns and the impact of clinical variables on employment outcome across a large sample of participants with a lifetime diagnosis of bipolar disorder.

3.4 Research question

This study sought to explore:

1a. The employment patterns of individuals with a mood disorder in terms of:

- rates of employment
- characteristics of employment patterns
- disclosure of their mental health
- perceived workplace support

1b. A description of those who are not in employment

2. What clinical and demographic factors are predictive of employment status for individuals with a bipolar disorder diagnosis?

3.5 Method

I will now provide an overview of the BDRN programme of research to describe how and for what purpose the data I used in this study was gathered. I will describe the method of recruitment for this sample, the eligibility criteria and data collection measures. I will then describe the process I followed to develop the work specific questionnaire and outline how I distributed this measure to the sample. I will conclude the method section with an overview of how the BDRN data and work questionnaire data were combined

and provide a summary of the analysis procedure before moving on to present the results.

3.5.1 The BDRN dataset

3.5.1.1 Recruitment

Participants are recruited to the BDRN programme of research via systematic and non-systematic research methods. Patients recruited systematically are screened through community mental health teams and Lithium clinics across the UK. Clinical Studies Officers from mental health trusts across the UK invite eligible and suitable participants to take part. Non-systematic participants are recruited via local and national media and patient support organizations (e.g. Bipolar UK) and via the BDRN research team's websites.

3.5.1.2 Eligibility criteria

The inclusion criteria require participants to be aged 18 years and over, to be able to provide informed consent, to meet the DSM-IV criteria for affective disorder and to be of UK/Eire white ethnicity (as they were recruited for molecular genetic studies). Participants are excluded if they: i) experience affective illness as a result of alcohol or substance dependence or ii) had only experienced affective disorder secondary to medical illness or medication.

3.5.1.3 The sample

The BDRN sample includes patients with a diagnosis of bipolar disorder. In addition to the BDRN sample, the mood disorder research group has also completed studies of major depression, therefore a sample of individuals with MDD was also available to be

approached. The BDRN programme was initially set up to recruit patients with a bipolar disorder diagnosis for molecular genetic studies. Therefore the bipolar disorder group makes up a much larger proportion of the overall sample. Subsequent smaller studies, over a shorter period of time, have been conducted by the mood disorder group on recruited patients with MDD. Having a sample that included participants with bipolar disorder and MDD influenced the design of the questionnaire and the terminology used.

3.5.2 Psychiatric assessment

Participants recruited to the BDRN programme are interviewed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (Wing et al. 1990) at a time and place convenient to them. SCAN is a set of semi structured clinical interviews that provide detailed information on lifetime psychopathology and behaviour associated with adult psychiatric disorders. Interviews last approximately 1.5 hours and are usually conducted at the participant's home. Psychiatric and general practice case notes are also reviewed where available. Based on data from the SCAN interview and a review of case notes, best-estimate lifetime diagnosis is made according to DSM-IV criteria, and key clinical variables, such as age of onset and number of mood episodes, are rated. Members of the team involved in the interview and diagnostic procedure are either research psychologists or psychiatrists. One member of the team typically provides diagnostic and clinical ratings; however, where there is doubt ratings are made by at least two members of the research team blind to each other's ratings and consensus is reached via discussion where necessary.

Inter-rater reliability has been formally assessed using 20 randomly selected cases. Mean kappa statistics were 0.85 for DSM-IV diagnoses and ranged between 0.81 and 0.99 for other key clinical categorical variables. Mean intra-class correlation coefficients were between 0.91 and 0.97 for key clinical continuous variables. Data from the SCAN interview is stored on the BDRN database.

3.5.3 Development and distribution of the 'work' questionnaire

Following the overview of the BDRN research programme I will now describe the development of the 'work' questionnaire.

3.5.3.1 Questionnaire development

The research aims, existing literature on clinical and occupational predictors of work impairment (as discussed in the background chapter, chapter one) and the focus group results were reviewed to identify the key themes to be addressed in the questionnaire. As the questionnaire content was largely informed by the focus group findings and specific aims there were no existing measures that captured all the data required for this study, therefore a new measure was deemed necessary.

The key themes explored in the questionnaire included:

- Employment status
- Workplace patterns of participants in employment (full time/part time/regular working hours/shift work)
- Workplace setting of participants in employment (small/large/public sector/private sector)
- Length of time participants have worked at the organization
- Whether participants have disclosed their mood disorder in the workplace and to whom
- Amount of sickness absence taken by participants
- Mood disorder symptoms that are problematic in the workplace
- Workplace support and adjustments offered by organizations to employees with a mood disorder
- Reasons for unemployment in participants with a mood disorder

As the sample included those with a bipolar disorder and MDD diagnosis, the more generic term 'mood disorder' was used when developing questionnaire items and considering a title for the measure and for the design of each item. Statements were developed that aimed to capture data on each of the key themes listed above. The ONS labour force surveys and validated measures such as the work ability index (Tuomi et al. 1998) were reviewed to identify how work data is typically collected. Items to capture demographic and clinical data were not required as this information was already available and would be extracted from the BDRN database.

Items were refined to ensure they were deemed clear and unambiguous with high face validity. The questionnaire items were reviewed by the supervision team who provided feedback on the ordering, wording and quantity of questions. As this was being distributed as part of a booklet of measures, the BDRN required measures to be short and precise to ensure participants did not feel over-burdened and to ensure maximal response rates. Questions were refined until 18 items were finalized and agreed. The questionnaire was reviewed and piloted among the BDRN research team prior to distribution. The team were informed of the research aims, and were asked to complete the questionnaire and comment on face validity, ease of completion and understanding of items. The review process highlighted that the instructions directing participants to different parts of the questionnaire were not clear and required rewording. The questionnaire was amended until the supervision team was satisfied with the content and instruction set. No major amendments to the questionnaire content were required during the review process.

3.5.3.2 Questionnaire content

The final questionnaire was titled 'Cardiff Mood Disorder and Work Questionnaire' (appendix 1). The first question of the questionnaire asked participants to state their

employment status based on a list provided. The response to this question determined how the participants would proceed through the remaining items. Participants in employment continued through the questionnaire to item 14. Participants not in employment were asked to answer items 15-18. The vast majority of items were multiple choice and asked participants to tick the answer that best described their situation or perceptions.

3.5.3.3 Questionnaire formatting

The Formic Fusion (Formic Ltd: Middlesex, UK) data capture system was used to design the questionnaire. The software allows the questionnaire to be designed in a format that is suitable for scanning. The completed questionnaires are scanned using this software, and verification checks are made on the data. Scanned data is stored on a central database in an Excel format. Data was extracted on two Excel spreadsheets: one from BDRN containing demographic data and the second from Formic containing work questionnaire responses. The two data files were merged and imported into the Statistical Procedures for the Social Sciences (SPSS) version 20 for data cleaning and analysis.

3.5.4 Recruitment

The Cardiff Mood Disorder and Work Measure was included in a questionnaire pack sent to all participants on the BDRN database that had consented to ongoing contact. These included participants with MDD, schizoaffective bipolar disorder, bipolar I disorder and bipolar II disorder. The self-completion questionnaire packs were sent to participants' home addresses. Completed questionnaire packs were returned to Cardiff University via prepaid envelopes.

3.6 Statistical analysis

The data was analysed using the SPSS version 20 for Windows. To determine the employment patterns of individuals with a mood disorder, descriptive analysis was undertaken. Additionally, logistic regression analysis was carried out to determine which combination of clinical and demographic features was associated with employment status. The descriptive analysis and logistic regression analysis process will now be described in turn.

3.6.1 Recoding data – outcome variable

The research questions aimed to compare differences in employment patterns and clinical features across the 'employed' and 'not employed' samples. Employment status was collected across seven levels, which were recoded to form a dichotomous outcome variable. In response to the questionnaire measure 'Are you currently employed?' participants who answered 'yes', 'yes, but on sick leave' or 'yes, I am on maternity/paternity leave' were grouped and defined as the 'employed' sample. Participants who answered 'no', 'no, I am a homemaker', 'no, I am a carer' or 'no, I am a student' to this question were grouped and defined as the 'not employed' sample.

3.6.2 Descriptive analysis

Descriptive statistics quantitatively describe or provide a summary of data in a meaningful way. This form of analysis was used to describe the data on working environment, level of sickness absence taken, disclosure of the disorder and workplace support offered to the 'employed' sample. Additionally, this form of analysis was also carried out to describe the length of time the 'not employed' sample had been out of work and the reasons for this. The descriptive statistics and frequency distribution will be discussed in the results section.

3.6.3 Logistic regression

The demographic and clinical variables of the employed/not employed groups were compared using univariate analysis. Normality was tested using a histogram and Q-Q Plot. Chi-square tests were undertaken on categorical data, t-tests for parametric data and a Mann-Whitney test for non-parametric continuous data. All clinical and demographic variables relating to employment status that were significant at a $P < 0.05$ level in the univariate analysis were considered for the regression model.

A binary logistic regression was carried out to determine which combination of clinical and demographic features was predictive of employment status. Logistic regression is a generalised linear model for binary response variables. This method allows analysis of datasets where one or more independent variables can determine an outcome.

A logistical regression is associated with a number of assumptions:

- A large sample size is required for a regression analysis to minimize the risk of a skewed result. A minimum of 50 cases per predictor is recommended (Brace et al. 2009), which was easily achievable for this study with a sample size of n = 1857.
- A logistic regression requires a dichotomous outcome variable. The outcome variable for this study was employment status (employed/not employed).
- A logistic regression requires independent variables to not be highly correlated. A test for multicollinearity was conducted prior to variables being entered into the model. Variables too highly correlated were omitted from the model.

A standardized residual plot was used prior to entering variables into the model to identify outliers; extreme scores were identified before variables were entered into the model. Normality and linearity were also tested before regression analyses were performed.

3.7 Results

Thus far, I have described the BDRN programme of research, the development of the 'work' questionnaire and the analysis process. I explained how the 'work' questionnaire data was combined with the BDRN data and the analysis that was conducted. I will now provide a comprehensive overview of the questionnaire study results in two parts.

Part I – Work questionnaire results

1. Response rate to questionnaire
2. Participants' employment status (employed/not employed) across DSM diagnostic disorder
3. Employment setting of the employed bipolar disorder sample: amount of sickness absence taken by the employed bipolar disorder sample, perceptions on disclosure and workplace support
4. Comparison of employment patterns across the bipolar disorder and MDD sample
5. Reasons for and length of time out of work for the 'not employed' sample

Part II – Clinical and demographic predictors of employment status

1. Clinical and demographic factors predictive of employment status across the bipolar disorder sample

3.7.1 PART I – Cardiff Mood Disorder and Work Measure Results

In total 6447 BDRN participants with bipolar disorder and MDD were sent the questionnaire pack, with an overall response rate of 39% (n = 2484). Out of the overall sample, 5216 of the participants had bipolar disorder, with a response rate of 41% (n = 2 124).

Analysis was only undertaken on participants where BDRN demographic/clinical data and Cardiff Mood Disorder and Work questionnaire data were available. Participants where work measure data was available but demographic/clinical data had not been uploaded to the database were excluded from analysis. Additionally, if demographic/clinical data was available but work questionnaire data was not, these participants were also excluded from analysis. In total 627 had incomplete datasets and were excluded from all statistical analyses. Preparation of the BDRN demographic and clinical data for input on to the database is time-consuming and labour intensive, and resources at the time of the study were allocated to uploading the 2484 questionnaire pack responses. Therefore, there was a delay in entering newly collected demographic and clinical data onto the database for a large number of recruited participants. The 627 incomplete datasets also account for those where clinical data was available but participants did not complete the work questionnaire. Complete data sets were available for n = 1857 participants. Analysis was undertaken on this sample, which will now be discussed.

The distribution of mood disorder diagnosis across the sample of 1857 participants is shown in table 11.

Table 11: Distribution of mood disorder diagnosis across the sample

Diagnosis	Frequency	Percentage
BPI	1129	61%
BPII	490	26%
SABP	55	3%
MDD	182	10%

Table 11 illustrates that 61% (N = 1129) of the sample analysed had a diagnosis of BPI disorder, 26% (N = 490) BPII disorder, 3% (n = 55) SABP and 10% (182) MDD. As stated earlier in this chapter, the BDRN programme of research has primarily focused on recruiting patients with bipolar disorder for genetic studies. The distribution of the bipolar disorder sample in this study is opposite to what you would expect in the

general population, as bipolar II disorder is more common than bipolar I disorder. However, the BDRN programme of research had focused on recruitment of patients at the more severe end of the bipolar disorder spectrum which accounts for the high proportion of patients with a bipolar I disorder diagnosis. Patients with MDD were recruited for smaller sub-studies and only account for 17% of the overall sample. This therefore accounts for the much smaller sample of MDD patients in this analysis in comparison to the bipolar disorder groups.

The gender split of the participants was 71% female and 29% male. In total, 85% of participants stated they were married, 14% stated they were not married and 1% did not disclose marital status.

3.7.2 Employment status

3.7.2.1 Employment status of the bipolar disorder and MDD sample

The Cardiff mood disorder and work questionnaire first asked participants to state their employment status. Table 12 illustrates the employment status of the bipolar disorder and MDD sample.

Table 12: Employment status of bipolar disorder and MDD sample

Are you currently employed?		**Frequency**	**Percentage**	**Percentage once recoded as 'employed' and 'not employed'**
Yes	Employed	669	36%	N=39% (Inc MDD) N= 663 (40%) Exc MDD
Yes, but on sick leave		45	2%	
Yes, but on maternity/ paternity leave		8	1%	
No	Unemployed	941	51%	N= 61% (Inc MDD) N = 1007 (60%) Exc MDD)
No, I am a carer		44	2%	
No, I am a homemaker		117	6%	
No, I am a student		25	1%	
Total		1849		

Table 12 illustrates that 51% of the whole sample stated they were not in employment, and 36% were in employment, whilst 2% of the sample were on sick leave at the time of completing the survey, 2% were not working due to caring responsibilities, 6% were homemakers, 1% were students and 0.4% were on maternity/paternity leave. As stated earlier in this chapter, employment status was recoded to form a dichotomous variable, 'employed' and 'not employed', as shown in table 12. Following recoding of the data 39% of the samples were considered 'employed' and 61% were considered 'not employed' at the time of the survey.

3.7.2.2 Comparison of employment status across diagnostic groups

A chi-square test was conducted to test for a difference in employment rates across mood disorder diagnostic groups as defined by the DSM classification (BPI, BPII, SABP and MDD).

Table 13: Employment rate and frequency and percentages across DSM diagnosis

Status of Employment	**BPI**	**BPII**	**SABP**	**MDD**	**Total**
Not employed frequency	699	277	43	120	1,139
Not employed percentage	*62%*	*57%*	*78%*	*67%*	*62%*
Employed frequency	425	210	12	58	705
Employed percentage	*38%*	*43%*	*22%*	*33%*	*38%*
Total	1,124	487	55	178	1,844
	100	100	100	100	100

Chi-square (df = 4, n = 1849, P = .002)

The chi-square analysis suggests there is a significant relationship between mood disorder diagnosis and employment status: X^2 (df = 4, n = 1849, exact P = .002). Table 13 illustrates that the highest rate of participants 'not employed' is among the sample with a diagnosis of SABP (78%), followed by MDD (67%). The highest rate of employment was among participants with a diagnosis of BPII disorder (43%), followed by BPI disorder (38%).

3.7.2.3 Comparison of employment status across bipolar I and II disorder diagnoses

Table 14: Comparison of employment status across bipolar disorder diagnosis

Status of Employment	BPI	BPII	Total
Not employed frequency	689	275	976
Not employed percentage	*61%*	*56%*	*60%*
Employed frequency	437	214	635
Employed percentage	*39%*	*44%*	*40%*
Total	1,126	489	1,615

Chi-square (df = 1, n = 1615, P = .062)

MDD disorder and SABP were excluded from the analysis in order to compare the employment status of participants across the bipolar I disorder and bipolar II disorder sample only. There was no significant difference between employment status across the two diagnostic groups.

To identify which group is the driving force behind the difference identified in employment status across mood disorder diagnostic groups further chi-square tests were conducted. The second set of chi-square tests compared each individual diagnosis against other diagnostic groups combined.

- BPI vs other diagnoses combined Chi-square (df = 1, n = 1849, P = .793)
- BPII vs other diagnoses combined Chi-square (df = 1, n = 1849, P = .013)
- SABP vs other diagnoses combined Chi-square (df = 1, n = 1849, P = .008)
- MDD vs other diagnoses combined Chi-square (df = 1, n = 1849, P = .079)

To control for multiple testing and the increased risk of a Type I error a Bonferroni adjustment to the alpha level was applied. The alpha level (0.05) was divided by the number of tests undertaken (4) to set a more stringent level for each comparison (0.01). The results suggest BPII and SABP were accountable for the difference in employment status identified in the overall chi-square test.

3.7.3 Employment setting of participants in employment

A detailed description of the employment setting of the employed bipolar disorder sample will now be discussed. At the end of this section a comparison between the employment setting across diagnostic groups (bipolar disorder and MDD) will be presented. The next set of results describe the bipolar disorder sample as a whole, which include patients with BPI, BPII and SABP. Participants that stated they were 'employed' at the beginning of the questionnaire were instructed to complete a set of questions to further explore their workplace setting. The results of these questions will now be discussed in the following order:

- Job fit based on education level of employed bipolar disorder sample
- Employment type of the employed bipolar disorder sample
- Size of organization
- Type of organization and working schedule for those with bipolar disorder in employment
- Length of time the employed bipolar disorder sample have worked at the current workplace
- Disclosure and sickness absence of the employed bipolar disorder sample

3.7.3.1 Job fit based on education level of employed bipolar disorder sample

Table 15: Perceptions of job fit based on education level

Job fit based on educational level	Frequency	Percentage
Working above education level	51	8%
Working at education level	322	50%
Working below education level	277	42%
Total	650	

Exactly half (n = 322) of the employed bipolar disorder sample perceived they were working to a job that matched their level of education, whilst 8% (n = 51) perceived they

were working in a job above their level of education and 42% (n = 277) described themselves as working in a job role below their level of education.

3.7.3.2 Employment type of the employed bipolar disorder sample

Figure 5: Employment type

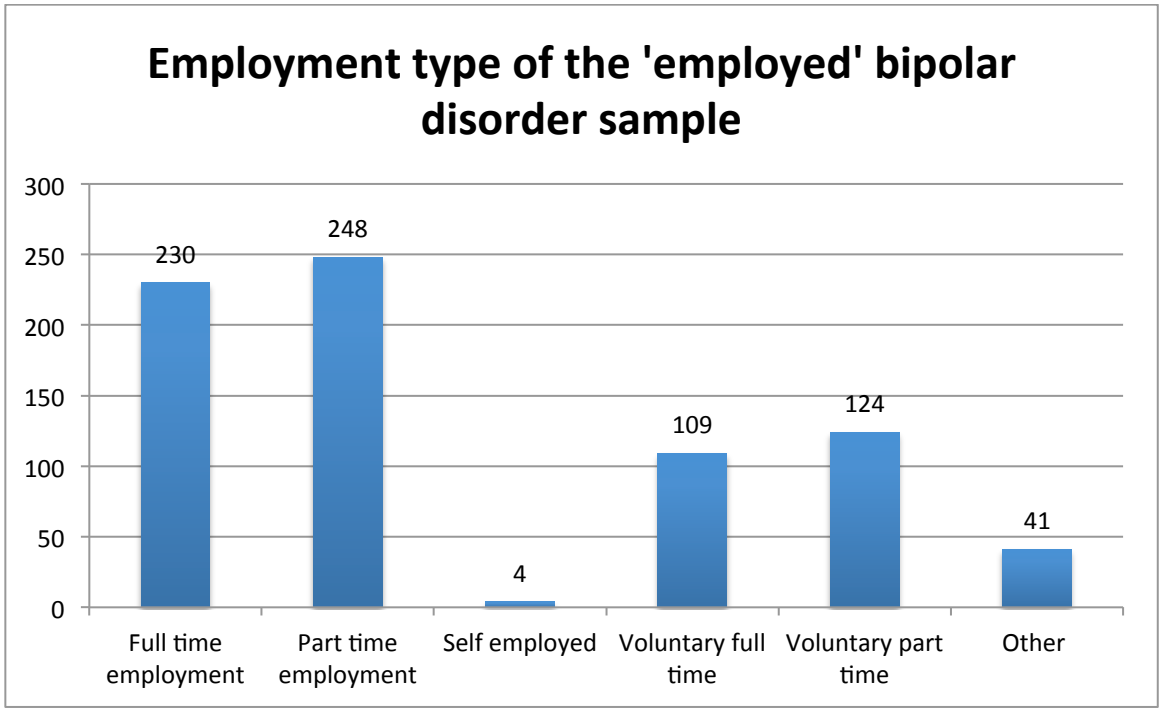


Figure 5 demonstrates that the majority of the employed bipolar disorder sample were either in full-time or part-time paid employment. Only 4 participants were self-employed, 109 worked full time in a voluntary position, 124 were in part-time voluntary work and 41 stated 'other'. When participants were asked to state their type of employment they were instructed to tick all answers that applied, which accounts for the number of responses being higher than the sample total, therefore suggesting a proportion of the sample worked in more than one job role.

3.7.3.3 Size of organization

Table 16: Size of organization

Size of organization	Frequency	Percentage
Small organization	214	34%
Medium organization	85	13%
Large organization	72	11%
Very large organization	265	42%
Total	644	

The majority of the employed bipolar disorder sample worked in either small organizations (34%) or very large organizations (42%), whilst 13% worked for medium-sized organizations and 11% for large organizations.

3.7.3.4 Type of organization and working schedule for those with bipolar disorder in employment

Table 17: Type of organization

Type of organization	Frequency	Percentage
Public sector organization	256	40%
Private sector organization	236	37%
Third sector organization	152	23%
Total	644	

The majority of the bipolar disorder sample worked in either a public sector (40%) or a private sector organization (37%). A smaller proportion of the sample (24%) worked in a third sector organization.

Table 18: Working schedule

Working schedule	Frequency	Percentage
Regular schedule	453	70%
Rotating schedule	19	3%
Irregular schedule	140	22%
Contract work	34	5%
Total	646	

The majority of the bipolar disorder sample worked a regular working schedule (70%), indicating they worked roughly the same hours and days on a weekly basis, whilst 22% worked irregular shifts and a much small proportion of the sample worked a rotating schedule or contract work.

3.7.3.5 Length of time the employed bipolar disorder sample have worked at the current workplace

Table 19: Length of time the employee has worked at the organization

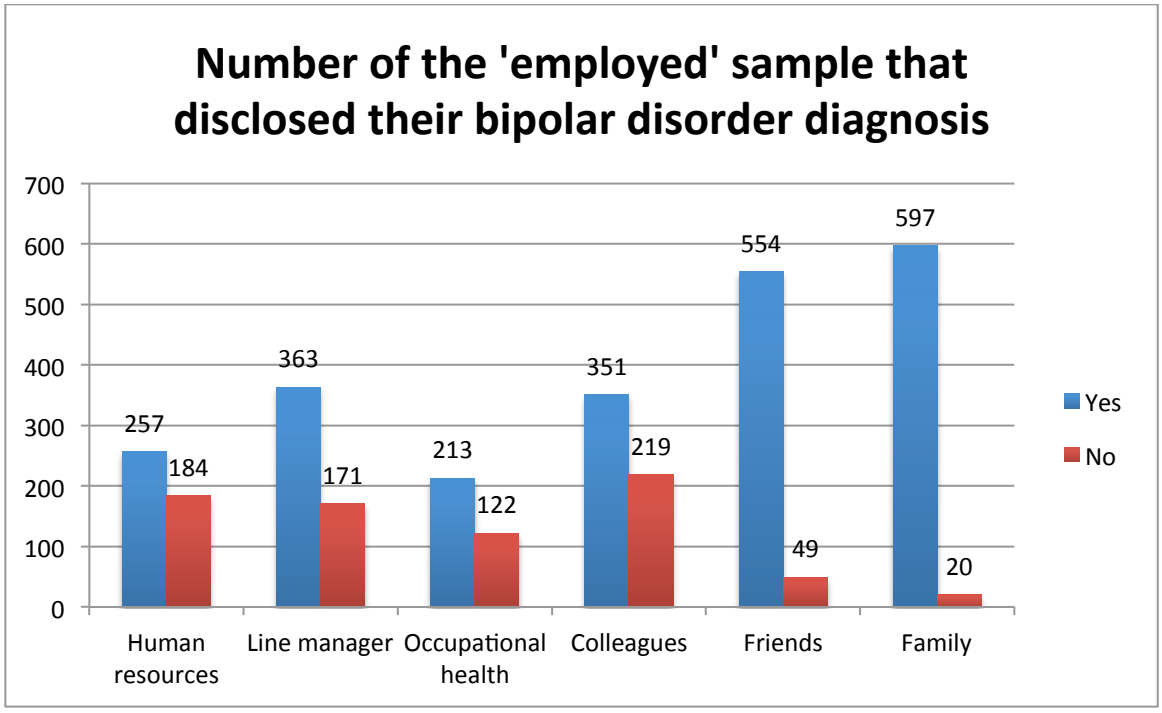
Length of time worked at the organization	Frequency	Percentage
Less than 1 year	84	13%
1 year up to 2 years	95	14%
2 years up to 5 years	148	23%
5 years up to 10 years	127	20%
10 years or more	192	30%
Total	646	

Exactly half of the employed bipolar disorder sample had worked for the current employer for 5-10+ years. Of the rest, 23% of the sample had worked at their current organization for 2-5 years, whilst a much smaller proportion had been with their employer for 1-2 years (15%) or for less than 1 year (13%).

3.7.3.6 Disclosure and sickness absence of the employed bipolar disorder sample

The next set of questions in the Cardiff mood disorder and work questionnaire explored whether participants had disclosed their mood disorder diagnosis and to whom. The measure then explored the amount of sickness absence participants had taken within the previous 12 months as a result of bipolar disorder related symptoms. The results of these two measures will now be presented.

Figure 6: Disclosure of bipolar disorder



Participants were excluded from the analysis if they had stated N/A when asked if they had disclosed their bipolar disorder diagnosis to each of the stakeholder groups shown in the graph. It was assumed that if participants answered 'yes' or 'no' to this question, it implied they had access to, and the opportunity to disclose their diagnosis to, each of these groups. It was assumed an N/A response to the question implied that the participant did not have access to, or the opportunity to discuss their condition with, the stakeholder group in question. The majority of the sample stated they had shared their diagnosis with family and friends, with only 49 participants not telling friends, and 20

withholding the information from family. In the workplace setting more participants had disclosed their diagnosis to the LM, OH, HR and colleagues than had not. However, there were still a large number that had decided not to share their diagnosis, with 219 not telling colleagues, 122 not disclosing to OH, 171 not disclosing to LMs and 184 not disclosing to HR.

3.7.3.7 Amount of bipolar disorder related sickness absence

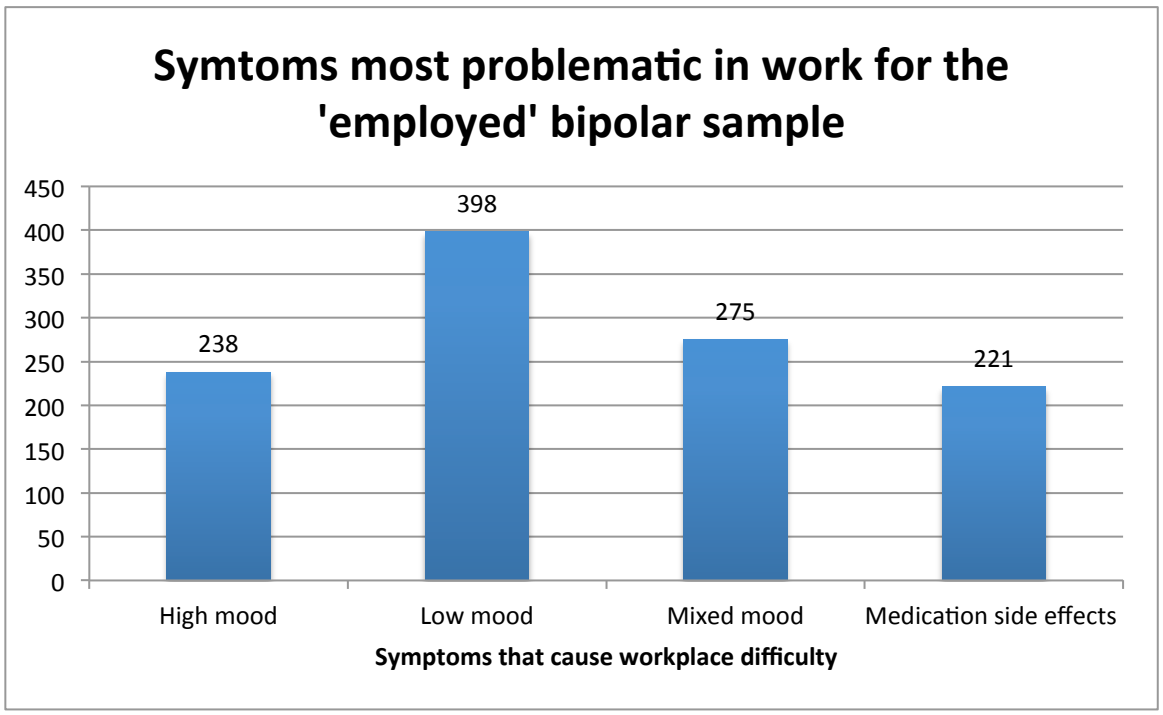
Table 20: Amount of sick leave taken in the previous 12 months

Length of sickness absence within the last 12 months	**Frequency**	**Percentage**
None	358	55%
Less than 1 week	94	14%
1 week up to 1 month	83	13%
1 month up to 3 months	68	10%
3 months up to 6 months	25	4%
6 months up to 9 months	6	1%
9 months up to 12 months	18	3%
Total	652	

When asked about the amount of sick leave taken in the previous 12 months at the time of completing the questionnaire (2011), just over half of the employed bipolar disorder sample stated they had taken no sickness absence. Of the rest of the sample, 14% had taken less than one week, 13% 1-4 weeks, 10% 1-3 months and a very small proportion of the sample (4%) had taken between 3 and 12 months.

3.7.3.8 Symptoms described as problematic at work

Figure 7: Bipolar related symptoms described as problematic for participants in work

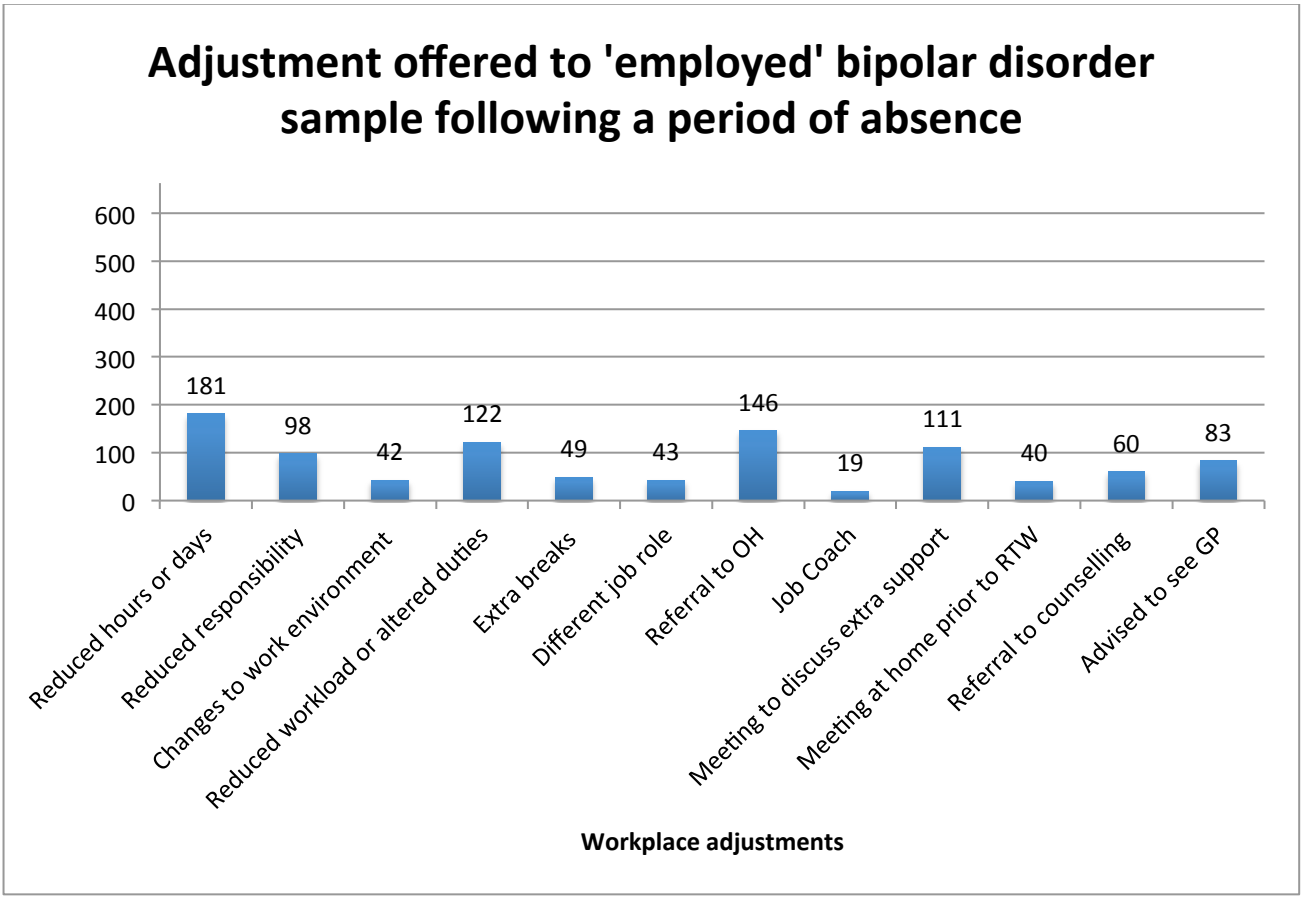


Low mood was described as the most problematic symptom for 'employed' participants with bipolar disorder. The second most reported symptom was mixed moods (275), followed by high mood (238) and medication side effects (221). When converted to percentages this equates to 69% of the employed sample reporting low mood as problematic, 43% high mood, 50% mixed mood episodes and 40% medication side effects. On answering this question participants were asked to 'tick all answers that applied', therefore the question response rate is higher than the sample number. This suggests that the majority of participants stated a combination of symptoms and that not one in particular was the cause of workplace difficulty.

3.7.3.9 Workplace support

The next section of the questionnaire explored the workplace support and adjustments offered to participants in employment with bipolar disorder. Participants in employment were asked to tick all the support and workplace adjustments that were offered by the employer/LM during a time when the symptoms of their mood disorder had affected their ability to work or following a period of absence.

Figure 8: Adjustments offered to the employed bipolar disorder sample



A large proportion of the 663 participants in employment with bipolar disorder had been offered at least one of the workplace adjustments listed in the questionnaire. The adjustments most commonly offered to the sample were reduced hours or days, referral to OH, reduced workload and a meeting to discuss extra support.

Thus far this chapter has provided an overview of the questionnaire response rate of the whole sample (MDD and BPD), followed by the employment rate across the mood disorder diagnostic group. The results then focused on the bipolar disorder group only. A comprehensive overview of the working patterns and workplace settings across the employed bipolar disorder sample was provided, followed by the findings in relation to disclosure of participants' conditions and workplace support. The working patterns and workplace settings of the bipolar disorder sample will now be compared to the MDD employed sample to identify differences across mood disorder diagnostic groups.

3.7.4 Comparison of working patterns and workplace settings across mood disorder diagnostic groups.

Following the review of the workplace setting among participants with bipolar disorder, the MDD sample was then included in the analysis to compare workplace characteristics across diagnostic groups. The findings from this analysis will now be discussed.

3.7.4.1 DSM diagnosis and workplace setting

A chi-square test was conducted to test for differences in workplace setting and working patterns of the employed sample across diagnostic groups as defined by the DSM classification (BPI, BPII, SABP and MDD). A second analysis was conducted that excluded the MDD and SABP sample to test for differences across the more prevalent bipolar disorder diagnosis (bipolar I and bipolar II disorder).

The working patterns and workplace settings compared across diagnostic group included:

- Size of organization
- Type of organization
- Job fit to education level

- Work schedule

Table 21: Size of organization across diagnostic group

	Small organization	Medium organization	Large organization	Very large organization
BPI	141 (34%)	55 (13%)	53 (13%)	171 (41%)
BPII	67 (33%)	30 (15%)	18 (9%)	90 (44%)
SABP	6 (55%)	0 (0%)	1 (9%)	4 (36%)
MDD	18 (32%)	4 (7%)	9 (16%)	26 (46%)

Table 21 illustrates that the majority of participants in each diagnostic group worked in either a small or a very large organization.

Table 22: Employment sector across diagnostic group

	Public sector organization	Private sector organization	Third sector organization
BPI	168 (39%)	161 (38%)	98 (23%)
BPII	84 (41%)	72 (35%)	50 (24%)
SABP	4 (36%)	3 (27%)	4 (36%)
MDD	27 (47%)	23 (40%)	8 (14%)

Table 22 illustrates that the majority of participants with BPI, BPII and MDD worked in either the public or private sectors. However, the majority of participants with SABP worked in either the public sector or third sector organizations.

Table 23: Perception of work in regard to education level across diagnostic group

	Above education level	At education level	Below education level
BPI	34 (8%)	215 (50%)	184 (43%)
BPII	16 (8%)	105 (51%)	85 (41%)
SABP	1 (9%)	2 (18%)	8 (73%)
MDD	5 (9%)	32 (55%)	21 (36%)

Table 23 illustrates that the majority of the BPI, BPII and MDD sample worked either at or below their level of education. The vast majority of participants with SABP worked below their level of education.

Table 24: Work schedule across diagnostic group

	Regular working schedule	Rotating working schedule	Irregular working schedule	Contract work
BPI	304 (71%)	11 (3%)	93 (22%)	21 (5%)
BPII	142 (69%)	7 (3%)	46 (22%)	11 (5%)
SABP	7 (64%)	1 (9%)	1 (9%)	2 (18%)
MDD	41 (70%)	2 (3%)	14 (24%)	2 (3%)

Table 24 illustrates that the majority of participants across all diagnostic groups work a regular work schedule.

The chi-square analysis indicated there are no significant differences in the size, working schedule and type of organizations worked in across all the diagnostic groups. There were also no significant differences identified in the job fit against educational attainment across the diagnostic groups.

3.7.5 Questionnaire responses from the 'unemployed' bipolar disorder sample

3.7.5.1 Questionnaire data on the 'unemployed' sample

Participants who stated they were not employed at the time of completing the questionnaire were directed to a different set of questions to those completed by the 'employed' sample. These questions explored the reasons why this sample had stopped working and the length of time they had been out of employment. The results of these questions will now be discussed.

A total of 1007 participants stated they were not in employment when completing the questionnaire. The reasons given by the participants for leaving employment are shown in figure 9.

3.7.5.2 Reason for leaving employment given by the bipolar disorder sample

Figure 9: Reasons for leaving employment

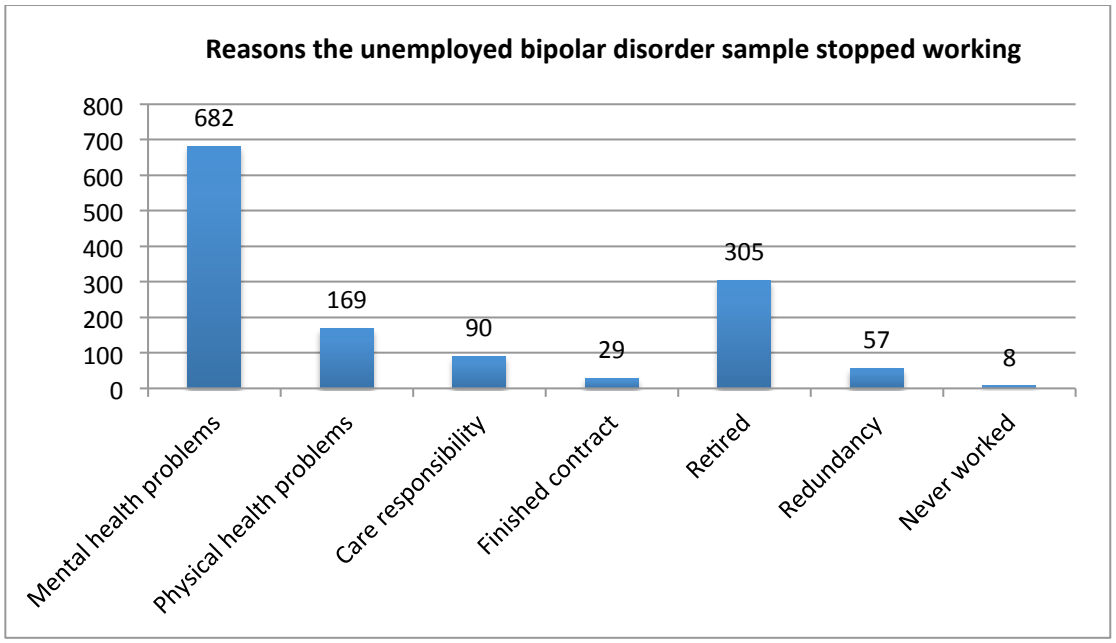


Figure 9 illustrates that of the 1007 unemployed bipolar disorder sample, 682 (68%) had stopped working due to mental health problems, 305 stopped working due to retirement, 169 had physical health problems, 90 had care responsibilities and 57 were made redundant. Only 8 (1%) of the unemployed sample had never worked.

3.7.5.3 Length of time the bipolar disorder sample have been out of employment

Figure 10: Length of time out of employment

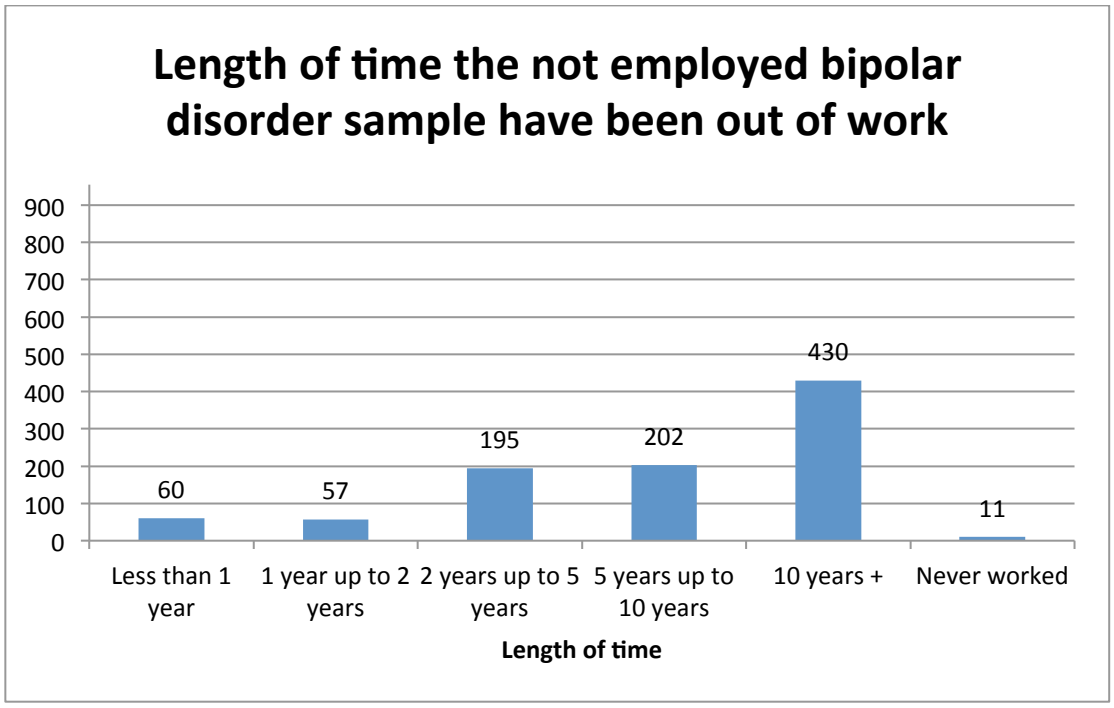


Figure 10 Shows that almost half of the unemployed sample had been out of employment for over 10 years, whilst 202 had been out of work for between 5 and 10 years, 195 for 2-5 years, 57 for 1-2 years and 60 for less than 1 year.

Figure 11: Factors that affect the ability of those unemployed with bipolar disorder to return to employment

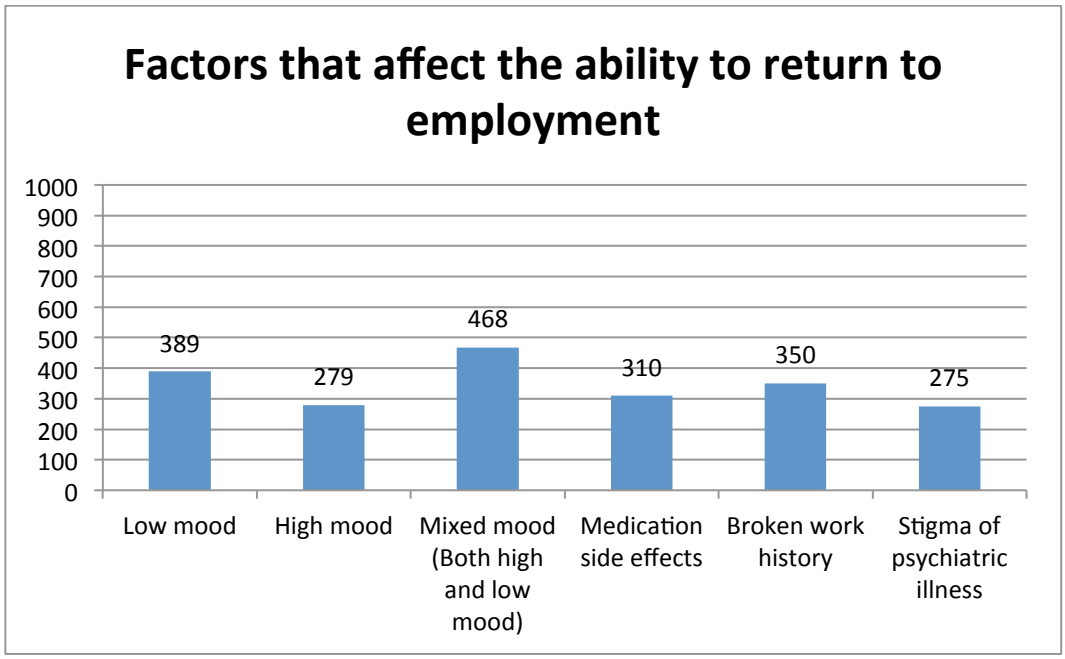


Figure 11 illustrates that almost half of the unemployed sample stated that mixed mood affected their ability to return to employment. This was followed by low mood, broken work history, medication side effects, high mood and stigma associated with psychiatric illnesses.

3.7.6 Part II – Clinical and demographic factors associated with employment status

I will now move on to discuss the analysis undertaken to determine the clinical and demographic factors best associated with employment status.

3.7.6.1 Variable selection

The BDRN database contains a large volume of clinical and demographic data on recruited patients. The database guidance document was reviewed to identify variables that were identified in the literature as commonly associated with occupational

impairment. These measures were then extracted from the BDRN database for analysis. A total of 25 clinical and demographic variables were selected for inclusion in the analysis, as shown in table 25. To account for differences in recruitment, the variable on the method by which participants were recruited (systematically/not systematically) was included in the analysis.

Table 25: List of clinical variables and definitions

Variable	**Definition of variable**
Age onset symptoms	Age (years) of first symptom of affective/psychotic illness
Age onset impairment	Age (years) of first impairment due to affective/psychotic illness
Age onset admission	Age (years) of first admission to psychiatric hospital
Age onset contact	Age (years) of first contact with psychiatric services for affective/psychotic disturbance
Depression age first impairment	Age (years) of first impairment due to depression
Psychosis age first impairment	Age (years) of first psychosis (hallucination or delusion)
Mania age first impairment	Age (years) of first impairment due to mania
Number of episodes of depression	Number of episodes of depression
Number of episodes of mania	Number of episodes of mania
Number of mixed episodes	Number of mixed episodes
Longest duration depression	Longest episode of depression, in weeks
Longest duration mania	Longest episode of mania or hypomania, in weeks
Number hospital admissions	Number of psychiatric admissions
Length of longest hospital admission	Longest psychiatric admission, in weeks
GAS worst depression	Measure of lowest level of functioning as a result of lifetime worst depressive episode
GAS worst manic episode	Measure of lowest level of functioning as a result of lifetime worst manic episode
GAS lifetime worst ever	Measure of lowest level of functioning as a result of lifetime worst ever episode

Ever sectioned	Ever sectioned
Suicidal ideation	Most severe lifetime suicidal ideation
Highest educational attainment	Highest educational attainment
Marital history	Marital history
Recruitment (systematic vs non-systematic)	Recruited via systematic or non-systematic methods
Polarity first episode	Polarity of first affective episode
Rapid cycling	Presence of rapid cycling
DSM Diagnosis	DSM-5 diagnosis (BPI, BPII, SABP)

The dependent variable was employment outcome, defined as 'in employment' or 'not employed'. Consistent with the assumptions set for a logistic regression this variable is dichotomous and mutually exclusive.

3.7.6.2 Exploratory test prior to entering data into the regression model

The demographic and clinical variables of the employed/not employed groups were compared using univariate analysis. Normality was tested using a histogram and Q-Q Plot. Chi-squares tests were undertaken on categorical data, T-tests for parametric data and the Mann-Whitney test for non-parametric continuous data, as illustrated in table 26. All clinical and demographic variables relating to employment status that were significant at a $P<.05$ significance level in the univariate analysis were considered for the regression model.

3.7.6.3 Univariate analysis output

Table 26: Table illustrating the method of analysis used for each variable

IV Variable	Data Type	Analysis
Age onset impairment	CONTINUOUS	Independent sample t-test (data normally distributed)
Age onset symptoms	CONTINUOUS	
Age onset admission	CONTINUOUS	
Age onset contact	CONTINUOUS	
Depression age first impairment	CONTINUOUS	
Mania age first impairment	CONTINUOUS	
Psychosis age first impairment	CONTINUOUS	
GAS lifetime worst ever	CONTINUOUS	
GAS worst depression	CONTINUOUS	
GAS worst manic episode	CONTINUOUS	
Number of episodes of mania	CONTINUOUS	Mann-Whitney Test (data not normally distributed)
Longest duration mania	CONTINUOUS	
Number of hospital admissions	CONTINUOUS	
Number of mixed episodes	CONTINUOUS	
Length longest admission	CONTINUOUS	
Number of episodes of depression	CONTINUOUS	
Longest duration depression	CONTINUOUS	
DSM Diagnosis	CATEGORICAL	Chi-square Test
Ever sectioned	CATEGORICAL	
Suicidal ideation	CATEGORICAL	
Highest educational attainment	CATEGORICAL	
Marital history	CATEGORICAL	
Recruitment (systematic vs non-systematic)	CATEGORICAL	
Rapid cycling	CATEGORICAL	
Polarity first episode	CATEGORICAL	

Table 27: Results of independent sample t-test

IV Variable	Employment status	N	Mean	Std deviation	t	P value
Age onset impairment	Not employed Employed	N=950 N=368	23.6 22.1	9.9 8.3	3.4	**.001**
Age onset symptoms	Not employed Employed	N=917 N=611	20.5 18.9	10.1 8.0	3.4	**.001**
Age onset admission	Not employed Employed	N=760 N=446	31.3 28.9	11.0 9.0	4.1	**.001**
Age onset contact	Not employed Employed	N=950 N=630	29.6 27.6	11.3 9.2	3.9	**.001**
Depression age first impairment	Not employed Employed	N=891 N=600	23.9 22.2	10.4 9.0	3.6	**.001**
Mania age first impairment	Not employed Employed	N=858 N=596	30.5 27.3	12.0 9.4	5.8	**.001**
Psychosis age first impairment	Not employed Employed	N=430 N=283	30.3 28.1	10.1 9.0	3.1	**.002**
GAS lifetime worst ever	Not employed Employed	N=29 N=9	25.8 33.0	9.1 12.2	-1.6	.065
GAS worst depression	Not employed Employed	N=989 N=649	97.0 84.8	228.3 197.4	1.2	.250
GAS worst manic episode	Not employed Employed	N=993 N=653	59.9 56.1	151.7 135.3	0.5	.594

An independent-samples t-test was conducted to test for a significant difference in clinical and demographic variables, and employment outcome. Table 27 shows there was a significant difference in the age of onset of impairment (P = .001), symptoms (P = .001), admission (P = .001) and contact (P = .001). Participants in employment had a lower age of first admission to hospital (M = 29, SD = 9.0), onset of symptoms (M = 19, SD = 8.0), onset of impairment (M = 22, SD = 8.3) and onset of contact (M = 28, SD = 9.2).

There was also a significant difference in depression (P =.001), psychosis (P =.002) and mania age of first impairment (P =.001) between the employed and not employed sample. The age of first impairment across these variables was lower among the employed group.

Table 28: Results from descriptive analysis and Mann-Whitney test

Clinical variable	Employment status	N	Median	Interquartile range	Range	P value
Number of episodes of mania	Not employed Employed	919 633	7.0 5.0	8.0 6.0	1-100 1-100	**.015**
Longest duration mania	Not employed Employed	924 634	8.0 6.0	11.1 9.5	0-104 0-78	.667
Number of hospital admissions	Not employed Employed	967 650	3.0 2.0	4.0 3.0	1-30 1-20	**.001**
Number of mixed episodes	Not employed Employed	516 395	0 0	1.0 1.0	0-40 0-50	.357
Length longest admission	Not employed Employed	694 427	8.0 6.0	12.0 8.0	0-78 0-104	**.023**
Number of episodes depression	Not employed Employed	888 620	10.0 6.0	15.0 12.0	1-100 1-150	**.001**
Longest duration depression	Not employed Employed	873 601	26.0 26.0	36.5 40.0	2-572 2-520	.123

A Mann-Whitney test was conducted to test for a significant difference in clinical and demographic variables and employment outcome, where data did not meet the assumptions for parametric testing. There was a significant difference in the number of episodes of mania (P = .015), number of hospital admissions (P = .001), length of longest admission (P = .023) and number of episodes of depression (P = .001). The median scores show participants in employment had fewer hospital admissions and hospital stays were shorter in duration compared to participants who were not employed. The number of episodes of mania and depression were also lower among employed participants compared to those who were not employed.

Table 29: Results of the chi-square analysis

IV Variable	Employed		Not employed		P value	df
	N	%	N	%		
DSM Diagnosis					**.004**	**2**
BPI	437	66%	689	68%		
BPII	214	32%	275	27%		
SABP	12	2%	43	4%		
Ever sectioned					**.007**	**4**
No	411	64%	596	61%		
Yes	26	4%	80	8%		
Unknown	11	2%	29	3%		
Once/minority admissions	136	21%	185	19%		
Majority all admissions	62	10%	91	9%		
Suicidal ideation					.075	6
Absent	65	10%	97	10%		
Tedium vitae	64	10%	83	8%		
Suicidal ideation	221	34%	281	28%		
Suicidal attempt – unlikely result death	152	23%	239	24%		
Suicidal attempt – likely result death	85	13%	147	15%		
Multiple suicide attempts	52	8%	117	12%		
Unknown	21	3%	33	3%		
Highest educational attainment					**.000**	**7**
None	9	1%	76	8%		
11+	3	1%	11	1%		
CSE (NVQ)	24	4%	38	4%		
O-level/ GCSE	73	11%	184	19%		
A-Level/AS-Level	153	24%	244	25%		
Degree	239	37%	261	27%		
Postgraduate	127	20%	116	12%		
Unknown	22	3%	50	5%		
Marital history					.206	2
Has married	509	83%	799	85%		
Never married	95	16%	199	13%		
Unknown	8	1%	18	2%		
Recruitment					**.001**	**1**
Systematic	120	19%	251	26%		
Non-systematic	521	81%	722	74%		
Rapid cycling					.154	3
Not present or suspected	330	50%	466	47%		
Occurrence during illness, 4 or more episodes	119	18%	266	23%		
Predominates course of illness, present for at least 5 years	4	1%	4	0%		
Insufficient information for rating	207	31%	305	31%		
Polarity first episode					.259	2
Depression	413	69%	584	66%		
Mania	128	21%	193	22%		
Unknown	61	10%	114	13%		

A chi-square analysis was conducted to test for a significant difference in the categorical clinical and demographic variables and employment outcome. The results suggest there is a significant relationship between DSM diagnosis X^2 (df = 2, n=1670, exact p = .004), sectioning history X^2 (df = 4, n = 1627, exact p = .007), educational attainment X^2 (df = 7, n = 1630, exact p = .001) recruitment method X^2 (df = 1, n=1614, exact p = .001), and employment status.

3.7.6.4 Regression analysis

A total of 25 variables were included in the univariate analysis, 15 of which were identified as significant at a level of .005, as shown in tables 27, 28 and 29. Prior to entering the data into the model a test for collinearity was undertaken.

3.7.6.4.1 Collinearity

A total of 15 variables were tested for multicollinearity prior to being entered into the model. The test indicated that two of the 15 variables were too highly correlated (listed below); therefore one variable was excluded from analysis.

- Age of onset of impairment
- Age of onset of first depressive impairment

Age of onset of first depressive impairment had a very high number of missing cases and was therefore omitted from analysis but the age of onset of impairment was retained.

3.7.6.4.2 Missing data

The number of missing cases across the 14 remaining variables was reviewed due to the list case deletion process used when undertaking a regression analysis. SPSS omits incomplete data sets from the analysis, which can substantially reduce the sample size. To maintain a large sample size for analysis, predictor variables with ≥150 cases of missing data were excluded. Five variables (listed below) met this criterion therefore

were excluded from analysis:

- Mania age first impairment
- Age onset admission
- Psychosis age first impairment
- Length longest admission
- Number episodes depression

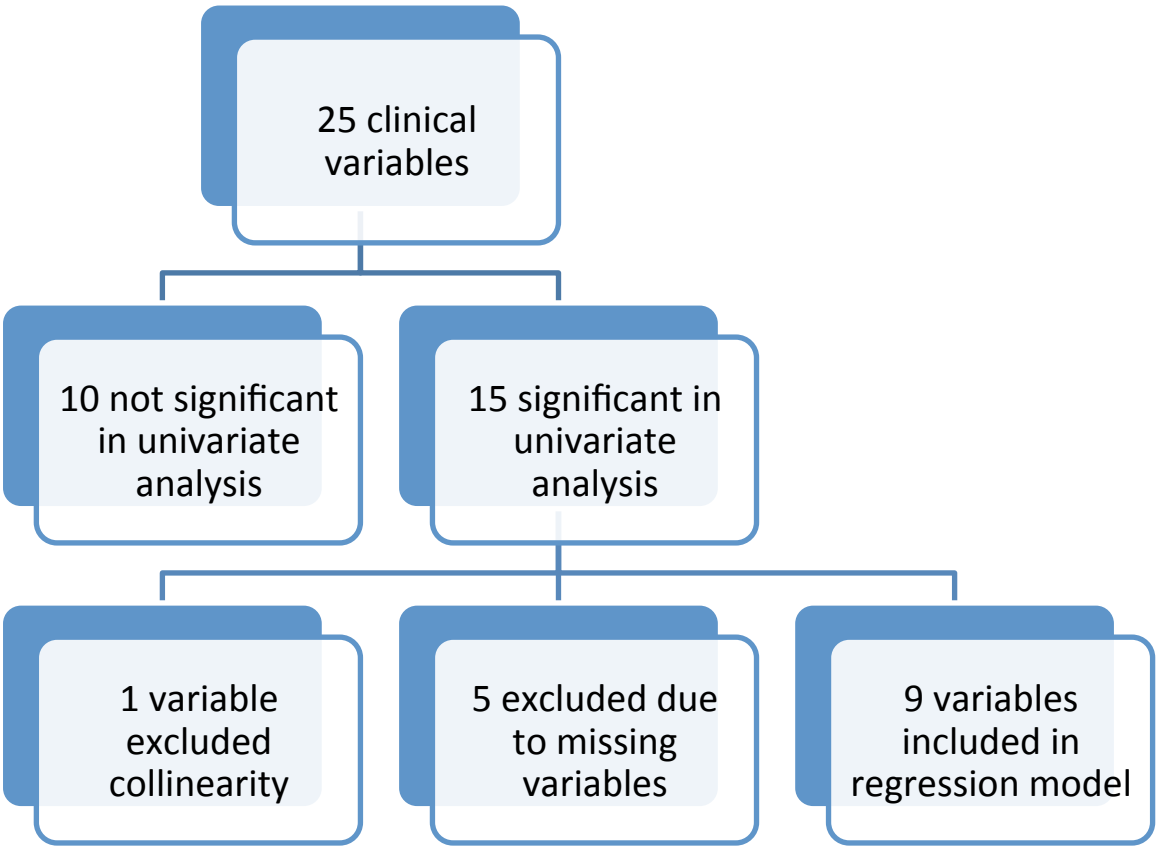
The BDRN dataset has been developed over a 20-year period with measures being added at various time points in response to new and evolved research questions, so the time at which a participant was recruited would determine the measures collected. It was therefore expected that a large amount of data would be missing for patients where measures were added after their date of recruitment.

Eight variables remained, which then were entered into the model. The two variables not normally distributed (number of episodes of mania and number of hospital admissions) were recoded into categorical measures prior to being entered into the model, as highlighted: The nine variables entered into the model were:

- Age onset impairment
- Number episodes of mania
- Number hospital admissions
- DSM Diagnosis
- Ever sectioned
- Highest educational attainment
- Recruitment
- Age onset contact
- Age of onset of symptoms

The process undertaken to select variables for the regression analysis is illustrated in figure 12.

Figure 12: Flow chart illustrating the process of selecting variables for regression analysis



3.7.6.4.3 Results of logistic regression analysis

A binary logistic regression was run to test for an association between employment status and the clinical and demographic factors listed above. A total of 1264 cases were analysed and the full model significantly predicted employment status (omnibus chi-square = 145.1, df = 29, P < .001). The model accounted for between 10.8% and 14.6% of variance in employment status. Overall, 58% of predictions were accurate. The regression analysis output is illustrated in table 30.

Table 30: Regression analysis output

		B	S.E.	Wald	df	Sig.	Odds ratio
Number of episodes of mania	0-10			4.827	7	.681	
	11-20	-.236	.168	1.981	1	.159	.790
	21-30	-.708	.421	2.826	1	.093	.493
	31-40	.302	.666	.205	1	.650	1.352
	41-50	.036	.394	.009	1	.926	1.037
	51-60	-20.870	22807.142	.000	1	.999	.000
	71-80	21.338	40192.969	.000	1	1.000	1.849E+9
	81+	-.123	.676	.033	1	.856	.884
Number of hospital admissions	0-5			23.184	5	**.000**	
	6-10	-.661	.186	12.586	1	**.000**	.516
	11-15	-1.466	.473	9.600	1	**.002**	.231
	16-20	-1.607	.809	3.945	1	.047	.201
	21-25	-20.888	16199.420	.000	1	.999	.000
	26+	-.759	1.284	.349	1	.555	.468
	Age onset impairment	.002	.012	.024	1	.878	1.002
DSM	BPI			3.172	2	.205	
	BPII	.138	.147	.881	1	.348	1.148
	SABP	-.528	.370	2.035	1	.154	.590
Ever sectioned	No			14.073	4	.007	
	Yes	-.473	.293	2.606	1	.106	.623
	Unknown	-.923	.526	3.078	1	.079	.398
	Once/minority of all admissions	.363	.165	4.847	1	.028	1.437
	Majority of all admissions	.274	.223	1.501	1	.221	1.315
Highest educational attainment	None			42.163	7	**.000**	
	11+	1.026	.833	1.515	1	.218	2.789
	CSE (NVQ 1, GNVQ, GSVO, Foundation level)	1.957	.529	13.710	1	**.000**	7.080
	O-Level/GCSE (NVQ Level 2)	1.205	.469	6.600	1	**.010**	3.338
	A-Level/AS-Level/Scottish higher	1.657	.455	13.260	1	**.000**	5.245
	Degree (NVQ Level 5)	1.945	.452	18.507	1	**.000**	6.996

		B	S.E.	Wald	df	Sig.	Odds ratio
	Postgraduate degree	2.196	.465	22.296	1	**.000**	8.992
	Unknown	1.312	.554	5.607	1	.018	3.714
Recruitment	Recruitment	-.309	.150	4.261	1	.039	.734
	Age onset contact	-.025	.008	10.186	1	**.001**	.975
	Age onset symptoms	-.011	.011	1.080	1	.299	.989
	Constant	-.953	.494	3.716	1	.054	.386

When analysing categorical data in this way, SPSS creates dummy variables based on the baseline categories as shown in table 30. Table 30 gives the coefficients, probability values and the odds ratio for each predictor variable. To control for multiple testing and the increased risk of a Type I error, a Bonferroni adjustment to the alpha level was applied. The alpha level (0.05) was divided by the number of tests undertaken (nine) to set a more stringent alpha level (0.005). Therefore, only P values <.005 were accepted as indicators of statistical significance. On entering all nine variables into the regression model, the clinical and demographic measures that reliably predicted employment status were number of hospital admissions, educational attainment and age of onset of contact.

A highly significant overall effect was found between the number of hospital admissions and employment status (Wald = 23, df = 5, P<.001). Table 30 shows those hospitalized 16-20 times, 21-25 times and 26+ times did not differ in terms of employment status from those hospitalized 0-5 times. However, those hospitalized 6-10 times (OR = .516) and 11-15 times (OR =.231) were less likely to be in employment compared to those hospitalized 0-5 times when controlling for educational attainment and first contact with psychiatric services.

Table 30 also shows that an increase in the age of first contact with psychiatric services for affective disturbance is associated with a decrease in the odds of being in employment (OR = 0.98). The older the age of onset of impairment the less likely an individual is to be in employment.

A highly significant overall effect was found between educational attainment and employment status (Wald = 42, df = 7, P<.001). Table 30 shows an increase in education level from GCSE to postgraduate was associated with increased odds of being in employment. The odds ratio tells us that those with an A-Level qualification are 5.25 times more likely to be in employment than those without any educational attainment. Participants with a degree and postgraduate degree were 6.99 and 8.92 times respectively more likely to be in employment than those with no educational background.

Thus far, this chapter has described the questionnaire study that in collaboration with the BDRN programme of research collected work specific data on 1857 patients with a mood disorder diagnosis. This chapter outlined the development of the work questionnaire and described how the findings from this measure were combined with clinical and demographic BDRN data. This was followed by an overview of the analysis plan and a comprehensive summary of the results, which were split into two distinct parts. Firstly, a summary of the results from the 'Cardiff mood disorder and work questionnaire' was provided. Secondly, the results on the analysis exploring the clinical and demographic predictors of employment status were described. The key findings from this study will now be discussed in the context of current literature and findings. This will be followed by a discussion on the methodological limitations and implications for future research, and the chapter will close with a conclusion on the findings.

3.8 Discussion

This study employed quantitative methodology to explore the employment patterns and the impact of clinical and demographic variables on employment outcome across a large sample of participants with a lifetime diagnosis of a mood disorder. I will now discuss the key findings from this study, the limitations of the methodology and the implications of this data on policy and practice.

3.8.1 Key findings

3.8.1.1 Key finding – Employment rates

Consistent with current literature, 40% of the bipolar disorder sample were in employment at the time of the survey. In a systematic review by Marwaha et al. (2013) the authors reported employment rates among those with bipolar disorder at 40-60%. This figure is considerably lower than the employment rate among the UK population for those aged 16-64, which is reported at 74% (ONS 2016). Consistent with findings by by Marwaha et al. (2013) this study highlight the effect bipolar disorder has on employment prospects, making it less likely for those with the condition to be in work compared to the general population.

However, it is important to note that 40% of the sample were in employment, which highlights that those with the condition can achieve functional recovery to a level that enables them to gain and sustain work. A comparison of study and population/published data needs to be interpreted with some caution due to the differences in definitions of 'employment' status, sampling strategies and outcome measures. For example, the inclusion of 'voluntary' work in the employment definition differs across studies.

3.8.1.2 Key finding – Employment rates across diagnostic groups

When comparing diagnostic groups, participants with SABP were the least likely group to be in employment. Patients with bipolar disorder who experience schizoaffective type symptoms may be more comparable to those with schizophrenia in terms of their level of work impairment. Employment rates among those with schizophrenia are reported at 10-20% (Marwaha and Johnson 2004), which is substantially lower than for the bipolar disorder and general population. Therefore with a symptom set that is on the border of a schizophrenia diagnosis it is unsurprising that higher rates of unemployment are reported among this group.

Inconsistent with current literature, in this study the employment rate among participants with a diagnosis of depression (33%) was significantly lower than the figures reported (60-70%) by the Depression Alliance et al. (2016) for this population. However, there are clear methodological issues that could account for this difference. Depression is a broad term covering an expansive area of symptoms that range in severity from mild to severe impairment. The patients in this study sample were all diagnosed with MDD, which is associated with a higher level of impairment and a more severe symptom set than those with mild depression. Additionally, the BDRN programme of research targeted recruitment of severe familial cases of MDD, which are unlikely to be representative of MDD in the general population.

The questionnaire study results showed lower rates of employment among the MDD sample compared to the bipolar disorder group. This finding contradicts current literature. Chacko et al. (2011) reported poorer overall function and work functioning in those with bipolar in comparison to participants with major depression. To try to understand why the MDD participants were more likely than those with bipolar disorder to be unemployed, I reviewed the severity (GAS Score), duration and frequency of depressive episodes across both diagnostic groups. These measures were explored as they are directly comparable across the two diagnostic groups. The MDD sample

reported depressive symptoms at a severity (major impairment to functioning) that matched that of the bipolar disorder sample. The depressive episodes for the MDD sample were less frequent (5 compared to 12-15 for the bipolar disorder sample) but of a much longer duration (92 days compared to 42-46 days).

For those with bipolar disorder the depressive pole of the condition is commonly recognized as the main impairing symptom (Goldberg and Harrow 2011). However, it has been reported that the depressive episodes experienced by those with bipolar disorder are of a higher intensity and frequency than those experienced by patients with MDD (Forty et al. 2008). The findings from this study both support and contradict this evidence. The bipolar disorder sample did report a higher frequency of depressive episodes, but the intensity was matched across diagnostic groups, and the duration averaged 46 days longer among the MDD sample. Therefore, due to the similarity in the severity of episodes you would expect to see similar rates of employment being reported across the MDD (33% in employment) and bipolar disorder (40% in employment) sample, which is what was identified in this study.

The slightly higher rate of employment among the bipolar disorder sample, however, could be linked to the presence of hypomanic episodes. Based on the study results we can conclude that among this sample manic symptoms (in terms of number of episodes of mania, longest duration of mania and worst manic episode) were not predictive of employment outcome. This is consistent with current literature where hypomanic and sub-threshold manic symptoms have been associated with lesser, if any, impairment of functioning (Deckersbach et al. 2016; Goldberg and Harrow 2011). Depressive symptoms drive work impairment to a far greater degree than manic symptoms. What we cannot determine from this study, but what may need further investigation, is whether hypomanic symptoms can be positive in terms of work outcome. This may account for higher rates on employment among the bipolar sample in comparison to the MDD group.

3.8.1.3 Key finding – Workplace setting and employment patterns

Moving beyond current literature, this study also explored the work environment and job characteristics of the bipolar sample.

The majority of the employed bipolar disorder sample worked regular hours in full-time or part-time paid employment, with only a small proportion of the sample working an irregular schedule (shift work) or in voluntary employment. Shift work was described as problematic among the focus group participants due to the inability to set a routine, which would assist them in managing their condition, and that may account for the small number of participants working this schedule.

A key finding was the high number of participants in competitive, full-time or part-time employment. Current literature suggests that clinicians can have low occupational expectations of those with psychiatric disorders and sometimes consider this group as more suited to voluntary work (Marwaha et al. 2009). A large proportion of the sample had a bipolar I diagnosis which highlights that even those with a condition at the more severe end of the spectrum can obtain competitive employment. Establishing competitive employment also offers individuals the added financial security that would not be available in a voluntary role. As highlighted by Marwaha et al. (2009), it is unsurprising that individuals are able to sustain competitive employment as the skills and tasks carried out across the two forms of work are likely to be similar regardless of whether the role is voluntary or paid. Competitive employment should, at the very least, be considered as a realistic goal by any stakeholder involved in supporting individuals with bipolar disorder to obtain employment or return to work.

Moving beyond current literature in this field, this study also explored the size and type of organization in which participants were employed. As shown in the results chapter, the majority of the sample worked in either a very large (42%) or small (34%)

organization, evenly matched across the public and private sectors. In the EEF survey of manufacturing companies across the UK (345 responses covering over 83000 employees) the authors identified that the level of intervention related to sickness absence is directly related to company size, with the exception of staff support (EEF 2015). Therefore large organizations may be considered appealing to those with a mental health condition due to the level of resources and support that is more likely to be available during symptomatic periods or following sickness absence. Employees working in large organizations are more likely to have access to OH support and workplace adjustments (Black and Frost 2011). Additionally, mental health training and management policies are also more common in larger organizations (Black and Frost 2011), therefore managers may be more equipped with the knowledge and resources to deal with issues related to the condition.

However, smaller organizations should not be dismissed, as only a slightly smaller proportion of participants were employed in a workplace of this size. Although smaller businesses may not have the same resources as a larger organization, the level of staff support provided or available is often consistent, regardless of size (EEF 2015). Additionally, a smaller workplace with a more 'personal' work environment may be considered more appealing and less daunting than a large organization with a workforce consisting of thousands of employees (Rebeiro-Gruhl and Laporte 2008). The reasons behind the choice of employment setting would be an interesting area to explore further to determine whether the size of an organization is consciously taken into account by this group of individuals when making employment decisions. Is it an informed decision to work in an organization of that size, to support the management of their bipolar disorder illness, or is this factor not even considered when looking for employment? If this is an informed decision, then identifying the organizational setting that is most conducive to vocational recovery would be an important factor in the development of interventions to support employment for those with bipolar disorder.

It is also important to note that the resource gap between large and smaller organizations is beginning to reduce following the introduction of the 'fit for work' service in 2015. This service offers employers access to free OH advice for employees who are absent from work for four weeks or more. Therefore smaller organizations with fewer resources can now access professional advice from OH specialists to identify the obstacles preventing employees from returning to work, to assist them in developing a return to work plan.

A further important finding that adds to the current literature was the length of time participants had been employed at their current organization. Exactly half of the employed bipolar disorder sample had worked for the current employer for 5-10 years or more, with only 13% working within an organization for less than a year. This finding clearly shows that individuals with bipolar disorder can sustain employment for prolonged periods of time. This is not consistent with other studies which report high rates of job loss and difficulty in sustaining employment among this diagnostic group (Becker et al. 1998).

3.8.1.4 Key finding – Sickness absence

A further key finding was the low rate of sickness absence reported among some participants. The majority of the sample (69%) reported none or less than 1 week of sickness absence in the previous 12 months. Levels of sickness absence among the general population are reported at an average of 6.6 days per year, and slightly higher at 7.9 days per year for public sector organizations (CIPD 2015). Therefore, the majority of the bipolar disorder participants in this study had taken on average the same amount of sickness absence as those without a mental health condition. Only 8% of the sample had reported longer-term periods of absence of between 3 and 12 months, which is significantly lower than is reported in the literature for those with psychiatric conditions. In a study by Zimmerman et al. (2010), the authors reported that 34.5% of

their study sample had missed up to two years or more of work. It is important to note that comparing absence data across studies should be undertaken with some caution due to differences in sampling and methodology. Zimmerman et al. (2010) recruited participants primarily via psychiatric services, which could result in a sample being over representative of those with a more unstable condition with higher levels of work impairment. It is also important to note that participants were only questioned about absence related to their bipolar disorder, so if multiple episodes of absence were taken for other conditions they were not captured in this study. High levels of comorbidity are often reported among this group, therefore exploring overall levels of absence would be an important consideration for future studies.

3.8.1.5 Key finding – Disclosure and workplace support

Consistent with current literature, a number of participants had not disclosed their bipolar disorder diagnosis to their LM, OHP and HR representative. A survey by the Mental Health Foundation (2015) reported that only 61% of respondents had disclosed their mental health problem to their manager. The remaining 39% of respondents had reported feeling fearful of disclosing their mental health condition due to the associated stigma and discrimination. Due to the methodology of this study it is not possible to determine the reasons why participants choose not to disclose their diagnosis. Reasons could include a fear of stigma and discrimination or, alternatively, it may feel unnecessary if the individual is functioning well within the workplace. A key consideration for future studies would be to explore the reasons why participants had or had not chosen to tell individuals in the workplace about their condition.

The majority of the sample had been offered at least one of the workplace adjustments listed. The most commonly offered adjustments were reduced hours or days, referral to OH, reduced workload and/or a meeting to discuss extra support. This is consistent with findings by the EEF (2015), where the most common interventions implemented were

changing employees' work duties, reducing working hours or altering working patterns (EEF 2015).

3.8.1.6 Key finding – Clinical and demographic predictors of employment status among the bipolar disorder sample

This analysis was purely exploratory, therefore it did not focus on a set of narrow assumptions. The aim was to include as many of the preselected clinical and demographic variables in the regression model as possible. The advantage of the multivariate analysis is that it takes account of all the associations together. This was highlighted when a number of the variables found to be significant in the univariate analysis were not significant in the multivariate analysis when taking account of other associations together. This analysis did identify three important findings that will be discussed in turn.

A key finding from the multivariate analysis was the association between employment outcome and hospitalization when taking account all other predictor variables. Consistent with current literature, individuals hospitalized more frequently were less likely to be in employment (Bowden 2005). Frequent hospitalization is described as an indicator of a more severe and recurrent disorder (Harrow et al. 1990). Individuals with a greater illness severity are less likely to be in employment (Deckersbach et al. 2016). This finding may suggest a directional effect, with an increase in condition severity directly resulting in a decreased likelihood of employment. However, because of the retrospective design of this study, it is not possible to assume a directional finding.

Furthermore, the possibility of a directional effect in the opposite direction cannot be discarded. Zimmerman et al. (2010) reported that prolonged unemployment was associated with an increased frequency of depression episodes and an increased likelihood of hospitalization. Burns et al. (2009) also reported that individuals in work

following an IPS intervention were more likely to be in remission at the end of the study than the non-working group. Therefore, it could be assumed that the lack of engagement in employment may be driving symptom severity. To answer this question with any certainty would require a prospective longitudinal study.

This study also identified an association between educational attainment and employment status. Consistent with current literature, higher educational attainment was associated with an increased likelihood of employment (Deckersbach et al. 2016; Waghorn et al. 2007). In support of current findings the age of onset of symptoms among this sample was 18-20 years (Pinia et al. 2005), which is the average age at which individuals would be in higher education. Therefore, even with the onset or presence of bipolar disorder symptoms, a proportion of the sample were still able to manage their condition to a level that allowed them to study for and obtain A-Level and postgraduate qualifications. The coping skills they developed during this period may have formed the grounding for future engagement in the work environment, as the age of onset of symptoms among this sample coincides with a time when individuals are most productive in developing their education and work skills (Stimmel 2004).

The final key finding was an association between a lower age of first contact with psychiatric services for affective illness and an increased likelihood of employment. This could suggest that individuals with bipolar disorder seek work that is appropriate for them, considering their illness. Individuals are more likely to find work at a level they can cope with if they are entering the world of work following the onset of the bipolar disorder illness. This would be an important consideration for future research as age of first contact with psychiatric services may be the crucial time point at which intervention is required, in order to assist individuals in finding work that is appropriate and manageable taking into account their bipolar disorder illness. It is important to note that the effect size for age of contact with psychiatric services was very small. This suggests that with such a large sample size even a very modest effect such as this can be

significant. However, although statistically significant it may not be clinically significant. It would be interesting to explore this finding further in future studies.

3.8.2 Limitations

The results of the questionnaire study need to be interpreted in light of several limitations.

3.8.2.1 Representativeness of the sample

A total of 2484 patients with a mood disorder returned the questionnaire, which is a response rate of 39%. This would be considered above average for a study of this nature. 626 participants were excluded from analysis as we had work data but no clinical/demographic data for them. The clinical and demographic data collected by the BDRN were reviewed and scored by the team. This process is time and labour intensive and therefore there was often a delay in newly collected data being entered onto the database. This process was further delayed as resources were allocated to manually scan and review the 2484 returned questionnaires. Future work on this data would be to include the additional 626 patients, as this was not feasible within the time constraints of this study.

Within the sample the proportion of patients within each diagnostic group was not evenly matched or representative of the distribution of the disorders that you would expect in the general population. There was a much larger sample of patients with bipolar I disorder than bipolar II disorder, and an even smaller sample of patients with MDD. The BDRN sample was primarily recruited as part of an ongoing bipolar disorder molecular genetic study. Therefore recruitment was targeted at participants with bipolar I disorder as opposed to BPII and SABP, and with patients with MDD being recruited for subsequent smaller sub-studies.

The distribution of the bipolar disorder sample in this study was opposite to what you would expect in the general population, as bipolar II disorder is more common that bipolar I disorder. The diagnostic groups (bipolar I and bipolar II) were not separated in analysis, despite knowing the clinical differences across the groups. Therefore the results may be more reflective of those with a course of illness at the more severe end of the spectrum. It should also be noted that the BDRN sample only included patients of UK/ Eire white ethnicity to reduce heterogeneity and minimize false positives that could be caused by differences in genetic background. These inclusion criteria and the overrepresentation of those with a bipolar I diagnosis could limit the generalizability of my findings. Future research could compare the diagnostic groups to identify predictors that are unique to each group.

3.8.2.2 Definition of employment

On reporting the questionnaire study results the 'employed and 'not employed' samples as defined in this study need to be considered in light of several limitations. Those working in voluntary full-time and part-time employment were considered 'in employment' for the purpose of this study. However, this differs from the definition used by the ONS, who define voluntary employment as 'unemployed'. Therefore caution is needed when making assumptions based on direct comparisons across the two data sets.

There is often very little difference in the skills and tasks carried out across paid and voluntary work (Marwaha et al. 2009) This study set out to understand the workplace characteristics of those in employment, and therefore participants in voluntary work were able to contribute to answering this important research question. For the purpose of this study those in voluntary employment were better suited to being included in the employed sample than grouped with those not involved in any form of employment.

Defining this sample is inherently complex, as in addition to voluntary employment, 'caring' and 'homemaking' is also considered a form of work. However, these were excluded from the 'employed' sample in this study. These groups were excluded due to the level of complexity it would have added to the questionnaire measures, and the inability to collect data from these groups that would contribute to answering the research question. The questionnaire items for the employed sample queried data such as employment sector, workplace support, working schedule and sickness leave. Therefore, the vast majority of the items would be irrelevant to this group and would not provide data on workplace characteristics as set out in the aims. Defining the sample in this manner has made it difficult to make comparisons with the existing literature, but it has provided the optimum sample with which to answer the research questions and meet the study aims.

On reflection, the collection of data on the retired sample could be improved. On completion of the questionnaire, those in retirement would currently state they are not in employment and state the reason as retired at the end of the measure. The first questionnaire item could be amended for future studies to give participants the option of stating retirement at the beginning. Therefore, they would not be required to answer any further questions, unless a retrospective measure of past employment were to be included for this sample. In the current measure those in retirement were still instructed to answer questions on reasons for unemployment, although they were not applicable to this group. Amending the measure to address these issues would be a key consideration for future studies.

3.8.2.3 Variable selection

A further limitation of the questionnaire study was the failure to consider work history when designing the questionnaire and in considering the model for analysis. Work history has been identified as one of the strongest predictors of employment in other serious psychiatric condition (Marwaha and Johnson 2004) and in bipolar disorder

(Bowden 2005). Michalak et al. (2007) identified cycles in working life often mirrored cycles in mood episodes in patients with bipolar disorder. For future research it would be important to collect data on work history to determine whether the factors identified in this study would still remain predictive of employment status if work history was controlled for. This explorative analysis has been key in formulating hypotheses that could lead to new data collection and studies.

3.8.2.4 Design

The retrospective assessment method of the questionnaire could be considered a limitation of the study. The questionnaire was self-completion and reliant on the participants understanding the items, and answering the questions truthfully and accurately. Some of the items in the questionnaire (length of sickness absence taken in the previous 12 months) were reliant on participants recalling past events over a 12-month period. The findings of these questions need to be reported with caution to allow for recall error. However, the retrospective design of this study allowed me to obtain data on employment over the participants' lifetime to date, and is in general a more cost-effective method than a longitudinal design.

As briefly mentioned above, some of the questionnaire items (e.g. the disclosure question) would need to be refined for future studies. On reflection it would have been beneficial to ask the target population to review the questionnaire throughout the development process. The questionnaire review team were all Cardiff University employees in full-time employment; therefore they may have failed to consider more complex working situations that could have made it difficult for participants to answer the questions. Development of the measure followed a systematic process, and although formal tests of validity or reliability were not undertaken, the questionnaire findings were largely consistent with current literature in this field where validated measure have been utilized.

3.8.3 Future research

This questionnaire study has identified the direction for future studies exploring employment outcome for a mood disorder sample. One important consideration is to consider the mood disorder diagnostic groups independently, to identify important predictors unique to each group. Future work should also further explore the level of impairment among those with MDD, separating this sample from those with mild to moderate depression to identify the resources and intervention required to assist in job retention and return to work. As identified by Chacko et al. (2011), intervention and resources to support those with bipolar disorder could prove cost-effective in terms of service cost and work productivity. MDD has a higher population prevalence than bipolar disorder therefore supporting this group could also prove to be cost-effective.

An important consideration for future research would be to further explore the impact of hypo/manic symptoms on work-related domains. A higher rate of employment was identified in the bipolar sample compared to the MDD group. Therefore, it would be interesting to explore whether manic symptoms are associated with higher rates of work attendance and whether this is a short-term or long-term effect.

An important opportunity for future work would be to incorporate assessment of work-related domains into the BDRN battery of measures. This would ensure initial measures are collected via the research team, which could limit responder bias. In addition, work-related measures could be collected annually to determine the impact of bipolar disorder on employment over an extended period of time. The BDRN also now electronically collects prospective mood ratings on 700 bipolar participants as part of the TRUE COLOURS study. Utilizing this technology could provide an opportunity to explore the effect of mood on work-related measures to determine the impact of both manic and hypo/manic symptoms.

3.9 Conclusion

This questionnaire study described the employment rate, work patterns and workplace setting of those in employment with bipolar disorder. In addition, preliminary exploratory analysis looked at the clinical and demographic factors best associated with employment outcome. This study identified that individuals with bipolar disorder can obtain and sustain employment for prolonged periods, with 69% of those employed reporting sickness absence levels that match those without a mood disorder. A major strength of this study was that it focused more broadly on mood disorder and the workplace setting. In addition to exploring employment rates in isolation it explored the workplace setting and working patterns of those in work. It also identified some of the key clinical and demographical variables best associated with employment outcome. This explorative work forms a strong grounding for formulating hypotheses that could lead to new data collection and studies.

Chapter 4

Development of the 'Working with Bipolar' Intervention

4.0 Chapter 4 – Development of the 'Working with Bipolar' Intervention

In this chapter I describe the processes undertaken to develop the intervention 'Working with Bipolar'. I firstly describe the framework and research activities that informed the content and the build of the intervention. I then provide a step-by-step overview of the intervention, describing how the user is taken through the programme. Finally I describe the small pilot study that was undertaken, followed by a comprehensive summary and discussion of the findings.

4.1 Rationale

An overarching aim of this thesis was to develop an intervention, informed by the literature review and focus group findings, to improve the interactions and conversations between the three key stakeholders (employee with bipolar disorder, LM and OHP) in regard to the management of bipolar disorder and work.

The focus group participants were integral to the development process. The three stakeholder groups explored the challenges to the management of bipolar disorder and work and the solutions to overcome these. They worked closely with the research team to define the key content to be included in the intervention. This style of research bridges the gap between theory and practice. This study worked 'with' the target group to ensure the problems being addressed were reflective of working practice and that the intervention being developed was fit for purpose.

The research reported in chapters one and two of this thesis clearly highlighted that an intervention targeted at the three stakeholder groups needed to provide condition specific information and skills training in order to improve communication and the interactions in regard to the management of bipolar disorder and work.

The research activities that informed this intervention have already been explored and discussed in previous chapters. Therefore, in this chapter I will only provide brief summaries of the research findings to demonstrate how they directly informed the content and design of the intervention.

4.2 Intervention aims

The aims that emerged from the focus groups findings and literature review were to develop an intervention that:

1. increased the users' confidence in engaging in complex conversations about bipolar disorder and work.
2. increased the users' knowledge and understanding of bipolar disorder.
3. provided signposting to further support and resources related to both bipolar disorder and work.

4.3 Intervention framework

The conversations and interactions around work and mental health are complex. Therefore, development of an intervention to target these interactions across a number of user groups must involve physical, personal and social components that address knowledge, skills and attitudes. To ensure the development of the intervention followed a systematic process the Medical Research Centre (MRC) (2008) guidelines for the development, evaluation and implementation of complex interventions to improve health were followed.

A complex intervention is defined as an 'intervention that contains several interacting components which may act both independently and inter-dependently' (MRC 2000). In this study the intervention was considered complex due to the following factors:

- The number and variety of expected outcomes
- The number of stakeholder groups that the interventions targeted (employee, LM, OH)

- The number and difficulty of behaviours exhibited by those receiving the intervention
- The degree of tailoring of the intervention

The MRC guidelines initially published in 2000 and updated in 2008 (MRC 2000, 2008) provide guidance to researchers on the development, evaluation and implementation of interventions to improve health. The guidance helps researchers to choose appropriate methods and weigh up evidence in light of practical and methodological constraints. The initial guidance document was updated in 2008 to address limitations that had been identified. The latest edition adopts a more flexible and less linear approach to development and piloting. It also includes several case studies to provide examples of successful approaches to the development and evaluation of complex interventions.

The MRC frameworks describe four key elements to the development and evaluation process:

- Development
    - Identifying the evidence base
    - Identifying/developing the theory
    - Modelling process and outcome
- Feasibility/piloting
    - Testing procedures
    - Estimating recruitment/retention
    - Determining sample size
- Evaluation
    - Assessing effectiveness
    - Understanding the change process
    - Assessing cost-effectiveness
- Implementation
    - Dissemination
    - Surveillance and monitoring
    - Long-term follow up

This study primarily focuses on the first two steps of the MRC process, intervention development and feasibility/piloting, as there was not sufficient time within this PhD to design and conduct a formal evaluation and to explore implementation. This chapter will firstly describe the intervention development process and secondly provide an overview of the pilot study methodology and results.

4.4 Intervention development

The MRC guidance (2008) describes a three-step approach to the intervention development process, as outlined in table 31. By following the systematic development process outlined in the MRC guidelines the intervention could be reasonably expected to have a worthwhile effect.

Table 31: Stepwise approach outlined in the MRC guidelines for developing a complex intervention (MRC 2008)

MRC three-step approach to intervention development	**Definition and research activities undertaken to meet each step in the process**
Identifying the evidence base	Identify relevant and existing evidence base *Research activity* • Literature review
Identifying/developing appropriate theory	Identify existing evidence and relevant theory Identify changes that are expected and how changes will be achieved Supplement with new primary research with those targeted by the intervention *Research activity* • Focus group meeting with target user groups • Consultation with expert panel • Identify psychological theory (MI)
Modelling process and outcomes	Modelling to provide information on the design of the intervention and evaluation *Research activity* • Development of a logic model to describe information on the design and evaluation

I will now describe the research activities undertaken to meet each of the three steps outlined in the MRC guidance. Firstly, I will provide an overview of the key findings from the literature review that formed the evidence base in the development of the intervention. Secondly, I will provide an overview of the focus group findings and describe the expert group consultation meetings that informed the process of identifying and developing appropriate theory. Finally, I describe the conceptual model that was developed to inform the design and outcome of the intervention that formed the modelling aspect of the development process.

4.4.1 Identifying the evidence base

A literature review was conducted to identify relevant and existing evidence on workplace interventions and mental illness, as outlined in the background chapter (chapter 1) of this thesis. The literature review assisted in defining the target groups and identifying measures for change. The main evidence that was considered in preparation for the development of the intervention is summarized in table 32.

Table 32: Literature reviewed for the development of the intervention 'Working with Bipolar'

Author	Key Messages
Waddell, G. et al. (2009) Vocational rehabilitation: what works, for whom, and when?	- For rehabilitation to be successful communication between key players, i.e. individual employees, healthcare professionals and the workplace, was of high importance. - Key principles of vocational rehabilitation, such as intervening early to prevent people losing their jobs, professional support and adopting the biopsychosocial approach.
Black, C. (2008) Review of Britain's working age population: Working for a healthier tomorrow	- Interventions that focused on the interaction between employer and employee that facilitated communication and shared decision making were of high importance.
McHugo, G. J. et al. (2012) A 10-year study of steady employment and non-	- Workplace focused interventions can play a significant and positive role in supporting and encouraging individuals back to work.

vocational outcomes among people with serious mental illness and co-occurring substance use disorders	
Tremblay, C. H. (2011) Workplace accommodations and job success for persons with bipolar disorder	- The employee's relationship with their supervisor was critical to their job performance
Yarker, J. et al. (2010) Managing rehabilitation: A competency framework for managers to support return to work	- Developed a competency framework for LMs to support return to work. The framework suggested that effective communication and sensitivity, as well as understanding of the individual, were the most valuable skills when supporting an employee.
Michie, S. et al. (2011) The behaviour change wheel: A new method for characterising and designing behaviour change interventions	- Interventions that use training and organizational approaches to increase participation in decision making and problem solving were most effective at reducing work-related psychological ill health and sickness absence.
Thornicroft, G. et al. (2008) Reducing stigma and discrimination: Candidate interventions	- Due to the relapsing nature of bipolar disorder the need for ongoing tailored support is high. Interventions that adopt a recovery, empowering and individually led model that allows shared decision making and flexibility are deemed to be the most successful.
Cohen D. (2008) The Sickness Certification Consultation in General Practice	- Training about the conversation and developing more complex communication styles using the principles of MI have been shown to be effective in improving the return to work interviews with GPs and LMs

The literature review clearly highlighted the need for an intervention that:

- integrated the needs of all stakeholders.
- provided information to increase understanding of bipolar disorder.
- offered skills training to increase the confidence of all stakeholders to engage in complex interactions in regard to job retention and return to work.

4.4.2 Identification and development of appropriate theory

4.4.2.1 Focus groups

To build on the literature findings and to gain an in-depth understanding of the challenges that needed to be addressed among the target population, focus group meetings with the three stakeholder groups (employee, LM and OH) were conducted, as described in chapter two. The focus group meetings identified the main challenges experienced by each of the three stakeholder groups and the solutions to overcome these. Based on these discussions each stakeholder group identified the key content required in an intervention that would assist them in the management of bipolar disorder, job retention and return to work. Integrating with the user groups at all stages of development is associated with better science and an increased chance of producing an implementable intervention (MRC 2008). The key themes identified by the three stakeholder groups to be integrated into the intervention have been combined and are summarized in the table 33.

Table 33: Table illustrating the combined key findings from the employee, line manager and occupational health focus groups that informed intervention content

Focus groups themes	Intervention content
Knowledge	Information on bipolar disorder
Stigma	Information on bipolar disorder and mental illness to address misconceptions
Timing of return to work meetings	Highlight the importance of meeting with the employee before they return to their role following a period of absence
Defining roles	Illustrate the role of each stakeholder in the absence management process
Ongoing support	Demonstrate the need for ongoing support and monitoring at a level agreed jointly across the key stakeholder groups
Communication	Demonstrate how to engage in skilful conversations and interactions
Contact with an employee whilst out of work	Highlight the importance of keeping communication open and supportive whilst an employee is out of work
Three-way communication	Demonstrate the benefits of engaging with all stakeholders involved in the job retention and return to work process
Joint decision making	Highlight the importance of joint decision making

Confidentiality	Highlight the importance of confidentiality and setting an environment where employees feel safe to discuss mental health
Disclosure	Demonstrate the complexity associated with disclosure and the potential benefits that can achieved from being open about one's condition

4.4.2.2 Expert group

To supplement the research findings an expert group was convened to oversee and further inform the development of the intervention. An 'expert group' for the purpose of this study was defined as a group of professionals with expertise in the field of 'work' and 'mental health'. The group consisted of representatives from Bipolar UK, OH physicians, a senior manager from a large UK organization, and experts in the field of work and rehabilitation. Experts who sat on the group included Professor Sir Mansel Aylward, Professor Kim Burton, Dr Paul Litchfield and Professor Bob Grove. The group convened at three crucial time points during the intervention development. An initial meeting was held to discuss the background literature and the aim of the intervention. The second meeting reviewed the findings of the qualitative focus groups. The third meeting reviewed the intervention prior to piloting.

In addition to the expert group, the expertise of the supervision team (IJ and DC) in intervention development in the field of work and mental health was sought. IJ is a consultant psychiatrist with expertise in developing psychoeducation and online programmes for patients with bipolar disorder. DC is an OH physician with expertise in developing online programmes for health professionals and organizations in relation to work and health.

4.4.2.3 Identifying appropriate psychological theory

From a review of existing research MI was identified as the behaviour change model that had informed interventions in similar target populations (Cohen 2008), to encourage skilful interactions and more effective communication styles. Therefore, MI was chosen as the model to best inform and underpin the development of the intervention for this

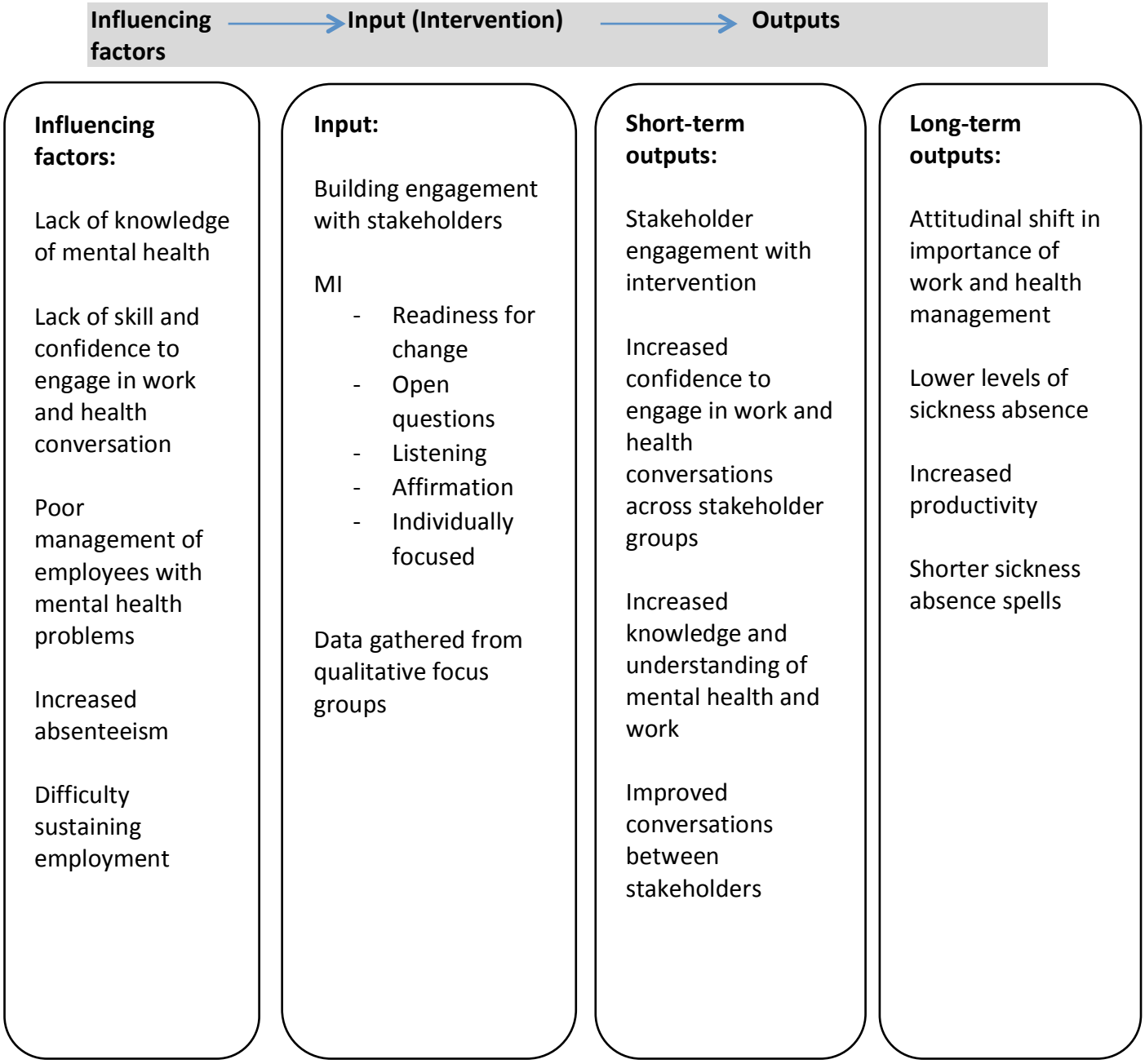
study. Based on the principles of MI the intervention would focus on a guiding style of training and not simply 'tell' (inform) the user how to change. The intervention content would provide evidence, strategies and resources to support the user groups to engage in more skilful interactions. Finally, the intervention would be grounded in the premise of MI, which aims to elicit the user's own motivation to use the new skills being presented.

4.4.3 Modelling process and outcomes

This study made use of a logic model, also known as a logical framework, to illustrate the factors that informed the intervention (influencing factors), the input required to meet the study aims and the expected short-term and long-term outcomes. A logic model illustrates the logical relationship between input into the intervention, the research activities and theoretical models, and the expected outputs. It provides a conceptual map for exploring the relationships between practice and outcome (Baxter et al. 2010). A logic model is developed by first exploring the outcomes which the study aims to achieve then considering the influencing factors and input that would be required to achieve the desired outcome, as shown in figure 13. Focusing on the ultimate outcome helps identify the ways in which to best achieve the desired results.

Figure 13: Logic model - Intervention modeling

Purpose: To develop an intervention to increase the user's level of knowledge and confidence to engage in complex conversations about bipolar disorder and work.



4.4.3.1 Influencing factors

The first section of the logic model details the factors responsible for poor management in relation to bipolar disorder and work. This section also outlines the outcomes that are associated with these factors, in terms of increased levels of sickness absence and difficulty among employees in sustaining employment.

4.4.3.2 Input

The second section of the model outlines the input required to address the influencing factors. This section describes the intervention. The intervention was informed by and developed in collaboration with the focus group participants. This stakeholder groups were engaged in the process, working with the research team to develop an intervention that addressed the challenges for each group, was authentic and fit for purpose. The intervention was underpinned by the behaviour change model, MI. Informed by this model, the interventions focused on a guiding style of training, providing strategies and resources to support the user groups to engage in more skilful interactions. The intervention was built on the premise that if you increase the user's level of 'confidence' in their ability to change behaviour (through skills training) and the level of 'importance' they assign to the change (through information and reflections), they are more likely to be ready to change their behaviour and engage in more skilful interactions (as shown below).

IMPORTANCE + CONFIDENCE = READINESS TO CHANGE

4.4.3.3 Outputs

The third and fourth sections of the model outline the expected short-term and long-term outcomes of the intervention. A short-term aim is for each stakeholder group to become engaged in using the intervention. This, in turn, would lead to an increased understanding of bipolar disorder and work, and an increase in confidence to engage in complex work and health conversations. In the long term it is expected the change in behaviour among the user groups will lead to a lower level of sickness absence, increased

productivity and an attitudinal shift across the stakeholder groups in the management of bipolar disorder and work.

4.5 Intervention design and build

The design of the intervention was developed in consultation with the focus group participants and the programme developers (Healthcare Learning Company [HLC]), with oversight from the expert group. The final set of focus group meetings asked the three user groups to consider several questions in regard to the design and delivery of the intervention. The questions and full responses are detailed in chapter three, and are briefly summarized below:

- *How should the intervention be accessed?*
    - Internet, intranet, mobile apps and mental health websites
- *What would make the programme user friendly?*
    - Straightforward language that does not include 'business' or 'medical' terminology
- *What would attract you to using such an intervention?*
    - Endorsement or recommendations from organizations such as Bipolar UK
    - Access to reliable and up-to-date information
    - Content that was interactive where possible
    - Visually attractive and easy to navigate
- *What would the intervention need to include to make it feel relevant to you?*
    - Inclusion of case studies or scenarios that feel authentic and 'real'

There was clear consensus across the three user groups that the intervention should be Internet based. This mode of delivery was considered easily accessible and provided the flexibility to be accessed on an individual basis at the discretion of the user, or alternatively in a group or taught setting. Based on previous online interventions and with agreement among focus group participants, 40 minutes was deemed an acceptable

running time for an intervention of this nature, with built-in capacity to pause and restart at the user's discretion.

Thus far I have described how the MRC framework was utilized to inform the elements of the intervention. I also summarized the research processes that were undertaken to inform the content, design and delivery of the intervention. I will now provide an overview of the final steps in the development process. I will describe how the content was written and finalized, and provide an overview of how the intervention was built by the IT company (HLC). Finally, I will provide a step-by-step account of how the user would progress through the final version of the intervention.

4.6 Writing the content

The written content of the intervention model was based on the principle of MI, as described above. Therefore the intervention was grounded in a guiding style of training that aimed to guide users to reflect on their own management practices, and that offered strategies and information to inform future more skilful practice. To achieve this, the intervention was centred around two return to work scenarios. The first scenario reflected 'everyday/common practice' and the second scenario represented 'better practice'. Recent interventions using MI have found better user engagement when using 'common' and 'better' practice scenarios compared to 'bad' and 'better' (Cohen 2008). Common practice scenarios feel more authentic to the user; therefore they are able to relate the content to their own practice and consequently consider change, whereas 'bad practice' may not appear to reflect standard practice therefore the user is unlikely to see a need for change that is based on an unrealistic scenario.

The first scenario aimed to replicate a 'common' return to work interview, where several improvements to the interaction and conversation could be made. The second scenario aimed to address these issues and demonstrate a more skilful return to work interview. Two case studies were written for common and better practice. The first case study was based on a return to work interview with an employee (Kara) who had disclosed her bipolar disorder to her employer. The second case study focused on a return to work

interview with an employee (Chris) who had not informed his employer of his bipolar disorder condition. Both case studies followed the same format (common and better practice) but the content and dialogue differed slightly to reflect their different circumstances.

Discussions that had taken place across the three sets of focus groups about the nature of the return to work interview were considered when writing the scenarios. The first draft of these scenarios was sent to focus group members for review, to ensure they reflected practice and felt authentic to each of the three user groups. The expert panel were also sent the scenarios for review and comment. The reviewers were asked to consider whether the scripts felt representative of a 'real life' return to work scenario. The feedback was collated and minor amendments were made.

In addition to the main intervention an additional resource section was developed. The expert panel and focus group participants were asked to suggest resources to be included in this part of the intervention. The suggestions were compiled and all resources and information that were accessible, evidence-based and from a reliable/accredited source were included in this section.

The resource section was developed in parallel with the main intervention and included the following:

- Information on bipolar disorder
- Links to resources for employers
- Information on research in the fields of work and health
- Links to support organizations

The resource section was accessible independently or via links in the main intervention.

4.7 Construction of the intervention

The intervention was built by HLC, a software design company that specialises in e-learning in healthcare. Construction of the intervention was staged. Firstly, an outline

design was agreed and constructed by the software company. It outlined the architecture, features and design specifications of the intervention based on the study requirements. Once agreed, the content (as described above) for each section was built and formed the detailed design. In collaboration with the research team and HLC the content was finalized and converted into script format. The video content for the programme was filmed in a studio in London with oversight from the research team. The research team attended all filming sessions to ensure the guiding style was clearly evident and the content was portrayed accurately.

The focus group participants had stated that an introduction to the programme by a well-known celebrity would attract the user groups to engage with the intervention. Therefore, the Welsh actor Michael Sheen was approached due to his interest and previous work in supporting mental health charities. He agreed to film the introduction section of the intervention which is shown in figure 15.

4.8 Intervention review

Prior to completion and 'sign off', the intervention was critically reviewed by the focus group participants and the expert group. As part of this process, reviewers were asked to comment on the design, ease of use and flow of the intervention, and the authenticity of the content. Examples of the issues identified by reviewers and the agreed solutions are summarized in table 34.

Table 34: Table to illustrate the issues identified by the focus group participants and expert panel and the agreed solutions

Issues highlighted	**Solutions**
Employee's (Kara) tone in intervention scenario	Videos edited and voice-over segments added to highlight the responsibility of the employee
Timing of the RTW interview with OH was wrong (after RTW)	Voice-over added to highlight timing of interview (before RTW)
Key messages too academic	The wording of the key messages was amended to be less academic
Context in which medication is mentioned slightly wrong	Wording in relation to medication changed
Two introductions considered too much	One introduction removed
Intervention should highlight other agencies, e.g. Bipolar UK	Other suggested agencies added to resource pages
End summary should be stronger and longer	Summary rewritten to give stronger take-home message
Difficulty accessing resources	Healthcare Learning Company to ensure all resources are accessible
Difficulty seeing full screen	Healthcare Learning Company to look into solutions such as providing the intervention in CD ROM format

Issues were identified in regard to the length of the introduction and final summary, timing of the return to work interview, context of key messages and medication information, the tone of one case study and technical difficulties. The research team and HLC met to discuss the issues identified and to agree feasible solutions. The technical issues were the responsibility of the software company and considered straightforward to resolve. It was agreed the introduction was too lengthy therefore this was cut down. The key messages were rewritten in a style more suited to a lay person and the end summary was extended to strengthen the take-home messages of the intervention. It was not possible within the time constraints of the study to arrange further filming

sessions, therefore the issues in regard to the tone of the Kara case study were addressed by HLC through video editing and voice-over segments. The intervention was edited in light of the review process and finalized. The 'Working with Bipolar' intervention was hosted online in preparation for the pilot study.

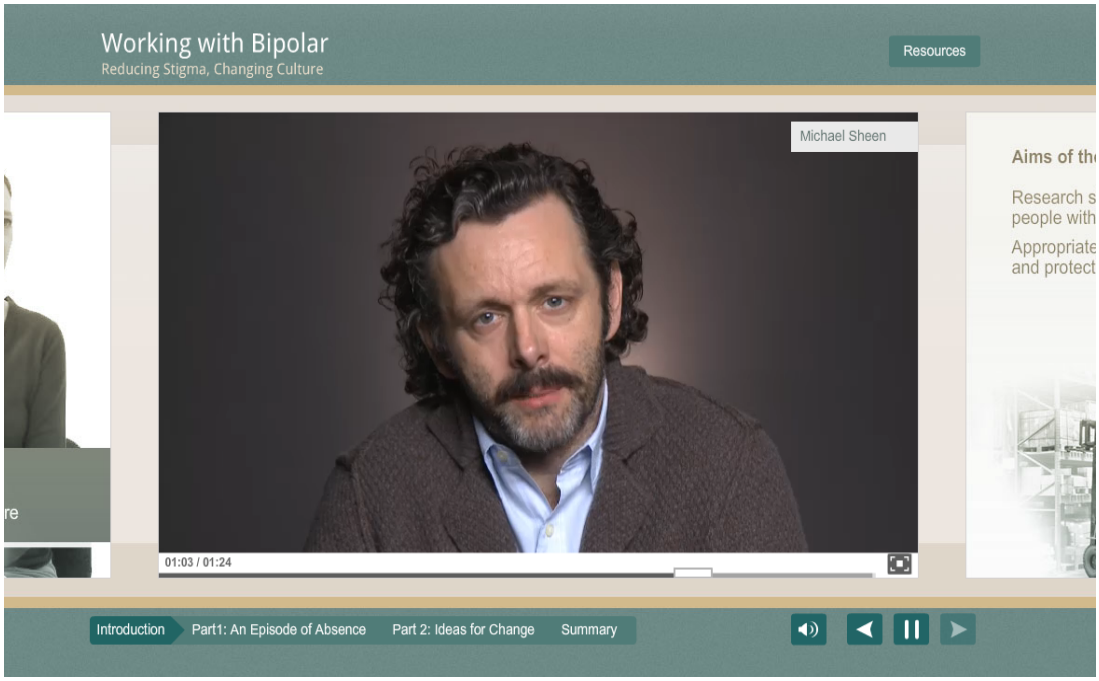
The final intervention is accessible via CD (appendix 2).

4.9 Step-by-step overview of the intervention 'Working with Bipolar'

I will now provide a step-by-set overview of the finalized intervention, titled 'Working with Bipolar'. On opening the programme the user is presented with the home screen (figure 14), followed by an introduction video (figure 15).

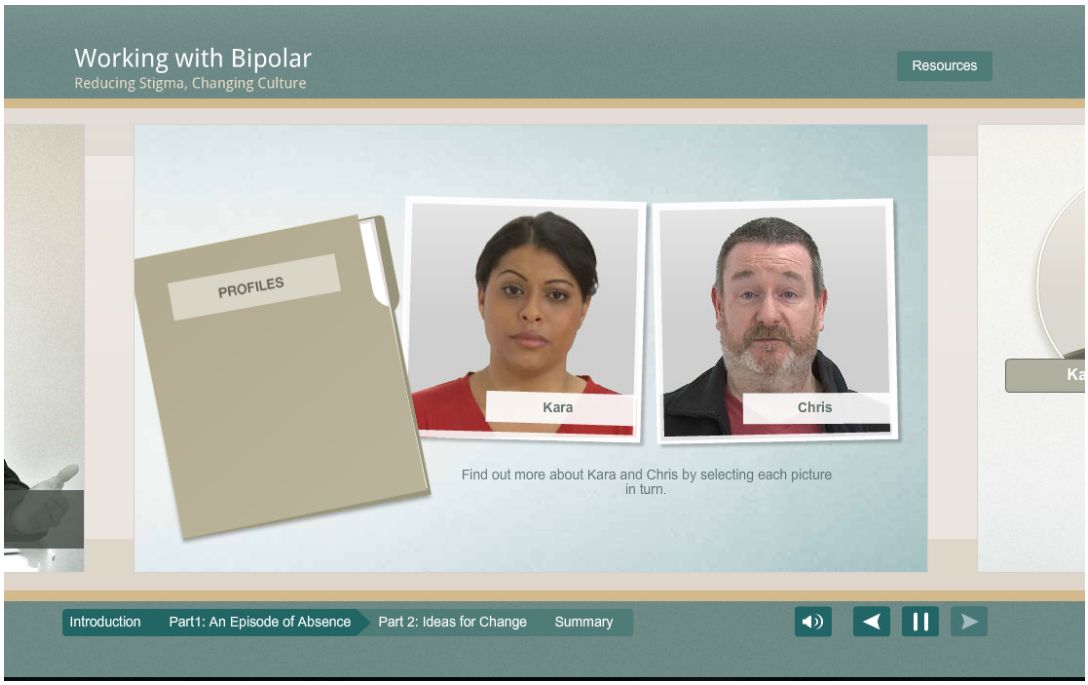
Figure 14: Home screen of the 'Working with Bipolar' programme

Figure 15: Screenshot of the 'Working with Bipolar' introduction



The user is then given the option of following one of two return to work case studies. Two employee profiles are presented (shown in figure 16), allowing the user the opportunity to choose the case study they wish to follow.

Figure 16: Screenshot of employee profiles

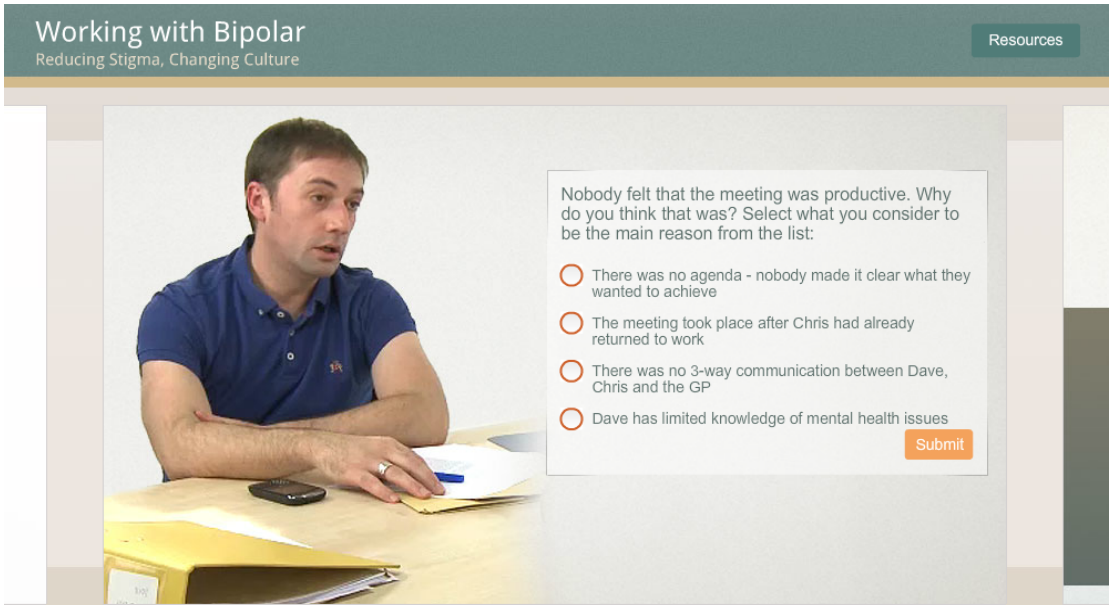


The main difference between the two case studies is that employee one (Kara) had disclosed her bipolar disorder to her employer whereas employee two (Chris) had not. Additionally, the organization that Kara worked for had OH support whereas Chris's did not. Therefore, video clips are shown of Chris discussing his work and health issues with his GP, in the absence of OH support in the workplace. The aim is to show the user the role the GP can play in supporting individuals to make decisions in regard to work.

Both case studies follow the same format but with slightly varied content and dialogue. At the end of the intervention the user is given the opportunity to watch the other case study. Both case studies start with a video clip of the 'common practice' return to work interview. At the end of the video clip the user is then asked to rate how well they thought the meeting went, using a Likert scale. An audio response is played depending on the chosen rating (e.g. "So you weren't too impressed with how Dave (LM in the intervention scenario) handled that, there wasn't anything obviously wrong with that, Dave tried hard but when the conversation got difficult he backed off and changed the subject"). Short video extracts are then played of the LM, employee and OHP providing reflective accounts on how they had felt during and after the return to work meeting.

An overview of the first scenario is then provided, guiding the user to think about the challenges faced by each of the stakeholders (e.g. no agenda set, meeting held after the employee had returned to work, LM had poor knowledge of the condition), as shown in figure 17. This aimed to engage the user by presenting a scenario that reflected everyday practice and to guide the user to consider different ways of approaching the return to work consultation. The reflective accounts aimed to guide the user to consider the impact of poor management and the benefits of adopting better management practices.

Figure 17: Screenshot of the overview of case study one: 'common practice'



Next, the intervention asked the user to select a list of statements that reflect the purpose of a return to work interview. The statements include:

- Build relationships
- Ensure employee feels valued and supported
- Empower employee
- Identify obstacles
- Set realistic goals
- Identify obstacles to the employee's return to work
- Highlight how the LM can support and manage the employees return to work
- Ensure a safe return

A description of each statement and its importance was then provided via a voice-over segment. This section aimed to educate the user on the purpose of the return to work meeting, and reinforce that message. The intervention also informed the users of the outcome of the 'common practice' return to work meeting. In both case studies, Kara and Chris had taken further periods of sickness absence. This section aimed to reinforce the negative outcomes that can occur from poor management, therefore highlighting the importance of adopting better practices.

The next section of the intervention is titled ‘ideas for change’. The same case studies are played but with subtle differences in the manner in which the return to work interviews are approached. This adapted approach is titled ‘better practice’. Again the user is asked to rate the new scenario using a Likert scale and is provided with an audio response dependent on their chosen rating. The LM, employee and OHP then provide reflective accounts based on this second scenario. A summary is then provided identifying the differences in the second scenarios that led to better practice and a better outcome for all involved, as shown in figure 18.

Figure 18: Screenshot of summary of successful return to work scenario

This section aimed to reinforce how subtle differences in management and style of communication on the part of the LM led to more skilful interactions and better outcomes. The intervention demonstrated the importance of three-way communications, forward planning and how to engage in active listening and joint decision-making. The reflective accounts that followed reinforced the benefits of engaging in better practice. For example, in the employee reflective account that followed the ‘better practice’ scenario Kara and Chris described how they felt listened to, supported and valued by

their LM. The LM also described how they felt more satisfied with the outcome as they had gained an in-depth understanding of the issues, and had implemented plans for the future. The intervention also informed the users of the outcome of the 'better practice' return to work meetings. In both case studies, Kara and Chris were back in work being supported by their LM and had not taken any further periods of sickness absence. This section aimed to reinforce the positive outcomes that can occur from better management, and how investing in the health and wellbeing of staff and adopting better management practices can have long-term benefits.

The intervention concluded with a short graphic and audio clip that presented evidence on the benefits of skilful communication in regard to the return to work interviews. Again, this aimed to engage the user in considering the importance of addressing work and health in a more constructive and effective manner.

4.10 Resources

The resource section of the intervention provides the user with further information on bipolar disorder and links to support organizations and resources (figure 19). As mentioned previously, the resource section can either be accessed independently or via links in the main intervention.

Figure 19: Screenshot of the resources section

Thus far, this chapter has described the process undertaken to develop the intervention 'Working with Bipolar'. The intervention was developed using the MRC's (2008) complex intervention principles. It was developed in collaboration with the three user groups and sought to demonstrate how a more skilful interaction could lead to more effective communication and better outcomes for all those involved. The information in the intervention was delivered both visually and in text form, adopting a flexible approach that allowed the user to 'dip in and out', pause and re-watch at their preferred pace. The blend of visual, audio and written content ensured the intervention was accessible and appropriate to all learning styles.

The next section of this chapter will describe the small-scale pilot study undertaken to test the acceptability of the intervention among the target user groups. I will provide an overview of how the pilot study was conducted and a comprehensive overview of the results.

4.11 Pilot study

A small-scale pilot study was undertaken to test the acceptability, usability and validity of the intervention and the feasibility of a more formal evaluation across a small sample of the target population. Pilot studies such as this play a key role in the refinement of new interventions, and assist in evaluating the feasibility of the assessment procedures used and recruitment to a more formal and systematic evaluation (Leon et al. 2011).

4.11.1 Aim

The pilot study aimed to explore two areas:

(i) The users' perceptions of the usability, accessibility and appropriateness of the intervention

(ii) The impact of the intervention on the users' perception of their confidence to engage in a return to work discussion

4.11.2 Design

The pilot study was split into three stages:

- Stage 1: Participants completed a pre intervention questionnaire
- Stage 2: Participants watched the intervention 'Working with Bipolar'
- Stage 3: Participants completed a post intervention questionnaire

4.11.3 Sample

This small-scale pilot study adopted a pragmatic approach to recruitment. This study was not designed to test a hypothesis, therefore sample size calculations were not required. A convenience sampling strategy was adopted. Employees, OHPs and LMs who had not been involved in the development of the intervention were to be recruited to the pilot study. This type of recruitment method relies on collecting data from individuals who are conveniently available to participate in the study. The participants had not had any prior involvement in the focus groups or intervention development, therefore they were more

likely to provide an impartial and unbiased view of the intervention. The aim was to recruit a group of between 10 and 30 employees, LMs and OHPs. This was deemed an adequate sample size to test the aim within the time constraints of the study, whilst taking into account the difficulty associated with recruiting the target population.

4.11.4 Recruitment

The employee participants were recruited via an advert published in the Bipolar UK newsletter. The LM and OHP participants were recruited via the organization, British Telecom (BT). Other organizations who initially expressed an interest in the pilot study (Cwm Taff Health Board, Public Health Wales, Cardiff University and Capita) were invited to take part however, all consequently opted out due to work demands and resource issues. An HR contact within BT distributed an email inviting LMs and OHPs to take part in the pilot study.

4.11.5 Measures – Questionnaire development

Two questionnaires for each of the three user groups were developed, to be administered pre and post intervention:

- Questionnaire 1 – Completed immediately before watching the intervention
- Questionnaire 2 – Completed immediately after watching the intervention

Existing validated measures for the evaluation of work-focused interventions that were developed as part of two previous projects at Cardiff University were reviewed ('Sick Note or Bust' and The Royal Mail evaluation questionnaire) (Cohen 2008). Items deemed relevant formed the basis of the 'Working with Bipolar' pilot study questionnaire set. Questionnaire items were also developed to identify an initial change in the user's perception of their confidence to manage complex return to work interactions and conversations post intervention. Participants were asked to rate how confident they felt in relation to a set of statements on a four point Likert scale that ranged from 'very confident' to 'not at all confident'. The 'confidence' statements differed slightly across the three user groups to address their differing roles within the return to work process.

Participant groups were asked to complete the same set of 'confidence items' pre and post intervention. Additionally, the post intervention questionnaire also contained items on the usability, accessibility and appropriateness of the intervention.

The pre intervention questionnaire items for each of the three user groups are outlined in table 35. The additional items included in the post intervention questionnaire are outlined in table 36. The full questionnaire sets are included in appendix 3.

Table 35: Pre and post intervention questionnaire items for each user group

Items	Employee questionnaire items	Line manager questionnaire items	Occupational health questionnaire items
	How confident are you in ……..		
Q1a	Approaching your line manager to seek support when you are concerned that your mental health is affecting your work	Having enough knowledge to discuss returning to work with employees who have been off with mental illness	Having enough knowledge to discuss returning to work with employees who have been off with a mental health problem
Q1b	Telling your line manager about the nature of your mental health issue	Having enough knowledge to advise individuals with mental illness on modifications or adjustments to their work	Having enough knowledge to advise individuals with a mental health problem on suitable adjustments to their work
Q1c	Telling your colleagues about the nature of your mental health issue	Your skills to manage a return to work interview for an individual returning to work with a mental health problem	Discussing disclosure with an individual with a mental health problem
Q1d	Knowing where to access information on work and mental health	Discussing disclosure with an individual with a mental health problem	Providing advice for an employee with a mental health problem about support services available to help them return to or remain in work
Q1e	Having a return to work conversation with your line manager following an absence	Developing a plan for the ongoing management when supporting an individual in work with a mental health problem	Providing advice for the employer about support services available for employees with a mental health problem
Q1f	Negotiating temporary changes to your work	Setting appropriate goals for an individual	Having enough knowledge about self-

	with your line manager	returning to work with a mental health problem	help tools available for individuals with mental health problems
Q1g	Discussing work and health issues to help you remain in work when unwell	Setting appropriate goals for an individual who is already in work with a mental health problem	Developing a plan for the ongoing management when supporting an individual in work with a mental health problem
Q1h			Setting appropriate goals for an individual returning to work with a mental health problem
Q1i			Setting appropriate goals for an individual who is already in work with a mental health problem

Table 36: Intervention specific questions that supplemented the post programme questionnaire

	Post intervention pilot questions
1	Did you have any difficulty getting online to watch the programme?
2	Did you watch the programme from start to finish?
3	Did you experience any difficulty using the programme online?
4	Did you skip through any parts of the programme?
5	Do you think an online programme is a good way to learn about how to manage mental health in work?
6	How useful was the information provided in the programme for you?
7	Do you think the programme was the right length?
8	What would be your preferred method of training about managing mental health concerns?
9	If the scenario and information were changed to be about depression and anxiety do you think the programme would be useful for supporting people with mental health concerns more widely?
10	To what extent do you feel that the programme has influenced how you manage employees with mental health problems.

Questionnaire completion took approximately 5 minutes pre and 10 minutes post intervention. The pre and post intervention questionnaires were hosted online via the survey tool Bristol Online Survey. The questionnaires were accessible via a URL that was distributed via email to pilot study participants.

4.11.6 Pilot study procedure

Employees, LMs and OHPs who expressed an interest in the pilot study were sent an information sheet. Participants who agreed to take part were sent a unique ID number and instructions on how to access the questionnaires and intervention. Participants were asked to provide their participant ID number at the beginning of the pre and post questionnaires to allow data to be matched whilst ensuring questionnaire responses were kept confidential.

A consent page was presented to participants at the beginning of each questionnaire. The consent form required agreement via a tick box before participants were able to access the questionnaire. The pilot process consisted of three steps:

1. Participants accessed and completed the pre intervention questionnaire via the URL provided. At the end of the questionnaire participants were provided with a link that directed them to the 'Working with Bipolar' intervention.
2. Participants watched the intervention. At the end of the intervention participants were provided with a link to access the final questionnaire.
3. Participants were instructed to complete the post intervention questionnaire in relation to the 'Working with Bipolar' intervention.

Participants were instructed to allow enough time to complete the questionnaires and watch the intervention in one sitting. However, for those participants unable to do this, I distributed two reminder emails requesting that all steps of the process were completed.

4.11.7 Analysis

Pre and post intervention questionnaire data were merged in Excel and exported into SPSS 20 for analysis. Simple descriptive analysis was undertaken on the data.

4.11.8 Pilot study results

A total of 18 employees, 51 LMs and 7 OHPs from BT were initially recruited. However, not all of those recruited completed the questionnaires, as shown in table 37. Only 7 employees, 16 LMs and 6 OHPs progressed to the post intervention questionnaire.

Table 37: Number of participants that completed the pilot study questionnaires

BT Sample	Recruited	Completed Q1	Completed Q2
Employee	18	11	7
Line manager	51	24	16
Occupational health	7	7	6

The pilot study results will now be reported in two parts. Part I provides an overview of the responses to the 'confidence' statements pre and post intervention, across the three user groups. Part II reports the overall findings on the accessibility, usability and appropriateness of the intervention.

Part I – Results of the 'confidence' measures

4.11.8.1 Employee confidence results (n=11)

In total, 11 employees completed the pre intervention questionnaire and 7 completed the post intervention questionnaire. The employees' responses to statements on their perceived level of confidence to manage work and health situations pre and post intervention are shown in figures 20 and 21.

Figure 20: Employee responses to 'confidence' measures pre-intervention

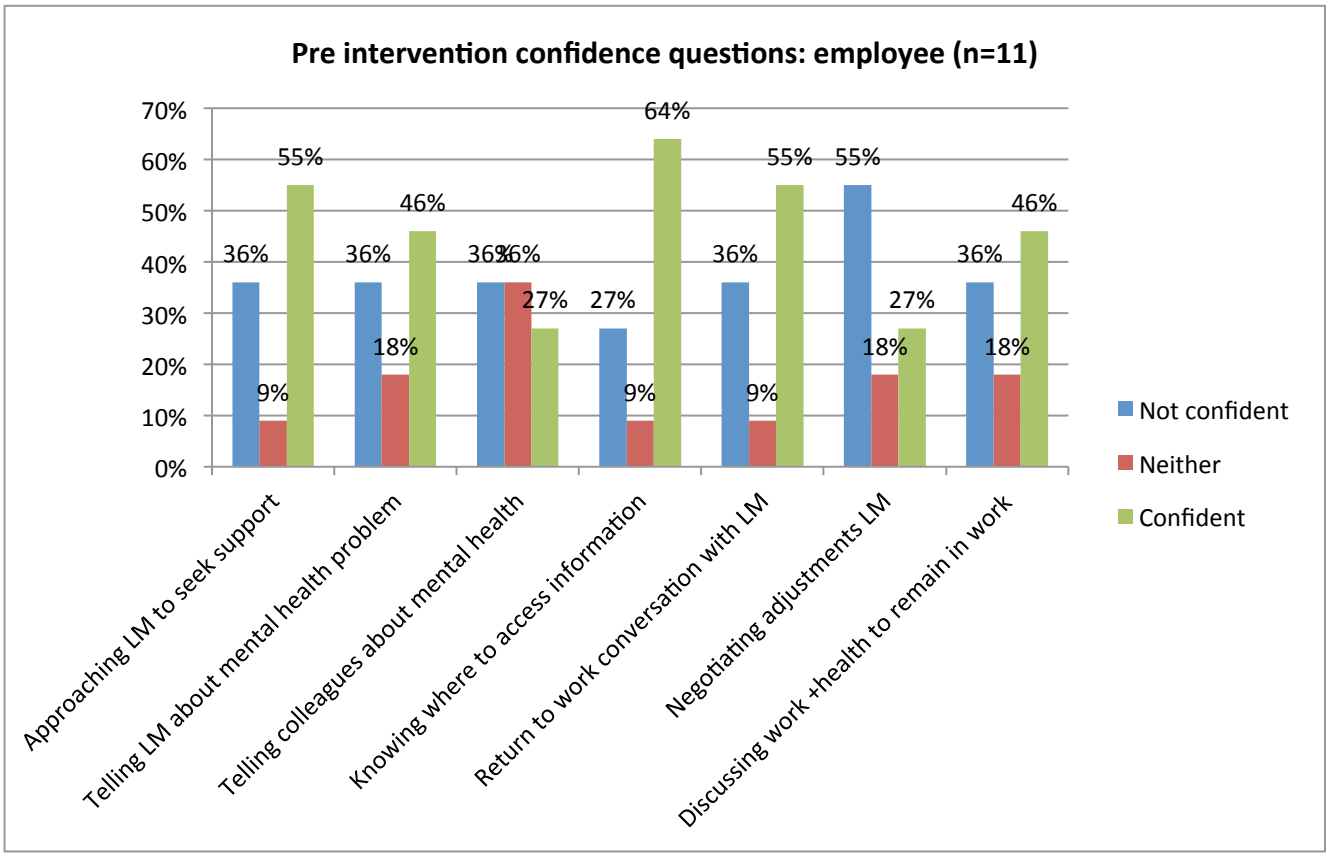


Figure 20 illustrates that just over half of the employee sample felt confident in knowing where to access information, in having a return to work conversation and in seeking support from their LM. Only 27% of the sample felt confident in negotiating adjustments with their LM and telling colleagues about their mental health condition.

Figure 21: Employee response to the 'confidence' measures post-intervention

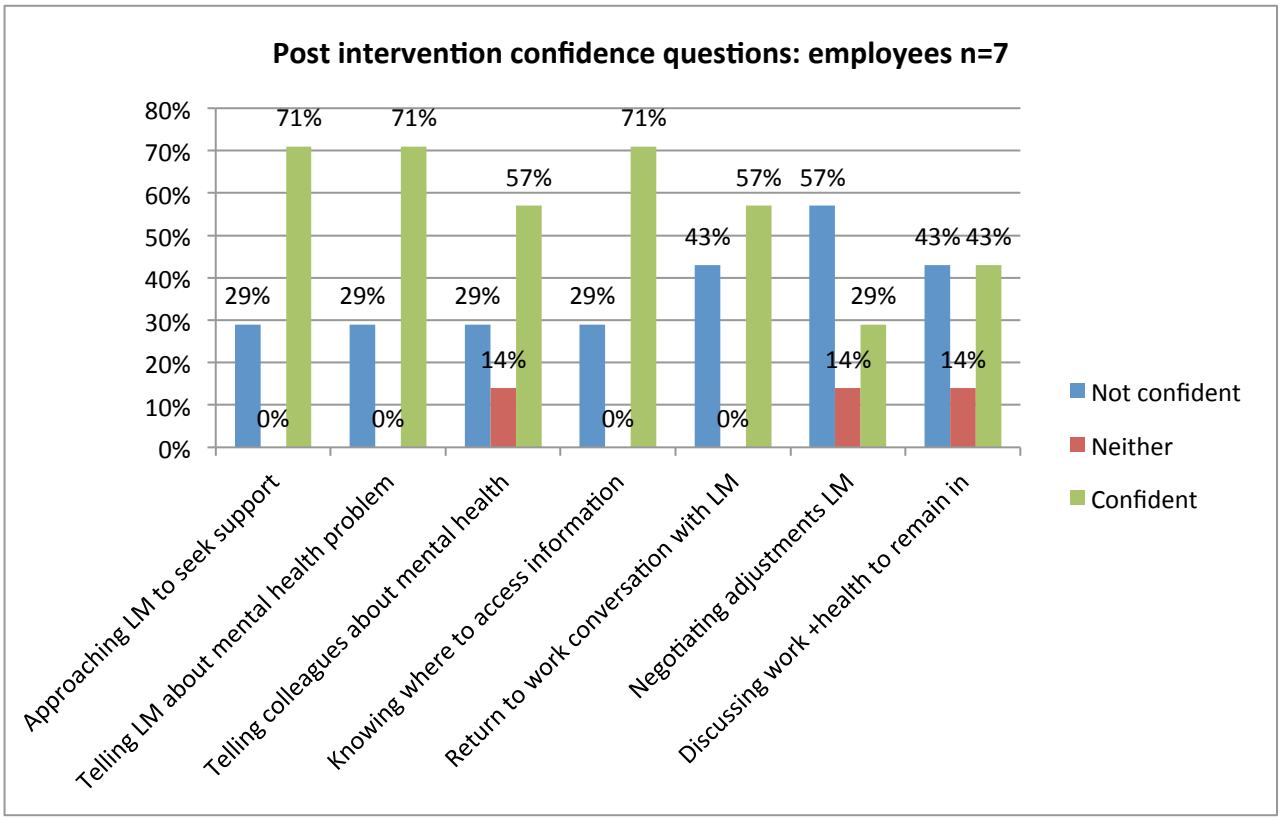


Figure 21 highlights that post intervention the employees' level of confidence had increased across seven of the eight measures. However, although employees reported feeling more confident in negotiating adjustments post intervention, over half of the employee sample were still not confident in doing this.

The main areas in which employees reported an increase in confidence post intervention are listed below:

- Approaching the LM to seek support (increase 16%)
- Telling the LM about the nature of their mental health issue (increase 25%)
- Telling colleagues about the nature of their mental health problem (increase 30%)
- Knowing where to access information (increase 7%)

The employee sample reported a slight increase in confidence (2%) in negotiating adjustments and having a return to work conversation with their LM post intervention.

Negotiating adjustments appeared to be particularly problematic among this group, with over half of the sample reporting a lack of confidence in this area.

4.11.8.2 Line manager confidence results (n=24)

A total of 24 LMs completed the pre intervention questionnaire and 16 completed the post intervention measure. The LMs' response to questions on their perceived levels of confidence to manage work and health situations pre and post intervention are shown in figures 22 and 23.

Figure 22: Line manager response to 'confidence' measures pre-intervention

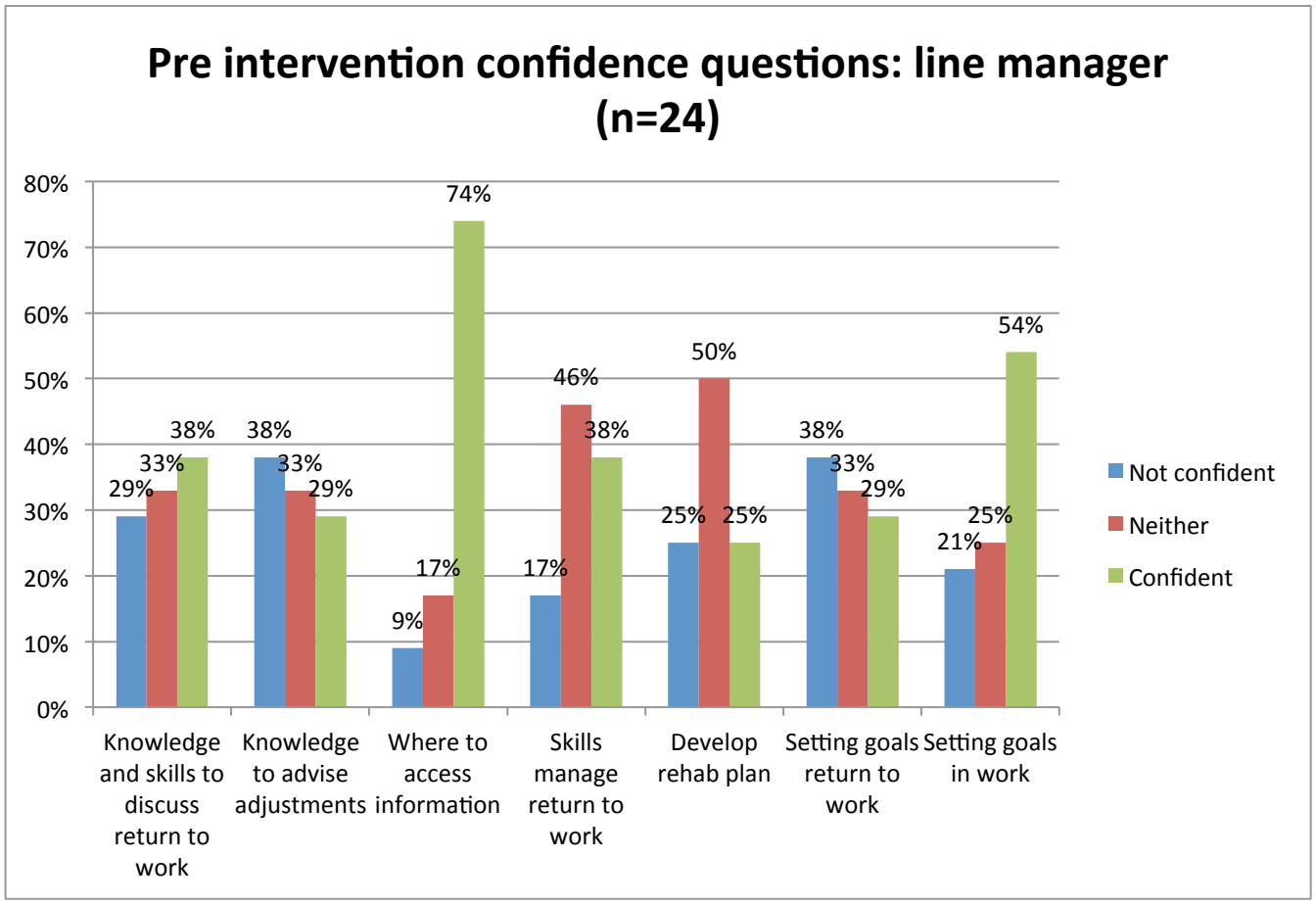


Figure 22 illustrates that pre intervention the majority of the LM sample felt confident in knowing where to access information and in setting goals within the workplace. In total, 46% and 50% of the sample identified 'neither' in relation to whether they were 'confident' or 'not confident' about their skills to manage a return to work meeting and to

develop a rehabilitation plan. There was also very little difference in those reporting 'confident' and 'not confident' across the measures of knowledge to discuss a return to work, knowledge to advise adjustments and setting goals in preparation for an employee to return to work.

Figure 23: Line manager response to 'confidence' measures post-intervention

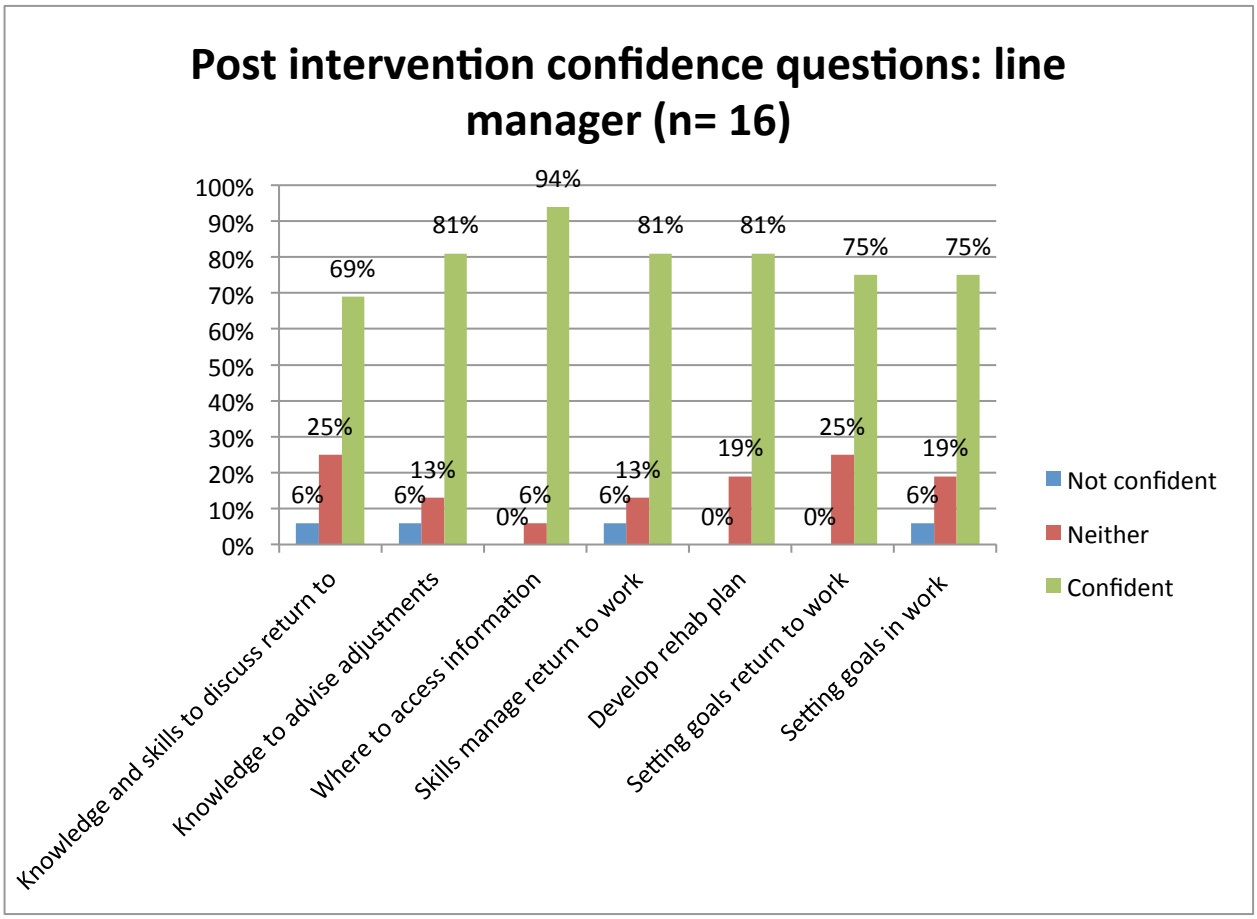


Figure 23 illustrates that the LM sample felt more confident post intervention across all measures. The LMs' level of confidence had increased post intervention by the following percentages:

- Having enough knowledge to discuss returning to work with employees who have been off work with a mental health problem (increase of 31%)
- Having enough knowledge to advise individuals with a mental health problem on modifications or adjustments to their work (increase of 52%)

- Knowing where to access information on mental health and work (increase of 20%)
- Skills to manage a return to work interview for an individual returning to work with a mental health problem (increase of 43%)
- Developing a rehabilitation plan when supporting an individual in work with a mental health problem (increase 56%)
- Setting appropriate goals for an individual returning to work with a mental health problem (increase 46%)
- Setting appropriate goals for an individual who is already in work with a mental health problem (increase 21%)

4.11.8.3 Occupational health confidence results (n=7)

Seven OHPs completed the pre intervention questionnaire and six completed the post intervention measure. The responses given by the OHP participants in regard to questions on their perceived levels of confidence to manage work and health situations pre and post intervention are shown in figures 24 and 25.

Figure 24: Occupational health professionals' response to 'confidence' measures pre-intervention

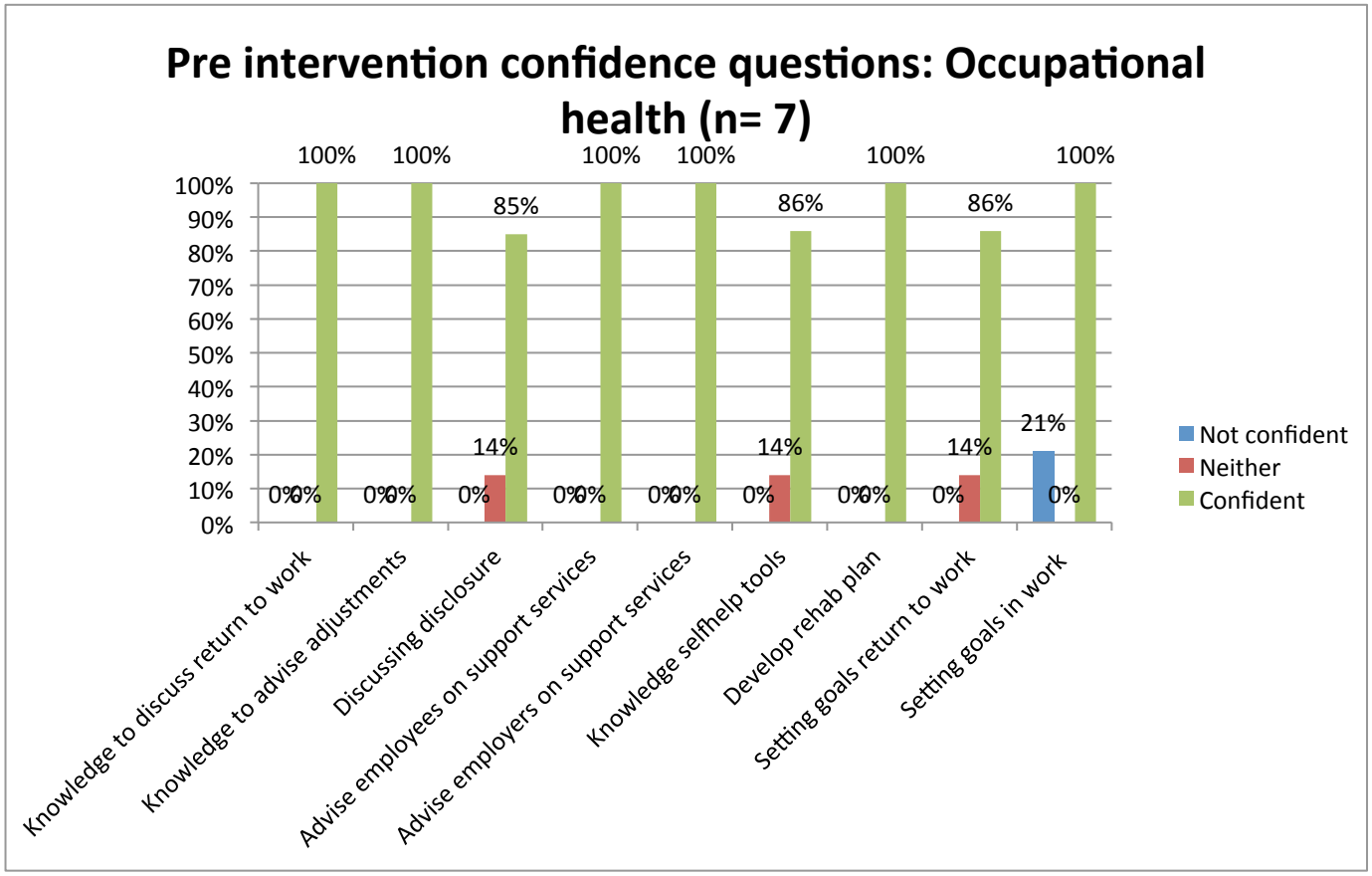
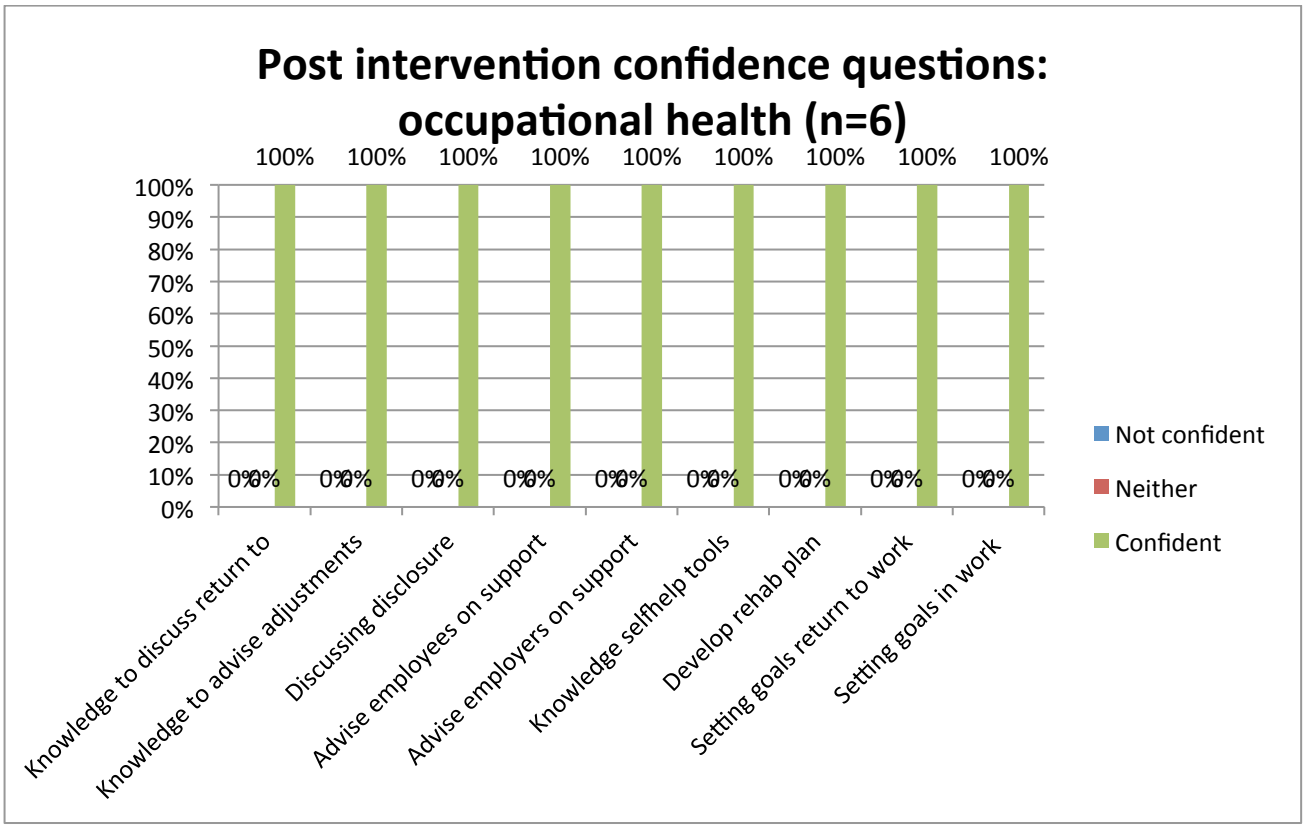


Figure 24 illustrates that the vast majority of the OHP participants felt confident across all measures, although 14% (n=1) reported slight uncertainty in discussing disclosure with an employee, in their knowledge of self-help tools and in setting appropriate goals for an employee returning to work pre intervention.

Figure 25: Occupational health professionals' response to 'confidence' measures post-intervention



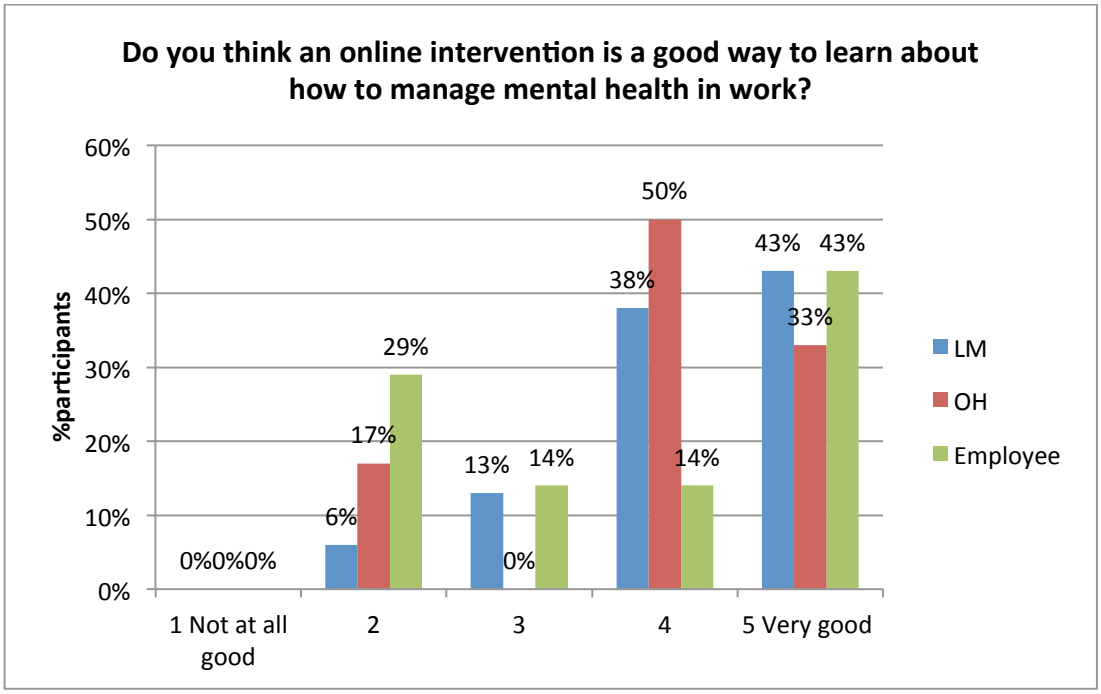
The whole OHP participants reported feeling confident across all measures post intervention.

Part II – Intervention specific results

4.11.8.4 Results

I will now provide an overview of the results of the intervention specific questions. All participants reported that they were able to access the online intervention and did not report any technical difficulties when doing so. All of the employee and OHP samples stated they had watched the intervention from start to finish, but two of the LM sample reported they had not. A small proportion of the sample reported technical difficulties whilst using the programme. The problems encountered included difficulty in opening the resource section, screen resolution issues and Internet related problems.

Figure 26: Appropriateness of online intervention for learning about work and health



A total of 57% of employees, 81% of LMs and 83% of the OHP sample stated that an online intervention was an appropriate way to learn about the management of mental health in the workplace, as shown in figure 26.

Figure 27: Participants perception of the usefulness of the information provided in the intervention

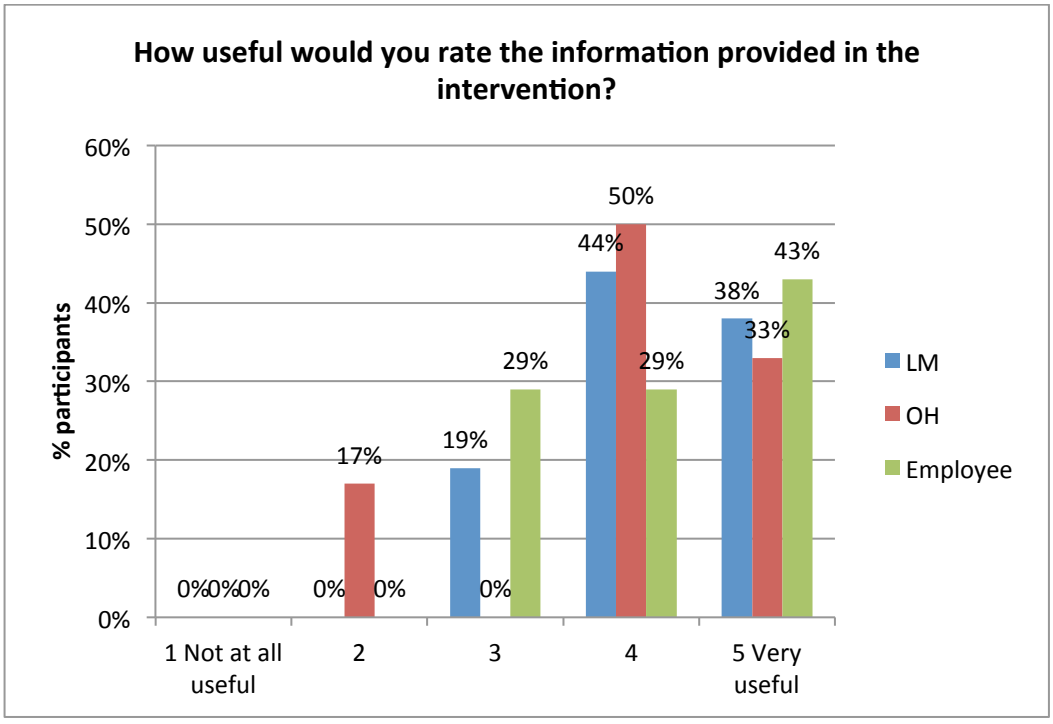
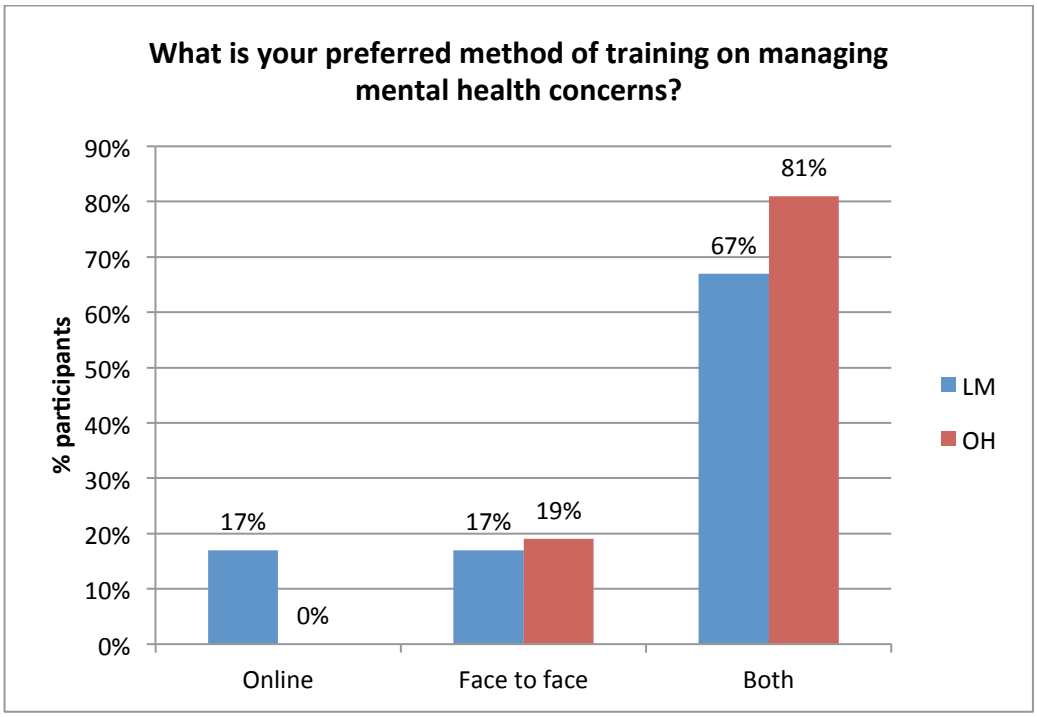


Figure 27 illustrates that 72% of employees, 82% of LMs and 83% of the OHPs in the sample felt that the information provided in the intervention was useful to them to assist in the management of return to work and mental health.

Figure 28: Participants preferred method of training



Participants were then asked to consider their preferred method of training for managing mental health concerns in the workplace. A total of 81% of the OHP sample and 67% of the LM sample preferred a combination of online and face-to-face training, as shown in figure 28.

The next question asked each user group to consider whether the intervention would also be useful for supporting people with mental illness more widely if the content was altered to be more focused on depression and anxiety. Overall, 94% of LMs, 67% of OHPs and 71% of employees stated that it would be useful for supporting mental health concerns more widely.

The final question asked the LM and OHP samples if they thought the intervention had influenced how they would now manage employees with mental health problems. Overall, 44% of LMs and 50% of the OHP sample felt that the 'Working with Bipolar'

intervention had influenced their future management. Some of the LM and OH samples described how the intervention had influenced their practice:

Line managers….

- "Greater realization of the need to more proactively manage prior to return to work."
- "I have always been conscious of the employees being involved in their RTW plan, this emphasized that even more communication is required when dealing with mental health."
- "Made me more aware to listen to what they have to say and also engage them more fully in any solution."

OHPs….

- "It gives clear objectives from the employee and manager perspectives. It allows me as an OHP to better understand the expectation of both the employee and the manager."
- "It is always useful to see it presented in a different way and to allow reflection."
- "More confident about discussing disclosure and involving employee in decision."

The final section of the questionnaire provided participants with the opportunity to comment further on the intervention. The open comments from each of the three user groups are outlined below:

OH comments:

- "I found the pace a little slow but accept for others it may need to be at this pace."
- "I thought it was excellent, and would be a great tool for any manager/individual with ANY mental health issues, not just Bi Polar."

LM comments:

- "A good overview, but needs more detail for the circumstance and there is no better teacher than experience in having to deal with some of these issues."
- "I enjoyed the programme and would recommend it to my colleagues."
- "I think the difference in the scenarios was a great way understanding the condition. The first scenario was dealing with someone who was honest about having a condition, the second not so, so it was more difficult for the manager to deal."

Employee comments:

- "I think every line manager should have at least this level of training and without it, I have low confidence in having the appropriate discussions with my line manager."
- "It's a good start but teams should also be encouraged to discuss the issue (on a non-personal level) as well so that we de-stigmatize the ideas of mental illness. Companies should also be encouraged to refrain from the macho mindset that working umpteen extra hours a day is a good thing. It just adds to the pressure on people."
- "Thought the programme was very informative and would hope that my manager and all managers took the opportunity to watch this."

Thus far, this chapter has provided an overview of the process undertaken to develop the intervention 'Working with Bipolar'. I provided:

- an overview of the framework and research activities that informed the content and build of the intervention.
- a step-by-step description of how the user progresses through the intervention.
- an overview of the pilot study methodology and findings.

The main findings, limitations of the intervention and pilot study, and the implications for practice will now be discussed.

4.12 Discussion

This study involved the development of the intervention 'Working with Bipolar'. The intervention attempted to address the issues identified in the focus group meetings. Underpinned and informed by the MI behaviour change model the intervention guided users to reflect on their own practices and consider alternative strategies for more effective interactions and communication. The content of the intervention was grounded in scientific literature and informed by the themes and practical tips that emerged from the focus group meetings. The information provided in the intervention was delivered via a blend of audio, written text and visual content to ensure it was accessible and appropriate to all learning styles. Reflective accounts and assessment tasks were used throughout the intervention to encourage the user groups to think about the scenario being delivered and to identify better management practices, and to reinforce the key messages. The addition of the resource section provided additional information to offer the user the opportunity to learn more about work, health and bipolar disorder at their own discretion and pace.

4.12.1 Key findings – Intervention development

A systematic method, guided by the MRC framework (2008), was followed when developing the intervention. The three user groups were actively involved in the development of this context-bound learning intervention to ensure the end product was authentic and reflective of everyday practice. This iterative development process is consistent with the methodology used to develop programmes such as 'Beating Bipolar' which is highly regarded among the user group population (Smith et al. 2011).

Consistent with findings by Black (2008), this intervention focused on the interaction between the employer and employee to facilitate communication and shared decision-making. Expanding beyond this literature the intervention also highlighted the importance of the third key stakeholder (OH) involved in the process. As 30% of organizations do not have access to OH support (FOM 2010), the intervention addressed this by highlighting the role the GP can play. The GP is ideally placed to assist the

employee in managing decisions in regard to the management of their condition and work. Highlighting the role of health professionals in the process fits with the cultural shift that has occurred in recent years. GPs and other health professionals are now expected to discuss work and health, and make recommendations on the circumstances in which a patient may be able to return to work, a change that has been supported and reinforced by the introduction of the fit note (2009).

4.12.2 Key findings – Pilot study findings

The pilot study results clearly showed improvements in the participants' perceived confidence to manage interactions in relation to bipolar disorder and work post intervention.

4.12.2.1 Line manager participants

The biggest shift in confidence was identified among the LM participants. This study highlighted a significant lack of confidence among the LM sample to manage all areas of work and health. This is consistent with current literature, as although LMs are in a key position to support employees, they often lack adequate knowledge and skills to do so (Black and Frost 2011). Yarker et al. (2010) reported that skilful conversations about complex issues are not easy and LMs often report a lack of confidence to engage in these interactions.

Consistent with the focus group recruitment, the pilot study participants were also recruited from a large organization, where OH support and management practices were available. Therefore, the confidence to manage complex work and health interactions may be an even greater issue for LMs in small organizations where training and support may not be available (Black 2008). Consistent with the focus group findings, this study has identified a clear gap in resources and training to assist LMs in the management of complex interactions in regard to work and health.

4.12.2.2 OHP participants

Overall the OH sample reported high levels of perceived confidence in their knowledge and skills pre and post intervention. OHPs are ideally placed to support those with mental health conditions to return to work due to their medical training and understanding of the workplace environment. It is well documented that occupational support is effective in tackling long-term absence and can have a powerful effect on returning employees to the workplace quickly (Black and Frost 2011). As their training is targeted at the management of work and health it is therefore unsurprising that high levels of confidence in this role are reported by this group.

4.12.2.3 Employee sample key findings

The employee sample reported relatively low levels of confidence across all measures, but it did increase slightly post intervention. Negotiating adjustments appeared to be particularly problematic among this group, with over half of the sample reporting a lack of confidence in this area. Adapting the workplace environment is a commonly reported intervention used by those with mental health conditions when symptoms become problematic (Laxman et al. 2008). Therefore an intervention that could improve employees' confidence to engage in these conversations is of high value and importance. To my knowledge, this is the first study that has developed an intervention informed by employees with bipolar disorder to assist in the management of their condition in relation to the workplace.

4.12.3 Key findings – Did the intervention meet the aims?

This study set out to develop one intervention targeted at all three stakeholder groups that would increase the users' confidence and knowledge to engage in complex conversations about bipolar disorder and work. The pilot study results suggest this was achieved in part. All three stakeholder groups recognized the usefulness of the intervention, although the results clearly demonstrated the intervention was of most use to the LM group. The biggest shift in confidence post intervention was clearly among

LMs. The OHP and employee participants did rate the intervention as highly useful; however, on review of the open question responses it was evident that these two groups may have identified the intervention as useful for LMs as opposed to their own stakeholder groups. In the open responses one employee stated that 'every line manager should have this level of training' and another commented 'I hope my manager took the opportunity to watch this'. One of the OHP participants wrote 'I think every line manager should have at least this level of training'.

The OHP sample reported high levels of confidence to engage in work and health conversations pre intervention, which suggests the skills training embedded in the intervention may not be relevant to this group. The intervention did appear to have some impact on the employees' level of confidence but to a much lesser extent than was identified among the LM participants. At post intervention, only a modest increase was reported in the employees' levels of confidence to negotiate workplace adjustments and have a return to work conversation. This would also suggest the skills training in the programme was not fully meeting the needs of the employee group. A key consideration for further work would be to explore the impact of the intervention across the three groups more fully. Qualitative interviews could be utilized alongside quantitative measures to help identify why the intervention was not meeting the needs of the OHP and employee participants to the same extent as the LM group.

It is important to note that the intervention was built in collaboration with the stakeholder groups and it includes the content identified as key among these groups, in agreement with the expert group. The intervention content was written to:

- highlight the importance of confidentiality and suggest ways in which to create an environment where employees feel safe to disclose their condition.
- highlight the role of each stakeholder within the process and the associated complexities.
- demonstrate the importance of building a rapport and relationship between stakeholder groups, and the associated benefits.

- provide information on bipolar disorder to increase the knowledge of stakeholder groups.
- demonstrate to the LMs the uncertainty associated with disclosure from the perspective of the employee.
- demonstrate to the employee the benefits of disclosure to obtain support within the workplace.
- highlight the importance of open communication and joint decision making.
- demonstrate the complexity associated with negotiating adjustments and setting up the process of support when dealing with a remitting condition such as bipolar disorder.

Until further piloting is conducted a formal judgement on whether the intervention has met its aims cannot be made.

A further consideration when evaluating the intervention would be to explore the appropriateness of using an almost identical questionnaire measure for each stakeholder group. The OH sample did not appear to benefit from the skills training, but the open responses did suggest that the information about bipolar disorder and the roles of each stakeholder group were beneficial for this group. The user groups' levels of knowledge of bipolar disorder was not tested pre and post intervention; therefore, this would be an important area to explore in future studies. Future piloting work would require careful consideration of what each group is likely to gain from the intervention, to inform the outcome measures for each specific stakeholder group.

Another key consideration for future studies would be to explore whether a shift in the user groups' confidence to engage in complex conversations about bipolar disorder and work would directly result in a change in behaviour. This pilot study explored a theoretical change and not an actual change in behaviour. Motivating the users to consider engagement in more skilful conversations and interactions is the first step in helping them do this in everyday practice. Motivation to change is considered one of the most promising mechanisms in the MI model (Copeland et al. 2015). To determine

whether the intervention led to an actual change in communication and workplace interactions would require a longitudinal study that measured behaviour change in a systematic way. An RCT would be the most robust design to answer this question with any degree of confidence.

It is also important to note the complexity associated with facilitating behaviour change, particularly when one intervention is targeted at three stakeholder groups. Even when individuals want to change their behaviour and adopt better management practices, organizational, professional and environmental pressures can influence the outcome. Therefore evaluation of the intervention may not show the desired outcome due to factors outside the researcher's control. Grol and Grimshaw (2003) noted that there were many claims for interventions to provide 'solutions' to problems' but understanding which ones were effective and efficient remained unclear .

The pilot study results did confirm the acceptance of the online delivery method of the intervention across all stakeholder groups. This mode of delivery is associated with many benefits, including improved access and engagement (Coyle et al. 2007). It is a cost-effective method of making learning accessible to a wide audience in a standardized way. There is now a growing acceptance of online health information and web-based learning due to the demand for quick and accessible information.

Although they accepted the intervention's mode of delivery, the LM and OH groups did state a preference for combined online and face-to-face training when learning about work and health. A major benefit of this intervention is its versatility to be used online or within a group or individual face-to-face setting. The intervention could be used in group training where participants watch the programme and then engage in facilitated conversations around the content and key messages. Additionally, the intervention could also be included as a component in a suite of interventions to support the target populations. For example, this intervention could be used alongside the 'Beating Bipolar' programme, to cover the work specific issues that are currently missing from the programme. Combing the two interventions would therefore cover all areas of condition and workplace management.

4.12.4 Limitations

The intervention needs to be considered in light of its limitations. The intervention failed to explicitly highlight the importance of exploring non-work related psychosocial factors during conversations in relation to job retention and return to work. The literature review clearly highlighted the importance of psychosocial factors, which are reported as a stronger predictor of work outcome than psychiatric factors (Hammen et al. 2000). In a recent literature review on the nature, characteristics and causes of sickness absence MacDonald and Asanati (2016) identified a number of psychosocial factors strongly associated with sickness absence which included, marital status, number of dependents, level of job satisfaction and non-work related stress. The intervention does provide training on communication skills and management practices therefore, it is anticipated that a 'good' return to work conversation would draw upon all biological, psychological and social factors that contribute to sickness absence and difficulties with job retention. However, in developing the intervention future it would be important to include information in both the resource section and main body of the intervention on the importance of considering psychosocial factors and the impact they can have on work and absence. In addition, the resource section could be utilized further to include information and signpost to services that assist in the management of non-work related factors such as counseling services and debt management. Additionally, future research should look to develop prospective measures to identify the impact of psychosocial factors on organisation performance and sickness absence.

The pilot study findings also need to be considered in light of several limitations. The pilot study participants were recruited via convenient sampling, self-selecting from one organization (BT). This recruitment method is associated with inherent selection bias and is unlikely to be representative of the population being studied. This means that caution is needed in making generalisations from the results reported here. It was anticipated that recruiting to the pilot study would be difficult, therefore the most straightforward method of recruitment was utilized. A sample size of 10-30 was set as a target; however, fewer than 10 participants were recruited to each of the OHP group. An inherent aim of a

pilot study is to test the feasibility of recruitment (Leon et al. 2011) and this study clearly did that.

The pilot study clearly highlights barriers to participation and the time and investment that would be needed in recruiting participants to a full-scale evaluation. Recruitment is a common challenge, particularly for RCTs, which are considered the gold standard method of evaluation for healthcare interventions (MRC 2008). In a study of 114 multi-centre MRC and Health Technology Assessment programmes, less than one third of trials recruited the original sample size within the target time specified. Recruitment to the pilot study was further complicated due to the involvement of three user groups, which led to further time and resource needs. Further feasibility work would be required to test recruitment strategies prior to a more formal evaluation. A key consideration for future research may be to include some form of incentive to encourage more participants to take part. In RCTs hospitals are often given a payment for a complete set of data, therefore a similar incentive approach could be utilized to encourage organizations to engage in research.

The pilot study also identified limitations with the measures used to test the intervention. The pre and post intervention measures were self-completion and subjective in nature. As mentioned previously, the measures only collected information on intention to change and not actual behaviour change. These findings can inform the development of future measures in preparation for a more formal evaluation. A key consideration for future research would be to capture data on both aspects of the MI conceptual model. This would include measuring attitudes in terms of both the importance of change and confidence to change. Additionally, observational methods could be utilized to observe return to work interviews with participants that had and had not received the intervention. Studies such as this should be considered to test whether the intervention does lead to an actual change in behaviour. Capturing data on sickness absence would be also required to identify whether the long-term outcomes of the intervention were achieved.

In spite of these limitations, this pilot study did, however, provide a platform to generate hypotheses to take this study forward to design a more formal evaluation. The pilot study did not set out to test hypotheses but, as intended, it did inform the feasibility of future evaluation.

4.12.5 Implications for policy and practice

This intervention fits with the current cultural shift in terms of the promotion of functional recovery. There has been little research into the workplace setting and the practices that may assist those with bipolar disorder to return to and stay in work. With the high levels of work disability reported among those with bipolar disorder and the lack of sickness absence policies and occupational services within organizations (Black 2008), investing in interventions (such as 'Working with Bipolar') could have substantial social, psychiatric and economic gains (Boardman 2003). Providing an intervention to support those with bipolar disorder to retain work could, in effect, assist in lowering the impact of the condition and be associated with high productivity gains.

4.12.6 Future studies

Designing and conducting an RCT to evaluate this intervention would be complex and costly and was outside the scope of this study. Further piloting or feasibility work across a larger sample will be required prior to a formal evaluation, to further explore the desired outcome measures and to develop strategies to overcome the difficulties associated with recruiting the target populations.

The intervention was informed by theory, therefore a more formal evaluation would allow an insight into the mechanisms of change, to define what aspects of the programme are causal pathways to change, and to define how the intervention works and in what settings it is most useful. If this intervention does influence the attitudes of the user groups, you would expect to see a change in behaviour in terms of communication style and management practices. In the long term this could translate into a decrease in the number and length of sickness absence spells among the bipolar

disorder sample. The sustainability of the change in management behaviours and communication skills would also be an important long-term outcome measure to consider for future studies.

If a positive outcome was identified following formal evaluation, it would be interesting to consider whether the intervention model could be made more generic to assist in the management of those with other types of enduring conditions or common mental health problems. The model that underpins the intervention includes variables empirically associated with good practice, which may indicate its applicability across other target populations. The majority of pilot study participants stated that the intervention would be useful more widely if the content was altered to cover mental illness more generically. With the high level of burden associated with mental illness due to its high prevalence, chronicity and early age of onset and impairment (WHO 2000), interventions such as 'Working with Bipolar' would provide a cost-effective method of providing training to a large population. Further work would also provide an opportunity to fully explore the aspects of the intervention that work well and where further improvements can be made.

4.12.7 Conclusion

This is the first study to investigate the interactions and interconnectivity between all three stakeholder groups together (employee, LM, OHP) in order to develop an intervention that provides synergistic messages and common strategies that are applicable to all those involved. This rigorous method of enquiry led to the development of an intervention that was well regarded among the target users and allowed positive and constructive ideas for change. The pilot study provided significant insights into the key feasibility work that would be required in developing a more formal and comprehensive evaluation.

Chapter 5

Overall Discussion

5.0 Discussion

A discussion on each component of this PhD study has already been presented in previous chapters. This chapter will initially discuss the overall key findings from across the three studies in the context of the current literature. This will be followed by a discussion of the findings in terms of the implications for policy and practice, and suggestions for future research to take the study findings forward in this field. The thesis will finish with a formal conclusion.

This thesis set out to develop an intervention informed by focus group findings, to improve the interactions and conversations between the three key stakeholders (employees, LMs and OHPs) in regard to the management of bipolar disorder and work. Research exploring the adequate management of this condition in regard to employment could potentially have a major impact on productivity within society (Alonso et al. 2010). With the high levels of work disability reported among those with mental health conditions and the lack of occupational services within organizations (Black 2008), investing in interventions could be associated with substantial social, psychiatric and economic gains (Boardman 2003). This is the first study to investigate the interactions and interconnectivity between all three stakeholder groups together to develop an intervention that provides shared messages and common strategies that are applicable to all those involved. More is known and researched about the clinical features and treatment of the condition than the non-illness and psychosocial factors of the condition that impact employment outcome. This thesis moved beyond illness-related features to explore the psychosocial factors that impact employment outcome.

This thesis employed a mixed methodological approach, using both qualitative and quantitative research methods to understand the important clinical, workplace and interpersonal factors associated with bipolar disorder, job retention and return to work. This rigorous method of enquiry led to the development of an intervention that was well regarded among the target users and allowed positive and constructive ideas for change.

5.1 Key findings

Consistent with current literature, this study identified high rates of unemployment (Dean et al. 2004) among the bipolar disorder participants, suggested the condition affected the employment prospects, to the extent that those with the condition are less likely to be in employment than individuals without a mental health condition (Marwaha et al. 2009). However, 40% (n=663) of the sample were in employment at the time of the study, with the majority in full-time or part-time competitive employment. The majority of those in employment had worked in their current organization for a sustained period of time (5 years or more), and had taken very little sick leave (comparable to the general population) within the previous 12 months. Bipolar I disorder was the most prominent diagnosis among the sample, demonstrating that even those with a condition at the more severe end of the spectrum were still able to gain and sustain employment.

This study also compared the clinical profiles of the bipolar disorder participants in employment and those not employed. The number of hospital admissions and age of first contact with psychiatric services were the main clinical drivers of employment outcome among this group of individuals. Frequent hospitalization could imply a more severe and recurrent disorder (Harrow et al. 1990), suggesting that those with a greater illness severity are less likely to be in employment (Deckersbach et al. 2016). In addition, the association between a lower age of first contact with psychiatric services and an increased likelihood of employment could suggest that individuals with bipolar disorder seek work that is appropriate, considering their illness. This area needs further exploration, as there are several unanswered questions that remain. Firstly, as discussed in previous chapters, is there a directional effect between condition severity and employment? Researching disorders in relation to the workplace, particularly when making comparisons against a general population cohort does need to be considered with some caution due to the healthy worker survivor effect. This effect relates to the out-selection of less healthy workers (Virtanen et al. 2005) as there is a tendency for those with disease to leave the workforce. Morbidity and mortality rates among the workforce are often reported as lower than among the general population (Li and Sung 1999); this can result in the sample being considered biased. However, there is opposing evidence to suggest

that being employed and engaged in work offers those with long term conditions the social, financial and psychological benefits that improve their wellbeing. Therefore, when reporting findings in relation to disorders, the workplace, and workability, it is important to be mindful of the healthy worker affect and to control for, and consider this when planning future research in this area.

Secondly, do those individuals who enter the workplace already diagnosed make informed employment decisions, choosing a work environment that is most appropriate considering their condition? A final important consideration would be to explore the time period from the onset of the condition to developing the coping strategies that assist those with the condition to achieve educational goals. Higher educational attainment was associated with increased likelihood of employment. Therefore, could interventions that support individuals during the onset of their condition to develop the coping strategies necessary to achieve their educational and employment goals lead to long-term benefits for both the individual and the productivity of society?

The research undertaken to inform the intervention developed as part of this PhD study showed clear consensus across stakeholder groups on the challenges associated with the management of bipolar disorder in the workplace and the solutions to overcome these. The qualitative methodology allowed a range of views on the important clinical, workplace and interpersonal factors associated with bipolar disorder, job retention and return to work to be conveyed and systematically incorporated into the intervention. The groups clearly identified the need for clear information about the condition, and for skills training to support collaborative relationships and skilful communication and management practices. The quantitative survey reinforced the messages about implementing workplace adjustments and the ease with which these could be achieved. The majority of survey participants had been offered at least one of the adjustments listed in the questionnaire. The EEF survey identified that only 8% of the employers surveyed were not able to make any adjustments (EEF 2015). This illustrates that implementing a flexible and supportive work environment is achievable for the vast majority of small to medium enterprises.

Developing one intervention targeted at all three stakeholder groups was deemed appropriate and achievable by focus group participants and the 'expert group'. The key focus group findings were clearly transferrable into intervention content to support the three stakeholder groups in the management of bipolar disorder and work. Participants were familiar with the ways to improve communication and management practices but lacked the skill, training and confidence to do so. The provision of training, support and resources was clearly required to assist in adopting workplace cultures that actively promote employee wellbeing. There are few resources and little training currently available to demonstrate how to achieve this, and none that is specific to bipolar disorder.

This is the first to study to explore the complexity of bipolar disorder and work from the perspective of all stakeholders involved in the interaction, in order to inform an intervention to address the gap in current resources by providing the information and skills training to promote skilful communication and best practice. A systematic method, guided by the MRC framework (2008), was followed when developing the intervention. The three user groups were actively involved in all stages of development to ensure the end product was authentic and reflective of everyday practice. The factors that maintained their current behaviour and were barriers to change were explored. Adopting the psychological theory of MI the intervention guided users to reflect on their own practices and to consider alternative strategies for more effective interactions and communication. Interventions grounded in theory allow an understanding of how the intervention will cause a change in behaviour and will also identify weak links that can be strengthened through the review and refining process.

Training on how to develop workplace cultures that proactively manage the health and wellbeing of employees could boost productivity and result in lower levels of sickness absence (EEF 2015). Mental health training is rarely provided or available within organizations, with the EEF (2015) reporting only one-tenth of organizations providing mental health training for LMs and supervisors. The 'Working with Bipolar' intervention complements the 'fit note' model that encourages open discussion about work, health and functional capacity. It also aims to improve knowledge and awareness of mental

health and the skills required to proactively support employees to maintain employment. Adopting these management practices can lead to lower levels of absenteeism and can help employees return to the workplace more quickly (Black and Frost 2011).

The 'Working with Bipolar' intervention was piloted with a small sample of the target population. It explored a theoretical change by asking participants about their perceived confidence to engage in aspects of the return to work process pre and post intervention. All three stakeholder groups recognized the usefulness of the intervention; however, the pilot study results clearly demonstrated the intervention was of most use to the LM group. A key consideration for further work would be to explore the effectiveness of the intervention across the three groups more fully. A lack of impact on the employee and OHP groups may reflect failures with the pilot study design or the implementation of the intervention as opposed to genuine ineffectiveness. The pilot study was the first step in exploring the effectiveness of the intervention and it is common practice to undertake several stages of piloting work to progressively refine an intervention and evaluation methodology before embarking on a full-scale evaluation (MRC 2008). Until further piloting is conducted a formal judgement on whether the intervention has met its aims cannot be made.

An intervention such as this is associated with huge potential gains. Providing an intervention to support those with bipolar disorder to retain work could, in effect, assist in lowering the impact of the condition and be associated with increased productivity gains. Access to effective vocational programmes and services is a key part of what patients believe can help their recovery from mental health (Milton et al. 2015)

5.2 Future studies

Moving forward, a key step would be further piloting of the intervention to determine its true effectiveness across the three user groups. Further feasibility work would also inform recruitment strategies and the methodological decisions to be taken forward for a formal full-scale evaluation. Future studies should include a detailed evaluation of the intervention to identify whether the changes in confidence and attitude identified in the

pilot study equate to a change in behaviour in terms of communication style and management practices. In the long term this could translate into a decrease in the number and length of mental health related sickness absence spells. The sustainability of the change in management behaviour and communication skills would also be an important long-term outcome measure to consider for future studies.

A further consideration for future research would to explore the application of such an intervention to assist in the management of other types of mental health conditions. Adding case studies and information on other conditions such as depression or stress would mean the intervention could be used for other mental health conditions. The model that underpins the intervention includes variables empirically associated with good practice, which may indicate its applicability across other target populations. With the high level of burden associated with mental illness due to its high prevalence, chronicity and early age of onset and impairment (WHO 2000), interventions such as 'Working with Bipolar' could provide a cost-effective method of providing training to a large population.

The delivery method of the intervention should also be investigated. Delivering the training via group face-to-face training could also be a cost-effective way in which to manage the skill and training gap identified among the target population.

An unexpected finding that requires further investigation is the employment rate identified among the MDD sample. Inconsistent with current literature, lower rates of employment were reported among the MDD sample in comparison to those with a bipolar disorder diagnosis. However, the severity of depressive symptoms was equally matched across the two diagnostic groups. The high levels of impairment identified among this diagnostic group highlight the need for investment in resources and intervention to support this group, and to lower the impact of the condition on their occupational functioning.

The higher rates of employment among the bipolar disorder sample compared to those with MDD may relate to the manic pole of the condition. A key question would be to

consider the impact of hypomanic symptoms on employment outcome and workplace impairment. Consistent with current literature, this study did not find a significant association between mania and employment (Goldberg and Harrow 2011). However, this association was not a key focus of this study and therefore it was not fully explored. Moving forward, a key study would be to explore whether the symptoms of mania/hypomania are driving the difference in employment outcome between the bipolar disorder and MDD participants. Existing research has found that hypomanic episodes can be associated with increased productivity, higher levels of problem solving ability and increased enthusiasm, creativity and confidence (Angst 2007; Tse and Walsh 2001), which would contribute to increased productivity. This may be driving the higher rates of employment reported among the bipolar disorder sample. However, an important long-term consideration would be to explore the implication of these symptoms over time, to determine whether there is a point at which hypomanic episodes become problematic and lead to impairment.

More broadly, a final consideration for future research in the fields of work and health would be to explore alternative methods by which to collect data about the target groups. Utilizing the increased presence of technology in society would be a cost-effective and convenient manner by which to collect data. The Internet is now accessed by 39.3 million adults (78% of adults) in Great Britain (ONS 2015) and has become an accepted health information resource. Smart phones, tablets and computers are now easily accessible and widely used in society. With the development of a specialist app or webpage, these devices could be used as a means to collect real time data on mood and work productivity outcomes. They could provide an opportunity to collect data at frequent intervals to track the episodic nature of the condition and the impact it has on an individual's occupational functioning. They would also provide a convenient method by which to prompt the participants to complete the various aspects of the study, and provide a means to maintain contact for follow-up measures. The BDRN now electronically collects prospective mood ratings on 700 bipolar participants as part of the TRUE COLOURS study. Utilizing this technology could provide an opportunity to explore the effect of mood on work-related measures to determine the impact of both manic and hypomanic symptoms. Utilizing these technological advances offers an important

opportunity to improve the way in which data is collected for fluctuating conditions such as bipolar disorder.

5.3 Implications for policy and practice

Bipolar disorder is recognized as the second greatest cause of workdays lost and is reported as one of the top five most disabling conditions (Alonso et al. 2010). The condition is associated with high rates of sustained unemployment, absenteeism and poor work performance (Dean et al. 2004). The symptoms and side effects of this condition make it very difficult for individuals to function productively in a workplace environment and occupational impairment is profound among this group. This is the first to study to explore the complexity of bipolar disorder and work from the perspective of all stakeholders involved in the interaction, in order to inform an intervention to address the gap in current resources by providing the information and skills training needed to promote skilful communication and best practice.

Consistent with the IPS programme, the 'fit for work' service and the 'fit note', the intervention is based on collaborative and interactive management of work and health, thus moving away from silo practices where each stakeholder group works in isolation. The intervention differs from the IPS model as in addition to focusing on reintegration into the workplace, 'Working with Bipolar' highlights the importance of ongoing long-term communication and support to sustain individuals in employment. The intervention fits with the current cultural shift in terms of the promotion of functional recovery. There has been little research into the workplace setting and the practices that may assist those with bipolar disorder to return to and stay in work. With the high levels of work disability reported among those with bipolar disorder and the lack of sickness absence policies and occupational services within organizations (Black 2008), investing in interventions (such as 'Working with Bipolar') could have substantial social, psychiatric and economic gains (Boardman 2003).

5.4 Conclusion

This thesis set out to develop an intervention informed by focus group findings, to improve the interactions and conversations between the three key stakeholders (employees, LMs and OHPs) in regard to the management of bipolar disorder and work. This thesis is important as it is the first study to investigate the interactions and interconnectivity between all three stakeholder groups in regard to bipolar disorder and work. The strength of this study was that it involved all three 'key players' that are involved in return to work and retention in the workplace. It gave 'a voice' to all three groups individually whilst also allowing dialogue and feedback between the groups as a whole. This rigorous method of enquiry led to the development of an intervention that was well regarded among the target stakeholders and allowed positive and constructive ideas for change.

6.0 References

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Appendix A- Cardiff Mood Disorder and Work Questionnaire

QUESTIONNAIRE 1

This questionnaire asks about your current employment and past employment history.

1. ***Are you currently employed? (please mark one box):***

Yes	
Yes but on sick leave	
No	
No I am a carer	
No I am a homemaker	
No I am a student	
No I am on maternity/paternity	

IF YOU ANSWERED <u>YES</u> TO QUESTION 1 PLEASE COMPLETE <u>QUESTIONS 2 – 14 ONLY</u>

IF YOU ANSWERED <u>NO</u> TO QUESTION 1 PLEASE GO TO PAGE 6 AND COMPLETE <u>QUESTIONS 15 - 18 ONLY</u>

QUESTIONS 2 - 14 ARE ONLY TO BE COMPLETED IF YOU <u>ARE</u> CURRENTLY IN EMPLOYMENT

2. ***What is your current employment situation? (please mark <u>all</u> that apply):***

Full time paid employment	
Part time paid employment	
Voluntary work full time	
Voluntary work part time	
Self employed	
Other	

If other please give a brief description

The next sets of questions ask about who you are employed by, and the kind of work that you do.

3. ***What is your job title and current role? (please give a brief description)***

4. ***Is the organisation that you work in a: (please mark the <u>one box</u> that is the nearest fit for you, it doesn't have to be exact. Think about the organisation as a whole and not your immediate workplace e.g if you work in a bank, you would think of the whole organisation and not the branch you work in):***

Small organisation (approximately less than 50 employees)	
Medium organisation (approximately 51 – 250 employees)	
Large organisation (approximately 251 - 500 employees)	
Very large organisation (approximately 500+ employees)	

5. Which of the following best describes the type of organisation you work for? (please mark <u>one</u> box):

Public sector (organisations that provide government services i.e. NHS, Police, public	
Private sector (Profit making organisations run by individuals or groups)	
Third sector (organisations that are neither public or private such as; charities, voluntary organisation, co-operatives, community groups and social	

6. How long have you worked for your current employer or been self employed? (please mark <u>one</u> box):

Less than 1 year	
1 up to 2 years	
2 up to 5 years	
5 up to 10 years	
10 years or more	

7.How far does your job fit your level of education and training? (please mark <u>one</u> box):

I am working above my level of education and training	
I am working at my level of education and training	
I am working below my level of education and training	

8. Is your work schedule best described as a (please mark <u>one</u> box):

Regular schedule (roughly the same hours every week)	
Rotating schedule (working a day shift some days and a night shift other days)	
Irregular schedule (unpredictable hours controlled by situations or workload)	
Contract work (working as and when work is available)	

The next sets of questions are about how your mood disorder affects your ability to work

9. ***Have you formally told the following people about your mood disorder? (please mark yes / no / not applicable for all of the following):***

	YES	NO	N/A
Human Resources (HR)			
Line manager (person who manages you from day to			
Occupational health (if you have it)			
Colleagues			
Family			
Friends			
Other			

If other please give a brief description

10. ***Approximately how much time off sick have you taken in the <u>past 12 months</u> due to your <u>mood disorder?</u> (please mark <u>one</u> box):***

None	
Less than 1 week	
1 week up to 4 weeks	
1 month up to 3 months	
3 months up to 6 months	
6 months up to 9 months	
9 months to 12 months	

11. ***During the <u>past 4 weeks</u> have you had any of the following problems with your work as <u>a result of your mood disorder?</u> (please mark yes / no / not applicable for all of the following):***

	YES	NO	N/A
Cut down on the amount of time you spent in work			
Accomplished less than you would like			
Didn't work as carefully as usual			
Worked at a faster pace than normal and tried to take on more work than should have			

12. ***What symptoms cause you the most difficultly at work? (please mark yes/no for <u>all</u> of the following):***

	YES	NO
Symptoms of low mood (depression)		
Symptoms of "high" mood (mania or hypomania)		
Symptoms of both "high" and low mood – mood unstable		
Medication side effects		
Other		

If other please give a brief description

13. ***During times when the symptoms associated with your mood disorder were affecting your ability to do your job properly or meant you were absent from work, did your employer / line manager offer you any of the following? (please mark <u>all</u> that apply):***

Reduced days or hours	
Reduced responsibility	
Changes to work environment (e.g. moved to quieter	
Reduced workload or altered duties	
Extra breaks	
Different job role	
Referral to occupational health services	
Job coach / personal assistant	
A meeting at work to discuss extra support	
A meeting at home prior to returning to work to discuss extra support	
Referral to counselling	
Advised to see your GP for advice	
Other	

If other please give a brief description

14. ***What things would be most useful in helping you stay in employment or return to work?***

If you are in employment you have now finished Questionnaire 1.

QUESTIONS 15-18 ARE ONLY TO BE COMPLETED OF YOU ARE NOT EMPLOYED.

15. ***Why did you stop working? (please mark <u>all</u> that apply):***

Mental health problems	
Physical health problem	
Finished contract	
Retired	
Made redundant	
Dismissed	
Never worked	
Other	

If other please give a brief description

16. ***How long have you been out of employment (this could be full, part time, voluntary etc.)? (please mark <u>one</u> box):***

Less than 1 year	
1 year up to 2 years	
2 years up to 5 years	
5 years up to 10 years	
10 years or more	
Never worked	

If other please give a brief description

17. Do any of the factors below affect your ability to go back to work? (please mark all that apply):

Symptoms of low mood (depressive symptoms)	
Symptoms of "high" mood (manic or hypomanic symptoms)	
Symptoms of both "high" and low mood – mood unstable	
Medication side effects	
Broken work history because of mood episodes	
Stigma against people with psychiatric illness	

18. What things would be most useful in helping you return to work

Appendix B- Working With Bipolar CD

Appendix C –Pilot Study Questionnaires

Employee Pilot Study Questionnaire

LM Pilot Study Questionnaire

OH Pilot Study Questionnaire

EMPLOYEE POST INTERVENTION QUESTIONNAIRE

In order to link your responses to the different questionnaires we would like to use your employee number. The responses to the questionnaires will be sent directly to the researchers who will not have access to any employee information and your workplace will not have access to your questionnaire responses. So the responses you give will be anonymous.

Employee ID Number:

CONFIDENCE
Please read each statement and rate on a scale of 1-5 how confident you would feel in relation to each item: (1 = not at all confident and 5 = very confident)
How confident would you be in:

- **a.** Approaching your line manager to seek support if you were concerened that your mental health was affecting your work.
- **b.** Telling your line manager about the nature of your mental health issue
- **c.** Telling your colleagues about the nature of your mental l health issue
- **d.** Knowing where to access information on work and mental health
- **e.** Having a return to work conversation with your line manager following a period of absence due to a mental health problem
- **f.** Negotiating temporary changes to your work (e.g. less hours, working in quieter space etc) with your line manager relating to a mental health problem
- **g.** Discussing work and health issues to help you remain in work when feeling unwell with a mental health problem

The next set of questions are about your views after watching the on line training programme

1 . Did you have any difficulty getting on line to watch the programme?
Yes
No

2. Did you watch the programme from start to finish?
Yes
No

3. Did you experience any difficulty using the programme online?
Yes
No
If yes why?

4. Did you skip through any parts of the programme?
Yes
No
If yes why?

5. Do you think an online programme is a good way to learn about how to manage mental health in work?
(Very good - Not at all good)

6. How useful was the information provided in the programme for you *(where 1 is Not at all useful and 5 is very useful)*

7. Do you think the programme was the right length (please rate on a scale where 1 is much too short and 5 is much too long)

8. If the scenarios and some of the information was changed to be about depression and anxiety do you think the programme would be useful for supporting people with mental health and work concerns more widely:

Yes
No
Maybe

9. If you were to experience a health issue that affected your ability to work, do you think watching this programme has influenced the way you would talk to people about your health and work issues
Yes
No
Don't know

If yes, please describe how
_____
_____
_____

Please add any additional remarks/comments about the programme

LINE MANAGER POST INTERVENTION QUESTIONNAIRE

In order to link your responses to the different questionnaires we would like to use your employee number. The responses to the questionnaires will be sent directly to the researchers who will not have access to any employee information and your workplace will not have access to your questionnaire responses. So the responses you give will be anonymous.

Employee ID number _____

The first set of questions ask about how confident you feel in managing employees in work and returning to work with a **mental health** problem.

1. Please read each statement and rate on a scale of 1-5 how confident you would feel in relation to each statement (where 1 is not at all confident and 5 is very confident)

a. Having enough knowledge to discuss returning to work with employees who have been off work with a mental illness
b. Having enough knowledge to advise individuals with a mental health problem on modifications or adjustments to their work
c. Your skills to manage a return to work interview for an individual returning to work with a mental health problem
d. Discussing disclosure with an employee with a mental health problem
e. Developing a plan for the on-going management when supporting an individual in work with a mental health problem.
f. Setting appropriate goals for an individual returning to work with a mental health problem
g. Setting appropriate goals for an individual who is already in work with a mental health problem

The next set of questions will ask about your views and experience of the online training you completed.

1. Did you have any difficulty getting on line to watch the programme?
Yes
No

2. Did you watch the programme from start to finish?
Yes
No
Other

3. Did you experience any difficulty using the programme online?
Yes
No
If yes why?

4. Did you skip through any parts of the programme?

Yes

No

If yes why?

5. Would you rather have training about managing mental health concerns:

Online face to face both

6. How useful was the information provided in the programme for you *(where 1 is Not at all useful and 5 is Very useful)*

7. Do you think the programme was the right length? (please rate on a scale where 1 is much too short and 5 is much too long)

8. If the scenarios and some of the information was changed to be about depression and anxiety do you think the programme would be useful for supporting people with mental health and work concerns more widely:

Yes

No

Maybe

9. To what extent do you feel that the programme has influenced how you manage employees with mental health problems (please rate on a scale of 1-5 where 1 is *no impact and 5 is considerable impact)*

10. If you feel it has impacted on the way you manage employees with mental health problems please describe briefly how it has made a difference to you

_____

_____

_____

Please add any additional remarks/comments about the online programme

OCCUPATIONAL HEALTH POST INTERVENTION QUESTIONNAIRE

MANAGING WORK AND HEALTH

The first set of questions ask you about how confident you feel in managing employees in work and returning to work with a **mental health** problem.

How confident are you in:

a. Having enough knowledge to discuss returning to work with employees who have been off with a mental health problem
b. Having enough knowledge to advise individuals with a mental health problem on suitable adjustments to their work
c. Discussing disclosure with an individual with a mental health problem
d. Providing advice for an employee with a mental health problem about support services available to help them return to or remain in work
e. Providing advice for the employer about support services available for employees with a mental health problem
f. Having enough knowledge about self-help tools available for individuals with mental health problems
g. Developing a plan for the ongoing management when supporting an individual in work with a mental health problem.
h. Setting appropriate goals for an individual returning to work with a mental health problem
i. Setting appropriate goals for an individual who is already in work with a mental health problem

The next set of questions will ask about your views and experience of the online training you completed.

1. Did you have any difficulty getting on line to watch the programme?
Yes
No

2. Did you watch the programme from start to finish?
Yes
No
Other

3. Did you experience any difficulty using the programme online?
Yes
No
If yes why?

4. Did you skip through any parts of the programme?
Yes
No

If yes why?

5. Would you rather have training about managing mental health concerns:
Online face to face both

6. How useful was the information provided in the programme for you? *(where 1 is Not at all useful and 5 is Very useful)*

7. Do you think the programme was the right length? (please rate on a scale where 1 is much too short and 5 is much too long)

8. If the scenarios and some of the information was changed to be about depression and anxiety do you think the programme would be useful for supporting people with mental health and work concerns more widely:
Yes
No
Maybe

9. To what extent do you feel that the programme has influenced how you manage employees with mental health problems (please rate on a scale of 1-5 where 1 is *no impact and 5 is considerable impact)*

10. If you feel it has impacted on the way you talk to people about your mental health and work please describe briefly how it has made a difference to you

_____
_____
_____

Please add any additional remarks/comments about the online programme