TUC Education

Mental health and the workplace

A TUC Education workbook

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Acknowledgements

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Foreword

Unions have a long history of campaigning for change in the workplace and beyond, not only on employment rights or safety issues but also on the way people are viewed in the workplace and in society. There is much stigma and discrimination around mental health and particularly mental ill health. These are issues of justice, equality and fairness – core trade union business.

With the impact of austerity contributing to ever-increasing levels of workplace stress, there has been an increase in the prevalence of mental ill health. In response, unions have often taken the lead both in securing the best outcomes for individual members with mental health issues, and in working with employers to develop 'mentally healthy' workplaces.

Mental health and the workplace is an increasingly important issue for trade unions. This second edition of Mental Health and the Workplace has been updated to keep pace with the changing world of work. The workbook is for all workplace reps and helps to explain what they can do to support those in the workplace with mental health problems.

TUC Education is grateful to all those who have shared their stories. I urge you to make full use of this publication and to let us know what you think – comments, stories and feedback of all kinds are welcome to Jackie Williams at jwilliams@tuc.org.uk.

Frances

Frances O'Grady
TUC General Secretary

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Introduction

Work is more than a source of income: it provides social status and aids self-esteem; and it offers a way for people to make a contribution, to reach their full potential and to develop and maintain valuable social networks. For people with mental health problems work can provide crucial links to a wider community, as well as being an important part of maintaining mental health wellbeing or as part of recovery.

Mental health is important in trade union activity and functions: health and safety; conduct; performance; workplace relationships; equality issues; ill health; learning and training; union workplace democracy; and many others. Workplace union reps have a vital role to play in raising awareness on mental health as a workplace issue, as well as supporting members with mental health problems in the workplace and signposting members to further sources of support and guidance.

Many people experience mental health problems at some point in their lives (see Section 1), and most reps and members will know somebody with a common mental health problem. There will be members in every union, every branch and every workplace affected by mental health problems. In a 2015 survey report, Time to Change, which campaigns against discrimination on mental health grounds, found that 65 per cent of people know someone with a mental health problem.[1] The Office for National Statistics Labour Force Survey in June 2015[2] suggests that employment rates for people with 'mental illness' is 38.9 per cent (below 30 per cent for non-white ethnic groups) and for people with depression it is 39.3 per cent. However, government data[3] also shows that 70 per cent of people in work have a common mental health problem.

Understanding the issues facing people with mental health problems and the importance of making reasonable adjustments in the workplace to accommodate their needs is vital for unions and employers. It will help overcome a major obstacle to building a more socially inclusive society.

How to use this workbook

The term 'union reps' is used in this workbook to cover a range of roles including: shop steward; safety representative; union learning representative; union official; lay workplace rep and other types of rep.

This workbook will help reps to:

▸ help prevent stress-related mental illness

▸ develop an understanding of mental health and common mental health problems

▸ be aware of diversity issues impacting on members with mental health problems

▸ develop an understanding of the law and mental health in the workplace

▸ identify good practice around workplace policies on mental health

▸ explore the role of union reps in supporting and representing members with mental health problems

▸ identify organising and campaigning opportunities for trade unions around mental health.

This workbook is intended to be used actively – in courses, at branch meetings and in informal discussions. As well as being an information resource, it seeks to ask questions to stimulate discussion and debate so that individuals and groups can act on their commitment to challenge mental health discrimination and promote equality wherever they work and in their communities.

Notes

[1] Time to Change April 2015, www.time-to-change.org.uk/sites/default/files/Attitudes_to_mental_illness_2014_report_final_0.pdf

[2] Office for National Statistics 2015, Labour Force Survey available at www.ons.gov.uk

[3] www.gov.uk 2014, Chief medical officer report: public mental health, available at www.gov.uk

Section 1

Knowledge

What is mental health?

The World Health Organization defines mental health as: "… a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (World Health Organization 2014).[1]

If you are in good mental health you can make the most of your potential, cope with life and play a full part in your workplace, community, family and friends.

Like all health, mental health doesn't always stay the same but changes as life and circumstances change. Everyone has periods of feeling stressed, frightened or low. Sometimes people recover from the changes in their mental health, but at other times they may be affected for a long period. Someone diagnosed with a serious mental health condition may have a very positive mental health state: or someone with no diagnosis may have very poor mental health state.

•No absolutes   **Maximum mental wellbeing**   •The continuum…

A person with a diagnosis of a serious illness but who copes well and has positive mental health

A person with no illness or disorder and positive mental health

Maximum mental illness/disorder

Minimum mental illness/disorder

A person with a diagnosis of a serious illness and who has poor mental health

A person with no diagnosable illness or disorder but who has poor mental health

Minimum mental wellbeing

Source: ACAS Advisory Booklet *Promoting Positive Mental Health at Work*[2] (adapted from *Mental Health Promotion: Paradigms and Practice* K Tudor)

The independent review commissioned by the government in 2017 considered the "three phases that most of us go through at different points and between which we fluctuate during our lives. First, people who are at any point in time are thriving, second, people who are struggling and third, people who are ill and possibly off work. People with poor mental health including common mental health problems and severe mental illness can be in any of these groups. An individual can have a serious mental health problem but – with the right support – can still be thriving at work."
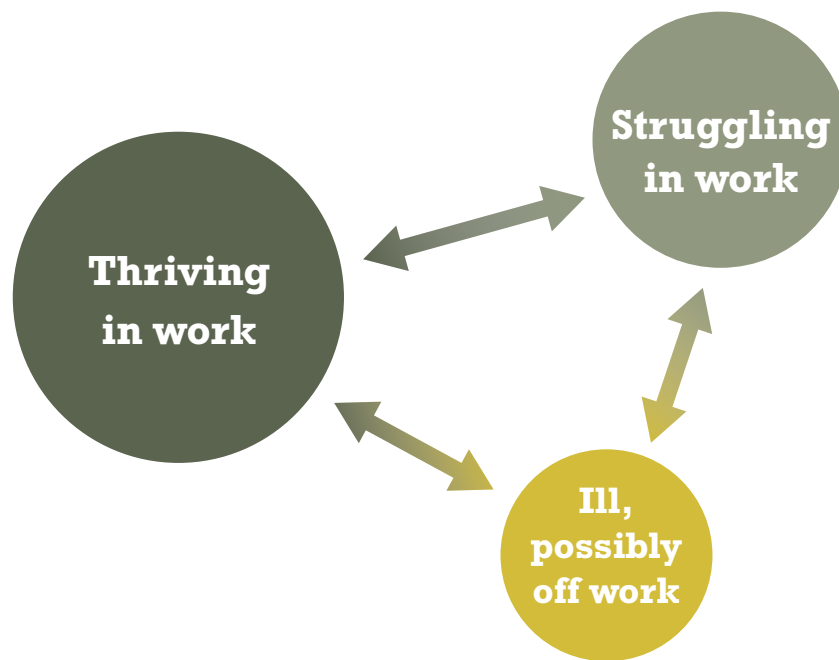
Unlike many physical health conditions, there is a stigma attached to mental health problems. In many cultures and societies it can be difficult and uncomfortable to discuss feelings and emotions. And it may not be easy to identify if someone has a mental health problem and needs support or adjustments made in the workplace.

What are mental health problems?

One in four of people will have problems with their mental health at some point. These problems range from the day-to-day worries that everyone experiences to longer-term serious conditions. The majority of people who experience mental health problems can get over them or learn to live with them – just as with physical health problems. About one in a hundred people will experience severe mental illness.[3]

Traditionally, health professionals have split mental health symptoms into two groups – neurotic (related to depression, anxiety and panic) and psychotic (related to perceptions of reality and which may include hallucinations, delusions or paranoia). More recently these have been referred to as 'common mental health problems' and 'severe mental health problems'.

Common mental health problems[4] include:

▸ anxiety – about 1 in 10 people in the UK

▸ depression – about 1 in 10 people

▸ mixed anxiety and depression – about 1 in 10 people

▸ post-natal depression – between 8 and 15 per cent of women

▸ obsessive compulsive disorder – 3 per cent of people

▸ phobias (and panic attacks) – between 1 and 3 per cent of people.

Severe mental health problems[5] are:

▸ psychosis – one in 200 people in the UK

▸ bipolar disorder – between one and two per cent of people

▸ schizophrenia – between one and 2.4 per cent of people

Other types of mental health problems:[6]

▸ eating disorders

▸ Attention Deficit Hyperactivity Disorder. Further information on page 70.

▸ alcohol and substance dependency – three per cent of adults

▸ dementia – five per cent of people over 65 and one in 1,000 of people age under 65 in the UK[7]

Appendix 1 has more information on mental health problems.

The role of the union rep

Union reps have a vital role in supporting members with mental health problems in the workplace. Union reps can:

▸ promote good mental health and wellbeing

▸ raise awareness of mental health issues and mental health wellbeing

▸ help to create a supportive environment, including talking openly about mental health and wellbeing

▸ tackle and challenge stigma about mental health

▸ help and support people with mental health issues or problems

▸ represent members on workplace issues

▸ negotiate appropriate workplace policies and procedures

▸ provide advice and guidance, including signposting members to local mental health support services

▸ monitor and review workplace actions on mental health issues.

Section 2 goes into more detail about representing and support members.

Section 3 goes into more detail about organising and campaigning around mental health.

What about work-related stress?

Stress is not a mental health diagnosis and is not a recognised mental health condition. Most people with work-related stress will have anxiety, depression or what is termed 'generalised anxiety disorder'.

Work-related stress is the second-biggest occupational health problem in the UK[8] and costs the UK £3.6bn every year.[9] Research has suggested that 30–40 per cent of sickness absence is linked to work-related stress.[10]

See also 'work-related stress and the law' on page 12.

Social aspects of mental health

Health and wellbeing, including mental health is affected not only by individual characteristics but also by the social circumstances and environment in which people live. These factors interact with each other and they may adversely affect or support a person's mental health state. The mental health charity Mental Health Foundation identify three factors that can lead to mental health inequalities:

▸ material inequality – poverty, poor housing, lack of employment opportunities

▸ social inequality and injury – stigma and discrimination related to:

   – homelessness and being vulnerably housed

   – immigration status

   – ethnicity

   – sexual orientation

   – disability

   – experience of violence or abuse

▸ health inequality – including having long-term physical health conditions

Inequality and discrimination in society and the workplace are key areas for trade union action and activity. Trade unions need to work to address the causes and factors that negatively influence mental health in the workplace and beyond. Trade unions should be working with members, employers and communities to improve the social aspects of mental health and how society and communities respond.

The social and economic costs of mental health problems

Research undertaken as part of an independent review on behalf of the UK government into mental health at work identified that poor mental health costs employers between £33bn and £42bn a year. (*Thriving at Work*, www.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf). That's an average cost for each and every employee, not just those who are ill, of between £1,205 and £1,506 per year. The report also identified that costs per employee are higher in the public sector (£1,551 to £1,878 per year) than the private sector (£1,119 to £1,481 per year).

The review identified the direct cost of poor mental health to the UK government as being between £24bn and £27bn per year. The impact on the UK economy was estimated as being a total cost of between £77bn and £99bn per year.

The social model

TUC policy is to promote and support the social model of disability rather than the medical model. The medical model, predominant in society and legislation, assumes that disability is an individual problem caused by impairment. The medical model focuses on treating the impairment with the aim of improving or restoring the function that is lost or missing. Its focus is therefore on investing in health care and related resources to research, identify, diagnose, cure, manage, alter and control illness. By contrast, the social model of disability suggests that systemic barriers, negative attitudes and exclusion by society lead to a person being defined and disempowered by society. The social model is one "in which the disability is understood to be the result of barriers preventing the inclusion of people with impairments, and not the impairment itself – is used as the foundation for unions' work in this area. This is not a philosophical distinction – it has real significance in society, in the workplace and in the way that unions work."

For more information on the social model, see the TUC guidebook *Trade Unions and Disabled Members: why the social model matters*, available at www.tuc.org.uk

Mental health and the law

Legislation

The Equality Act 2010 protects people from being discriminated against because of certain specific characteristics. (The Equality Act 2010 does not apply to Northern Ireland.) The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity.

Mental health problems are covered by disability under the Act.

The Equality Act 2010 protects people who have or have had a disability in the past. This includes protection where they are perceived to have a disability or are associated with a disabled person.

The meaning of 'disability' and 'disabled person'

The Act provides that

(1)   A person (P) has a disability if –

    a. P has a physical or mental impairment, and

    b. The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

A formal medical diagnosis is not always necessary. The Act does not define impairment but it can include the effects of or symptoms of any illness. This includes the side effects of any medication, for example being very tired due to antidepressants.

Substantial means it is more than minor or trivial – for example it takes much longer than it usually would to complete daily tasks.

Determining if the impairment has a substantial adverse effect requires comparison between the way a person carries out an activity *with the impairment* and the way they would carry out the activity *without the impairment*. It is not a comparison with other people.[11]

Long-term means likely to have or has lasted for 12 months or more. This can include fluctuating or recurring conditions such as depression.[12]

An Employment Appeal Tribunal case in 2004[13] identified that the question is not whether the illness is likely to recur but whether at some stage the substantial adverse effect on normal daily activities will recur. To help decide this the tribunal identified five questions:

1. Was there at some stage an impairment?

2. Did the impairment have a substantial adverse effect on the applicant's ability to carry out normal day-to-day activities?

3. Did the impairment cease to have a substantial adverse effect on the applicant's ability to carry out normal day-to-day activities, and if so, when?

4. What was the substantial adverse effect?

5. Is that substantial adverse effect likely to recur?

Day-to-day is not defined in the Act, nor is there a list of capacities that may be affected. What should be assessed is what the person *cannot do*, not what they *can do*.[14]

The UK Government Office for Disability Issues Guidance[15] lists the following specific mental health conditions as being covered by the Act:

▸ Anxiety

▸ Low mood

▸ Panic attacks

▸ Phobias

▸ Unshared perceptions

▸ Eating disorders

▸ Bipolar affective disorders

▸ Obsessive compulsive disorders

▸ Personality disorders

▸ Post-traumatic stress disorder

▸ Some self-harming behaviour

▸ Depression

▸ Schizophrenia

The Act specifically excludes addiction to or dependency on alcohol or any other substance – other than where this is a consequence of the substance being prescribed.

Note: Although drug and alcohol abuse/dependency are not covered by the Equality Act, trade unions may want to consider including these in negotiations about a workplace mental health policy. If there is a distinct workplace policy on substance abuse and dependency already in place, then there should be links with the mental health policy.

Rights and duties under the Equality Act 2010

It is unlawful under the Act to:

▸ discriminate against a worker because of a mental disability or

▸ fail to make reasonable adjustments to accommodate a worker with a disability.

The Act defines a number of types of discrimination:

Direct – where an employer, because of someone's protected characteristic, treats them less favourably than they treat or would treat others.

> **Example:** Azi has bipolar disorder. He wants to apply for a new post, doing work he is able to do. His employer tells him he cannot apply because he has a mental health problem. The employer encourages a less experienced member of staff who does not have a mental health problem to apply.

The less favourable treatment does not have to just be connected to a person's own protected characteristic; it could be because someone is associated with a person with the protected characteristic (discrimination by association).

> **Example:** Sylvia does not have any mental health problems but she looks after her partner who does. Her employer treats her worse because of this. This is direct discrimination – discrimination by association.

The less favourable treatment does not have to just be connected to a person's own protected characteristic; it could be because the employer thinks they have a protected characteristic (discrimination by perception).

> **Example:** Georg does not have a mental health problem. Georg is treated worse than his colleague because his employer thinks he is 'odd' and that he has a mental health problem. This is direct discrimination – discrimination by perception.

Indirect – where an employer applies a provision, criterion or practice that is discriminatory in relation to a protected characteristic. The employer can justify indirect discrimination if it is a *"proportionate means of achieving a legitimate aim"*. There is no definition of legitimate aim in the Act but it could include:

▸ the health and safety of staff or people using a service

▸ the business needs of the employer or service

▸ needing to make a profit.

Proportionate means that there should be a fair balance between the employer's needs and the rights of the disabled person. The burden is on the employer to show that the unfavourable treatment was objectively justified.

> **Example:** Nisha works for an organisation where everyone works 8am to 4pm. Nisha takes medication for anxiety that makes it difficult for her to get up in the morning. Nisha requests later start and finish times of 10am and 6pm. Her employer refuses the request. This could be indirect discrimination. However, the employer says that they cannot change her hours because there is no site security after 4pm and the organisation operates only between the hours of 8am and 4pm. The employer may be able to argue that its refusal to change her hours are a proportionate means of achieving a legitimate aim.

Discrimination arising from disability

This occurs where a disabled person is treated unfavourably because of something connected to their disability. As with indirect discrimination, the employer can claim that the treatment was 'proportionate to achieving a legitimate aim'. The employer can also claim that they didn't know (or couldn't reasonably be expected to know) that the worker was disabled. However, the employer should take reasonable steps to explore with the worker whether any difficulties are because of the consequence of a disability.

> **Example:** Josef has a good employment record but has recently become emotional and upset at work. His standard of work has become poor and is causing problems for his employer and other workers. The worker is disciplined without being given the opportunity to explain that his difficulties at work are linked to depression and that his depression has recently worsened. It would be reasonable to expect the employer to explore these changes in behaviour and whether they are linked to a disability.

Failure to make reasonable adjustments

An employer has a duty to make 'reasonable adjustments' – changes that make it easier for the disabled person. The Act does not provide a specific list of adjustments. However, the Statutory Code of Practice[16] suggests that adjustments can include:

▸ changing equipment

▸ providing aids – including extra support and equipment

▸ changing the location of work or allowing working from home

▸ changing policies and procedures

▸ allowing extra time off work eg for counselling or other medical appointments

▸ allowing flexible working

▸ changing the worker's role or parts of the worker's role

▸ offering counselling or mentoring.

When deciding what is reasonable, an employer can take into account:

▸ the size of the organisation and its financial situation

▸ the cost of making the change

▸ how helpful the adjustment would be to the individual

▸ how practical it is to make the change.

The employer cannot charge the worker for making the changes.

> **Example:** Rachel has post-traumatic stress disorder (PTSD) and works for a very large employer. She finds it difficult to travel to and from work in the dark as she gets severe panic attacks related to her PTSD. She requests to change her working hours during the winter months. Her manager refuses. This is likely to be a failure to provide reasonable adjustments, as a large employer should be able to change her working pattern with little difficulty but with great benefit to Rachel.

Victimisation

The Act protects people from being treated detrimentally because they have made an allegation about discrimination or you supported someone who has made an allegation of discrimination. A detriment can be 'something that the individual affected might reasonably consider changes their position for the worse'.[17]

> **Example:** Samantha's colleague has schizophrenia. Samantha supports her colleague to complain to their employer about disability discrimination. After this, Samantha's manager refuses her promotion on the basis that she isn't loyal to the company.

Trade unions

Under the Equality Act 2010 trade unions are classified as a 'trade organisation'.[18] The Act places duties on trade organisations not to discriminate or victimise a member or applicant to membership on the grounds of a protected characteristic. The duty to make reasonable adjustments for disabled members also applies to trade organisations.

> **Example:** Shindi has obsessive compulsive disorder and cannot eat food where different food groups have come into contact with each other. Her union branch organises a meeting for members at the end of a shift and provides food. It may be reasonable for Shindi to request that her specific eating habits are provided for in the catering arrangements for the meeting.

Work-related stress and the law

The law states that employers have to try to remove or reduce stress "as far as is reasonably practical". Under Section 2 of the Health and Safety at Work Act 1974 employers have a general duty of care to ensure the health, safety and welfare of all their employees and this includes employees' mental health.

The Management of Health and Safety at Work Regulations 1999 requires employers to carry out suitable and sufficient assessments of health and safety risks. Following the risk assessment employers have the duty to identify preventative and protective measures to reduce risks. This includes risks to mental health.

The Safety Representatives and Safety Committee Regulations 1977 give safety reps the right to investigate and tackle workplace stress. This includes the right to:

▸ investigate potential hazards

▸ inspect the workplace and talk to members

▸ be consulted about the employer's health and safety arrangements.

To help employers manage stress the Health and Safety Executive (HSE) has developed management standards which employers should seek to use (see managing stress).

As well as the duties placed on an employer under health and safety law there is a common law duty of care between an employer and employee.

This duty of care includes the duty not to cause personal psychiatric injury. This means that:

▸ there must be expert medical evidence showing psychiatric injury

▸ the psychiatric injury was caused by work-related factors

▸ the psychiatric injury to the employee was reasonably foreseeable

▸ there was something that the employer reasonably could do to avoid the psychiatric injury.

It is worth noting that tribunal cases related to stress at work have made it clear that suffering stress on its own is not enough for a claim to succeed. The individual must have suffered personal psychiatric injury.[20]

The Enterprise and Regulatory Reform Act 2013 amended the Health and Safety at Work Act 1974 so that the burden is now on the employee to prove that the employer was negligent and that the negligence caused the injury. To prove negligence, the employee will need to show that: the employer had a duty of care towards them; the employer did not take reasonable care to fulfil the duty; the employer's actions actually caused any injury; the harm from the actions was foreseeable; and the negligence resulted in actual damages to the person (physical, mental or financial).

In a 2010 employment appeal tribunal case[19] a person suffering an adverse reaction to problems at work resulting in "anxiety, stress and low mood" was found not to qualify as disabled under the Equality Act due to the short duration of their ill health. In reality this means that adverse reactions will need to be long-term before falling under the Equality Act 2010.

Workplace policies

Employers and union(s) should negotiate and implement a workplace mental health policy.

A good workplace mental health policy should cover the following:

▸ **Recruitment and selection**

Encourages, supports and provides reasonable adjustments for applicants with mental health issues.

▸ **Mental ill health definition**

Clear definition of mental health and mental health problems – not limited to stress or anxiety.

▸ **Links to other policies and procedures**, eg flexible working, disability leave, career breaks, grievances, disciplinary procedures, capability, sickness absence, performance management, substance abuse and dependency, dignity at work (bullying and harassment), training and development.

Identifies how the mental health policy relates to other policies and procedures in the workplace, identifying how the employer supports people with mental health problems through these linked policies/procedures, for example recording absence related to disability separately to absence related to sickness.

▸ **Provision of some indicators of mental ill health**

Signs that an individual may be having mental health problems, eg changes in an employee's usual behaviour.

▸ **Promotion of good mental health wellbeing**

Identifies steps employer will take to support and promote mental health wellbeing.

▸ **Links to health and safety stress management policies**

Identifies how the policy relates to health and safety policies and procedures on work-related stress, including reference to risk assessment and implementing control measures.

▸ **The role of line managers**

Identifies the role of line managers in encouraging people to disclose mental health problems and their role in supporting people with mental health problems.

▸ **The role of human resources**

Identifies the role of HR departments and staff, including monitoring the effectiveness of the policy and linked policies/procedures in developing a mentally healthy workplace; this could include services available through HR, such as occupational health or access to a confidential counselling service.

▸ **The role of union reps**

Defines the roles of union reps, including shop stewards, safety reps, union learning reps and other reps such as equality reps; identifies the role reps have in the workplace to promote mental health, supporting members, representing members and monitoring the impact of workplace policies and procedures on mental health.

▸ **The roles and responsibilities of employees**

Clarifies the responsibilities employees have towards each other on mental health issues; this could include roles for specific employees such as mental health first aiders.

▸ **Commitment to promote awareness**

How the policy will be promoted as well as how awareness and understanding of the policy will be shared across the organisation.

▸ **A list of key contacts**

Internal and external to the employer who employees can contact in the organisation should they need advice or support (for themselves or others in the workplace) as well as information about support and advice available in the local community.

Training should be provided to support the workplace policy including raising awareness, roles and responsibilities and mental health first aid.

▸ **Mental health first aid**

Teaches people how to identify, understand and help a person who may be developing a mental health issue. It teaches people how to recognise the crucial warning signs of mental ill health. It also includes how to provide help on a first aid basis and effectively guide someone towards the right support services.[21]

The policy should be further supported through a workplace campaign providing:

▸ information for workers about mental health wellbeing, mental ill health, help available and the workplace policy

▸ sources of help and advice available locally, external to the employer

▸ information on the workplace mental health first aid arrangements.

Equality and mental health

Research has shown that certain groups have higher than average mental health problems compared to the general population. The reason for this prevalence is complicated containing elements of material inequality, social inequality and injury and health inequalities.

What is clear from the research is that a person's sexual orientation, trans status, race, age and gender are contributing factors to mental health problems. However, the mental health problems are not a result of those characteristics in themselves but a result of the bigotry and discrimination these groups experience because they have these characteristics.

Research into the experiences of these groups is captured below highlighting the levels of disadvantage faced.

Transgender workers and mental health

A 2018 report by the Royal College of Psychiatry confirms that psychiatric disorders (particularly anxiety, depression and acts of self-harm) in treatment-seeking transgender people are much more common than in the general population. www.rcpsych.ac.uk/pdf/PS02_18.pdf

This is backed up by a 2012 survey that showed that almost half (48 per cent) of trans people in Britain have attempted suicide at least once, while 84 per cent have thought about it. More than half (55 per cent) have been diagnosed with depression at some point.

Far too often it is claimed that the high incidence of depression, anxiety, self-harm and suicide amongst trans people is a direct result of the gender variance itself while it is clear that these are a result of the bigotry and discrimination that trans people experience.

According to a study published in the July 2016 edition of *The Lancet*, there is significant evidence that the "distress and impairment, considered essential characteristics of mental disorders" among trans individuals primarily arises in response to the discrimination, stigma, lack of acceptance, and abuse they face on a regular basis.

Lesbian and gay/bisexual workers and mental health

The TUC report *Being Out at Work* identified that over half of the research respondents who had experienced discrimination or harassment at work reported that it had a negative impact on their mental health.

A research article published in the journal BMC Psychiatry in 2015 concluded that "adults identifying as lesbian, gay, bisexual or 'other' are at increased risk of poor mental health and low wellbeing compared to those identifying as heterosexual" (Source: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-016-0767-z)

The experience of discrimination, prejudice, victimisation and stigmatised experiences of LGB people can negatively affect their long-term mental health. This is compounded by LGB people experiencing discrimination and prejudice in the facilities and services offered and provided. Many LGB people report wide spread heterosexism (the presumption that someone is heterosexual or that heterosexuality is the social or cultural norm) amongst health care practitioners and that their experiences of accessing healthcare services are negative. (Source: The Rethink mental health charity factsheet *LGBT+ Mental Health* – www.rethink.org/resources/l/lgbtplus-mental-health-factsheet)

Black and minority ethnic (BME) workers and mental health

The Mental Health Foundation's 2016 Fundamental Facts report identifies that BME communities are generally considered to be at increased risk of poor mental health. (Source: www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016). But the Adult Psychiatric Morbidity Survey (2014) found the prevalence of common mental health problems to vary significantly by ethnic group for women, but not for men. Non-British white women were the least likely to have a common mental health problem (15.6 per cent), followed by white British women (20.9 per cent) and black and black British women (29.3 per cent). Black adults were also found to have the lowest treatment rate of any ethnic group, at 6.2 per cent (compared to 13.3 per cent in the white British group).

The Mental Health Foundation's report also highlighted that in Northern Ireland the suicide rate amongst male Irish Travellers is 6.6 times that of men in the general population. The report cites prejudice, discrimination and lack of access to mental health services as significant contributory factors.

Mental Health Foundation's report further identifies that the experience of accessing health care services for BME people is a continuing experience of "impoverished or harsh treatment from primary and secondary mental health services."

Mental health and gender

Mental health problems affect both men and women but there are reported differences. The Mental Health Foundation's 2016 Fundamental Facts report identifies that one in five women have common mental health problems compared with one in eight men.

Women are twice as likely to be diagnosed with anxiety disorders. Three out of four suicides in the UK are men. 10 per cent of mothers and 6 per cent of fathers in the UK have mental health problems at any given time. Research by the World Health Organization (WHO) suggest that a combination of gender bias and gender specific risk factors affect the reporting, diagnosis and treatment of mental health problems. (Source: www.who.int/mental_health/prevention/ genderwomen/en/). The WHO report identifies that cultural and societal expectation can have a negative impact on mental health and wellbeing, as well as impacting on when or if people seek out support for their mental health. Trade unions can play a strong role in the workplace and society by challenging attitudes to stereotypes about gender role, gender identity and perceived gendered mental health problems.

Young people and mental health

As well as physical changes to the body and hormones, girls from about age 11 and boys from about age 14 experience significant behavioural and emotional changes. There are alterations to the functioning and make up of brain tissue, which is known as brain maturation. This continues until about the age of 30. During this period, teenagers in particular can experience emotional and mental turmoil. Though the links between genetic makeup and environmental factors and mental health are not fully understood, there are some identifiable risk factors affecting young people's mental health. These include:

▸ long-term physical ill health

▸ parents with mental health or substance misuse problems

▸ the death of someone close to them

▸ bullying and abuse

▸ poverty and/or being vulnerably housed

▸ experiencing discrimination

▸ taking on carer responsibilities

▸ problems in the education system

▸ a lack of work or job prospects.

A House of Commons briefing paper[23] on youth unemployment states that the unemployment rate for 16- to 24-year-olds in April 2015 was 16.1 per cent, with the largest section of this group being the 18–24 age range. As the February 2015 TUC briefing paper on Young Workers Issues[24] states, "youth unemployment remains scandalously high". The rate for unemployment is nearly three times that for people aged 25 and over.

Mental health problems affect about 1 in 10 children and young people.[25] Though research in 2014 by the Prince's Trust[26] found that 40 per cent of young people have experienced the symptoms of mental ill health, it also found that young people are less likely to seek or ask for help.

Common mental health problems experienced by young people include:[27]

▸ self-harm (8.9 per cent of 16- to 24-year-olds) – not a mental health condition itself, but it can be a sign of a mental health problem

▸ post-traumatic stress disorder (4.7 per cent of 16- to 24-year-olds)

▸ generalised anxiety disorder (3.6 per cent of 16- to 24-year-olds)

▸ depression (2.2 per cent of 16- to 24-year-olds)

▸ Attention Deficit Hyperactivity Disorder (ADHD) (1.4 per cent of 16- to 24-year-olds)

▸ eating disorders (0.5 per cent of 16- to 24-year-olds).

Trade unions also have an important role in supporting young people. Access to meaningful training, qualifications and sustainable employment is a vital element in supporting young people in general but particularly young people facing mental health problems. This could include, for example, reps negotiating high-quality Apprenticeships and workplace training programmes that support young workers with mental health problems.

It is equally important that young people have a democratic voice in society and the workplace and unions are uniquely placed to enable young people to have a voice in the workplace. This includes encouraging young people to take an active role in their trade union and identifying barriers in existing workplace structures to young people's participation.

Low pay and inadequate affordable housing affect young people and their mental health. Trade unions should ensure employers are paying the national minimum wage and, where employers can afford it, the living wage.

Young workers' story:
Liron Shekel – BECTU (sector of Prospect) member

I moved to London and it took two months before I finally came across something that seemed perfect, at my favourite London theatre. Filling out that application was stressful, and I decided to tick that 'disabled' box. Keeping my bipolar disorder quiet in the past always hurt me and I vowed I would never hide it again.

The next question was whether I would require any adjustments for the interview. The only image that came to my mind then was of a physically disabled person who has problems with their mobility and would therefore need some sort of adjustment to accommodate them. So I wrote "No, thank you" and moved on.

I got the job and no one ever stopped to ask "what is the disability you mentioned in your application?". In fact, legally they're not allowed to. They're not allowed to ask without my consent, and ticking a box isn't enough for consent.

There were times I considered mentioning it to my managers, supervisors or colleagues, but then I didn't want any special treatment. However, my bipolar meant being stressed, paranoid and anxious or getting depressed for no reason at times.

It meant taking everything a little more personally and having moments in which all I wanted was to lock myself in the staff toilets and cry nonstop. Unfortunately it also meant fighting with colleagues and those in charge because I had reached a point where I couldn't take things any more.

It was a couple of months before I gathered up the courage to apologise to everyone I felt I mistreated due to my symptoms and admitted that: "I will sometimes take things a little differently than I should. It's because I'm bipolar. Please don't judge me for it and if I act in a way that I shouldn't, please talk to me about it."

Most of my colleagues were very understanding and some adapted to this new 'information'. Some had more problems dealing with it or were already too prejudiced against me to adapt. I don't blame them: I don't blame anyone. I still find it hard to understand or accept that I might, at times, think so differently and process things in a way that others don't. It did, however, bring me to the point where I had to seek support once again as those terrible, harmful thoughts I hadn't had in five years crossed my mind once again. I got so scared of working sometimes, scared of what might be said to me and even more terrified of messing up, anything.

It also meant I worked harder, though, to make a good impression. I handled some situations so well I got amazing feedback from customers.

When I got to the point where I felt I could no longer continue this way – lying awake all night worrying about what might happen, not being able to eat because I was so afraid I might get fired for no reason (which also scares you twice as much when you're not a contracted employee), losing hair, being constantly anxious, locking myself in my room – that was when I finally asked for help.

Once I'd turned to our union representative and was ready to discuss my condition, I found a lot of support from HR and even found out we have a welfare consultant in the building. I turned back to therapy and medication.

If I'd discussed it from the start, it could have made a difference. I truly believe that. It's best to be honest from that very first moment. I am disabled because it affects me in every aspect of my life, and if I was a wheelchair user I wouldn't hide the fact I need a wheelchair, so if I think or feel differently because of a condition, I should discuss it with those around me.

The only thing I suggest for us is to talk about it. And for those working with us, our colleagues and managers, I suggest – be open-minded. From my own personal experience, the worst thing you can do is judge us or talk about us behind our backs. Nothing made me feel worse than hearing people were bad-mouthing me behind my back. It was my sign that my anxiety and paranoia were all correct. Don't feed our monsters: talk to us.

Nothing made me feel better than a sense of security and support and it can make our day-to-day lives so much easier – or at least more bearable.

http://strongerunions.org/2015/05/13/do-you-consider-yourself-to-have-a-disability-a-bipolar-worker-speaks-out/

Older workers and mental health

The World Health Organization (WHO) in December 2017 published a factsheet about the mental health of older adults (Source: www.who.int/en/news-room/fact-sheets/detail/mental-health-of-older-adults) – the factsheet identified that over 20 per cent of adults aged 60 and over suffer from "a mental or neurological disorder" and the most common of these are dementia, depression and anxiety. The factsheet highlights concern about mental health problems in older adults being overlooked or misdiagnosed.

Figures from the Office for National Statistics in 2018 show that there are nearly 10 million over-50s in work and an increase of over 1.6 million since default retirement age was abolished in 2011. Over the same period there has been an increase of over 300,000 over-65s in work. (Source www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentunemploymentand economicinactivitybyagegroupseasonallyadjusteda05sa)

Research commissioned by the charity Centre for Ageing Better found that older workers are more likely to be managing more than one health condition at a time, and that older workers often report issues around both physical and mental health. The research identified that older workers are more likely to "struggle on" without workplace support for mental health conditions or conditions such as musculoskeletal or breathing disorders. These conditions often have far less visible or obvious symptoms until they reach a point where they feel staying in work is no longer possible. The research also identified a significant factor in not disclosing a health condition or asking for support by older workers. This was fear of being negatively perceived or even dismissed as a result of having repeated periods off work.

Trade unions need to challenge workplace perceptions and attitudes that older workers are a burden on organisations. Research has shown that there are no negative impacts on workplace performance when there are changes in the proportion of older workers employed in an organisation. (Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/584727/older-workers-and-the-workplace.pdf)
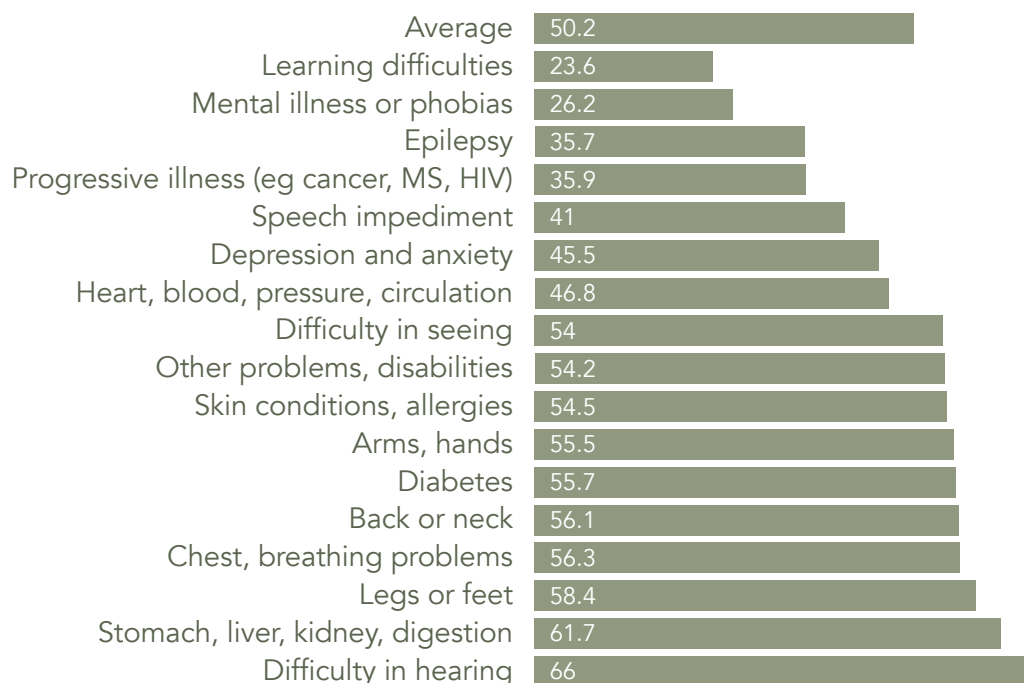
Trade unions play a key role in the workplace ensuring older workers are consulted and involved in developing workplace policies and procedures that support their needs. This should include organising and campaigning to affect the workplace attitudes and culture about older workers.

Mental health and employment

The TUC report *Mental Health and Employment* (May 2017) (Source: www.tuc.org.uk/sites/default/files/Mental_Health_and_Employment.pdf) identified that there is a significant employment gap between people defined as disabled under the Equality Act and non-disabled people. The report highlights that mental health problems are a significant barrier to getting into work. "45.5 per cent of disabled people with health problems lasting or expected to last more than one year who had depression and anxiety as their main health problem, were in employment. Just 26.2 per cent of disabled people experiencing long term mental illness or phobias as their primary, or most significant, health issue, were in employment."

The report also highlighted the issue that people with hidden mental health problems are less likely to be employed than people with physical long-term conditions.

Disabled people with health problems lasting, or expected to last, more than one year by main health problem, in employment rate. Q4 2016

Average	50.2
Learning difficulties	23.6
Mental illness or phobias	26.2
Epilepsy	35.7
Progressive illness (eg cancer, MS, HIV)	35.9
Speech impediment	41
Depression and anxiety	45.5
Heart, blood, pressure, circulation	46.8
Difficulty in seeing	54
Other problems, disabilities	54.2
Skin conditions, allergies	54.5
Arms, hands	55.5
Diabetes	55.7
Back or neck	56.1
Chest, breathing problems	56.3
Legs or feet	58.4
Stomach, liver, kidney, digestion	61.7
Difficulty in hearing	66

This suggests that appropriate changes are not being made in workplaces to enable people with mental health problems to get into and stay in work. Trade unions need to work with employers to make changes to the workplace to make it more accessible to disabled people. Trade unions also need to campaign and organise to tackle workplace and societal stigma and prejudice about mental health problems.

Austerity and mental health wellbeing

There is a clear link between income inequality and mental health wellbeing.[28] The larger the gap between the richest in society and the poorest in society, the more people will suffer from mental health problems. Anxiety disorders in particular have a strong link to inequality.

Research has shown that poor mental health is at least twice as likely for those experiencing the most social disadvantages compared with those experiencing the least social disadvantages.

Unemployment, loss of income, poor job security, problems with housing and social inequality are all consequences of austerity measures and this lowers people's mental health, wellbeing and resilience. This lowering of mental health wellbeing, alongside deteriorations in physical health, will in many instances increase mental health problems, substance abuse, suicide rates and social isolation.[29]

This is alongside a real-terms reduction in funding of mental health trust budgets. The NHS Confederation Mental Health Network January 2014 factsheet[30] identifies that there has been an increase in people needing to access mental health services but at the same time there has been a fall in investment in the priority areas of crisis resolution, early intervention and assertive outreach. The report also identifies that nearly 10 per cent of people accessing hospital inpatient services with mental health problems are in paid employment.

About half of people with common mental health problems are no longer affected after 18 months, but poorer, long-term sick and unemployed people are more likely to remain affected than the general population.[31]

During periods of government austerity, workplace initiatives become crucial to supporting people's mental health and wellbeing. Workplace action and programmes to improve mental health wellbeing have been shown to have a positive impact on mental health, as well as financial benefits for employers (saving £9 for every £1 spent on the programme, with an average cost of £80 per employee per year).[32]

Unions have a vital role to play in challenging the consequences for members. Campaigning and organising alongside community groups can help to protect local welfare services. Initiatives can be taken to increase participation in local and workplace democracy and to protect employment rights.[33]

Activity 1 ▸
Employer policies

Aims

To help you:

▸ identify your employer's policies on mental health

▸ clarify areas for development/improvement in your employer's policies.

Task

Talk to a senior union official or someone from human resources and find out if your employer has a mental health policy.

If yes:

▸ Does the policy cover all the areas identified in the example policy on page 13 of this workbook? Which areas need further development?

▸ Do members and other reps know about the policy?

If no:

▸ Are there plans to develop a mental health policy?

Think about who in your union can help you talk to the employer about this.

What other policies/procedures in your workplace relate to mental health?

Does your employer have trained mental health first aiders?

Prepare a report for the rest of the group or your union branch.

Activity 2 ▶
Trade union support

Aims

To help you:

▶ be clear about your union's policies on mental health

▶ identify support available to you

▶ suggest ways in which your union can be better prepared to meet its requirements under the Equality Act.

Task

Talk to other union reps in your workplace and union and find out if your union has a mental health policy.

If yes:

▶ Does the policy discuss the support and adjustments available to members with mental health problems?

▶ Does the policy cover stress prevention?

▶ Does the policy identify the support available to union reps?

▶ Does the policy identify training available for union reps on mental health?

If no:

▶ Will the union be developing a mental health policy?

Think about who in your union can help find out this information.

How does your union currently support members with mental health problems?

Prepare a report for the rest of the group or your union branch.

Activity 3 ▶
Members with mental health problems

Aims

To help you:

▶ understand the disability structures in your union

▶ consider how they can be used effectively.

Task

Using your union rule book and website and from talking to other union reps and officials, answer the following questions:

▶ Does your union hold regular meetings for members with mental health problems?

▶ What are the current disability committees or groups that members with mental health problems could take part in? (Think about locally, regionally and nationally.)

▶ Are there any members in your workplace with mental health problems that attend these committees or meetings?

▶ What support and training is available for members to get involved and active in the forums?

▶ Is their involvement recognised by the employer?

▶ Are there any members who could potentially get involved?

Prepare a report for the rest of the group or your union branch.

Notes

[1] World Health Organization 2014, *Mental Health: a state of well-being*, available at www.who.int

[2] Acas 2014, *Promoting Positive Mental Health at Work*, available at www.acas.org.uk

[3] Mental Health Foundation 2015, *Fundamental Facts about Mental Health*, available at www.mentalhealth.org.uk

[4–7] as 3

[8] Mental Health Foundation 2000, *Mental Health in the Workplace*, available at www.mentalhealth.org.uk

[9] European Agency for Safety and Health at Work 2014, *Calculating the Cost of Work-Related Stress and Psychosocial Risks*, available at https://osha.europa.eu

[10] as 9

[11] *Paterson v Commissioner of Police* [2007] IRLR 763 EAT

[12] gov.uk 2011, "Equality Act 2010: Guidance", available at www.gov.uk

[13] *Swift v Chief Constable of Wiltshire* [2004] IRLR 450 EAT

[14] *Deremi v London and South Eastern Railway Limited* [2012] UKEAT/0316/12/KN

[15] as 14

[16] Equality and Human Rights Commission 2015, Employment Statutory Code of Practice, available at www.equalityhumanrights.com

[17] Equality and Human Rights Commission 2014, glossary of terms, available at www.equalityhumanrights.com

[18] legislation.gov.uk 2011, Equality Act 2010 Part 5, available at www.legislation.gov.uk

[19] *J v DLA Piper UK LLP* [2010] UKEAT/0263/09/RN

[20] *Walker v Northumberland County Council* [1995] IRLR 35, *Sutherland v Hatton* [2002] IRLR 263 CA, *Barber v Somerset County Council* [2004] IRLR 475 H

[21] For more information on mental health first aid visit: http://mhfaengland.org/

[22] Time to Change 2015, "Mind your Language", available at www.time-to-change.org.uk

[23] House of Commons Library 2015, *Youth Unemployment Briefing Paper*, available at www.parliament.uk

[24] TUC 2015, *Young Workers Issues*, available at www.tuc.org.uk

[25] Mental Health Foundation 2015, *Children and Young People: mental health a-z*, available at www.mentalhealth.org.uk

[26] Princes Trust 2014, *Youth Index 2014*, available at www.princes-trust.org.uk

[27] YoungMinds 2015, *Young Adults Statistics*, available at www.youngminds.org.uk

[28] Wilkinson R, Pickett K (2010). *The Spirit Level*. London: Penguin Books.

[29] Hemingway S, Coxon G, Munday D, Ramsay M (2014). "Austerity is Bad for Mental Health", *Mental Health Nursing*, vol 33, no 6, pp 7–9.

[30] NHS Confederation 2014, "Mental Health: The Key Facts and Trends", available at www.nhsconfed.org

[31] Mental Health Foundation 2015, "Fundamental Facts about Mental Health", available at www.mentalhealth.org.uk

[32] Kings College London 2012, "Mental Health in an Age of Austerity", available at www.kcl.ac.uk

[33] as 32

This picture is used
here in this context for
illustrative purposes only

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Section

2

Representing
and supporting
members

27

Attitudes to mental health

Although the *Mental Health Report 2017* published by the charity Business in The Community (Source: https://wellbeing.bitc.org.uk/all-resources/research-articles/mental-health-work-report-2017) identified some improvements over recent years in employers' attitudes to mental health in the workplace, there are still significant problems in the way employers view mental health and mental ill health. The report highlighted that for the "vast majority of employees, mental health is still a no-go area".

Many organisations do not view mental health as a workplace issue and do not view changing the general workplace culture as being part of supporting mental health. Earlier research by the same organisation, (Workplace Report 2016 – Source: https://wellbeing.bitc.org.uk/all-resources/research-articles/mental-health-work-report-2016) found a "significant and potentially damaging disconnect exists" between the employers' perceptions of the way they address mental health in the workplace and those of workers. The report suggests that many employers view their role in addressing mental health as simply to provide time off work and promote employee responsibility for changes – an all too common employer approach to tackling work-related ill health – change the worker not the work.

Trade unions must work with employers to change attitudes to mental health and to change attitudes about how to support mental health in the workplace. One of the mental health core standards promoted by the government (*Thriving at Work* – Source: www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers) is that employers should "Provide employees with good working conditions and ensure they have a healthy worklife balance and opportunities for development".

Even where employers have recognised mental health as a workplace issue one of the key barriers identified in the *Mental Health Report 2017* was the lack of training for staff and managers on how to support a colleague with mental health problems in the workplace. The report highlights that most managers do not have the confidence or skills to hold a conversation with a colleague about their mental health. "Many people have experienced silence on their return from a period of sickness absence related to their mental health, which is completely at odds with the volume of communication following absence related to physical ill health."

> **John's story (union member in education)** – "When I broke my leg playing sport I had dozens of get well soon cards, and on my return to work I had a couple of meetings with my line manager about accommodating my temporary mobility issue. Everyone I met for the first two weeks asked how I was getting on and it was good to see me back. When I had a similar period of sick leave for depression and anxiety I didn't hear from anyone. When I returned to work I had one very brief meeting with my manager, where we didn't discuss any needs I might have. The only person that spoke to me about my health was my union health and safety rep – who said it was good to see me back, asked how I was doing and if I needed any support at work – he made the world of difference."

Training

Employers should develop mental health awareness amongst all staff, train managers to be able to hold conversations with their staff about their health and wellbeing. Mental health awareness will help ensure that line managers are better able to deal with any issues around mental health that arise but, equally importantly it should help organisations develop a workplace that is more supportive of those who have a mental health issue. Mental health awareness training is available from a large number of mental health third sector organisations. Employers should also consider joint training between management and union representatives.

In addition to awareness training organisations should consider developing mental health first aiders through accredited training to notice and support an individual who may be experiencing a mental health concern and provide help. For more information on mental health first aid – see appendix 2.

It is worth noting that, like all first aid, mental health first aid is mainly reactive – trade unions need to work with employers to take a preventative approach with mental health, especially relating to stress, bullying, harassment and workload. Employers need to consider stress as a prevention issue like chemicals or musculoskeletal disorders. As mentioned in more detail later in this workbook (See the section on Resilience) many employer attitudes to stress is simply to provide training in coping strategies or resilience. However, as The Department of Work and Pensions 2014 report into the HSE makes clear "Those who promote wellbeing in the workplace should not allow it to be confused with health and safety requirements" to prevent or reduce hazards and risks. (Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/275233/hse-function-form-governance-triennial-review.pdf).

Discriminatory language and mental health

Language related to mental health and mental health problems can lead to reinforcing stereotypes and myths about people with mental health problems. It may result in individuals and groups feeling isolated and vulnerable in the workplace and society. People with mental health problems can be disadvantaged through the attitudes expressed by people through the language they use. Expressions that define people in terms of their disability are unhelpful and can further reinforce myths and stereotypes.

The anti-stigma campaign Time to Change identifies some common phrases[22] that can cause offence and are inaccurate in their description of mental health problems, and it suggests possible alternatives for them.

Avoid using	Instead try
'a psycho' or 'a schizo'	'a person who has experienced psychosis' or 'a person who has schizophrenia'
'a schizophrenic' or 'a depressive'	'someone who has a diagnosis of/ is currently experiencing/is being treated for schizophrenia/depression'
'lunatic', 'nutter', 'unhinged', 'maniac' or 'mad'	'a person with a mental health problem'
'the mentally ill', 'a person suffering from', 'a sufferer', 'a victim' or 'the afflicted'	'mental health patients' or 'people with mental health problems'
'prisoners' or 'inmates' (about people in a psychiatric hospital)	'patients', 'service users' or 'clients'
'released' (from a hospital)	'discharged'
'happy pills'	'antidepressants', 'medication' or 'prescription drugs'

Inaccurate descriptions

'Schizophrenic' or 'bipolar' does not mean 'two minds' or a 'split personality'.

Somebody who is angry is not 'psychotic'.

Someone being 'fussy' or liking things done in a particular way is not 'a little bit OCD'.

A person's mental health is only one aspect of who the person is. If the information doesn't contribute to the topic, why mention it at all? If the information is important, use people-first language to talk about it. People-first language means we literally put ourselves and others first in a sentence. For example, instead of calling someone 'mentally ill', it would be more appropriate to say 'a person with a mental health problem'.

Changing language alone does not deal with the stigma but, because language is powerful, care and sensitivity about the language we use is important.

A thoughtful short film to help you think about your approach can be found on the RSA website at www.thersa.org

Stress and health and safety

The HSE defines stress as "the adverse reaction people have to excessive pressure or other types of demand placed on them". This definition is widely accepted.

We all recognise that a certain degree of pressure is part and parcel of all work and helps to keep us motivated. However, excessive pressure can lead to stress that undermines performance, is costly to employers and can lead to ill health.

The last figures from the HSE show that 487,000 people in the UK experience work-related stress at a level they believe is making them ill. Clearly, it is a major problem in our workplaces and research by the TUC confirms that. The 2016 survey of union health and safety representatives showed that 70 per cent of them identified stress as one of the top five hazards in their workplace (up 3 per cent since the 2014 survey) and is still the most common concern in all sizes of workplace and in every region/country in the UK. In the public sector the figure was higher, with 78 per cent of representatives reporting that it was one of the top five hazards.

The HSE and TUC both agree that work-related stress should be treated as any other workplace hazard. The HSE also emphasises that it is subject to risk assessment as required by the Management of Health and Safety Regulations 1999. To assist with this process, the HSE has developed Management Standards to assist employers in carrying out this duty.

The HSE's stress Management Standards classify the principal causes of work-related stress into six key areas:

▶ **Demands:** includes issues such as workload, work patterns and the work environment.

▶ **Control:** how much say the person has in the way they do their work.

▶ **Support:** includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

▶ **Relationships:** includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.

▶ **Role:** whether the person understands their role within the organisation and whether the organisation ensures that the person does not have conflicting roles.

▶ **Change:** how organisational change (large or small) is managed and communicated in the organisation.

Signs and symptoms of stress

Behavioural

▶ difficulty sleeping

▶ changed eating habits

▶ smoking and/or drinking more

▶ avoiding friends and/or family

▶ sexual problems.

Mental

▶ less decisive

▶ difficulty concentrating

▶ memory loss

▶ feelings of inadequacy

▶ low self-esteem.

Physical

▶ tiredness

▶ indigestion and/or nausea

▶ headaches

▶ palpitations

▶ aching muscles.

Emotional

▶ irritability

▶ anxiety

▶ feeling numb

▶ hypersensitivity

▶ feeling drained and listless.

Factors that cause or worsen stress

▶ long hours

▶ shiftwork

▶ unrealistic targets or deadlines

▶ poor management

▶ working alone

▶ job insecurity

▶ job or organisational change

▶ low pay

▶ bad relations with other work colleagues

▶ repetitive work, boredom and lack of job satisfaction

▶ too much or too little work, lack of control and conflicting demands

▶ jobs with heavy emotional demands

▶ bullying, harassment and either actual or threatened violence

▶ a poor working environment (such as excessive noise, the presence of dangerous materials, overcrowding, poor facilities or extremes of temperature or humidity)

▶ performance management of unrelenting intensity.

Stress is not a mental health diagnosis, but it can cause mental health problems. Work-related stress can lead people to develop anxiety, depression or combined anxiety and depression disorders.

As stress isn't a formal medical diagnosis there is no specific treatment for it. People will be treated for the anxiety, depression or other mental health problem they are presenting with. Treatments may include people taking steps to develop their mental health wellbeing and to reduce the impact that stress has on their lives; this is known as developing 'emotional resilience' and can include making lifestyle changes, improving physical health and developing support networks.

There are approximately 240,000 new cases of work-related stress every year.

The rates of work-related stress, depression and anxiety for total and new cases have remained flat for over 10 years.

In 2016/17 there were over 12 million working days lost due to stress, depression and anxiety.

The most affected industries are human health and social work, education, defence and public administration.

The most affected workers are: health professionals (in particular nurses); teaching and education professionals; health- and social care-associated professionals (in particular in the areas of welfare and housing).

Sources: Trades Union Congress, *Safety Reps Guide to the HSE Stress Management Standards*, available at www.tuc.org.uk

Health and Safety Executive, stress statistics, available at www.hse.gov.uk MIND, "Stress – Tips for Everyday Living", available at www.mind.org.uk

Employers have a legal duty to protect the mental health of their workers (see Work-Related Stress and the Law on page 12). Duties include the requirement to assess the risk to workers and to implement measures to control that risk.

Health and safety reps have the right to be consulted in good time on plans, risk assessments and control measures to manage work-related stress. This duty means that safety reps should be consulted on organisational change and the introduction of new working practices or technology that could cause stress in the workplace. Although the Approved Code of Practice (ACoP)[1] to the Safety Representatives and Safety Committee Regulations 1977 (SRSC) does not define 'in good time', it does say that before making decisions (involving work equipment, processes or organisation) employers should allow time to:

▸ provide reps with information about what they are proposing

▸ give reps the opportunity to express their views

▸ take account of any response.

Before implementing any change in the workplace that may affect the psychological health of the workforce, employers should:

1. Consider the hazards. What could cause harm, and how?

2. Consider who could be at risk of harm, and how. Are there any particular groups or individuals that are vulnerable?

3. Evaluate the risks. What control measures are already in place? Are existing measures sufficient and do they adequately control the risks? What new risks may be introduced? What are the priorities?

4. Record and implement the main findings.

5. Monitor and review the effectiveness of any control measures. Revise them, if needed.

Safety reps also have the right to investigate potential hazards and complaints from workers about health, safety and welfare in the workplace and to raise any issues identified with the employer. Once safety reps become aware that there may be work-related stress issues in a workplace, they have the right to raise these concerns with the employer.

Once work-related stress has been identified as a potential hazard, safety reps should be encouraging their employer to follow the five-step process above.

Whether the employer has considered work-related stress as the result of consultations with safety reps about a proposed change, or safety reps having raised it as a potential hazard, or safety reps having raised members concerns, the employer should review their risk assessments and control measures considering the HSE's stress Management Standards six key causes of work-related stress.[2]

Safety reps can encourage their employers to introduce and apply the HSE's stress Management Standards. The TUC and HSE have jointly prepared guidance for health and safety reps on using the management standards (available from: www.tuc.org.uk/sites/default/files/tacking-workplace-stress-guide.pdf). Unions should be involved in the introduction of the standards at every stage – without proper consultation and involvement from unions the standards are unlikely to be effective in tackling work-related stress. The TUC and HSE guidance identifies what employers should aim to achieve for each of the key factors affecting work-related stress:

▸ **Demands:** employees indicate that they are able to cope with the demands of their jobs.

▸ **Control:** employees indicate that they are able to have a say about the way they do their work

▸ **Support:** employees indicate that they receive adequate information and support from their colleagues and superiors

▸ **Relationships:** employees indicate that they are not subjected to unacceptable behaviours, eg bullying at work.

▸ **Role:** employees indicate that they understand their role and responsibilities.

▸ **Change:** employees indicate that the organisation engages them frequently when undergoing an organisational change.

It is important that work-related stress is discussed in an appropriate forum in the workplace, to allow key roles within the organisation to be involved. This could be within the existing health and safety committee or, if necessary, within a specific working group.

If a separate group is established, it is essential that there is trade union representation on the group and that the group reports back to and is accountable to the health and safety committee.

Key people to involve in tackling work-related stress include:

▸ senior management (leadership and resources)

▸ the health and safety manager/adviser (risk assessment and control measures)

▸ line managers (implementing policies and procedures, risk assessment and communication)

▸ human resources (development, implementation and communication of policies and procedures)

▸ occupational health services (supporting individuals experiencing work-related stress, and providing information to identify trends or problems)

▸ safety reps (leadership, development of policies and procedures, identifying and raising concerns about possible problems/solutions relating to work-related stress, and communication with workers).

The TUC and HSE guidance recommends that all members of the group have a good knowledge or understanding of work-related stress and where necessary receive full training on the approach at the beginning of the process.

The TUC and HSE guidance clearly identifies that employers should adopt the same model of approach for work-related stress as applied for any other occupational health & safety hazard, namely:

▶ look for the hazard – what could cause harm and how?

▶ identify people at risk who could be harmed, and how? Is anyone particularly vulnerable?

▶ evaluate the risks and apply the general principles of prevention

▶ record the main findings

▶ monitor and review the effectiveness of any control measures (revise them if necessary).

Since 2002, reps have used the TUC's Stress MOT[3] to survey people in the workplace and to survey the employer. The 'people survey' helps to identify if there is a stress problem in the workplace, while the 'organisation survey' helps to identify how well risks are being managed by the employer. The surveys help union reps develop a stress map of the workplace to identify areas of concern, as well as identifying the main stressors.

There may also be a role for union learning representatives (ULRs) in helping to identify members' training and development needs around work-related stress or in helping to identify and address any training and development issues that are contributing to members' stress and anxiety levels.

Employers trying to change the worker – not the workplace

Despite employers being encouraged to use the HSE stress management standards, cases of workplace stress are not falling. According to *Stress-Related and Psychological Disorders in Great Britain 2014*, an October 2014 report from the HSE, "The rates of work-related stress, depression or anxiety, for both total and new cases, have remained broadly flat for more than a decade."

Overall sickness absence has gone down. This, though, is mainly because of an increase in "presenteeism" as people fear taking sick leave. The recession and austerity cuts have also led to an increase in workplace pressure, especially in the public sector.

Many employers, rather than trying to reduce stress, are introducing what they call "stress management" programmes, which are really nothing to do with prevention.

Typically these programmes have three parts: a) employer attempts at employee support, usually a few sessions of cognitive behavioural therapy or counselling aimed at helping them "cope" and return to work; b) general training on how to deal with stress (usually through learning online) and often including "awareness raising"; and c) giving information or training to line managers on how to recognise and support those with a stress-related condition. Employers stress management programmes are often linked to "wellbeing" initiatives.

What these programmes have in common is that they focus on the effects of stress – not the problem. Although the employer accepts that there is a stress problem, at no time is the working environment being changed. The causes remain, while only the symptoms are being addressed. This is akin to management offering physiotherapy for production line workers with back pain caused by lifting and twisting, rather than reducing the manual handling itself.

Resilience

Additionally, there has been a recent increase in employers asking workers to cope better with stress – an approach called 'resilience'. Resilience is based on the idea that through training and personal development we can be helped to "bounce back" from adversity or change. We just need to develop the ability to handle the demands placed on us better. 'Resilience' is an example of 'blame the worker' (for nor being strong enough to cope with the work stressors), not the work.

As the 2013 article in *Hazards* magazine makes clear, "Resilience is looking at the wrong solution to the problem. We do not want to see workers moulded into robots that can 'bounce back' regardless of what is thrown at them. We want to see workers protected by their employer, reducing and managing the stress that they face. The bottom line is that if there is a problem with stress in the workplace change the workplace – not the worker." (Source: www.hazards.org/stress/resilience.htm).

Someone you know has a mental health problem.

Ready to start your conversation?

it's time to talk. it's time to change

let's end mental health discrimination

You don't have to be an expert to talk about mental health.

Talk, but listen too: simply being there will mean a lot.

Keep in touch: meet up, phone, email or text.

Don't just talk about mental health: chat about everyday things as well.

Remind them you care: small things can make a big difference.

Be patient: ups and downs can happen.

Find out more about mental health and how to be there for someone at time-to-change.org.uk

Sickness absence

Despite Office for National Statistics (ONS) labour market data[4] showing sickness absence rates in the UK consistently falling since 1993, there is still a media perception of a 'sickie' culture among British workers. The ONS data shows that there were 137 million working days lost to sickness absence in 2016, just 4.3 days annually per worker, and 15 million of those lost working days were due to stress, anxiety and depression. Serious mental health problems, such as bipolar disorder and schizophrenia, accounted for just 0.4 per cent of the reasons given for sickness.

The ONS data also shows that sickness absence increases with age, with higher rates for workers aged 35–64.

Research by the Chartered Institute of Personnel and Development (CIPD)[5] in 2013 identified that presenteeism (defined as "people coming in to work when they are genuinely ill and should be at home recovering") was on the increase. The public sector was reported as seeing the largest increase in presenteeism. The CIPD survey also found that 22 per cent of those people who went into work when they were genuinely ill and should have been at home recovering did so because there was an "expectation in their organisation that you come into work no matter what".

The CIPD survey reported that those organisations with an increase in presenteeism were also the organisations with the largest increase in stress and mental health problems.

The mental health charity Centre for Mental Health[6] suggests that presenteeism from mental health alone costs the UK economy £15.1bn annually, whereas absenteeism costs £8.4bn annually.

Unions work with employers to identify ways of supporting disabled people in taking appropriate breaks from the workplace and in managing sickness absence in a way that supports people rather than promoting or encouraging presenteeism.

Employers have a legal duty to maintain records of sickness absence lasting four days or more. Maintaining accurate records can help with their duty to identify hazards to health in the workplace and help them identify types of ill health, the type of worker affected by ill health, areas where there are high levels of absence and whether any of the ill health may have an underlying work-related cause.

Safety reps may find it useful to ask for sickness absence data and occupational health data to be raised at the health and safety committee so that hazards, 'hot spots' (areas of particularly high sickness absence, particularly absences related to mental health and wellbeing) and trends over time or following changes in work organisation may be identified, and to compare health and safety inspection or survey results with sickness absence trends.

Employees have certain rights to access the information held by their employer about them, including medical reports produced by either occupational health or their GP. The *TUC Guidance for Safety Reps on Confidentiality and Medical Records*[7] identifies what union reps should be seeking in order to protect workers on this issue.

Sickness absence policies and procedures

Unions should seek to negotiate agreements covering sickness absence and the rights and responsibilities of workers covered by the agreements.

The agreements would usually cover:

▸ absence definitions, eg sickness absence, disability-related absence, unauthorised absence

▸ how employees report sickness absence (including what needs to be reported, when and to whom)

▸ levels of sick pay

▸ procedures to follow when dealing with both authorised and unauthorised absence

▸ what information relating to absence will be recorded, who has access to the information and how it can and cannot be used

▸ the role of union reps in absence procedures – providing advice, support and representation to members in meetings to discuss absence

▸ rehabilitation and return to work – including reasonable adjustments

▸ the role of occupational health and human resources

▸ identifying and tackling underlying causes of work-related ill health (including mental ill health)

▸ 'trigger points' – levels of absence the employer considers to be of concern.

Trigger points should not be used unfairly to discriminate against workers with disabilities, including those with mental health problems. This would include workers taking time off to care for someone with a disability. Union reps should also seek to negotiate exemptions from sickness absence triggers for any work-related ill health. Case law (*Griffiths v The Secretary of State for Work and Pensions [2015] EWCA Civ 1265*) has established that where a trigger point in an absence policy could lead to a sanction for a disabled person then the duty to consider reasonable adjustment arises – this may include adjustments to the trigger points.

Reps may be required to represent members absent due to their mental health problem. Reps may also be required to represent members who have mental health problems through procedures where the issue is not related to the member's mental health problem. Trade unions and employers have a duty to make reasonable adjustments to support individuals with mental health problems and this may include adapting procedures if necessary.

> **Example:** Wendy has an anxiety disorder that she is managing well and her employer is aware of. She has recently had a period of significant ill health (not related to her anxiety). She has been called in for a routine sickness absence review with her line manager. Her union rep will accompany her to the meeting. Could there be any adjustments needed in the way the union rep and the line manager prepare for and hold the meeting?

Reasonable adjustments and mental ill health

The Equality Act 2010 requires employers (and trade organisations) to make 'reasonable adjustments' for people with disabilities. The duty applies where an employer is aware or 'should reasonably be aware' that a worker has a disability. Reps will need to think about what information the employer has (or has access to) that would help them identify that an individual had a disability. This would include information available through occupational health, for example. There is no legal requirement on the employee to inform the employer they have a disability: however, if a member wants their employer to consider making reasonable adjustments then the member should inform the employer, as the employer may be able to argue that they were not aware of any disability.

Most reasonable adjustments are not costly or complicated to introduce and implement.

The required adjustments can be:

▸ temporary, eg changes to a person's working hours during a phased return to work following a period of sickness absence due to their depression, or

▸ permanent, eg increasing 'personal space' in the office to reduce the impact of office noise and help a person with concentration problems.

The duty to provide reasonable adjustments applies to any disabled person who works for the organisation, applies for a job with the organisation or informs the organisation that they are thinking of applying for a job with the organisation. The duty also applies to trade unions (see Mental health and the law on p8) and can also apply to training and development opportunities.

There are three requirements of the duty to make reasonable adjustments:

▸ changing the way things are done

▸ overcoming physical features

▸ providing extra equipment.

It is vital that the individual's and appropriate specialist advice is sought when agreeing workplace adjustments, so that there is a good understanding of the individual's specific needs. This may include agreeing how questions from other workers will be handled and dealt with.

Sources of advice and information on what adjustments may be required and for how long will be:

▸ the individual

▸ the individual's GP, eg through the Fit for Work Statement ('Fit Note')

▸ any specialist mental health support the individual may be receiving, eg a community psychiatric nurse (CPN) or consultant psychiatrist

▸ occupational health services

▸ union reps, who may have examples from other members or workplaces.

However, it has been established through case law,[8] that the duty to determine reasonable adjustments rests with the employer. The Equality Act 2010 Employment Statutory Code of Practice[9] paragraph 6.24 makes it very clear that an employer cannot argue that its duty has been discharged just because the employee cannot suggest any suitable adjustments:

There is no onus on the disabled worker to suggest what adjustments should be made (although it is good practice for employers to ask). However, where the disabled person does so, the employer should consider whether such adjustments would help overcome the substantial disadvantage, and whether they are reasonable.

Worker's story 1: Reasonable adjustments

Unite is trying to get a food manufacturing employer to think at a different level because mental health is not visible. Members can be affected by changes at work (eg managers or HR practices) and disability. Reps are representing members on reasonable adjustments such as time off for counselling and avoiding being penalised because they can't deal with an interview. The equality rep has negotiated time to leave the job and attended members' homes with HR to discuss return to work with members who cannot yet face coming in to work.

Grievance and disciplinary cases

Grievances

The Equality Act 2010 and the statutory Code of Practice[10] say that employers should not discriminate in the way they respond to grievances. Grievance allegations of discrimination and harassment must be taken seriously and investigated promptly. The Code of Practice also states that where a complaint of discrimination is upheld against another employee, disciplinary action against the perpetrator should be considered.

Employers also have a common law duty to deal with employee grievances promptly and properly.

Many employers will have a grievance procedure in place for dealing with employee complaints. Some may also have separate procedures for dealing with complaints of discrimination or harassment.

If a member with a mental health problem has a complaint about the way they are being treated in the workplace, union reps should consider if the issue affects more than one person. It is important to recognise when individual issues are part of a larger problem that could be dealt with through collective action. Some workplaces have procedures for collective grievances.

It is important in all representation cases to respect the member's rights to confidentiality; this is particularly important in cases involving a member's mental health status. Union reps will need to discuss with the member the extent to which that confidentially extends. Union reps will need to be clear with the member whom else the rep may need to involve in order to represent and support the member.

In some grievance cases concerning members with mental health problems, it may be that the union rep has to express the member's own views and concerns. Some procedures limit the union rep's role to advice and support for their member; in these procedures the rep could request a reasonable adjustment to enable them to speak on their member's behalf.

When representing a member with mental health problems, it may be necessary for the union rep to discuss with the member the impact of their mental health problem on cognitive functions such as memory, concentration and emotions. This will enable the rep and member to discuss how best to deal with any issues during the representation relationship.

> **Example:** Ada has bipolar disorder and wants to lodge a grievance against her line manager for using discriminatory language. Although Ada's mental health problem is well managed, she does have problems with concentrating for long periods. Ada also sometimes finds it difficult not to talk excessively when nervous. Ada's union rep will need to consider how long meetings are (either when preparing for the grievance hearing or the hearing itself). The union rep may need to agree with Ada a 'talking strategy' for when they are in the meeting with the employer.

It is important to remember that only a small minority of people with mental health problems lack the ability to make decisions some or all of the time. Historically, people with mental health problems have been viewed as incapable of making 'good choices' and decisions. When decisions are made for them, people with mental health problems can often feel disempowered. Members with mental health problems should be engaged in discussions about the best way to proceed with their case, in the same way that members without mental health problems would. It is particularly important that members with mental health problems are engaged (and feel engaged) in decisions about their case.

Victimisation

The Equality Act 2010 protects people from being treated detrimentally because they have made an allegation about discrimination or they supported someone who has made an allegation of discrimination (see Victimisation page 12).

Representing members with mental health problems in disciplinary procedures

The Acas (Advisory, Conciliation and Arbitration Service) Code of Practice 1: Disciplinary and Grievance Procedures is the key source of information for employers and union reps when dealing with disciplinary matters in the workplace. The Code of Practice (COP) is supported by guidance. Unfortunately neither the COP itself nor the guidance makes any reference to protected characteristics under the Equality Act and reasonable adjustments to disciplinary procedures.

However, the Equality Act 2010 Employment Code of Practice does identify that modifying disciplinary procedures for a disabled worker is an example of a reasonable adjustment. The COP makes it clear that procedures should not discriminate against a disabled person in the way that it is either designed or put into practice. This means that an employer must not discriminate in the way it invokes the procedure or follows the disciplinary process. This includes an employer's procedures for dealing with both conduct and capability.

When members with mental health problems are faced with disciplinary procedures, reps should investigate the following:

▶ Does the disciplinary process itself treat the member less favourably than a member without a mental health problem? This could be indirect discrimination.

▶ Is the real reason for the disciplinary the member's mental health problem? This could be direct discrimination.

▶ Does the member have mitigating factors that are related to their mental health problem?

▶ Has the employer perceived the member's mental health behaviours as a disciplinary issue?

▶ Has the employer put reasonable adjustments in place? Are the adjustments suitable and sufficient to assist the member?

▶ Is the action related to attendance or sickness absence connected to the member's mental health problem?

▶ Does the employer recognise and accept that the member has a mental health problem and is therefore covered by the Equality Act?

An employment appeal tribunal judgement[11] in 2014 identified that for an employer to dismiss for gross misconduct there needs to be culpability on the part of the employee and that it is important for employers to take mitigating circumstances into account, such as the employee's mental health. To identify culpability the employer should explore whether the employee had committed the misconduct wilfully or in a grossly negligent way. The employer should ask the question, "Does the employee's mental health problem affect their ability to control their actions?" The case also highlights that employers should consider reasonable adjustments in order to support individuals in the workplace, even where their behaviour would normally be classified as gross misconduct.

An employment appeal tribunal judgement in 2016 (*City of York Council v Grosset [2016] UKEAT/0015/16/BA*) found that where the employer knows or should know of an employee's disability they are "put on notice" of that disability and that the employer should consider if the disability and any misconduct are linked.

Bullying and harassment

Despite mental health problems being very common there is still stigma attached to them. Research for Mind,[12] the mental health charity, suggests that 38 per cent of people with mental health problems have been teased, harassed or intimidated at work. A quarter of those said it was by their colleagues, with 16 per cent saying it was by their manager. Just over one in three people felt that they had been dismissed or forced to resign because of their mental health problem.

The Equality Act 2010 makes it clear that harassment related to a protected characteristic, such as a mental health problem, is a discriminatory act. Employers have a duty to protect their employees from harassment related to their mental health problem. Employers should make it clear that bullying and harassment are unacceptable in the workplace and acts of bullying and harassment will be subject to disciplinary procedures.

Worker's story 2: Disciplinary procedures

Our member was a senior teacher with over 25 years' service.

Six months before he was referred to his rep, his child had been the victim of a vicious attack. For several months the member cared for his child, who suffered severe nightmares and broken sleep patterns. The member made his line manager and head of HR aware of the situation, enquiring whether there was any assistance available to him. None was forthcoming. However, the school did have a stress policy that the member would have been covered by, as well as a discretionary absence policy for family matters. Neither procedure was triggered.

In a full staff meeting two months after this, staff were informed of a restructure. The member became aware that his role would no longer exist under the new proposed structure, with potential significant loss of income.

Six months after the attack on his son, the member was suspended from work for allegedly misappropriating belongings of pupils, staff and school from lockers and classrooms.

The member disclosed the background to his union and went to his GP. He was signed off initially for two weeks with anxiety and severe depression, and then there was an emergency referral to a mental health crisis team.

An adviser from the mental health team attended the disciplinary investigation meeting to support the member and provide information for the investigating officer. It was explained that he was still undergoing assessment, but it was likely that he was suffering from a disassociative state when he demonstrated odd behaviours in his colleagues' classrooms. The school was advised that they should have a full psychiatric assessment done, so that this could be confirmed and a line drawn under the matter.

However, the school went ahead with arranging a disciplinary hearing with potential allegations of gross misconduct. The rep intervened, querying why a hearing date had been set without having an OH report or a psychiatric assessment as they had been advised by the specialist mental health team. The rep raised the potential for disability discrimination if the disciplinary hearing went ahead.

The school agreed to postpone the hearing pending an OH referral and receipt of recommendations. These were in line with mental health team advice.

No disciplinary action was taken.

Union reps can work with employers to promote mental health wellbeing, reduce and tackle the stigma attached to mental health problems and educate employees about common mental health problems. Union learning representatives can play an important role in learning and training programmes that address mental health wellbeing and mental health awareness.

Bullying and harassment around mental health problems may take the form of:

▶ making public the nature of the person's mental health problem

▶ using offensive and discriminatory language to describe a person or their mental health problem

▶ spreading malicious rumours about the persons' mental health problem or their behaviours

▶ belittling, ridiculing or undermining the person due to their mental health problem

▶ excluding the person from workplace or social activities.

It should be remembered that the duty not to discriminate also extends to a 'perception' about someone's mental health. So, if someone without a mental health problem is harassed because their colleagues think they have one, this could amount to harassment under the Equality Act.

Work and suicide

According to the Office for National Statistics (ONS) there were 5,965 suicides in the UK in 2016. Around three-quarters of all suicides in 2016 were male. (Source: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ deaths/bulletins/suicidesintheunitedkingdom/2016registrations). The ONS figures show that there is a strong link between suicide and occupation, particularly amongst groups associated with increased workplace stress. The Samaritans and *Hazards* magazine have also reported job insecurity, zero-hour contracts, workplace downsizing, restructuring and job losses as important risk factors. (Source www.tuc.org.uk/sites/default/files/work-and-suicide.pdf).

Unions can have a role to play in helping to prevent suicides and supporting those who may have suicidal thoughts. The TUC guide *Work and Suicide* (available from: www.tuc.org.uk/sites/default/files/work-and-suicide.pdf) identifies that there are two main areas where union representatives can help make it less likely that someone in their workplace will end their lives.

Prevention

Unions can try to ensure that the workplace is not contributing to a person's mental health problems by tackling issues such as stress, bullying and harassment. They can also ensure that their employer has processes to help identify individuals at risk, support those people and raise awareness of the complex issues surrounding suicide. That means negotiating policies that cover these areas and reviewing existing policies.

Supporting individuals

Union representatives should not be expected to be qualified counsellors. But often they are the person that a worker will contact when they have a problem and representatives can support these people and ensure that they know where they can get help.

Union representatives should:

▸ raise the issue of suicide and suicide prevention as a workplace issue with the employer

▸ review existing policies on stress management, bullying and harassment, mental health, sickness absence management

▸ seek training on mental health issues

▸ ensure organisations supporting mental health are involved in any health or wellbeing events

▸ encourage members to talk to you about any problems that they are having at work.

Unions should also make their employer aware of the Public Health England and Business in the Community toolkit for employers on suicide prevention (available here: https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkit).

Member threatening imminent suicide

If a member tells you that they are actually going to try to kill themselves rather than they have had suicidal thoughts in the past you should treat it as a medical emergency and call 999.

For more information on work and suicide see the TUC guide to prevention for trade union activists www.tuc.org.uk/sites/default/files/work-and-suicide.pdf

Training and workforce development

The right training and development can be a significant factor in supporting people with mental health problems in the workplace. This could either be part of reasonable adjustments for an individual with mental health problems or as part of a wider approach to mental health awareness training for all workers.

Reps involved in negotiating and agreeing workforce development and training plans can include mental health as part of these discussions.

This could involve:

▸ individual assessment needs for members with mental health problems

▸ checking that learning and training providers can support members with mental health problems

▸ identifying the role of learning and training opportunities as part of the overall approach to reasonable adjustments

▸ identifying and developing mental health awareness training for all staff including, for example, stress awareness, understanding common mental health problems and mindfulness

▶ specific training for line managers such as supporting staff with mental health problems or handling difficult conversations

▶ specific training on mental health first aid (see appendix 2).

Reps may want to analyse information from such sources as disciplinary and grievance cases, accident and incident investigations, ill-health reviews, appraisal appeals and workplace inspections in order to identify any trends or issues that might relate to mental health and whether there are any training or development needs for individuals or the organisation.

Reps should ensure that any training provided as part of workplace policies and any wider workplace campaigning activities are suitable and sufficient. For example, clearly identifying who will be receiving mental health awareness training (general training developing a better understanding of mental health and wellbeing at work) and those people who will be receiving mental health first aid at Work (a specific course developing deeper understanding of mental health, the factors that can affect wellbeing, and developing practical skills to spot the signs of mental health distress and methods of supporting a person needing assistance).

Worker's story 3: Training and development

Linda Craven is full-time Usdaw convenor at a Manchester call centre, and Michelle Griffiths is her deputy.

Work in the call centre can be very stressful, dealing with angry callers and workers required to complete specific objectives with every caller, along with pressures on targets, performance, timekeeping, and out-of-work pressure. The union was aware that some long-term absences were due to stress, depression and anxiety.

Usdaw asked the employer to survey its members. The employer refused, so the union said it would do the surveying outside the workplace and distribute information about mental health. At this, the employer decided to begin a programme of mental health first aid training that would be cascaded down to 30 mental health first aiders who were trained to spot the early stages of mental health problems and provide help on a 'first aid' basis. The union argued successfully that the 10 existing Usdaw workplace reps be included because of the trust and confidentiality they already had with their colleagues.

Michelle Griffiths volunteered to attend the first set of training courses, having represented members in disciplinary meetings and finding that stress and anxiety were often raised in discussion.

The course was delivered over two days and comprised four sessions.

The first looked at what mental health is, the impact and cost of mental health problems, drugs, alcohol and depression and their influence on mental health and why there should be mental health first aid.

The second dealt with suicide and how to listen and help somebody who may be suicidal, treatment and resources for depression and about listening non-judgementally.

Session three covered anxiety, first aid for panic attacks, reactions to stress, self-harm and eating disorders.

The fourth session focused on psychosis, bipolar disorder and schizophrenia. It covered recovery from these conditions and action planning for using mental health first aid.

Overall, the training showed how to:

▸ spot early signs of a mental health problem

▸ feel confident in helping someone with a problem

▸ prevent someone harming themselves or others

▸ help stop mental illness getting worse

▸ help someone to recover faster

▸ guide someone to the right support, and

▸ very importantly, reduce the stigma attached to mental health problems.

The benefits for the business included:

▸ assistance in tackling prejudice and stigma

▸ assisting employees with mental health issues

▸ assisting employees to remain in work

▸ a reduction in sickness and absence

▸ the promotion of emotional and mental health and wellbeing.

The employer is now extending the same training to other sites.

In summary, the mental health first aid process:

▸ provides help on a first aid basis, using company restrooms when assisting individuals

▸ helps mental health first aiders be confident in helping someone experiencing a problem

▸ helps prevent someone harming themselves or others

▸ assists in faster recovery

▸ guides people to the right support

▸ promotes the company's mental health wellbeing.

Michelle has subsequently completed a certificate in mental health awareness at college, supported by Usdaw.

Worker's story 4: Training and development

A Unite learning rep in the steel industry noticed large numbers of people going sick with stress, and set up mental health first aid courses in the workplace supported by the union and the Wales Union Learning Fund. It has been attended by 700 people and has now been incorporated into the company's wellbeing policy.

Activity 4 ▸
Stress and mental health

Aims

To help you:

▸ think about stress in your workplace

▸ identify areas for development/improvement.

Task

Talk to other representatives in your workplace about work-related stress and determine:

▸ whether the union has carried out the TUC Stress MOT in your workplace

– If yes, are actions being taken to address the issues identified?

– If no, would it be useful to do so?

▸ whether union reps, safety reps and union learning reps routinely discuss work-related stress and mental health issues with the employer

▸ if the employer applies the HSE Stress Management Standards

▸ if there are any specific policies or procedures that relate to stress or mental health in your workplace

▸ what steps are being taken to tackle work-related stress

▸ what information or advice is available to members about maintaining mental health wellbeing.

Prepare a report for the rest of the group or your union branch on any additional steps or actions that may need to be taken.

Activity 5 ▶
Sickness absence and mental health

Aims

To help you:

▶ review your workplace procedures

▶ identify areas for development/improvement.

Task

Using your workplace's handbook or staff manual and from talking to other union reps and officials, find out:

▶ what procedures are used for managing sickness absence

▶ the trigger points for intervention

– Does absence related to mental health problems count?

– Does absence from work-related stress count?

▶ the role occupational health plays in sickness absence

▶ whether members with mental health problems are entitled to time away from work to receive help or treatment

– If yes, is this counted as an absence?

▶ how options for reasonable adjustments are identified and discussed

▶ the range of reasonable adjustments available.

Prepare a report for the rest of the group or your union branch on any additional steps or actions that may need to be taken.

Activity 6 ▶
Grievance and disciplinary policies and procedures

Aims

To help you:

▶ be clear about your employer grievance and disciplinary policies and how they relate to mental health

▶ identify areas for development/improvement in your employer's policies.

Task

Talk to a senior union official or someone from HR and obtain copies of your employer's grievance and disciplinary policies and procedures.

▶ Do the procedures allow members with mental health problems to be accompanied at all stages of the process?

▶ Do the procedures allow for reasonable adjustments based on disability? If yes, does this include mental health problems?

▶ Does the disciplinary procedure identify that the employer will consider mitigation in disciplinary hearings?

▶ Are there any issues relating to how the procedures are applied in practice?

Prepare a report for the rest of the group or your union branch on how the employer's procedures could be improved.

Activity 7 ▶
Support available to members

Aims

To help you:

▶ become familiar with the support available to members with mental health problems

▶ identify areas for development/improvement in the support available.

Task

Talk to other union officials and your employer and identify the support available to members with mental health problems through:

▶ the employer

▶ your union

▶ other organisations such as local charities or self-help groups. If support is available through other organisations, has this link been established by the employer or the union?

How do members access this support?

Are there any costs associated with the support?

▶ If yes, who meets the costs?

How well publicised is the support available?

Are there facilities for members to turn to in a mental health crisis?

Prepare a report for the rest of the group or your union branch on how the support for members could be improved.

Activity 8 ▶
Workplace issues

Aims	To help you:
	▶ clarify the types of mental health issues in your workplace
	▶ consider your priority actions.

Task	Talk to other union officials (for example reps, safety reps, equality reps, learning reps and full-time officials) and members and try to identify the types of issues and cases relating to mental health that are being faced in the workplace.

How is this information used by the union?
For example:

▶ Does it feed into the union's bargaining agenda?

▶ Are individual cases used to identify areas of wider concern?

▶ Are members with mental health problems involved in deciding union priorities on issues affecting them?

Prepare a report for the rest of the group or your union branch on how the information could be gathered and used to develop the union's profile and activity in the workplace.

Prepare a report for the rest of the group or your union branch on how the support for members could be improved.

Notes

[1] TUC 2015, *Safety Representatives and Safety Committees* (known as 'the brown book'), available at www.tuc.org.uk

[2] Health and Safety Executive 2015, "Management Standards for Work-Related Stress", available at www.hse.gov.uk

[3] TUC 2015, "TUC Stress MOT", available at www.tuc.org.uk

[4] Office for National Statistics (2016), *Sickness Absence in the Labour Market*, available at www.ons.gov.uk

[5] CIPD 2013, *Employee Outlook*, available at www.cipd.co.uk

[6] Centre for Mental Health 2010, *Economic and Social Costs of Mental Health Problems*, available at www.centreformentalhealth.org.uk

[7] TUC 2009, "Confidentiality and Medical Records", available at www.tuc.org.uk

[8] Bailii.org.uk, case law

[9] Equality and Human Rights Commission 2015, *Employment: Statutory Code of Practice*, available at www.equalityhumanrights.com

[10] as 9

[11] as 8

[12] University of Leeds, research for Mind, available at www.leeds.ac.uk

This picture is used here in this context for illustrative purposes only

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Section 3

Organising around mental health

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Campaigning

Unions have a long history of campaigning for change in the workplace and beyond, not only on employment rights or safety issues but also on the way people are viewed in the workplace and in society.

There is much stigma and discrimination around mental health and particularly mental ill health. These are issues of justice, equality and fairness – core trade union business.

People with mental health problems face social and workplace exclusion, particularly in times of austerity. They are at risk of being marginalised in the workplace and of being denied access to secure and sustainable employment and access to medical and social care.

There has never been a more important time for unions to campaign to raise awareness of the issues facing people with mental health problems, although they should always be linked to prevention as well.

Campaigns on mental health can:

▸ increase awareness of any problems with stress in the workplace and seek to ensure the employer takes action

▸ raise awareness about issues facing people with mental health problems and their causes

▸ provide information on practical solutions and examples of good practice

▸ increase people's understanding of mental health in workplaces and the community

▸ dispel myths and fears about people with mental health problems

▸ encourage people with mental health problems to talk about their experiences

▸ encourage people with mental health problems to become active in their workplace, communities and union

▸ engage with charities and local support/campaign groups to build relationships and access support and services.

It is important to involve people with mental health problems in designing and running your campaign. They have the best understanding of the issues and it helps to build trust and confidence. It may also give members with mental health problems an opportunity to engage in workplace or trade union activity in a way that they have not done before.

Worker's story 5: Campaigning

Paul Mooney is UCATT health and safety adviser and convenor at a major construction site in Glasgow. Paul described a four-year programme run with NHS Scotland and Healthy Working Lives to tackle mental health problems at work.

The challenges were:

▸ mental health, and the stigma attached to it

▸ health and safety at work

▸ the accident frequency rate

▸ the mentality of the construction industry.

The benefits of the programme were:

▸ support, advice and signposting for the workforce

▸ awareness training

▸ an educated workforce

▸ a workforce engaged with the programme

▸ sustainability.

The project involved:

▸ creating the DVD Ahead for Health, which encouraged workers to think about their mental health and included simple, everyday ways to stay well (www.youtube.com/watch?v=ABKuz8BCb_8)

▸ 'tool box talks' training on health and safety and mental health.

The campaign and awareness sessions covered the following topics:

▸ reading between the lines, illustrating ways of seeing when someone was hiding how they truly felt

▸ understanding stress

▸ advice sessions on debt

▸ health awareness roadshows

▸ information about cancers and awareness about drugs and alcohol.

The campaigns and awareness sessions continue. The programme has won the Multiplex Global Safety award and the good practice established on site is to run through Brookfield Multiplex Construction Europe. For the future, it is intended to run 'back to basics' campaigns and hold occupational health MOTs. This involves highlighting a circle of behaviour: accountability; supervision (going to the right person); information; safety; and communication, with 'you' in the middle of the interlocking circle.

The union's input has been recognised by the employer, the NHS, Healthy Working Lives (Scotland) and the Royal Society for the Prevention of Accidents (ROSPA), winning its Workforce Involvement in Safety and Health Award 2014.

Worker's story 6: Campaigning

Unite is running a Looking for Trouble campaign designed to get worker reps involved in dialogue with employers, particularly focused on creating a climate where workers will feel comfortable raising their concerns about stress and psychosocial risks.

The agenda for good health and safety aims to ensure that:

▶ work is designed to fit the worker

▶ mental health issues are dealt with appropriately

▶ stress management is undertaken with full participation in a workplace culture that encourages the raising of concerns without fear of ridicule or victimisation.

Organising and supporting members and workers with mental health issues

Trade unions organise and represent the collective interests of workers – locally, regionally and nationally.

There are several common issues raised by union members and potential members when identifying why they do not join or play an active part in their union. These can include:

▶ never having been asked

▶ union structures not representing particular groups.

Many people with mental health problems can face discrimination and prejudice and may feel invisible and under-represented in the workplace and union. They may initially feel more comfortable discussing their issues and concerns with people who have had similar experiences.

Union reps may want to consider:

▶ organising workplace forums for members with mental health problems

▶ talking to members informally and formally about their experiences in the workplace and union – what are their issues and what are their ideas for resolving the issues?

▶ organising union-led training on the issues that members with mental health problems have identified

▶ encouraging members with mental health problems to get actively involved, perhaps even asking members to run any workplace forums

▶ ensuring their union's equality structures are in place and supported

▶ engaging with local campaign groups and charities on equality campaigns in the workplace and local communities

▶ campaigning on stress.

When building alliances with other organisations, think about:

▸ developing relationships, and building on these to identify other allies

▸ identifying their issues and priorities and identifying common ground

▸ involving existing members and activists – they may have links to other organisations

▸ developing and nurturing new relationships

▸ organising joint events and activities that involve the wider community; union reps are opinion-formers in the community as well as in the workplace.

Worker's story 6: Organising by Louise Grainger, Equity

Arts' Minds is a joint initiative from three of the key players in the UK entertainment industry – Equity, *The Stage* and Spotlight. We came together following requests from performers and creative practitioners for there to be more awareness within our industry of the mental health issues they face. The catalyst for this was a very sad spate of suicides, which led to calls for action.

We responded by working with the British Association of Performing Arts Medicine (BAPAM) to create a survey, which we then put out to the members of Equity and Spotlight (the main casting resource for the UK) and further publicised through *The Stage*. We also sent it to people who had made use of BAPAM services. This gave us a very broad field of people working in the creative industries and some 5,000 people completed it.

Now we are using their responses to ensure that the website we are developing (www.artsminds.co.uk) includes the areas that are of concern to people in the entertainment industry. The industry has some very particular pressures and structures that throw up challenges for mental wellbeing. We are trying to ensure that the website will be a useful resource that deals with the specific issues and areas that came out of the survey, providing information and signposting to help and support.

In addition we are working with the Edinburgh Fringe again this year to provide a calm, secluded space where artists can find some peace and quiet in the pressurised hubbub that is the festival. The Sanctuary will be available on one day of each week of the Fringe and open to all performers. We are also including some wellbeing-orientated sessions within our events programme at the Fringe alongside the work issue ones; for example, we have a session on Staying Motivated and one on practical warm-up exercises in impossible spaces called Don't Break a Leg, and are working with the Samaritans to run a session in the final week of the Fringe entitled Your Emotional Health.

Finally, Equity is continuing to work jointly with the other entertainment unions (MU, NUJ, Writers' Guild and BECTU sector of Prospect) on its joint Creating Without Conflict initiative focused on bullying as we identified the entertainment industry as being a hotspot for bullying. Within Equity we have a members' working group and are about to produce some new material for members on what they can do and are looking at developing some new training to disseminate to members through our branch structures. Within the wider Federation of Entertainment Unions we are engaging with employers on these issues.

Preventing stress

The TUC has produced joint guidance on preventing stress using the HSE Stress Management Standards

www.tuc.org.uk/research-analysis/reports/safety-reps-guide-hse-stress-management-standards

This checklist tells you simply what you need to do.

TUC checklist for health and safety reps:

▶ Is there a problem with stress in your workplace?

▶ Has the employer taken effective action to address this?

▶ If not have they done a risk assessment that includes stress?

▶ If not, or it is inadequate – ask for one to be done (this is a legal requirement)

▶ If they have done a risk assessment, have they acted on the findings?

▶ If not – ask for a prevention plan.

If your employer has introduced support for people with stress-related conditions instead of prevention measures, insist that they use the HSE management standards.

Make every job a great job

In 2017, the TUC launched the campaign Great Jobs for Everyone. The campaign launched a charter to make every job a great job. The charter says that all workers must:

▶ be paid fairly

▶ work in a safe and healthy workplace

▶ be treated decently

▶ have regular hours

▶ get a voice on what matters at work

▶ get the chance to get on in life.

Securing great jobs for everyone means unions negotiating and campaigning for mentally healthy workplaces. You might want to include the charter to make every job a great job in your organising and campaigning activities around mental health.

Notes

[1] TUC 2015, *Safety Representatives and Safety Committees* (known as 'The Brown Book'), available at www.tuc.org.uk

[2] Health and Safety Executive 2015, *Management Standards for Work-Related Stress*, available at www.hse.gov.uk

[3] TUC 2015, *TUC Stress MOT*, available at www.tuc.org.uk

Activity 9 ▸
Campaigning on mental health

Aims

To help you:

▸ plan a workplace- or community-based campaign on mental health

▸ clarify your objectives.

Task

Talk to other reps and members in your workplace about developing a campaign around mental health.

From your discussion, develop an outline campaign plan. It should include:

▸ Your aim/purpose

– What do you want to achieve?

▸ Your objectives

– What smaller outcomes will help to achieve your overall aim?

– How will it benefit members, the union, the employer, other people and organisations?

▸ Tactics and actions

– What practical things will need to be done to help achieve the aims and objectives, eg leaflets, social media presence, letters, posters, demonstrations?

– How will the campaign be publicised?

▸ Resources

– This includes, finance, people and venues, as well as any campaign materials

– Who is in the campaign team?

– Do you need to build any alliances with other organisations?

▸ Timescale

– How long will your campaign last? Develop a timeline with key dates for actions and events.

▸ How the campaign will involve and engage with members (and potential members).

Prepare a report for the rest of the group or your union branch on your outline campaign plan.

Appendix 1
Mental health problems

Common mental health problems

Anxiety

Anxiety is something we all experience from time to time. Most people can relate to feeling tense, uncertain and perhaps fearful at the thought of sitting an exam, going into hospital, attending an interview or starting a new job. It is a feeling of unease and can be mild or severe.

If the anxiety stays at a high level for a long time, the person may feel that it is difficult to deal with everyday life. The anxiety may become severe; the person may feel powerless, out of control. Sometimes, if the feelings of fear overwhelm them, the person may experience a panic attack.

Anxiety is the main symptom of several mental health conditions, including:

▸ Generalised Anxiety Disorder: feeling anxious for a long time and often being fearful; not anxious about anything specific. This broad condition affects people in different ways.

▸ Obsessive Compulsive Disorder: see p63 for more information.

▸ Post-Traumatic Stress Disorder (PTSD): developing strong feelings of anxiety after experiencing or witnessing something very traumatic. PTSD can cause flashbacks and nightmares where the person is reliving all the emotions experienced during the event(s).

People with anxiety disorders can experience one or more of these symptoms:

▸ feelings of fear or dread

▸ feeling tense or 'jumpy'

▸ restlessness or irritability

▸ anticipating the worst and being watchful for signs of danger

▸ feeling the mind is overflowing with thoughts

▸ dwelling on negative experiences

▸ inability to concentrate or focus

▸ a pounding or racing heart and shortness of breath

▸ stomach upsets

▸ sweating, tremors and twitches

▸ headaches, fatigue and sleep disturbances

▸ frequent urination and diarrhoea.

Treatment can include counselling (sometimes called talking therapy), medication, relaxation and exercise programmes.

Five per cent of the UK population has anxiety problems.

Post-traumatic stress disorder affects 2.6 per cent of men and 3.3 per cent of women.

Generalised anxiety disorder affects between two and five per cent of the population.

The highest levels of anxiety are experienced in the 35–59 age group.

On average, all ethnic groups report higher levels of anxiety than people who describe themselves as White British.

Source: Mental Health Foundation, anxiety statistics, available at www.mentalhealth.org.uk

Depression

Feeling sad or fed up is a normal reaction to experiences that are upsetting, stressful or difficult, and those feelings usually pass. But sometimes the feelings interfere with your life and don't go away, or they come back, over and over again. Depression can mean having intense feelings of persistent sadness, helplessness and hopelessness, alongside physical effects such as sleep disturbance, lack of energy or feeling general aches and pains.

At its most severe depression (clinical depression) can be life-threatening. It can make the person feel suicidal or simply give up on life. Sometimes people may not realise how depressed they are, especially if they have been feeling the same for a long time.

Depression can happen to anyone.

There are some specific types of depression

▸ Seasonal affective disorder: this is linked to day length and usually comes on in the autumn and winter, when days are shorter and the sun is lower in the sky.

▸ Post-natal depression: it is estimated that as many as 85 per cent of mothers experience the 'baby blues', but this usually passes within a few days. Post-natal depression is more serious and can occur between two weeks and two years after the birth, affecting about 10 per cent of mothers.

▸ Bipolar disorder: see p66 for more information.

▸ Dysthymia: sometimes called persistent depressive disorder, this is a chronic (lasting longer than two years), usually mild-to-moderate depression. Many people with dysthymia may experience symptoms for many years before seeking help or being diagnosed. Some people believe that feeling like this is just part of their character and therefore never seek help or advice.

Common symptoms of depression include:

- tiredness and loss of energy
- difficulty concentrating
- finding it hard to function at work
- thinking about suicide and death
- loss of self-confidence and self-esteem
- not being able to enjoy things that are usually pleasurable or interesting
- undue feelings of guilt or worthlessness
- feelings of helplessness and hopelessness
- sleeping disturbance – difficulties in getting off to sleep or waking up much earlier than usual
- avoiding other people, sometimes even your close friends
- loss of sex drive and other sexual problems
- higher use of tobacco, alcohol or drugs than usual.

- persistent sadness
- loss of appetite
- physical aches and pains
- self-harm.

Treatment can include counselling (sometimes called talking therapy), medication, brain stimulation therapies, light therapy, mindfulness, relaxation and exercise programmes.

Between 8 and 12 per cent of the UK population experience depression in any year
1 in 4 women and 1 in 10 men will seek treatment for depression.
More than 50 per cent of people who have a depressive episode will have a second.
For 1 in 5 people the condition is chronic.
Irish people living in the UK have higher rates for depression than any other ethnic group.
LGBTI people are at a higher risk of depression.
Depression in ethnic minority groups is 60 per cent higher than in the white population.
80 per cent of those treated for depression have an improvement in their symptoms.
An estimated 50 per cent of unsuccessful treatment is linked to medication non-compliance, in part due to societal pressure to not be on medication long term: research has shown that societal and workplace support can increase medication compliance to 86 per cent.

Sources:
Depression Bipolar Support Alliance, depression statistics, available at www.dbsal.org
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk
Mental Health Foundation, *Mental Health A–Z*, available at www.mentalhealth.org.uk

Mixed anxiety and depression disorder

This is the most common mental health condition in the UK, with almost nine per cent of the population meeting the criteria for diagnosis. It is a condition where the person has a variety of symptoms of both anxiety and depression but none sufficient to warrant a separate diagnosis of either a depressive disorder or an anxiety disorder.

Many people with work-related stress will have the symptoms associated with mixed anxiety and depression disorder.

Treatment tends to be aimed at medication to treat the depression along with counselling for the anxiety symptoms. However, some newer antidepressant medications are being used that can treat both the depression and the anxiety.

Obsessive Compulsive Disorder (OCD)

This is a common form of anxiety disorder involving distressing and repetitive thoughts that come into the person's mind automatically, however irrational they may seem and no matter how much the person tries to ignore them. Unlike in psychotic conditions, the person knows that the thoughts are their own.

Compulsions are actions that people feel they must repeat in order to feel less anxious or in order to reduce or stop the compulsive thoughts. Carrying out the compulsion usually gives temporary relief from the anxiety. Sometimes the anxiety can increase, as the person feels that they did not carry out the compulsions properly.

Common obsessions include:

▶ fear of contamination

▶ fear of causing harm to someone else or themselves

▶ an urge to cause harm to someone

▶ fear of behaving unacceptably – this may be in a sexual or religious way

▶ the need for symmetry or exactness.

Common compulsions include:

▶ checking

▶ cleaning

▶ counting or repeating a specific word or phrase

▶ dressing rituals.

Treatment can include counselling (sometimes called talking therapy) and medication.

2 to 3 per cent of people will experience OCD during their lifetime; it often takes 10–15 years for people to seek help.

Research suggests that there is no significant difference in rates of OCD across age, gender, ethnicity, religion or socio-economic group.

Sources:
OCD-UK, "How Common is OCD?" available at www.ocduk.org
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Phobias and panic attacks

A group of disorders where anxiety is experienced in certain well-defined situations that are not dangerous. The fears are out of proportion to the real dangers. Often these situations are avoided or endured with dread.

There are three types of phobia:

▸ Social or situational: anxiety about how the person is seen or judged by other people or a fear of being humiliated in social situations; fear of flying, tunnels, specific types of travel, walking near water, going to the dentist.

▸ Fears of things: fear of animals, the natural environment (eg water, heights), fear of body-based things (eg blood, vomit), fear of objects (eg peanut butter, buttons).

▸ Complex phobias: this is where there are combinations of fears linked together, eg agoraphobia – a combined fear of leaving home, going into shops, crowds and public places or travelling alone in trains, buses or planes. Complex phobias tend to be more debilitating than single phobias.

People with phobias may experience panic attacks when they cannot separate themselves from the trigger for their phobia.

There is some debate about when a fear of something extends into a phobia. To be defined medically as a phobia the fear must cause a level of physical and/or psychological impairment.

Panic attacks and panic disorder

A panic attack is a severe attack of anxiety and fear that occurs suddenly and may include one or more of these symptoms:

▸ a thumping heart (palpitations)
▸ sweating and trembling
▸ a dry mouth
▸ hot flushes or chills
▸ chest pains
▸ feeling sick (nauseated), dizzy or faint
▸ feelings of dread or a fear of dying
▸ numbness or pins and needles
▸ feeling short of breath, sometimes with choking sensations
▸ feelings of unreality, or of being detached from oneself.

During a panic attack people tend to over-breathe (hyperventilate); due to a rise in carbon dioxide levels in the blood this can lead to further hyperventilation as the body tries to get rid of the carbon dioxide, and cramps, dizziness, pins and needles and confusion. Sustained hyperventilation can cause fainting, though once the person has passed out their breathing usually returns to normal.

One in fifty people may develop a panic disorder. This is anxiety disorder characterised by recurring severe panic attacks. Often there will be no trigger for the panic attacks and people become stressed, anxious and worried about when the next attack will occur.

Treatment can include counselling (sometimes called talking therapy), hypnotherapy and medication (to treat significant anxiety). First aid care may be required for someone experiencing a severe panic attack.

The NHS estimates that 10 million people in the UK have a phobia.

2.2 per cent of men and 3.3 per cent of women have a medically diagnosed phobia.

Sources:
NHS Choices, "Phobias", available at www.nhs.uk
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Severe mental health problems

Psychosis

Psychosis (sometimes called a psychotic experience or episode) is not a mental health condition in itself: it is triggered by other conditions, for example schizophrenia, bipolar disorder or severe depression. It can also be a symptom of physical conditions such as Parkinson's disease or a brain tumour, or as a result of drug and/or alcohol misuse.

▸ Psychosis is when a person loses touch with reality, having changed perceptions about the world. This could include experiencing hallucinations, delusions or flights of ideas.

▸ Hallucinations are when a person hears, sees, smells, senses (touches) or tastes things that aren't there.

▸ Delusions are when a person believes things that, when examined rationally, are obviously untrue.

▸ Flights of ideas are when the person's thoughts move very quickly from idea to idea, sometimes making links that other people don't.

The key difference between psychotic delusions and obsessions in OCD are the level of insight the person has into the origins of the thoughts. More often than not, people with OCD know the thoughts and obsessions are their own: in psychosis the person does not recognise the delusions as being their own thoughts.

The combination of hallucinations and delusional thinking can often severely disrupt perception, thinking, emotion and behaviour.

Treatment will depend on the underlying cause of the psychosis.

About one in 200 adults will experience a psychotic disorder in a year.

Less than 25 per cent of people who have psychotic experiences remain permanently affected by them.

Four per cent of people in the UK say they have experienced one symptom of psychosis, such as delusions or hallucinations during their lives, paranoid thoughts being the most common.

Source: Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Bipolar disorder

Bipolar disorder affects how people feel and can make their mood change dramatically. Their mood can swing between an extreme high (mania) and an extreme low (depression). Between these severe highs and lows the person may feel more stable. Some people with bipolar disorder experience psychosis. Many people with bipolar disorder see their energy and activity levels change with their moods. Bipolar disorder is normally diagnosed after at least two episodes in which a person's mood and activity levels are significantly disturbed. Someone with untreated bipolar disorder will experience one or two cycles a year.

The depression symptoms are similar to those described on page 61 for depression.

People may experience one or more of the following symptoms of mania:

▶ euphoria – happy or positive even if things aren't going well for them

▶ restlessness, feeling more active and energetic than normally

▶ extreme irritability

▶ talking very fast and racing thoughts

▶ lack of concentration, easily distracted

▶ a reduced need for sleep

▶ a sense of their own importance or an increased sense of their own capabilities

▶ poor judgement, risky behaviour

▶ excessive and inappropriate spending, gambling

▶ increased sexual drive, promiscuity

▶ misusing drugs or alcohol

▶ aggressive or argumentative behaviour

▶ heightened senses – feeling that sight, smell or other sense are sharper than usual.

Some people experience hypomania – a less severe form of mania that lasts for shorter periods.

There are several types of bipolar disorder:

▶ Type I: people with this diagnosis have episodes of mania. The person may also have periods of depression between these periods of mania.

▶ Type II: people with this diagnosis have periods of major depression, broken up by periods of hypomania. The hypomania may not affect their day-to-day lives.

▶ Cyclothymia: people with this diagnosis may experience regular mood swings of a relatively lower level (hypomania and low-to-moderate depression). The low mood can still affect their day-to-day lives.

▶ Rapid cycling bipolar: people are usually diagnosed with rapid cycling bipolar if they have four or more depressive, manic, mixed or hypomanic episodes in a 12-month period. Some people will experience ultra-rapid cycling bipolar where the change from mania to depression can happen on a monthly or weekly basis (though this is rare).

Almost everyone diagnosed with bipolar disorder will be offered medication to help manage their symptoms. This can include medication to help lessen the intensity of the manic episodes, antidepressants and/or antipsychotics. Treatment can include counselling (sometimes called talking therapy) to help reduce the relapse rate, as well as brain stimulation therapies.

Between 0.9 per cent and 2.1 per cent of adults in the UK will experience bipolar disorder during their lives.

There is very little gender difference in the incidence of bipolar disorder.

Between five and 15 per cent of people diagnosed with bipolar disorder will experience rapid cycling.

Less than one per cent of people with bipolar disorder will experience ultra-rapid cycling bipolar.

Sources:
Mood Disorders Association of Manitoba, rapid cycling mood disorder, available at www.mooddisordersmanitoba.ca
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Schizophrenia

Schizophrenia is a mental illness that affects the way people think. It often develops as a young adult. One common myth about schizophrenia is that it means someone has split or multiple personalities, which is not the case. Another is that people with schizophrenia are violent and a risk to the public and those around them; research shows that people with schizophrenia are not dangerous to other people and they are in fact more likely to be a danger to themselves. They are more likely to be the victim of violence then the perpetrator.

Someone will normally be diagnosed with schizophrenia if they have experienced certain symptoms for most of the time for a month prior to the diagnosis.

The symptoms are divided into 'positive' and 'negative' groups – positive in that they are an addition to reality and negative in that they involve losing enjoyment of life or abilities.

Symptoms are similar to those described for psychosis on p65.

Negative symptoms include:

▶ lack of motivation

▶ a change in sleep patterns

▶ changes in body language

▶ a reduced range of emotions

▶ little interest in sex

▶ difficulty in planning and setting goals

▶ withdrawing into oneself, not talking, not interacting with people.

▶ slow movement

▶ poor grooming or hygiene

▶ lack of eye contact

▶ little interest in hobbies

Treatment can include counselling (sometimes called talking therapy and particularly cognitive behaviour therapy (CBT)), art therapy and medication. The medication usually prescribed is antipsychotic drugs to control the positive symptoms.

Schizophrenia is the most common form of psychotic disorder – between one and 2.4 per cent of people at any one time.
25 per cent of people with schizophrenia will make a full recovery and experience only a single episode.
Only 10–15 per cent of people with schizophrenia will have long-term difficulties.
Most people with schizophrenia will experience recurrent acute episodes with periods of remission or only residual symptoms in between.
There is no gender difference in incidence of schizophrenia.
Afro-Caribbean people are three to five times as likely as white people to be diagnosed with schizophrenia.

Sources:
Mental Health Foundation, *Mental Health A–Z*, available at www.mentalhealth.org.uk
Mental Health Foundation, *Fundamental Facts*, available at www.mentalhealth.org.uk

Other types of mental health problems

Eating disorders

The term 'eating disorders' covers a range of conditions that can affect someone physically, socially and psychologically. Someone with an eating disorder may have severely reduced eating, an intense fear of weight gain, self-perception overly influence by weight or body shape, significant levels of self-induced vomiting, laxative abuse and excessive strenuous exercise to control weight or body shape.

The two most common eating disorders are:

▸ **Anorexia:** a serious mental health illness where people keep their body weight low by dieting, using laxatives or excessively exercising. People with anorexia do not see themselves as others see them and they will usually challenge the idea that they should gain weight. People with anorexia will often hide their behaviour from family and friends. People with anorexia usually don't eat enough food to get the energy and nutrition they need to stay physically healthy. Anorexia is often connected to very low self-esteem, negative self-image and intense feelings of distress.

▸ **Bulimia:** this is one of the most common eating problems. People with bulimia feel that they have no control over their eating and judge themselves relative to their weight and body shape or size. Bulimia is typified by a cycle of 'bingeing' (eating large quantities) and then 'purging' (either through vomiting or use of laxatives). This pattern of behaviour is normally hidden from other people and the person's weight is usually within a healthy range.

Treatment for eating disorders usually focuses on counselling (sometimes called talking therapy, particularly cognitive behaviour therapy (CBT)), with medication prescribed to treat underlying causes or any associative anxiety and/ or depression. Treatment may also involve medical interventions for any physical consequences of the eating disorder.

Nearly three-quarters of a million people in the UK are affected by eating disorders.
The most common ages for onset of an eating disorder is during the teenage years and in the early 30s.
Of those people seeking help and support for their eating disorder 10 per cent are male. However, research suggest that the female to male ratio of those suffering from an eating disorder is closer to 3:1, the suggestion being that males suffering from an eating disorder are less likely to seek treatment.
Recent research suggests that there is an increase in people in their 40s and 50s seeking treatment for eating disorders.

Sources:
BEAT– beating eating disorders, "Types of Eating Disorders", available at www.b-eat.co.uk
Eating Disorders Recovery Today website at www.eatingdisordersrecoverytoday.com
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Self-harm

Although self-harm is not classified as a mental health problem in itself, it can be a sign of mental health problems.

Self-harm is defined as when the person wants to harm or hurt themselves on purpose and can include:

- cutting
- burning or scalding
- banging or scratching the body
- breaking bones
- hair pulling or picking skin
- self-strangulation
- taking toxic substances or objects, including alcohol and drugs to hurt or harm themselves.

Because someone is self-harming it does not necessarily mean that they wish to end their life. However, people who self-harm are more likely to end their own life than someone that does not self-harm.

Treatment for self-harm will depend on any underlying mental health problem but usually focuses on counselling (sometimes called talking therapy, particularly cognitive behaviour therapy (CBT)), with medication prescribed to treat underlying causes or any associative anxiety and/or depression. Treatment many also involve medical interventions for any physical consequences of the self-harm. It may include discussions and advice on how to deal with any physical signs of self-harm, for example scarring.

Sources:
Rethink Mental Illness, "Self-Harm", available at www.rethink.org
Royal College of Psychiatrists, "Self-Harm", available at www.rcpsych.ac.uk

Attention deficit hyperactivity disorder

Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. There is considerable debate about whether it should be described as a mental health problem or a developmental disorder. There is also lack of agreement on the definition of and what the criteria are for a diagnosis of ADHD. The current medical belief is that ADHD cannot develop in adults without it first appearing in childhood. By the age of 25, about 15 per cent of people diagnosed with ADHD in childhood will still have a full range of symptoms, with 65 per cent having some symptoms that still affect their daily lives.

Treatment for ADHD usually starts with medication followed by advice and support on ways to manage the condition. These non-medication approaches include exercise, dietary advice, sleep management and behavioural therapies.

> Statistics vary greatly about the prevalence of ADHD but ranges from five per cent to 26 per cent among children.

Sources:
NHS Choices, "Attention Deficit Hyperactivity Disorder", available at www.nhs.uk
Mental Health A–Z, available at www.mentalhealth.org.uk
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Alcohol and substance dependency

Substance abuse is the continued misuse of any mind-altering substance that severely affects a person's physical and mental health, social situation and responsibilities. Alcohol dependence is the most common form of substance misuse but any drug (heroin, crack, cocaine, cannabis, M-Cat, ecstasy), as well as substances such as glues and aerosols, come into this category. Some organisations include excessive use of tobacco or coffee in the definition.

Most forms of substance abuse can give the person a temporary feeling of wellbeing or of being in control, but all of them can ultimately damage physical and mental health.

The most severe forms of substance abuse are normally treated by specialist drug and alcohol rehabilitation services. A common pattern of substance abuse can be the use of the substance as a 'prop' to help someone get through difficult times. However, the feelings of relief provided by the substance are only temporary and the problems don't disappear, the person returns to use of the substance more and more and eventually becomes dependent on it.

There is an overlap between substance abuse and other mental health problems. Over 50 per cent of alcohol-dependant adults say they have a mental health problem. Between a third and a half of people with severe mental health problems consume mind-altering substances to levels that are classed as problematic.

Treatment for addiction and substance abuse is based on the multiple needs of the individual. Treatment will usually include a combination of counselling (to address the underlying or trigger factors leading to the substance use), medications (for relief of symptoms, anxiety or depression and for medical detoxification), involvement in support groups and monitoring of substance use.

> Research suggests that 28 per cent of men and 15 per cent of women have a pattern of alcohol consumption that brings a risk of physical or psychosocial harm.
>
> Globally nearly two per cent of adults are thought to have an alcohol use disorder.
>
> Just under four per cent of adults in Britain are thought to be drug-dependent.
>
> Research in 2012 identified that nearly 50 per cent of family doctors have seen an increase in alcohol abuse among their patients, which they attributed to the current economic climate.

Sources:
Mental Health Foundation, *Mental Health A–Z*, available at www.mentalhealth.org.uk
National Institute on Drug Abuse, "Treatment Approaches for Drug Addiction", available at www.drugabuse.gov
Healthy Advice, the austerity Britain report, available at www.healthyadvice.org.uk
Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Dementia

Dementia is a progressive and irreversible condition that involves memory, thinking, problem solving, concentration, perception and language. In some types of dementia there can also be changes in behaviour, mood and personality. Dementia occurs as a result of the death of brain cells or damage to parts of the brain that deal with thought processes. The specific symptoms of dementia will depend on the parts of the brain that are affected.

The damage could be the result of a medical condition (eg Parkinson's disease or a brain tumour), trauma (eg a head injury), infection, vitamin deficiency or excessive alcohol intake. The most common form of dementia is Alzheimer's disease; aging is the main factor in this disease, though the full causes are not yet known.

Most types of dementia cannot be cured (the exceptions being those caused by vitamin deficiency and, in some cases, head injury).

Most treatment for dementia focuses on coping with the symptoms. Some medications have been shown to be effective in the treatment of mild-to-moderate dementia, particularly in the early stages. There are some cognitive stimulation therapies that aim to stimulate memory, problem-solving and language ability. Reality orientation therapy has also been shown to help people with dementia by reducing the feelings of disorientation, memory loss and confusion.

Research for the Alzheimer's Society in 2014 found that nearly 90 per cent of employers expect dementia to become a bigger issue for their organisation as retirement ages rise and the number of people with dementia increases. However, the research also identified that employers are likely to offer no reasonable adjustments to support people with dementia to continue employment. Employers were most likely to work towards offering early retirement or termination of employment due to increased sick leave.

The TUC has produced advice on dementia in the workplace as part of a new resource on work, health and wellbeing. Meanwhile, the Alzheimer's Society has produced a useful guide for employers that will also be of use to union representatives. It can be downloaded at www.alzheimers.org.uk/employers.

In 2014, there were over 42,000 people aged under 65 with dementia and 27 per cent of those caring for someone with dementia were in employment.

Sources:

Alzheimers Society, online information, available at www.alzheimers.org.uk

Ritchie L, Banks P, Danson M, Tolson D, Borrowman F (2015), "Dementia in the Workplace: a review", *Journal of Public Mental Health*, vol. 14, no. 1, pp 24–34

Mental Health Foundation, "Fundamental Facts", available at www.mentalhealth.org.uk

Appendix 2
Mental health first aid

This section is from an article first written for *Hazards* magazine, Number 141, 2018, by Hugh Robertson, TUC Senior Policy Officer Prevention, Rehabilitation and Compensation (www.hazards.org/stress/mentalhealth.htm)

Is mental health first aid the answer? Depends on the question.

Mental health first aid (MHFA) has been one of the biggest growing trends in the workplace in the past couple of years. It has been taken up with some employers with gusto and the 2017 Conservative Party manifesto even promised, "We will amend health and safety regulations so that employers provide appropriate first aid training and needs assessment for mental health." Although the promise/ threat of new regulation seems to have ebbed away the government has now announced a new £15m programme with the aim of seeing up to one million people trained in basic mental health "first aid" skills.

Given the importance of dealing with mental health issues in the workplace and the increasing popularity of this one approach – MHFA, how should unions be responding? Is it employers just passing the responsibilities on to workers for their own failures to deal with mental health issues or is it a genuine solution to a serious problem?

MHFA is a workplace mental health training programme that teaches participants how to spot and support an individual who may be experiencing a mental health concern. They can then provide help.

Once they are trained, the role of a 'mental health first aider' in the workplace is to be a point of contact for an employee who is experiencing a mental health issue or emotional distress. This interaction could range from having an initial conversation through to supporting the person to get appropriate help. There can also be a proactive role in making sure that fellow workers have a better understanding of mental health issues.

The MHFA was developed in Australia in 2000. It was brought to Scotland a couple of years later and promoted through the Scottish NHS, before being exported to England and Wales.

It is primarily overseen by non-profit bodies or the NHS, but the actual delivery in the workplace is often done by commercial bodies or consultants, who have to keep to the curriculum of the national body and use their materials.

Since 2007, almost 200,000 mental health first aiders have been trained in the UK.

There is a standard 12-hour course, usually delivered over two days or four half-days. It is comprehensive, and there are 'MHFA-lite' courses on offer as well.

Although there are some differences depending on whether you are in England, Wales, Scotland or Northern Ireland, the standard course will include:

▸ common mental health problems

▸ attitudes and the "see me" anti-stigma campaign

▸ the five steps of mental health first aid (ALGEE – see box)

▸ symptoms of depression

▸ alcohol, drugs and depression

▸ crisis first aid for suicidal behaviour and depression

▸ anxiety disorders

▸ crisis first aid for panic attacks and acute stress reaction

▸ psychotic disorders (schizophrenia, bipolar disorder)

> Those who are trained are encouraged to use an approach called **ALGEE**:
>
> **A**sk about suicide
>
> **L**isten non-judgementally
>
> **G**ive reassurance and information
>
> **E**ncourage the person to get appropriate help and support
>
> **E**ncourage self-help strategies.

Most third sector or public bodies typically charge between £100 and £200, but private providers can be much more expensive. In Scotland the courses are often provided free. The Northern TUC Better Work Initiative provided the training at £25 a person.

Does it work?

Well that depends on what you want to prove. In fact, there is little evidence about the actual impact of MHFA in the workplace in relation to the effect on individuals who experience problems. That does not mean that it does not have an impact, only that there is no real evidence yet.

And that is not surprising because it would be very difficult to prove that MHFA is responsible for any changes in a particular workplace, especially when it is often brought in along with other workplace initiatives, but there is no doubt that MHFA succeeds in increasing people's awareness.

There is a lot of evidence that people who are trained in MHFA are more knowledgeable and supportive. An analysis of data from 15 evaluation studies found that MHFA training "increases participants' knowledge regarding mental health, decreases their negative attitudes, and increases supportive behaviours toward individuals with mental health problems". What is not clear is whether this increased knowledge and change in attitudes is translated into action, and most of the evidence that does exist comes from the perceptions of those who have been trained, rather than from those with mental health problems who have been in contact with the trainees. That means that it is impossible, at the moment, to say there is any impact beyond the training.

However, there is a lot of anecdotal evidence from individuals who say that they have been helped by a mental health first aider.

Limitations and concerns

Different countries across the world put different emphases on certain aspects. For instance, in the USA the course seems to deal more heavily with substance abuse. The UK also puts more emphasis on suicide prevention than some other countries.

The curriculum is very much set by MHFA (or the Welsh/Scottish NI equivalent) and you cannot change it. There is a set workbook.

The training does deal with stress but not with prevention. This is often one of the main criticisms, but it is not the aim of the training. Much of MHFA is about signposting.

More valid is the criticism that there is a lack of recognition of the role that unions can play in supporting members with mental health issues and, although MHFA is, by its nature mainly reactive, it would be good to have some recognition how unions are key to helping prevent problems, especially when they are related to stress, bullying, harassment, workload, etc. The MHFA Line Managers Resource, published in 2016, only makes one mention of unions and that is how managers can use them if an employee who is off sick does not want to be contacted by management. Clearly this is a big omission.

There is also concern about the references in the course material to more controversial topics such as 'resilience' but the training does not place any great emphasis on the role of non-proven interventions such as resilience and mindfulness as a preventative measure, only as a way of helping those who actually have anxiety or depression.

Helping people deal with their mental health issues often has to include an element of empowering them. That is different from the idea of resilience but allows people to understand some of the context of their issues, and, when appropriate, to be angry about it. It also should ensure that employers are challenged when they refuse to make the necessary adjustments to support workers with a mental health condition, or try to victimise them. MHFA training does briefly cover what they call the "frame of reference" to mental health which covers some of the factors associated with mental health.

Another very big concern is that MHFA is simply a sticking plaster on the gaping wound that is mental health support in this country. The provision of services for those with mental health problems is poor, with some people having to wait months for a referral, and even then often being unable to access appropriate support and help.

Some mental health advocates have criticised MHFA as being far too ready to uncritically brand all mental health conditions as an "illness" that needs treated, while often they are just a variation from the norm that needs understanding. Not all people with a mental health condition see themselves as being "ill", nor do they see their condition as being a "problem". However, MHFA training does recognise this and emphasises what it calls the "mental health continuum".

Many of the criticisms of MHFA, while valid, are more just an acknowledgement that MHFA has its limitations and that it has never claimed to be any more than a first aid approach to mental health. Very similar criticisms could be made of traditional first aid training which is not a substitute for employers preventing injury and providing access to occupational health support and does not seek to replace paramedics or doctors, yet few people would doubt that first aid training has its uses.

Alternative and complementary models

MFHA is now a recognised brand with accreditation and certification, and can have a useful role to play in the workplace. But employers and unions should also consider other approaches. These include mental health awareness training, which can be offered to either staff or managers. Courses are available in almost every part of the UK, often through mental health charities. Often, they can be tailored to your workplace and could include a union input. In Wales the Wales TUC is closely involved in supporting workplace training with "Training in Mind". Mental health awareness training does not have to be an alternative to MHFA, but can run alongside it.

Certainly, all employers should be considering training their line managers in mental health issues. Scottish Healthy Working Lives offers a course for line managers called 'Mentally Healthy Workplace' that includes good practice in promoting positive mental health and wellbeing, as well as offering practical examples of how to support employees experiencing mental health problems. Other organisations such as the Centre for Mental Health also provide training, as do several mental health charities.

However, for trade union representatives, MHFA is probably not the most suitable training. This is because their role is not just to signpost individuals to a support service, but to try to resolve any workplace issues that may be either contributing to their mental health problems, or if the employer is failing to make any necessary adjustments, to support them.

That is why mental health awareness training is often more appropriate for workplace representatives. This means that there is much more emphasis on prevention rather than just awareness.

So, any employer who thinks that they can deal with mental health concerns just by introducing MHFA is very much mistaken. Often employers offer training to a few selected handpicked 'mental health champions' and think that they have ticked the box. That is certainly not the case. MHFA is not going to change the workforce on its own and should be seen as one of a range of initiatives that employers need to introduce.

MHFA, like conventional first aid, does not claim to be a solution to workplace mental health problems. First aid trainers in the workplace are not an alternative to having an occupational health service and good prevention procedures in place. Nor do first aiders seek to replace paramedics. The same is true of MHFAiders. Those who are trained in MHFA are not therapists or psychiatrists. Employers also have a major role in prevention and providing support over and above just providing MHFAiders.

Any employer who does want to address mental health issues in the workplace needs to look much wider than MHFA, and that is best done in cooperation with the union. Public Health England, along with Business in the Community have produced a toolkit for employers on what they should do.

A good policy will include:

▸ high level commitment to challenging the stigma that surrounds mental health issues

▸ a recruitment policy that does not discriminate against those with a mental health conditions

▸ a review of sickness absence policies to ensure that they do not discriminate against those with mental health conditions

▸ early access to occupational health services

▸ training all staff on mental health (ideally jointly with the union)

▸ separate mental health awareness training for all line managers

▸ the provision of an Employee Assistance Programme

▸ strong anti-bullying and harassment procedure

▸ a stress management policy

▸ if there are MHFAiders, a system of support for them, including regular meetings.

Unions clearly must be involved both in working with their employer around mental health and supporting members with mental health problems. That includes challenging any stigma or discrimination.

Appendix 3

Sources of further information

Acas

The Advisory, Conciliation and Arbitration Service provides free and impartial information and advice to employers and employees on all aspects of workplace relations and employment law. It produces statutory Codes of Practice and advice and guidance on employment matters.

Helpline: 0300 123 1100

Text relay service:
18001 0300 123 1100

www.acas.org.uk

Equality Advisory and Support Service (EASS)

EASS advises and assists individuals on issues relating to equality and human rights, across England, Scotland and Wales.

Tel: 0808 800 0082

Textphone: 0808 800 0084

www.equalityadvisoryservice.com

Equality and Human Rights Commission (EHRC)

The EHRC is an independent public body with the mandate to challenge discrimination and to protect and promote human rights.

www.equalityhumanrights.com

European Agency for Safety and Health at Work

The Agency prepares, collects, analyses and disseminates information on occupational safety and health (OSH) issues with the aim of improving OSH in workplaces across the EU.

https://osha.europa.eu/en

Health and Safety Executive (HSE)

The HSE is responsible for shaping and reviewing regulations, producing research and statistics and enforcing health and safety law in England, Wales and Scotland.

Tel: 0300 003 1747

www.hse.gov.uk

Mental Health Foundation

A charity that engages in research, campaigning and training programmes on mental health and learning disabilities.

www.mentalhealth.org.uk

Mind

The charity Mind provides advice and support on mental health issues. It campaigns to improve services, raise awareness and promote understanding about mental health.
Email: contact@mind.org.uk
Tel: 020 8519 2122
www.mind.org.uk

Samaritans

Offering emotional support 24 hours a day, 365 days a year.

Tel: 08457 909090

Time to Change

An anti-stigma campaign run by mental health charities Mind and Rethink Mental Illness.

Email: info@time-to-change.org.uk

Tel: 020 8215 2356

www.time-to-change.org.uk

Trades Union Congress (TUC)

The following publications are available from www.tuc.org.uk

Your Health at Work: an indispensable guide to physical and mental wellbeing. A new guide published in 2018 for all workers, unions members and reps, (published by Kogan Page in association with the TUC)

Trade Unions and Disabled Members: why the social model matters

Representing and Supporting Members with Mental Health Problems at Work

Good Practice in Workplace Mental Health

Email: info@tuc.org.uk

Tel: 020 7636 4030

www.tuc.org.uk

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