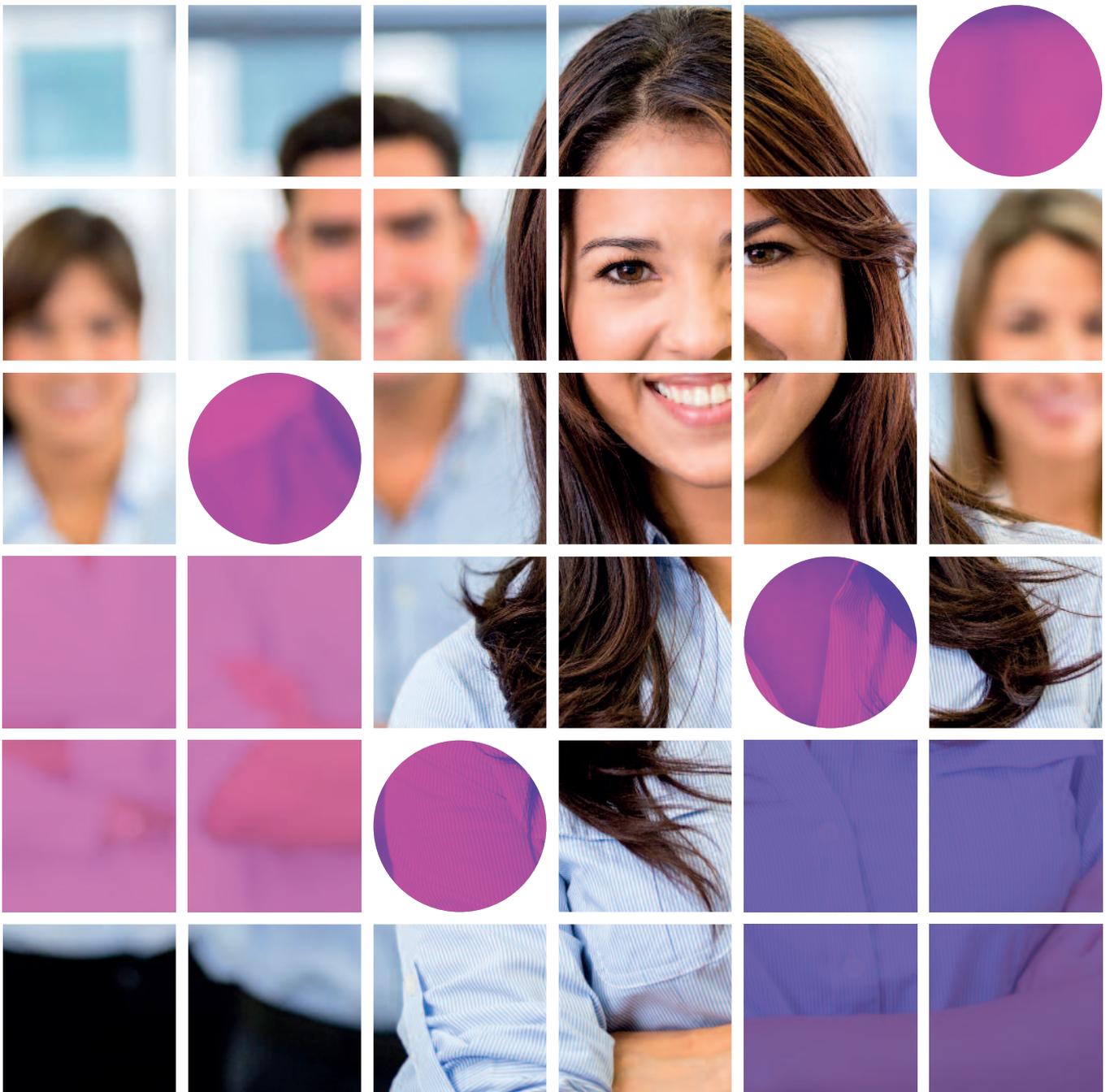


Mental health *and the workplace*





Mental health *and the workplace*

A TUC Education workbook

Acknowledgements

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Foreword



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

On 5 February 2015, 90 delegates attended a TUC seminar and heard presentations from six unions (and one employer) on the subject of workplace mental health. The seminar was organised following a proposal at the TUC Disabled Workers Conference 2014 but the wide spread of the delegates reflected the fact that mental health is a priority across the union agenda. The stated aim was to share good practice examples from different sectors and to match these against the experience of delegates. At the seminar, delegates were promised that TUC Education would develop a workbook to take forward the issues raised there and to integrate the union role in mental health at the workplace firmly within reps' training. The TUC has also recognised the disproportionate impact of mental health issues on particular equality groups and will be undertaking further work on this aspect of the subject.

This workbook is an important step in supporting reps to take forward the lessons of the seminar.

TUC Education is grateful to all those who participated and 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 Liz Rees at lrees@tuc.org.uk.

A handwritten signature in black ink that reads "Frances O'Grady". The signature is written in a cursive, flowing style.

Frances O'Grady
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 well-being 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.

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 2013 survey, Time to Change, which campaigns against discrimination on mental health grounds, found that 64 per cent of people know someone with a mental health problem.¹ The Office for National Statistics Labour Force Survey in June 2015² 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 data³ 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.

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 systematic 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.

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:

- 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.

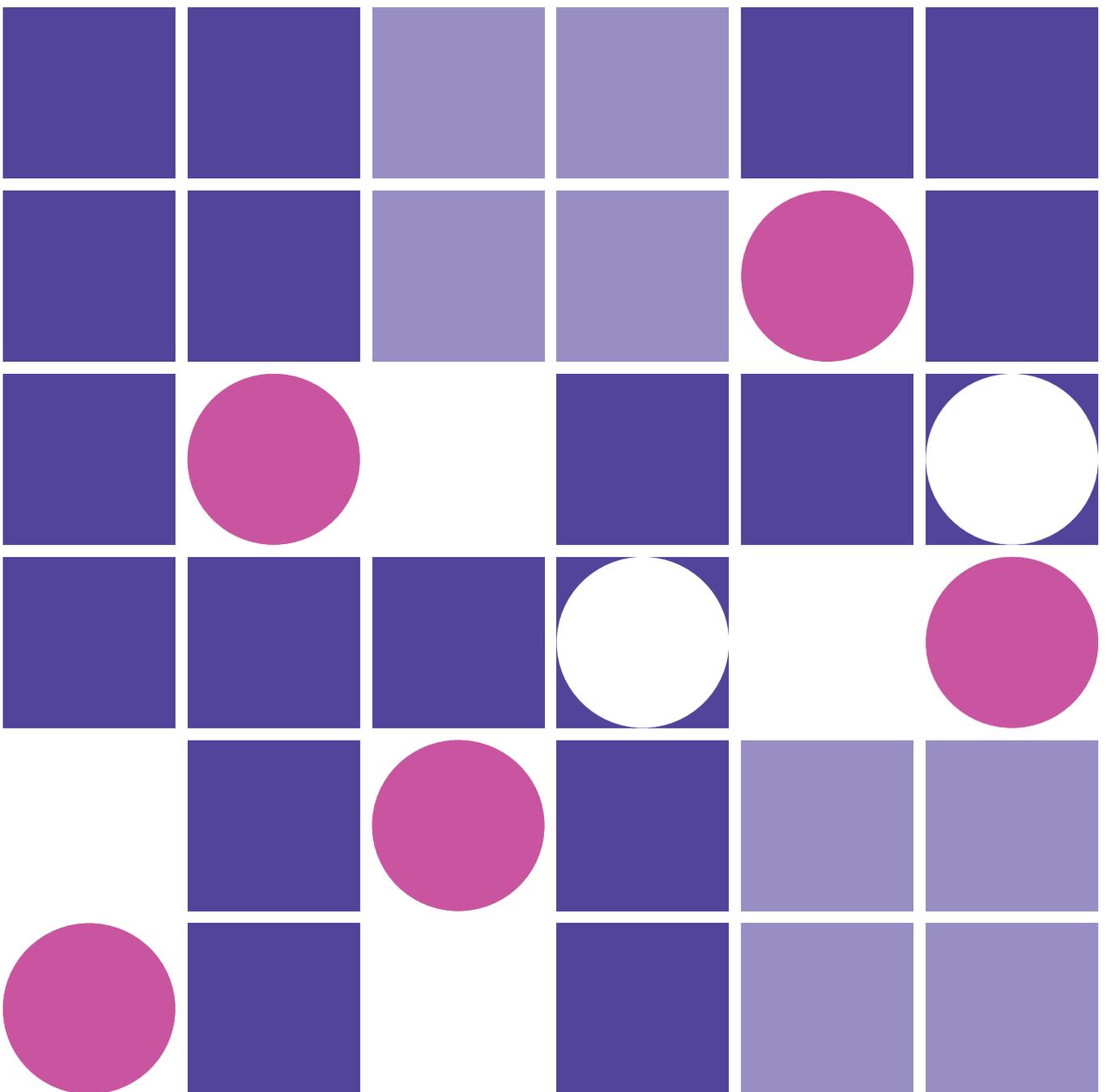
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¹ Time to Change 2013, Survey available at www.time-to-change.org.uk

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

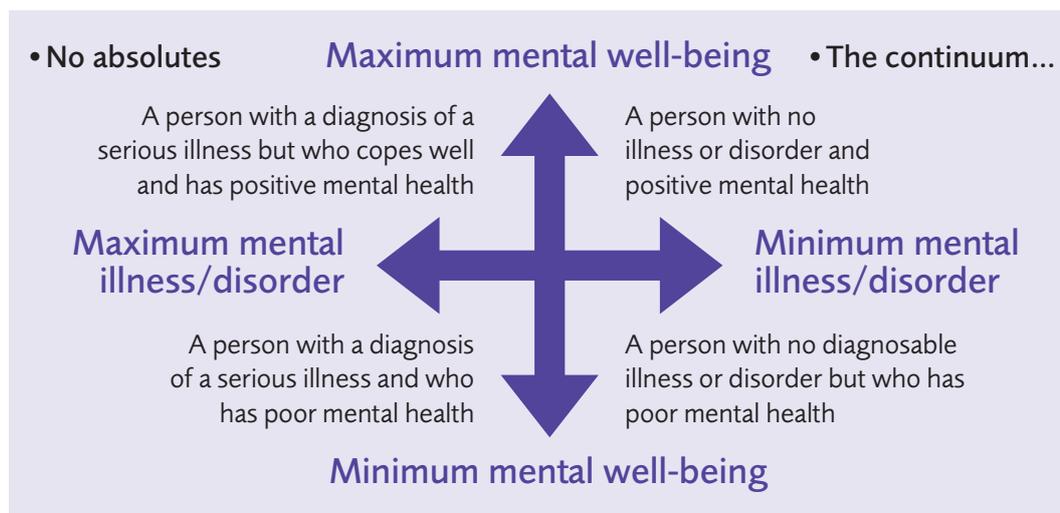
Knowledge



The World Health Organisation defines mental health as: "... a state of well-being 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 well-being and not merely the absence of disease or infirmity" (World Health Organisation 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.



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

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 problems⁴ include:

- anxiety – about one in 10 people in the UK
- depression – about one in 10 people
- mixed anxiety and depression – about one in 10 people
- post-natal depression – between eight and 15 per cent of women
- obsessive compulsive disorder – three per cent of people
- phobias (and panic attacks) – between one and three per cent of people.

Severe mental health problems⁵ 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
- 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 UK⁷

Appendix 1 has more information on mental health problems.

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 UK⁸ 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 9.

Appendix 2 also has more information about work-related stress.

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 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 2004¹³ 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 Guidance¹⁵ 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.

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.

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 unfavorably 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 Practice¹⁶ suggests that adjustments can include:

- changing equipment
- providing aids – including extra support and equipment
- changing the location of work
- changing policies and procedures
- allowing extra time off work
- 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.

Harassment

This is unwanted conduct related to the person with a disability and the conduct has the purpose or effect of:

- violating the person's dignity
- creating an intimidating, hostile, degrading, humiliating or offensive environment for the person.

Example: Michael has an eating disorder. His manager knows this and makes offensive remarks in the canteen about people with anorexia.

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

There is no specific legislation controlling stress at work. In a 2010 employment appeal tribunal case¹⁹ 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.

However, employers have some duties under the health and safety legislation, as well as some common law duties.

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 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).

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.

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 all the 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

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**, e.g. 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.

- **Provision of some indicators of mental ill health**
Signs that an individual may be having mental health problems, e.g. changes in an employee's usual behaviour.
- **Promotion of good mental health well-being**
Identifies steps employer will take to support and promote mental health well-being.
- **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 well-being, 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.

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 phrases²² 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 and common mistakes

'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

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 paper²³ 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 Issues²⁴ 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 one in 10 children and young people.²⁵ Though research in 2014 by the Prince's Trust²⁶ 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 1 Liron Shekel – BECTU member

I moved to London in September 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/>

Young workers' story 2 Kris Jones – NUT member

Being a young teacher has its challenges, four in ten newly qualified teachers quit within a year. The long hours, the stress, the pressure and the low pay all take their toll. Like most of my colleagues I have always managed to face these challenges head on and with the help of people around me. But what happens when you are feeling so low and helpless that on a regular basis you contemplate ending it all? Or, more seriously, even attempt to end it all? It's not like you can go to the doctors and they can give you some magical pills that make it all better like a common illness. It's the sort of illness that drives you insane wondering how on earth you got here in the first place.

Well, my story begins shortly after having surgery to repair my right eye socket after being attacked. While recovering I attended a rugby game with a buddy of mine who I hadn't seen in three years and we posted a selfie on Facebook. A colleague of mine reported me to HR who on my 'back to work' meeting had presented this photo to me blown up to A4. I was accused of being 'unprofessional' while signed off sick and was duly presented a 'letter of expectation', much to my shock.

I knew immediately that I had to get my union, the NUT, involved. My rep at the school was fantastic. He marched right into their office and accused them of entrapment, to which the school quickly backed down. I knew at this moment I had to be involved in the union more actively.

However, from this moment I was a marked man. I was made to feel that no matter what I did in school, it wasn't good enough. My marking wasn't good enough; my appearance wasn't good enough; my prep wasn't good enough. I felt stabbed in the back by my colleagues in my department. I felt like I was a worthless, rubbish teacher who harmed children's education instead of improving it.

I hated going to school. I couldn't face the people who had made me feel like I was worth nothing and it constantly played on my mind. I would wake up crying in the middle of the night, I was shaking every morning driving into school and, worst of all, I would go to bed thinking about ways of taking my own life.

I did what anyone would do in this situation. I confided in the people around me who I thought were my friends at the time. I told them my thoughts and how sad I was. The reaction I got was quite surprising. They distanced themselves from me, I wasn't invited out anywhere and I was even told that "You are seen more as a burden and we don't want to deal with you when you start crying".

I was destroyed. I had never felt so lonely. To me it was quite clear I was a burden and no one would miss me. I read a few articles about drowning and apparently how peaceful it feels. I had made my plan.

When I returned to Wales in the summer I ventured down to Aberavon seafront. I took my car keys, wallet and phone and placed them on the beach and went into the sea. Shaking with fear and disbelief at what I was about to do – I froze once the water got above my ankles. Still crying uncontrollably, I dragged myself back to my car where I phoned the Samaritans and spoke to a lovely guy for 40 minutes who suddenly made me feel like life was worth living. This one man whose name I never knew saved my life and whoever you are I can't thank you enough.

It was still tough after this. I still felt lonely and would cry a lot on my own but I suddenly felt purpose. I was thankful I had my best friend Emma, who dragged me to the doctors where I was diagnosed with severe depression and placed on anti-depressants. The medication has been amazing for me. Ever since taking them (started last September) I haven't felt suicidal once. I have never felt sad inside. I have never even contemplated harming myself.

I can't thank the NUT enough for all the help and support they have given me throughout this whole ordeal. We are stronger together and cannot let the workplace become a hunting ground.

<http://strongerunions.org/2015/05/15/mental-health-and-the-working-life-mhaw15/>

Austerity and mental health well-being

There is a clear link between income inequality and mental health well-being.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, well-being and resilience. This lowering of mental health well-being, 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 factsheet³⁰ 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 well-being. Workplace action and programmes to improve mental health well-being 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 in 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 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.

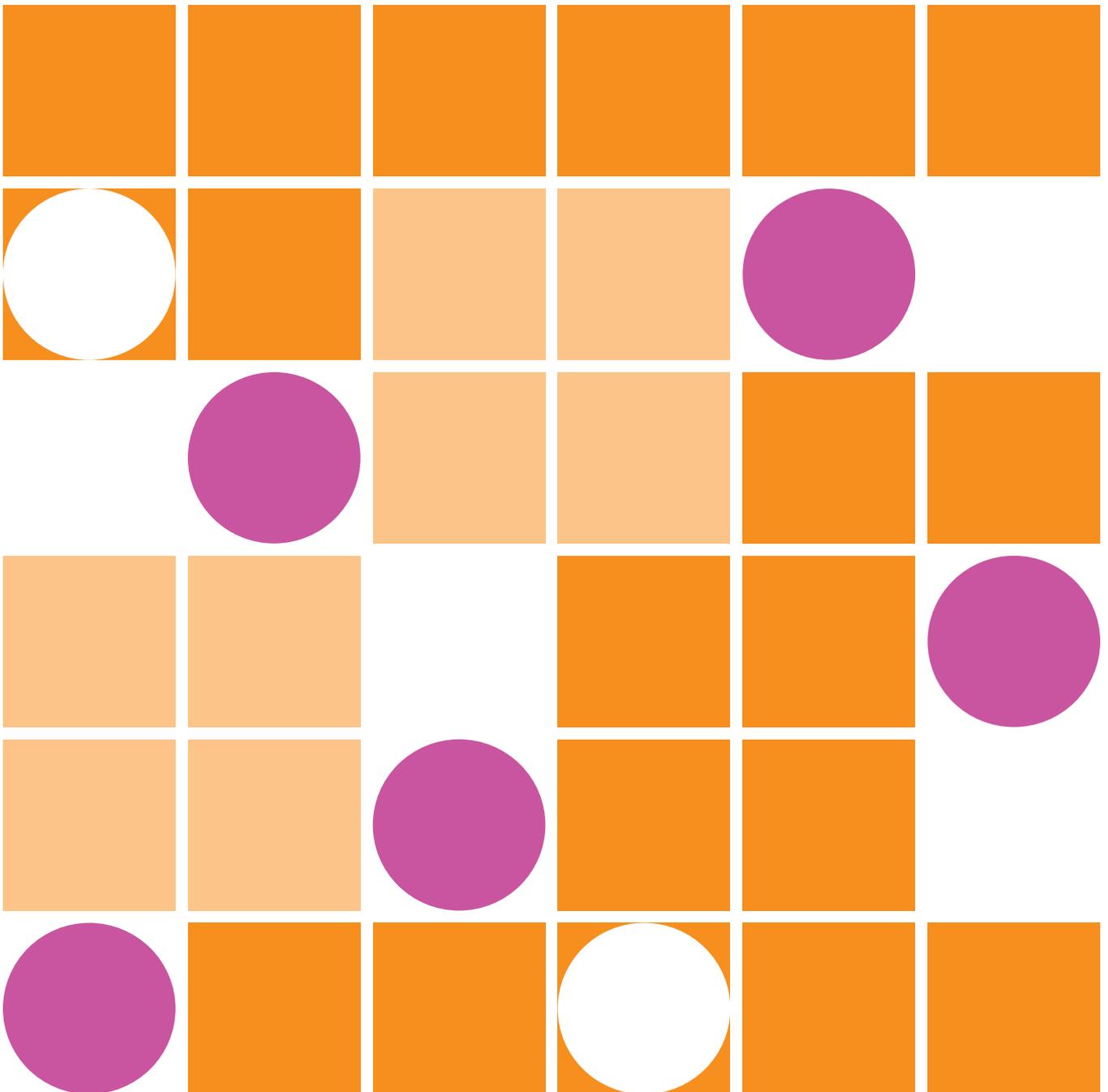
Activity 3 Members with mental health problems

- 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 Organisation 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
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- 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
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- ²⁴ TUC 2015, *Young Workers Issues*, available at www.tuc.org.uk
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- 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

Representing and supporting members



Stress and health and safety

Employers have a legal duty to protect the mental health of their workers (see Work-Related Stress and the Law on page 9). 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 six key causes of work-related stress:²

- **Demands.** This includes issues like workload, work patterns and the work environment.
- **Control.** How much say does the person have in the way they do their work?
- **Support.** This includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
- **Relationships.** This includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.
- **Role.** Do people understand their role within the organisation? Does the organisation ensure that these people do not have conflicting roles?
- **Change.** How is organisational change (large or small) managed and communicated in the organisation?

Safety reps can encourage their employers to introduce and apply the Health and Safety Executive's (HSE) Stress Management Standards. 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.

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).

Since 2002 reps have used the TUC's Stress MOT³ 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.

Workers' story 1 Stress

The Highways Agency employs 3,600 people working across the country.

Following recognition of significant impact of mental health on staff and therefore business efficiency, a joint management-trade union working group, including people who had experience of mental health issues, operational line managers and HR, came together to listen to experiences and seek a step-change in the organisation's practices. The group met quarterly and some forty people were involved.

The first key message was listening: staff were encouraged to raise issues through the intranet, while support was increased and a board director appointed as mental health champion to ensure that the policy was carried out across the organisation.

Among support measures was the development of a line manager training course. It is delivered by Remploy practitioners and over 25 per cent of the managers have attended so far.

Through the working group, other resources produced include a stress management toolkit and a reasonable adjustment agreement with the union specifically for mental health, enabling people to start conversations with their line management at an early stage.

The work continues and is reviewed. There has been an 18 per cent drop in mental health-related sickness absence.

The lessons learned since the launch in 2013 include the vital importance of personal experience as a tool for positive change. Creating the right environment for people to come forward is essential, as is convincing managers that they do not have to be experts themselves but that they can and must support people. A key finding was that managers are often scared of doing the wrong thing, which prevents them doing the right thing. Another key finding was that small actions and changes can have an impact.

The toolkit has been revised and initiatives taken around the hooks of European Health and Safety Week and Time to Talk Day. There is commitment from both sides to building on the progress.

"I have been expected to work up to 90 hours a week and this had a terrible impact on my family life and my health."

A member who decided to leave teaching because of work-related stress.



Sickness absence

Despite Office for National Statistics (ONS) labour market data⁴ 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 131 million working days lost to sickness absence in 2013, just 4.4 days annually per worker, and 15.2 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 one 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 Health⁶ 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 well-being) 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 Records⁷ 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 e.g. 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.

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** e.g. 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** e.g. 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 p5) 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, e.g. through the Fit for Work Statement ('Fit Note')

- any specialist mental health support the individual may be receiving, e.g. 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 Practice⁹ 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.

Workers' story 2: 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 (e.g. 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 Practice¹⁰ 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 confidentiality 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 Mental Health and the Law on p5).

Representing members with mental ill 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 judgement¹¹ 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.

Workers' story 3: 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.

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.

Union reps can work with employers to promote mental health well-being, 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 well-being 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.

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.

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.

Workers' story 4: 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.

Udaw 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 representatives 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 well-being.

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 well-being.

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

Workers' story 5: 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 well-being 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 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 well-being.

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 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:

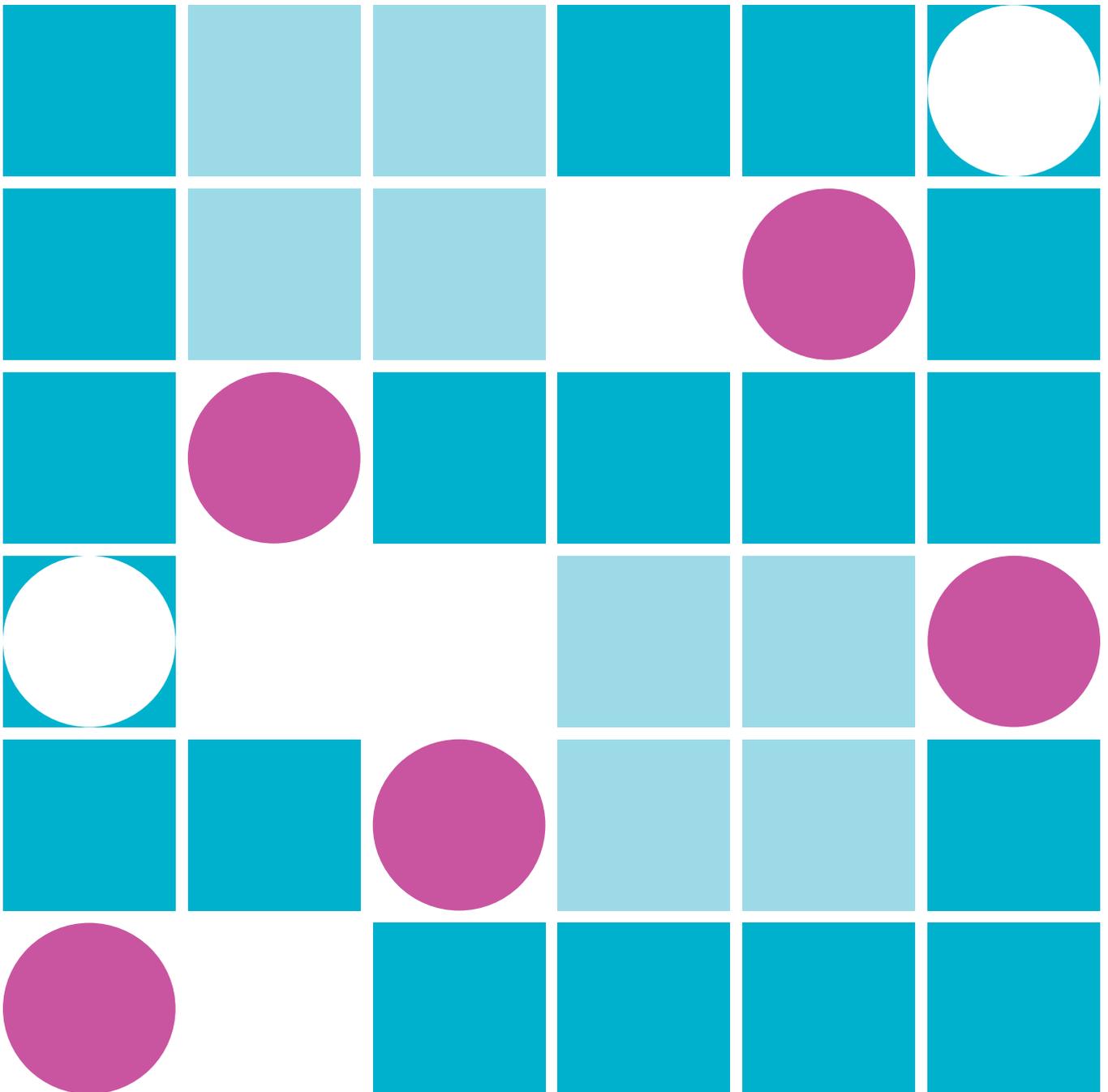
- Does it feed into the union's bargaining agenda?
- Are individual cases used to identify areas of wider concern?
- Are members with mental health problems involved in deciding union priorities on issues affecting them?

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.

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 of National Statistics (2014), *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

Organising around mental health



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.

Campaigns on mental health can:

- 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 with the mental health community. 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.

Workers' story 6: 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.

Workers' story 7: 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 ill 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 underrepresented 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.

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.

Workers' story 8: Organising

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 well-being. 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 well-being-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) 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 materials

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.

Louise Grainger, Equity

Activity 9 Campaigning on mental health

Aims

To help you:

- plan a workplace campaign on mental health
- clarify your objectives.

Task

Talk to other representatives 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 aim and objectives, e.g. 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.

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

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 p43 for more information.
- Post-traumatic stress disorder: 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 diarrhea.

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 p46 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
- persistent sadness
- loss of self-confidence and self-esteem
- difficulty concentrating
- 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
- finding it hard to function at work
- loss of appetite
- loss of sex drive and other sexual problems
- physical aches and pains
- higher use of tobacco, alcohol or drugs than usual
- thinking about suicide and death
- self-harm.

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

Between eight and 12 per cent of the UK population experience depression in any year

One in four women and one 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 one in five 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 which people 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
- counting or repeating a specific word or phrase
- cleaning
- dressing rituals.

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

Two to three 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 (e.g. water, heights), fear of body-based things (e.g. blood, vomit), fear of objects (e.g. peanut butter, buttons).
- Complex phobias: this is where there are combinations of fears linked together, e.g. 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 of more of these symptoms:

- a thumping heart (palpitations)
- sweating and trembling
- a dry mouth
- hot flushes or chills
- feeling short of breath, sometimes with choking sensations
- chest pains
- feeling sick (nauseated), dizzy or faint
- fear of dying or going crazy
- numbness or pins and needles
- 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 42 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.mooddordersmanitoba.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 than 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.

Positive symptoms are similar to those described for psychosis on p45.

Negative symptoms include:

- lack of motivation
- slow movement
- a change in sleep patterns
- poor grooming or hygiene
- difficulty in planning and setting goals
- withdrawing into oneself, not talking, not interacting with people
- changes in body language
- lack of eye contact
- a reduced range of emotions
- little interest in hobbies
- little interest in sex.

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 influenced 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 suggests 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 the 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

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 may 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 Foundation, *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 well-being 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 (e.g. Parkinson's disease or a brain tumour), trauma (e.g. 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 will be producing advice on dementia in the workplace as part of a new resource on work, health and well-being. 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: Work-related stress

The Health and Safety Executive (HSE) define 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 2014 survey of union health and safety representatives showed that 67 per cent of them identified stress as one of the top five hazards in their workplace and 32 per cent said it was the top hazard. In the public sector the figure was higher, with 75 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 behavior.
- **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
- too much or too little work, lack of control and conflicting demands
- poor management
- bad relations with other work colleagues
- repetitive work, boredom and lack of job satisfaction
- working alone
- job insecurity
- job or organisational change
- low pay
- 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 well-being 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 2013/14 there were 11.3 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

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 & 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, F: 020 8522 1725

www.mind.org.uk

Samaritans

The Samaritans offers 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)

Email: info@tuc.org.uk

Tel: 020 7636 4030

www.tuc.org.uk

TUC Publications

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

All available at: www.tuc.org.uk

Appendix 4: TUC Education contacts

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