Work adjustments for mental health:

A review of the evidence and guidance

Appendices

For Acas

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**APPENDICES**

1. **DETAILED METHODOLOGY**
   1. **Summary of Rapid evidence review extended methodology**
   2. **Table 1: Inclusion criteria**

**2. SEARCH TERMS AND HITS**

**2.1 Table 1: Search terms used in the review**

**2.2 Table 2: Hits found in ABI/Inform and Business source databases**

**2.3 Table 3: Hits found in the Cochrane Library**

**3. NESTA STANDARDS OF EVIDENCE**

**4. UK stakeholder organisations included in the search**

**5. AGREE Framework for evaluating rigour of Guidance**

**6. Summary of work adjustments referred to in guidance and evidence**

**6..1 Table 1: Work adjustment mapped against guidance, research reports**

**and academic papers**

**6.2 Table 2: Adjustment term used within peer reviewed papers, research**

**reports and guidance**

**6.3 Table 3: Adjustment noted in peer reviewed papers, reports and guidance**

**classified under the work adjustment term**

**7. Summary of evidence reviews**

**7.1 Table 1: Summary of systematic reviews**

**7.2 Table 2: Summary of over-time studies**

**7.3 Table 3: Summary of survey design studies**

**7.4 Table 4: Summary of interview design studies**

**7.5 Table 4: Summary of research reports**

1. **DETAILED METHODOLOGY**

## 1.1 Rapid evidence review extended methodology

Using the systematic approach as outlined by Barends, Rousseau & Briner (2017), the research team searched, identified and critically evaluated the strength of the evidence. The steps for the evidence review were as follows:

1. Identifying specific search terms through a preliminary search and in discussion with the research team
2. Identifying most appropriate search databases
3. Finalising the inclusion criteria
4. Conducting searches
5. Selecting studies for inclusion
6. Reviewing studies and extracting relevant information
7. Critically evaluating the quality of the studies included – how robust is the evidence?
8. Summarising findings – what was found?
9. Synthesising findings – what does this mean?
10. Identifying limitations and developing conclusions and implications for research and practice

The rapid evidence review began with a scoping phase during which a selection of relevant literature was examined and different search terms were applied across databases to identify the key terminology in this area. Findings from this scoping review were used as a platform for discussion between three researchers, from which a series of search terms was devised covering three main subjects:

* S1 – well-being and mental ill-health (e.g. anxiety, depression);
* S2 – work or workplace (e.g. work, employment, job, occupation); and
* S3 – interventions (e.g. adjustment, accommodation, adaptation, modification). The term ‘return’ was added to S3 to ensure that all articles looking at return to work were included. Please see Table 1 in Appendix 2 for more details on the search terms.

In addition, the scoping phase allowed the team to choose three databases for the evidence searches: ABI INFORM/Global, Business Source Premier and the Cochrane Library. ABI INFORM/Global and Business Source Premier were selected for their comprehensive coverage of peer-reviewed academic literature, while the Cochrane Library search and hand search process allowed for the consideration of robust empirical evaluations of workplace adjustments not published in peer-reviewed journals. It also helped finalise the inclusion criteria for the evidence searches, which were: peer-reviewed scholarly articles from academic journals or (for the Cochrane Library search) Cochrane reviews or (for stakeholder research reports) peer-reviewed in either the funding process or output stage; republished in English; and published between January 2009 and October 2019. A hand search of research reports commissioned by UK stakeholders within the mental health arena was also conducted. A list of UK stakeholders were identified through discussions with subject matter experts and are noted in Appx 4.

The first search combined S1, S2 and S3 across two databases: ABI INFORM/Global and Business Source Premier (BSP). Terms were searched both within abstracts and titles and the results were as follows: 2,083 from ABI INFORM/Global and 1,839 from BSP. Please see Table 2 in Appendix 2 for the search strings and results at each stage. A separate search was conducted in the Cochrane Library of Systematic Reviews using both S1 and S2 and an expanded set of ‘intervention’ terms (see S4 in Table 1 in Appendix 2). As well as the broad headings for interventions used in S3, more specific terms were included such as flexi, hours, home and environment. The result of this search was 559. Please see Table 3 in Appendix 2 for the search strings and results at each stage.

The abstracts of all the references that emerged from the three database searches were screened for relevance to the research topic and duplicates removed.

**1.2. Table 1: Inclusion criteria**

|  |  |  |
| --- | --- | --- |
|  | Inclusion | Exclusion |
| Population | Adults of working age | Unemployed |
| Date | Last 10 years |  |
| Language | English |  |
| Type of studies | Empirical - Quantitative, Qualitative | Not opinion/thought pieces |
| Study design | All |  |
| Measurement | All |  |
| Outcome | All |  |
| Context | Work setting | Not work setting |

Following this sift, 21 academic papers were deemed appropriate for final inclusion and data extraction. The reference lists for the empirical papers published between 2018 and 2019 were examined in order to identify other key literature of relevance that had not been obtained through our database searches.

For the data extraction process, an extraction template was used to maximise consistency and ensure that data relevant to the research topic was obtained.

A critical analysis of the studies was conducted using the Nesta Standards of Evidence. Nesta developed the standards of evidence to “help us know how confident we can be in the evidence provided to show that an intervention is having a positive impact.” This helps us select the most promising, safe and efficient evidence and guide and inform future research needs where evidence is lacking or less mature. There are many standards of evidence and the Nesta Standards of Evidence have been chosen as they retain academic standards while informing practical deliverables. An overview of the Nesta Standards of Evidence are provided in Appx 3.

# 2. SEARCH TERMS AND HITS

2.2 Table 1: Search terms used in review

|  |  |  |  |
| --- | --- | --- | --- |
| **S1 = mental disorder** | **S2 = work-related** | **S3= intervention terms** | **S4 = expanded intervention terms** |
| mental  well-being  wellbeing  “well being"  stress  anxiety  depress\*  bipolar  schizophreni\*  "personality disorder\*"  psychiatric  "eating disorder\*" | work\*  employ\*  job\*  occupation\*  vocation\*  organi\* | adjust\*  accommodat\*  adapt\*  modifi\*  rehabilitat\*  return\* | adjust\*  accommodat\*  adapt\*  modifi\*  rehabilitat\*  return\*  intervention\*  retention  “sick leave"  "sickness absence"  "sickness management"  "absence management"  flexi\*  hours  break\*  commut\*  home  "case management"  environment\*  task\*  role\*  quiet  light  shift  "reduc\* workload\*"  budd\* |

Please note the asterisk is a ‘wi**ldcard** symbol’, meaning that all words starting with the letters prior the asterisk were included.

**2.2 Table 2: Hits found in ABI/INFORM Global and Business Source Premier databases**

Papers were included if they were:

* Peer-reviewed scholarly articles from academic journals
* English only
* Published January 2009 to October 2019
* Included the search terms in title (TI) or abstract (AB)

|  |  |  |  |
| --- | --- | --- | --- |
| **Step** | **String** | **ABI/INFORM Global** | **Business Source Premier** |
| 1 | TI(mental OR well-being OR wellbeing OR "well being" OR stress OR anxiety OR depress\* OR bipolar OR schizophreni\* OR "personality disorder\*" OR psychiatric OR "eating disorder\*") OR AB(mental OR well-being OR wellbeing OR "well being" OR stress OR anxiety OR depress\* OR bipolar OR schizophreni\* OR "personality disorder\*" OR psychiatric OR "eating disorder\*") | 42797 | 45799 |
| 2 | Step 1 AND (TI(work\* OR employ\* OR job\* OR occupation\* OR vocation\* OR organi\*) OR AB(work\* OR employ\* OR job\* OR occupation\* OR vocation\* OR organi\*)) | 15448 | 16582 |
| 3 | Step 2 AND (TI(adjust\* OR accommodat\* OR adapt\* OR modifi\* OR rehabilitat\* OR return\*) OR AB(adjust\* OR accommodat\* OR adapt\* OR modifi\* OR rehabilitat\* OR return\*)) | 2083 | 1839 |

**2.3 Table 3: Hits found in the Cochrane Library (includes Cochrane reviews only)**

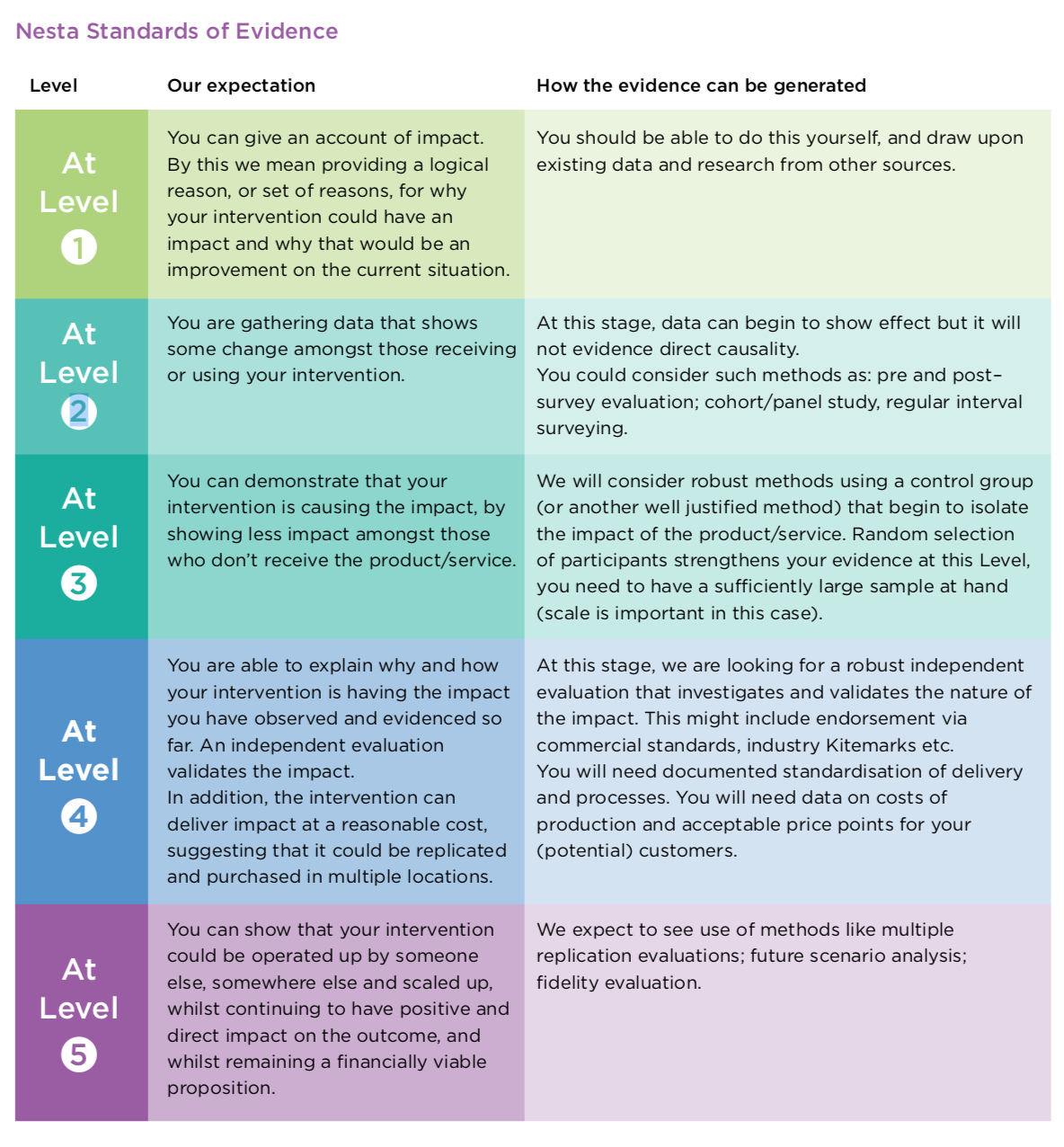
Papers were included if they were:

* English only
* Published January 2009 to October 2019
* Included the search terms in title, abstract or keyword

|  |  |  |
| --- | --- | --- |
| **Step** | **String** | **Cochrane** |
| 1 | Title/Abstract/Keyword (mental OR well-being OR wellbeing OR "well being" OR stress OR anxiety OR depress\* OR bipolar OR schizophreni\* OR "personality disorder\*" OR psychiatric OR "eating disorder\*") | 1340 |
| 2 | Step 1 AND Title/Abstract/Keyword (work\* OR employ\* OR job\* OR occupation\* OR vocation\* OR organi\*) | 657 |
| 3 | Step 2 AND Title/Abstract/Keyword (adjust\* OR accommodat\* OR adapt\* OR modifi\* OR rehabilitat\* OR return\* OR intervention\* OR retention OR "sick leave" OR "sickness absence" OR "sickness management" OR "absence management" OR flexi\* OR hours OR break\* OR commut\* OR home OR "case management" OR environment\* OR task\* OR role\* OR quiet OR light OR shift OR "reduc\* workload\*" OR budd\*) | 559 |

**3 . Nesta Standards of Evidence.**

Taken from Puttick, R., & Ludlow, J. (2013). Standards of evidence: An approach that balances need for evidence with innovation. Nesta: London



1. **UK stakeholder organisations included in the systematic manual search of research reports and guidance**

**UK charities and professional bodies**

Business In The Community

Chartered Institute of Personnel Development

Health and Safety Executive

Institute of Occupational Safety and Health

Society of Occupational Medicine

Mental Health Foundation

Mind

Samaritans

Mental Health at Work gateway

**UK government and public sector organisations**

Acas

Department of Health & Social Care

Department of Work and Pensions

National Health Service

Access to Work

Fit to work

Disability Confident

**Additional sources included in the research report review due to recommendation**

The depression collaborative: Canada

Occupational Health and Safety Agency for Healthcare: Canada

1. **Agree framework for evaluating guidance**

Taken from AGREE Next Steps Consortium. The AGREE II Instrument; 2009. Available from: http://www.agreetrust.org/wp-content/ uploads/2013/10/AGREE-II-Users-Manual-and-23-item- Instrument\_2009\_UPDATE\_2013.pdf.

**Domain 1: scope and purpose**1. The overall objective(s) of the guideline is (are) specifically described.  
2. The health question(s) covered by the guideline is (are) specifically described.  
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

**Domain 2: stakeholder involvement**4. Guideline development group includes individuals from all relevant professional groups. 5. View and preferences of the target population have been sought.  
6. The target users of the guidelines are clearly defined.

**Domain 3: rigour of development**7. Systematic methods were used to search for evidence.  
8. The criteria for selecting the evidence are clearly described.  
9. The strengths and limitations of the body of evidence are clearly described.  
10. The methods for formulating the recommendations are clearly described.  
11. Health benefits, side effects, and risks were considered in formulating the recommendations. 12. There is an explicit link between the recommendations and the supporting evidence.  
13. The guideline has been externally reviewed by experts prior to its publication.  
14. A procedure for updating the guideline is provided.

**Domain 4: clarity of presentation**15. The recommendations are specific and unambiguous.  
16. The different options for management of the condition or health issue are clearly presented. 17. Key recommendations are easily identifiable.

**Domain 5: applicability**18. The guideline describes facilitators and barriers to its application.  
19. The guideline provides advice and/or tools on how the recommendations can be put into practice. 20. The potential resource implications of applying the recommendations have been considered.  
21. The guideline presents monitoring and/or auditing criteria.

**Domain 6: editorial independence**

1. The views of the funding body have not influenced the content of the guideline.
2. Competing interests of guideline development group members have been recorded or addressed.

**Overall guideline assessment**

Brouwers M, Kho ME, Browman GP, Cluzeau F, feder G, Fervers B, Hanna S, Makarski J on behalf of the AGREE Next Steps Consortium. AGREE II: Advancing guideline development, reporting and evaluation in healthcare. Can Med Assoc J. Dec 2010, 182:E839-842; doi: 10.1503/cmaj.090449.

1. **Summary of work adjustments referred to in guidance and evidence**

**6.1 Table 1: Work adjustment mapped against guidance, research reports and academic papers.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Guidance** | **Research Reports** | **Academic papers** |
| **Adjustments to the work schedule** |  |  |  |
| *More breaks* | G1 | R4 | A14 |
| *Breaks when needed not at pre-determined time* | G1, G5, G8, G9 |  |  |
| *Early/ late start* | G1, G6, G5, G9, G14 |  |  |
| *Paid or unpaid leave for appointments* | G1, G5, G6, G8, G9, G10, G12, G14 | R4 | A14 |
| *Phased return* | G1, G17 |  |  |
| *Part-time working on temp basis* | G1, G19 |  |  |
| Flexible hours | G2, G4, G5, G6, G9, G13, G14, G17, G18 | R1, R8 | A3, A13, A14 |
| Working hours | G5, G17 | R4, R6, | A2, A15 |
| Reduced hours |  | R2, R5 |  |
| Change shift | G14 | R4 | , |
| Graduated return | G2, G8, G11, G12 | R8 | A8 |
| Allow someone to arrange their annual leave so it is spaced out regularly | G8 |  |  |
| **Adjustments to role and responsibilities** |  |  |  |
| *Review workload* | G1, G10, G14, G17 | R3, R8 | A15, |
| *Reassign duties they may struggle with* | G1, G14 | R5 |  |
| *Temporary transfer to alternative role* | G1, G15 |  |  |
| Temporary change in duties to remove stressful components of job | G5, G8, G10, G12, G14 | R1, R4, R5, R6, R7 |  |
| Autonomy |  |  | A13 |
| Modified duties | G14 |  | A2, A3, A6 |
| Breaking up tasks into small components |  |  | A3 |
| Alternative tasks |  |  |  |
| Reduced tasks |  |  |  |
| Reallocation of tasks | G4, G5, G6 | R4, R7 |  |
| Additional time to complete tasks | G2 |  |  |
| **Adjustments to working environment** |  |  |  |
| *Partitions or privacy screens* | G1, G8, G12 | R4 |  |
| *Reserved parking space to ease commute* | G1, G8 |  |  |
| *Home working* | G1, G4, G5, G6, G8, G13, G14, | R4 |  |
| *Increase size of ‘personal work space’* | G1, G8 |  |  |
| *Location of desk in quiet area* | G1, G4, G5, G9, G10, G18 | R1 | A15 |
| Ergonomic / Space changes | G5, G8, G14 | R4 | A2, A3 |
| Quiet space for breaks or work | G5, G6, G8, G14, G17 | R4 |  |
| Light box or natural light | G5, G6 | R4 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Policy Changes** |  |  |  |
| *Extend additional paid or unpaid leave during a hospitalisation or other absence* | G1 |  |  |
| *Allow additional time for them to reach performance milestones* | G1 |  |  |
| *Allow them to make certain personal phone calls during the day* | G1 |  |  |
| Relax absence rules and limits for those with disability-related sickness | G6 |  |  |
| **Ways to provide support and assistance** |  |  |  |
| *Assign buddy or mentor* | G1, G6, G8, G14, G15 |  |  |
| *Regular one-to-ones with manager to prioritise tasks* | G1, G6, G8 |  |  |
| *Provide personal computer to enable them to work at home* | G1 |  |  |
| *Additional training on skills and duties required for the job* | G1, G2, G4, G14, G15, G17, G19 |  |  |
| Supervisor support | G17 |  | A13, A18 |
| Modified supervision | G15, |  | A3 |
| Mediation with difficult colleague | G6, G8, G15 |  |  |
| Work coaching | G5 |  | A6 |
| EAP or counselling | G8 |  | A15 |
| Personalised / individual approach | G11 | R3, R6 | A19 |
| Remembering to say thank you | G5 |  |  |
| Provide written instructions for those whose MH affects their memory | G5 |  |  |
| Provide them with an action plan to manage their condition | G9 |  |  |
| Allow them time to exercise/ breaks | G14 |  |  |
| Allow them to make private calls | G14 |  |  |
| Redeployment | G6, G14, G17 | R4 |  |

**6.2 Table 2: Work adjustment term used within peer reviewed papers, research reports and guidance.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Workplace adjustment** | **Work accommodation** | **Reasonable adjustment** | **Reasonable accommodation** | **Task/ Job Modification** | **Workplace intervention** |
| Term used in peer reviewed papers | A1, A4, A7, A10, A12, | A1, A2, A3, A4, A9, A11, A13, A14, A15, A16, A17, A18, A20 |  | A 20 | A2, A3, A14, A19, | A5, |
| Term used in research reports | R1, R3, R4, | R5, R7, R8 | R2, R6, |  | R8 |  |
| Term used in guidance | G1, G3, G4, | G5, G7, G8 | G2, G6 |  | G8 |  |

**6.3 Table 3: Work adjustment noted in peer reviewed papers, reports and guidance classified under the work adjustment term used throughout that same document.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Workplace adjustment** | **Work accommodation** | **Reasonable adjustment** | **Reasonable accommodation** | **Task/ Job Modification** | **Workplace intervention** |
| **Adjustments to the work schedule** |  |  |  |  |  |  |
| *More breaks* | R4, G1 | A14 |  |  | A14 |  |
| *Breaks when needed not at pre-determined time* | G1, G5, G8 |  | G5, G8, G9 |  |  |  |
| *Early/ late start* | G1, G6 |  | G5, G6, G9, G14 |  |  |  |
| *Paid or unpaid leave for appointments* | R4, G1, G6, G8, | A14 | G5, G6, G8, G9, G10, G12, G14 |  | A14 |  |
| *Phased return* | G1 |  | G17 |  |  |  |
| *Part-time working on temp basis* | G1, G19 |  | G19 |  | G19 |  |
| Flexible hours | R1, R, G4, G5, G6 | A3, A13, A14, R8 | G2, G5, G6, G9, G13, G14, G17, G18 |  | A3, A14 |  |
| Working hours | R4 | A2, A15 | R6, G5, G17 |  | A2 |  |
| Reduced hours | R2 |  |  |  | R5 |  |
| Change shift | R4 |  | G14, |  |  |  |
| Graduated return | G8 | A8, R8 | G2, G8, G11, G12 |  | R8 |  |
| Allow someone to arrange their annual leave so it is spaced out regularly | G8 |  | G8 |  |  |  |
| **Adjustments to role and responsibilities** |  |  |  |  |  |  |
| *Review workload* | G1 |  | G14, G17 |  |  |  |
| *Reassign duties they may struggle with* | G1 |  | G14 |  | R5 |  |
| *Temporary transfer to alternative role* | G1, G15 |  |  |  |  |  |
| Temporary change in duties to remove stressful components of job | R1, R4, G5, G8 | R7 | R6, G5, G8, G10, G12, G14 |  | R5 |  |
| Autonomy |  | A13 |  |  |  |  |
| Workload balancing | R3 | A15, R8 | G10, G14 |  | R8 |  |
| Modified duties |  | A2, A3 | G14 |  | A2, A3 | A6 |
| Breaking up tasks into small components |  | A3 |  |  |  |  |
| Alternative tasks |  |  |  |  |  |  |
| Reduced tasks |  |  |  |  |  |  |
| Reallocation of tasks | R4, G4, G6 | R7 | G5, G6 |  |  |  |
| Additional time to complete tasks |  |  | G2 |  |  |  |
| **Adjustments to working environment** |  |  |  |  |  |  |
| *Partitions or privacy screens* | R4, G1, G8 |  | G8, G12 |  |  |  |
| *Reserved parking space to ease commute* | G1, G8 |  | G8 |  |  |  |
| *Home working* | R4, G1, G4, G6, G8 |  | G5, G6, G8, G13, G14, |  |  |  |
| *Increase size of ‘personal work space’* | G1, G8 |  | G8 |  |  |  |
| *Location of desk in quiet area* | R1, G1, G4, | A15 | G5, G9, G10, G18 |  |  |  |
| Ergonomic / Space changes | R4, G8 | A2, A3 | G5, G8, G14 |  | A2, A3 |  |
| Quiet space for breaks or work | R4, G6, G8 |  | G5, G6, G8, G14, G17 |  |  |  |
| Light box or natural light | R4, G5 |  | G6 |  |  |  |
| **Policy Changes** |  |  |  |  |  |  |
| *Extend additional paid or unpaid leave during a hospitalisation or other absence* | G1 |  |  |  |  |  |
| *Allow additional time for them to reach performance milestones* | G1 |  |  |  |  |  |
| *Allow them to make certain personal phone calls during the day* | G1 |  |  |  |  |  |
| Relax absence rules and limits for those with disability-related sickness | G6 |  | G6 |  |  |  |
| **Ways to provide support and assistance** |  |  |  |  |  |  |
| *Assign buddy or mentor* | G1, G6, G8, G15 |  | G2, G6, G8, G14 |  |  |  |
| *Regular one-to-ones with manager to prioritise tasks* | G1, G6, G8 |  | G2, G6, G8 |  |  |  |
| *Provide personal computer to enable them to work at home* | G1 |  |  |  |  |  |
| *Additional training on skills and duties required for the job* | G1, G4, G15, G19 |  | G2, G14, G17, G19 |  |  |  |
| Supervisor support |  | A13, A18 | G17 |  |  |  |
| Modified supervision | G15, | A3 |  |  |  |  |
| Mediation with difficult colleague | G6, G8, G15 |  | G8 |  |  |  |
| Work coaching | G5 |  | G5 |  |  | A6 |
| EAP or counselling | G8 | A15 | G8 |  |  |  |
| Personalised / individual approach | R3, G11 |  | R6, G11 |  | A19 |  |
| Remembering to say thank you |  |  | G5 |  |  |  |
| Provide written instructions for those whose MH affects their memory |  |  | G5 |  |  |  |
| Provide them with an action plan to manage their condition |  |  | G9 |  |  |  |
| Allow them time to exercise/ breaks |  |  | G14 |  |  |  |
| Allow them to make private calls |  |  | G14 |  |  |  |
| Redeployment | R4, G6 |  | G6, G14, G17 |  |  |  |

*n.b. Recommendations are presented using the framework used in the ACAS guide (G1) and those recommendations currently included are shown in italics to provide a quick view of where ACAS guidance is similar or different to the wider available evidence and guidance.*

1. **Summary of literature reviews**

In this appendix we have summarised the study approach, the key results (what was found?) and the implications (what does it mean?). Please note that we have used the terminology used in the original papers and reports (e.g. accommodation, adjustments) and therefore the inconsistency of terms reflects the inconsistency within the wider literature..

**7.1 Table 1: Summary of systematic reviews**

| **Number** | **Author and date** | **Study approach** | **Results – what was found?** | **Implications – what does it mean?** |
| --- | --- | --- | --- | --- |
| A1 | Dibben et al. (2018) | **Systematic narrative review** to evaluate the evidence on the employment outcomes and cost effectiveness of return to work initiatives for workers with disabilities and health conditions. | 154 studies were identified referring to employment outcomes of which 41 related to mental health disorders. The evidence base for interventions for those with mental health (MH) conditions was very weak. Moreover, very little of the research that showed positive employment outcomes was UK based. Knowledge remains inadequate, particularly where the definition of disability or incapacity to perform work may be open to contestation, such as in the area of mental health. The only areas with a reasonably strong body of evidence for positive employment outcomes relating to MH were: psychological interventions for depression; and supported employment for those with severe mental health conditions. Even in these areas, very few studies included information on intervention costs, and these were not balanced against employment outcomes. | * No evidence found on effectiveness of workplace adaptations, only more intensive rehabilitation programmes (such as psychological interventions) and supported employment. * Knowledge is hampered by poor research designs and lack of specificity around MH concepts (e.g. stress, burnout, clinically diagnosed condition) and interventions used. * Limited research conducted in the UK. Given the unique systems of health care, employment and social support available to UK employees, it would be interesting to better understand what impact work adaptations have for employees working and living in the UK. |
| A2 | Cullen et al. (2017) | **Systematic review** to synthesize evidence on the effectiveness of workplace-based return-to-work (RTW) interventions and work disability management (DM) interventions that assist workers with musculoskeletal (MSK) and pain-related conditions and mental health (MH) conditions with RTW. | Evidence (36 medium/high quality studies) was synthesized for 12 different intervention categories across three broad domains: health-focused, service coordination, and work modification interventions. There was evidence that duration away from work due to MH conditions was reduced by multi-domain interventions encompassing at least two of the three domains. | * Lack of evidence – despite substantial research literature on RTW, there are only a small number of quality workplace-based RTW intervention studies. * No evidence found specifically on effectiveness of workplace modifications for MH. * Evidence seems to suggest that multi-component interventions are preferable (especially work-focused CBT). |
| A3 | McDowell & Fossey (2015) | **Scoping literature review** (studies from 1993 and June 2013) to investigate the types of workplace accommodations provided for people with mental illness, and their costs and beneﬁts. | Nine studies were identified, all of which were exploratory except for one which only used a longitudinal design (Wang et al., 2011). For employees with persistent mental illness who were accessing a supported employment agency, the majority of accommodations related to support from a job coach or employment specialist, such as facilitating communication with the employer during hiring or on the job. The quality of the studies varied considerably and the beneﬁts of the accommodations were not well documented. There is limited evidence that a larger number of workplace accommodations are associated with longer job tenure. | * Lack of research - only two solely focused on workplace adaptations. * Some evidence about types of interventions that are most commonly applied (ﬂexible scheduling/reduced hours, modiﬁed training and supervision, and modiﬁed job duties/descriptions) but no evidence on effectiveness. * Main barriers seem to be a lack of awareness of rights, which leads people not to disclose, so accommodations cannot be identified. |
| A4 | Nevala et al (2015) | **Systematic review** on the effectiveness of workplace accommodation (WA) regarding employment, work ability, and cost-beneﬁt among disabled people. | Although MH and related terms were included in the search terms, no studies of disabled people with MH conditions met the inclusion criteria. | * No evidence identified for people with cognitive disability or mental disability. |
| A5 | Vilsteren et al (2015) | **Systematic literature review** to determine the effectiveness of workplace interventions in preventing work disability among sick-listed workers, when compared to usual care or clinical interventions. | 14 RCTs with 1897 workers – 5 of which included workers with MH problems. In studies of workers with MH problems, there was no evidence for effectiveness of workplace interventions in reducing sickness absence as compared to usual care. The quality of MH studies was low. | * No support for the benefit of workplace interventions in terms of reducing sickness absence for workers with MH. |
| A6 | Nieuwenhuijsen et al (2014) | **Literature review and meta-analysis** to evaluate the effectiveness of interventions aimed at reducing work disability in employees with depressive disorders. | 23 studies with 26 study arms, involving 5996 participants with either a major depressive disorder or a high level of depressive symptoms were reviewed. There was moderate quality evidence that a work-directed intervention added to a clinical intervention reduced sickness absence compared to a clinical intervention alone. There was moderate quality evidence based on a single study that enhancing the clinical care in addition to regular work-directed care was not more effective than work-directed care. | * Work-directed intervention in addition to clinical intervention seems likely to be more successful than clinical intervention alone for supporting RTW in those with higher level depressive symptoms. |
| A7 | Silva & Fischer (2012) | **Literature review** about medical leave due to mental and behavioural disorders and RTW of teachers**.** | 20 articles were identified. The prevalence of mental disorders and factors associated with the work organization were presented in the majority of studies but the papers lacked concrete examples of interventions of changes to be made. Studies were limited by the confused use of MH terms and under-representative samples within research. | * Lack of evidence with no mention of specific adjustments or accommodations. |

**7.2 Table 2: Summary of over-time studies**

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| **Number** | **Author and date** | **Study approach** | **Results – what was found?** | **Implications – what does it mean?** |
| A8 | Kools & Koning (2019) | **Longitudinal analysis of administrative data from a Dutch private workplace reintegration provider** to explore whether the effectiveness of graded RTW depends on the starting moment of the trajectory and the initial level of graded work resumption**.** Data draws from 11,741 sick-listed employees, of which 19% reported psychiatric or psychological conditions, over a period of three years. | Graded return-to-work did not change sick spells or RTW for individuals who have problems related to MH. Findings demonstrated that case managers differed in their use of graded returns, varying between 33.6% - 82.6% occurrences of recommendations. | * Contrary to other studies, suggests that graded return to work has no impact on those with MH conditions. * Need to better understand the rationale and consistency with which graded returns are recommended by healthcare professionals. * Authors suggest psychological issues are more often related to specific work environment features, such as high levels of work demands or lack of control, and therefore graded returns may be compromised by employees returning to an unchanged work environment. |

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| A9 | Streibelt et al (2017) | **Evaluation of a multimodal rehabilitation programme using a control group design with 381 matched pairs** at baseline and 15 months later to determine the effect of Graded return to work (GRTW) in addition to a multimodal rehabilitation on longer-term work participation in people with chronic mental disorders (CMDs). | At follow-up, 88% of the GRTW group had returned to work compared to only 73% of the controls. The mean sick leave duration during the follow-up period was 7.0 weeks in the GRTW group compared to 13.4 weeks in the control group. Additional explorative analyses showed that these effects were only observed in patients with an unsure or negative subjective RTW prognosis. | * Suggests benefits from graduated return to work, but the evidence is for those with fairly long-term MH issues who have already undergone an external rehabilitation programme and who have a fairly poor prognosis of RTW (self-rated) at baseline. |
| A10 | Wåhlin et al (2013) | **A prospective cohort study of 810 sick-listed patients** with musculoskeletal disorders (MSD) or mental disorders (MD) to describe the types of intervention offered and investigate the relationship between the type of intervention given, patient-reported usefulness, and the effect on self-reported work ability. | The adjustment of work tasks or the work environment were the most frequently used interventions. Patients with MD who received a combination of work-related and clinical interventions reported most usefulness and best improvement in self-rated work ability. | * Workplace adjustments are important in combination with other clinical or rehabilitative interventions. |

* 1. **Table 3: Summary of survey design studies**

**Number, author and date**

**Study approach**

**Results: what was found?**

**Implications: what does it mean?**

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| **Number** | **Author and date** | **Study approach** | **Results – what was found?** | **Implications – what does it mean?** |
| A11 | Villotti et al (2017) | **Exploratory, descriptive and cross-sectional investigation** to study the nature of work accommodations and natural supports available in social businesses i.e. those that aim to address social problems in a financially sustainable way. Convenience sample of 90 employees with self-reported psychiatric disabilities. | Social businesses provide many work accommodations and natural supports, especially those linked to schedule flexibility and support. Work accommodations related to training and schedule flexibility were linked to longer job tenure. Regression analysis demonstrated that respondents believed that flexibility offered enabled them to maintain employment. | * Social businesses provide examples of how workplaces can accommodate those with serious MH problems. It is not clear whether these findings would translate to other workplaces where employees may be less willing to divulge their condition. * Accommodations such as schedule flexibility and training are linked to more sustained employment for this population. * 'Natural supports' inherent, such as employer and colleague support, are also important in this context. |
| A12 | Andrén (2014) | **Analysis of data on a nationally representative sample** (629 individuals)extracted from the register in Sweden and supplemented with information from questionnaires, to explore whether combining sick leave with some hours of work (part-time sick leave, PTSL) can help employees diagnosed with a mental disorder (MD) increase their probability of returning to work. | PTSL is associated with a low likelihood of full recovery, but the timing of the assignment is important. PTSL’s effect is relatively low when it is assigned in the beginning of the spell but relatively high, and statistically signiﬁcant, when assigned after 60 days of full-time sick leave (FTSL). | * Suggests efﬁciency improvements from assigning employees with an MD diagnosis, when possible, to PTSL/ gradual return to work after an initial period of FTSL. |
| A13 | Tremblay (2011) | **Questionnaire survey completed by 39 adults who were in outpatient care** and diagnosed with bipolar I or II disorder about workplace characteristics that would enhance job performance. | Primary beneficial work characteristics reported are: schedule flexibility, autonomy, and supervisor willingness to provide accommodations. Specific helpful characteristics noted by participants include: allowances for working at home, leaves of absence, frequent breaks, barriers between work spaces, control over goal-setting, creativity, and avoidance of jobs with pace set by machinery. | * For those with bipolar disorder, flexibility, autonomy and having a supervisor who is willing to provide accommodations are likely to enhance job performance. |
| A14 | Peters & Brown (2009) | **Survey of 305 employees on their reactions towards co-workers with mental illness (MI).** | Co-workers were less likely to view longer/more frequent work breaks as appropriate accommodations for mental ill-health than flexible hours, banking of overtime hours, and counselling. Employees who believed that co-workers with MI were being equitably (or fairly) treated at work were more likely to report that they would self-disclose – and seek assistance for – MI. Employees with workplace contact with the mentally ill were more likely to support hiring people with MI. Contrary to what was expected, contact with MI is linked to lower support for accommodations but this may be due to the setting and employees thinking about contact with patients rather than colleagues. | * Flexible work hours, time off for counselling, and banking of overtime appear more accepted by co-workers as accommodations than longer/ more frequent work breaks (possibly because the latter are seen as unfair and having more of an impact on co-workers). |
| A15 | Mellifont et al (2016a) | **Thematic analysis of data collected through an online survey undertaken by 71 employees** diagnosed with at least one anxiety disorder to inform vocational rehabilitation professionals and managers of best practice accommodations for government employees with anxiety disorders. | Three key ﬁndings regarding desirable vocational outcomes: first, that the availability of ‘standard’ ﬂexible work arrangements, along with personalised accommodations, can assist persons with anxiety disorders (where needed) to reach and retain government positions. Second, the chief barriers to making accommodation requests revolve around fears of being stigmatised and penalised. Finally, there is a need for managerial decision-makers to remain open-minded, particularly when assessing requests for accommodations that may break from government norms. | * Small scale study that shows that those suffering from anxiety in government departments can be reluctant to disclose due to fear of stigma and penalties, but those that have disclosed received a range of accommodations, particularly flexible working. |
| A16 | Mellifont et al (2016b) | **Thematic analysis of open-ended responses to an online survey undertaken by 71 employees** diagnosed with at least one anxiety disorder to explore how anxiety disorders, when accommodated, can assist to improve job performance. | Accommodations can improve the work productivity of employees with anxiety disorders by keeping stress at a manageable level. However, a possibility exists that some people with anxiety disorders are able to maintain strong performance while experiencing an elevated level of anxiety. | * Accommodations can lead to an improvement in performance by keeping anxiety at a reasonable level. * Some believe the anxiety in itself can improve their performance. |

**7.4 Table 4: Summary of interview design studies**

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| **Number** | **Author and date** | **Study approach** | **Results – what was found?** | **Implications – what does it mean?** |
| A17 | Bastien & Corbière (2019) | **Semi-structured telephone interviews with 219 Human Resources Directors (HRD)/employers about RTW of employees after depression.** | HRD/employers specified accommodations. The most common categories identified were related to: work schedule, task modifications, job change and work environment change. Accommodations directly related to the employee or the colleagues were considerably less mentioned and those concerning other RTW stakeholders, including supervisor, were almost absent. These results contrast with employer best practice guidelines for the RTW of workers with common mental disorders. | * Accommodations directly related to work aspects seem to predominate in the views of HRD/employers, while relational aspects and the involvement of the different stakeholders are not prioritized. |
| A18 | Negrini et al (2018) | **Telephone interviews with 74 supervisors working with employees who were already back at work or still on sick leave due to depression** to determine the types and prevalence of supervisor contributions during the different phases of the RTW process (before and during the sick-leave absence, and during the RTW preparations). | Supervisors’ “intention to take measures to facilitate their employees’ RTW” was the only significant predictor of the RTW at the time of the interview. Four of the most frequently implemented work accommodations were actions directly involving the supervisor (providing assistance, feedback, recognition, and emotional support to the employee). | * The attitude of the supervisor is key: having a positive attitude, keeping in contact, and not pressuring employees to return are all predictors of successful return to work. * Limited evidence about accommodations, but some of the key ones were around having a good interpersonal relationship with the supervisor. |
| A19 | Jansson & Gunnarsson (2017) | **Interviews with 12 employers with experience of employees with a Mental Health Problem (MHP)** to **i**dentify and characterise employers’ perceptions of the impact of MHP on work ability. | The first emerging theme “Experiences of employees with MHP” included experiences of diffuse and unexpressed signs of the onset of MHP, and frustration among employers and work-mates which was difﬁcult to verbalise. MHP could also be turned off, thus having no impact on work ability. The second emerging theme, “Strategies to handle effects of MHP in the workplace” included the importance of continual responsiveness and communication, and of ﬂuctuating adaptations. Diversity in the workplace also emerged as a strategy. | * Adaptations depend on the individual: some employees make adaptations themselves, whereas others don't know how to adapt their workplace. * Some people with a MHP can switch it off at work, and value work as a distraction rather than something that needs to change. * Some adaptations involve the manager closely controlling the amount of work, whereas in other cases it is about giving more freedom to the individual to manage their workload. * Disclosure is important: lack of awareness of the cause of a MHP can lead employers and co-workers to get frustrated with the employee when they notice changes in their work behaviour. |

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| A20 | Peterson et al (2017) | **Interviews with 15 pairs of employers and employees** (interviewed individually but consecutively, using a semi-structured interview schedule) about perceptions of the critical factors that enabled and sustained the employee’s employment. | Themes raised in the interviews included the meaning of work, disclosure of mental illness, the beneﬁts of working, special arrangements/accommodations, the work environment, and key things employers and employees do to sustain successful employment. Four critical success factors were identiﬁed relating to: disclosure, the employment relationship, freedom from discrimination and workplace ﬂexibility. | * Flexibility for those with MH problems is important: ﬂexibility of working hours, location, and sick leave arrangements. (Employers saw this as good practice for all employees, not just those with MP problems.) * None of the employers mentioned their legal obligations to provide these reasonable accommodations, and instead saw them as the right things to do (although sampling means probably more progressive employers than most). * General features that help include open, honest and reciprocal relationships between employee and employer. |
| A21 | Lemieux et al (2011) | **Exploratory qualitative study using semi-structured interviews** to investigate the perception held by 11 supervisors involved in work disability management of the factors facilitating or hindering the RTW of workers with common mental disorders. | Twenty-four factors that could hinder or facilitate the return-to-work process were found and classified into three main categories: factors related to the worker, work context, and RTW process. Most of the supervisors interviewed were very open to finding ways to facilitate the RTW of these workers, but felt that the interventions used should take both their perspective and the constraints they face in the workplace into account. | * Supervisors appear to be open to finding accommodations, but need to balance workplace constraints with worker needs. * Worker-related factors, the workplace context, and aspects of the RTW process need to be taken into account to ensure successful RTW. |

**7.5 Table 5: Summary of research reports**

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| **Number** | **Organisation and date** | **Summary and approach** | **Results – what was found?** | **Implications – what does it mean?** |
| R1 | National Institute for Health and Clinical Excellence (2019) | This report presents draft guidelines that build on the 2009 Nice Guidelines for long-term sickness absence. While all conditions are considered, the guidelines are developed by a multi-disciplinary group, and are informed by evidence reviews and consultation. | The following adjustments are put forward for consultation: consider 3-month structured support to reduce recurrence likelihood.  The committee identified that interventions for those with mental ill-health should be a research priority. | * While in the process of consultation, the inclusion of a proposed 3 month supported return is likely to encourage organisations to consider a longer term approach to the implementation of adjustments. |
| R2 | CIPD (2019) | This report presents an overview of health and wellbeing at work, within which return to work and work adjustments are a small component. The findings are based on replies from 1078 organisations across the UK, in reference to 3.2 million employees. | Phased return continues to be the most commonly taken action in relation to mental health with 61% of organisations reporting that they use a phased return or other work adjustments. Unfortunately, specific adjustments were not explored in the survey. Encouragingly, there is an upward trend of awareness of mental health issues. | * This gives an indication of the prevalence of phased returns and the use of other reasonable adjustments. Given the survey is completed by those responsible for health and wellbeing it is discouraging that this figure is not higher. |
| R3 | BITC - Business in the Community (2019) | This report outlines the findings of the annual mental health at work survey, in collaboration with business and partners. | Key findings in relation to work adjustments include: 41% of employees experiencing mental ill-health reported no changes take; 30% reported support with workload was the most useful response when they disclosed they were overwhelmed. Only 8% of managers had received training in return to work or rehabilitation. | * While there is some activity to support those in work or returning, more needs to be done to adapt work. * Additional support with workload is a useful adjustment * Managers require training in supporting return to work and implementing adjustments. |
| R4 | Farmer & Stevenson (2017) – Independent Review for UK Government | This report provides an independent review into how employers can better support the mental health of all people, of which work adjustments is one component. The report draws from an evidence review and consultation. | The report highlights the need to offer workplace adjustments as a Core Standard and importantly recommends the Government should review legislation to protect those with fluctuating health conditions such as mental health condition and clarify the role of employers in providing reasonable adjustments. | * Work adjustments are brought to the fore as core component of an organisations work and health strategy and obligation. |
| R5 | Joosen et al. (2017) – Report for Institute of Occupational Safety and Health | This report presents findings of stakeholder focus groups and interviews with 34 workers at the beginning of their sickleave and at the point of return or six months. A focus is placed on the barriers and facilitators of return to work following mental ill-health absence. | There were many shared perspectives however occupational health physicians reported that making work accommodations were difficult to implement, managers reported difficulties in realising and implementing work adjustments. The role of colleagues and managers accepting work accommodations contributed to feeling safe and accepted at work. | * There is a common understanding of the barriers and facilitators, but perhaps different perspectives about why these occur. All parties would welcome greater communication. * The role of the line manager in successful implementation of work adjustments is key. |
| R6 | Hudson (2016)­ – Report for Acas | This report examines the management of mental health at work. 30 semi-structured interviews were conducted with stakeholders, largely within six case study organisations. | Where reasonable adjustments had been made, these were recognised as helping the employee avoid absence or supporting a return to work. Disclosure was highlighted as an issue by employees and managers, while examples of lack of awareness of the need for adjustment was also noted. | * Reasonable adjustments were reported to help employees stay in or return to work. * Disclosure is important in order to access work adjustments. * Managers may not be aware of their responsibility in relation to reasonable adjustments. |
| R7 | Occupational Health and Safety Agency for Healthcare in British Columbia (2010) | This report provides an overview of best practices in relation to return to work stay at work interventions. It draws from an evidence review and feedback from a stakeholder group including employer and union representation. | A collaborative return to work approach, where there is a good manager-employee relationship, regular check-ins and well designed and planned accommodations. In addition to workplace adjustments the report identifies the role of work-focused CBT, and continued access to treatment and support. | * The role of manager-employee relationship is key to ensuring interventions are effective. |
| R8 | Blisker et al. (date unknown) – Report for The Depression in the Workplace Collaborative: Canada | This report aims to synthesise knowledge and practice concerning depression in the workplace. Evidence reviews, focus groups and guidelines, policies and programme information are used to inform the conclusions. | Early case management is highlighted as beneficial and can support the communication between the employee and organisation. A case manager can support an early return to work and develop close links with the manager and occupational health staff to ensure a best fit job modification throughout the transition. | * Case managers could provide a useful intermediary between the employee and manager to support adjustment decisions and conversations about adjustments. |