MAIN

THESIS

Nicola Walker

TITLE

The design and feasibility of a work-focused relational group-CBT treatment programme to enhance job retention in employed service-users with moderate-severe recurrent depression.

Thesis submitted to Derby University in fulfilment of the requirements for the degree of Doctor of Health and Social Care Practice.

DECLARATION

I declare that I, Nicola Walker, am the sole author of this thesis. This research project has been ethically approved by the University of Derby and the Yorkshire and the Humber NHS Research Ethics Committee.

ABSTRACT

Background

Employees with moderate-severe recurrent depression are at risk of losing their jobs. A search of the literature revealed that most psychotherapeutic interventions are not work-focused, and there are none that have been specifically designed to enhance job retention in employed service-users of UK Community Mental Health Teams.

Methods

The Medical Research Council guidance for the development and evaluation of complex intervention was used throughout this study. Firstly, an effectiveness review of relevant psychotherapeutic interventions revealed several over-arching principles which appeared to underpin their effects such as using a care pathway incorporating multi-disciplinary teamwork, guideline concordance, informed clinical decision-making, tracking of progress, and the use of outreach to encourage clients to complete treatment.

Secondly, a stakeholder consultation was undertaken during the planning period, and realist analysis of the focus group data identified six plausible mechanisms of change which allowed for modification of the new intervention design and refinement of the programme theory.

Thirdly, piloting involved a small feasibility study using a quasi-experimental pre-post design with eight participants which generated both quantitative and qualitative data regarding clinical and work outcomes.

Fourthly, a further stakeholder consultation was undertaken during the reviewing period to consider re-design of the new intervention in terms of improving acceptability and accessibility.

Finally, a process of mixed methods data integration was used to make recommendations for further implementation and evaluation in a definitive trial.

Results

Six provisional Context-Intervention-Mechanism-Outcome (CIMO) configurations were developed into a programme theory. Overall, implementation and evaluation of the new intervention were feasible although problems were encountered in recruiting sufficient numbers for randomisation, and with collecting follow up data. It was also expensive to provide compared to CBT programmes in primary and secondary mental healthcare services. Outcomes suggest the new intervention is a promising treatment for moderate-severe

recurrent depression for some women, and may help them in maintaining their employment. Acceptability could be improved by making the new intervention more interesting and stimulating, with a focus on coping over the long-term. Accessibility could be improved by making the new intervention more understandable, delivering it at the worksite, and making it peer-led.

Conclusions

Job retention for employed service-users may be enhanced if the tertiary individual level Treatment Programme is re-designed as a primary organisational level Training (and staff support) Programme informed by group-CBT.

[The host of the study is referred to as the There and Then Partnership Foundation Trust to provide anonymity to participants and clients].

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ABBREVIATIONS

ADM	Anti-depressant medication
ARM-5	Agnew Relationship Measure
BABCP	British Association of Behavioural & Cognitive Psychotherapies
BDI-II	Beck Depression Inventory version 2
BOHRF	British Occupational Health Research Foundation
CAU	Care As Usual
CBT	Cognitive behavioural therapy
CG	Control group
CMHT	Community Mental Health Team
CORE	Clinical Outcomes in Routine Evaluation
CPA	Care Programme Approach
CQC	Care Quality Commission
DH	Department of Health
DWP	Department of Work and Pensions
GAF	Global Assessment of Functioning scale
GCBT	Group cognitive behavioural therapy
HAM-D	Hamilton Rating Scale for Depression
HR	Human Resources
HSE	Health and Safety Executive
HTPFT	Here and There Partnership NHS Foundation Trust
IAPT	Improving Access to Psychological Therapies Service
IPS	Individual Placement and Support
LREC	Local Research Ethics Committee
LTSA	Long-term sickness absence

MRC	Medical Research Council
NHS	National Health Service
NICE	National Institute of Healthcare and Clinical Excellence
NWPHO	North West Public Health Observatory
OA	Outcome Assessor
OECD	Organisation for Economic Cooperation and Development
OHS	Occupational Health Service
OT	Occupational therapy/therapist
PTS	Psychological Therapies Service
RCT	Randomised controlled trial
RE/RS	Realist Evaluation/Realist Synthesis
RTW	Return-to-work
SMT	Stress management training
SPA	Single Point of Access
SPSS	Statistical Package for the Social Sciences
STSA	Short-term sickness absence
SURG	Service-user reference group
TUC	Trades Union Congress
W-CBT	Work-focused cognitive behavioural therapy
WHO	World Health Organization

APPENDICES & MANUAL

Appendices are presented in Volume 2 and the Client Facilitator Manual is presented in Volume 3 of this thesis.

CONTENTS

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1 BACKGROUND INFORMATION

1.1 INTRODUCTION

This research is focused on employees with moderate-severe recurrent depression seeking help from secondary mental healthcare services in the UK.

Difficulties sustaining employment across the life span and low rates of labour market participation mean that if employees with depression are sacked, resign or retire early from work, some are unlikely ever to work again.

Once unemployed those who have been looking for work for over 6 months are three times more likely to be depressed than those in jobs with an increasing effect the longer they are out-of-work (Koenig *et al*. 2014) . These employees are at greater risk of worsening depression and a cluster of comorbid medical conditions linked to the stress of unemployment, poverty, social exclusion and widening health inequality (World Health Organization, 2014; Marmot, 2005).

New psychotherapeutic interventions are needed that prevent sickness absence (absenteeism) without increasing sickness presence (presenteeism) by treating depression at the same time as addressing occupational stressors that might trigger a relapse or recurrence of depression.

A glossary lists terms used throughout this thesis (Appendix 1).

1.2 STRUCTURE OF THE CHAPTER

The chapter begins by outlining the origins of this study. The Occupational Health Framework is used to describe different levels of preventative intervention. The importance of work is briefly outlined. ***Problems*** are identified as the prevalence of depression, the proportion of employees with depression, and the serious consequences of this. ***Solutions*** to these problems are shaped by different models of 'disability' which are summarised. Evidence regarding current interventions follows showing a gap in knowledge. The chapter concludes by articulating five research questions and clarifying the overall aims of the thesis.

1.3 ORIGINS OF THE STUDY

The author was appointed in 2010 as a Cognitive Behavioural Therapy (CBT) Group Psychotherapist in an NHS outpatient psychotherapy service that provided interventions to service-users of several inner-city and rural Community Mental Health Teams (CMHTs). She worked with colleagues from a variety of professional backgrounds to develop the theory

and practice of relational group-CBT as part of a practitioner doctorate in CBT. The author became interested in job retention in people with moderate-severe recurrent depression because almost half of her caseload comprised service-users who were struggling to maintain their employment.

1.4 OCCUPATIONAL HEALTH FRAMEWORK

The Occupational Health Framework (Murphy, 1988) for preventative interventions is used to structure the presentation of background information (Appendix 2).

The Framework has three levels:

- **Individual or micro-level**. Interventions designed to bring about changes in the worker's behaviour or attitudes.

- **Organisational or meso-level**. Interventions designed to bring about changes in the work environment.

- **Societal or macro-level**. Interventions designed to bring about changes in social policy, cultural mores or institutional practices.

1.5 IMPORTANCE OF WORK

Work is valued by people with depression who report 'treasuring [their] work identity' (Cameron *et al*. 2016), and the workplace is also recognised as the 'primary extra-familial social context' (Cockshaw & Shochet, 2007). So whilst the family is 'the most important element of happiness...work is as important as spending time on leisure…over 2 million people prefer being at work to being at home' (Isles, 2004 p.3). However, people suffering from stress-related disorders 'usually give up leisure and social activities in favour of work activities' (Eriksson *et al*. 2010 p.30), and work is now the most stressful thing in people's lives, above money worries, marriage or relationship issues (MIND, 2011a; MIND, 2011b)

At the societal level, policy is based on the view that work is good for health (Mental Health Taskforce, 2016) so the government aims to increase the numbers of people in work (which boosts tax revenues) and to reduce sickness absence (which cuts the welfare bill).

At the organisational level, businesses need workers to function well because profits fall when they are off sick or struggling to perform.

At the individual level, most people need to earn a wage, but employment can also provide them with career fulfilment, a sense of purpose, belonging, and connectedness, and is a source of personal worth, normality, emotional security and socio-economic status (Saunders

& Nedelec, 2014). For employees with depression, going to work can contribute to their wellbeing by giving them a reason to get up, helping them maintain a daily routine, and providing them with opportunities to meet people (Steadman & Taskila, 2015).

1.6 THE PROBLEMS

1.6.1 Prevalence of depression

Depression is one of the most common mental health problems in the UK (Appendix 3), and according to the Adult Psychiatric Morbidity Survey which found that about 3.8% of respondents met criteria for depression (an increase from 2.6% in 2007) (Lubian *et al*. 2014). It has been estimated that 10% of people in England are likely to experience a depressive disorder in their lifetime (McManus *et al*. 2007). Likewise, a survey of 'community-dwelling US adults' found that of the total sample 5.2% had moderate depression, 2.4% moderately severe depression, and 1.2% severe depression on the PHQ-8 (Strine *et al*. 2009).

Furthermore, in the UK one adult in 27 (just over 4%) is in contact with secondary mental healthcare services (HSCIC, 2015). A survey of patients in two CMHTs found that just over half had a mood disorder (Elisei *et al*. 2013).

1.6.2 The proportion of employees with depression

Approximately 15% of the UK working population have symptoms of mental health disorders, with diagnoses of depression and anxiety showing the biggest rises (Stevenson, 2017). One survey found an estimated 17-20% of employees are affected by mental health problems in any 12-month period (De Lorenzo, 2013), and another found that 56% and 40% respectively of people with 'moderate to severe life course trajectories of depression' were employed (Heinz *et al*. 2018).

People with depression are at greater risk of losing their employment (Lerner *et al*. 2004) such that 2-4% of unemployment across several European countries can be attributed to depression (Porru *et al*. 2018). In Europe between 20-55% of depressed employees go off sick every year (Evans-Lacko & Knapp, 2014), and at least 20% have had previous episodes of depression i.e. recurrent depression (Glozier, 2002).

The proportion of secondary mental healthcare service users who are employed is not reported in the Adult Psychiatric Morbidity Survey (Glossop, 2017) or the Community Mental Health Survey (Care Quality Commission, 2018). However, a Canadian survey of CMHT clients identified a subpopulation of clients (17%) who are at risk of losing their jobs (Kehyayan *et al*. 2014).

Whilst people who are unemployed have worse mental health than people who are employed (Marin *et al*. 2004; Ezzy, 1993), and employment is especially beneficial for employees with depression (Van Der Noordt *et al*. 2014), poor quality jobs that have high levels of psychosocial stress are not a protective factor for mental health compared to 'optimal' high-quality jobs which have low levels of psychosocial stress. Likewise, mental health is no different or worse for those in poor quality jobs compared to those who are unemployed (Butterworth *et al*. 2011).

1.7 SERIOUS CONSEQUENCES

1.7.1 At the societal level

The Organisation for Economic Co-operation and Development (OECD, 2014), found that overall lost earnings due to depression in England were approximately £5.8 billion in 2007, and that these are projected to increase to £6.3 billion by 2026. Likewise, welfare benefit spending, with total expenditure on Employment and Support Allowance (ESA) is estimated at £3.6 billion in 2011-2012, is up from £1.3 billion in 2009-2010 (Emmerson *et al*. 2010). The costs to the UK economy in 2010 were estimated to be £15.1 billion a year for presenteeism and £8.4 billion for absenteeism (Sainsbury Centre for Mental Health, 2010).

Recent government interventions closed the disability employment gap, and the employment rate of people with disabilities rose from 40.2% to 42.7% between 2013 and 2014 (Department for Work & Pensions, 2015), but these rates are still low compared to that for working-age adults with no disabilities (79.7%). The employment rate for people with mental health disability is 22.8% (Trades Union Congress, 2015).

1.7.2 At the organisational level

Depression has a negative impact on productivity (Steadman & Taskila, 2015) . The bill for European businesses of depression-related sickness is estimated at £77 billion a year (Evans-Lacko & Knapp, 2014). Depressed employees tend to make more mistakes, lose interest in work, have difficulty with learning and remembering tasks, withdraw from interaction and experience increased conflict and tension with colleagues (Cox *et al*. 2010).

However, depression is often seen less as an 'illness to be treated', but rather as a 'limitation on productivity' (Teghtsoonian, 2008), and responsibility for the self-management of depression (using CBT and other psychological or pharmacological treatments) is placed on individuals (Esposito & Perez, 2014).

1.7.3 At the individual level

Depression is associated with limitations in work functioning and work participation (Lagerveld *et al*. 2010) that may result in exit from permanent employment on health grounds (Van Rijn *et al*. 2014).

Employees with depression have three main problems: (1) getting to work; (2) doing the job; and (3) working with people (Steadman & Taskila, 2015). Depressed employees may have trouble concentrating, may be preoccupied with their emotional distress, and are prone to negative thinking, procrastination and rumination (Steadman & Taskila, 2015). Depression-related somatic symptoms such as insomnia and fatigue might also impede employees' performance. Depression-related social withdrawal may cause difficulty in interacting with colleagues and customers, and this might result in inter-personal problems (Steadman & Taskila, 2015). Colleagues and customers might say things like, 'You're in a really bad mood all the time; cheer up, what's the matter with you?' (p.9). If the employee internalises this criticism, it can lead to further shame, withdrawal and isolation.

Cockshaw & Shochet (2007) suggest that the behaviour of individuals with depression may be shaped by their self-focused rumination, hypercritical self-concept and low mood:

> *[this can] …lead others in the social environment to develop negatively valanced person schemas and attributions regarding the individual which in turn give rise to increased rejection, criticism and non-genuine support (p.5).*

Moreover, one of the main reasons people with mental health problems give for leaving employment is emotional distress in response to difficulties with workplace relationships, over and above the nature of the job, with poor social skills / functioning being a 'strong and consistent predictor of vocational outcome' (DEEWR, 2008 p.19).

The return-to-work process is often problematic for employees with depression, and if they go off sick for an extended period, they frequently struggle to resume work because functional recovery does not necessarily follow symptomatic recovery (Vemer *et al.* 2013; Schene *et al*. 2007; Timbie *et al*. 2006). Some employees return-to-work quickly but tend to take more time off sick in the future, some return-to-work slowly but reduce their working hours, some never return-to-work (Hellström *et al*. 2017). A subgroup are at increased risk of permanent disability (Wedegaertner *et al*. 2013), and early retirement (Lahelma *et al*. 2015).

Longitudinal studies show that the trajectory in terms of labour market participation for people with mental health problems involves several different states such as being in employment, short-term sickness absence, long-term sickness absence, receipt of statutory sick pay, unemployment and disability benefits with the employee often having many

episodes of ill-health before losing their job permanently (Pedersen *et al.* 2016). The prognosis for return-to-work is not good for employees who go off sick with a depression-related disability, and employees continue to face 'persistent socioeconomic inequalities in work disability due to depression in terms of onset, recovery and recurrence' (Ervasti *et al*. 2015 p.14).

Being unemployed on health-related grounds or in receipt of disability welfare benefits appears to be a 'psychologically toxic experience and one likely to create loss of hope' (Kellett *et al*. 2013 p.17) It seems vital to intervene at an earlier stage, certainly before an employee has gone off sick (Pransky *et al*. 2016).

Whilst both work and worklessness can have a negative impact on mental health, the depression rate in long-term unemployed people is greater than that in the rest of the population. However, moving from unemployment to employment in a poor-quality job is associated with worse health and more chronic stress than for people who remain unemployed (Chandola & Zhang, 2018) . So whilst employees with chronic conditions want 'jobs not charity', they 'refuse to accept that the simple assertion that employment integration is always good for disabled people' (Goodley, 2005 p.3).

However, having to opt for a less stressful but lower-skilled job is a negative experience too. A qualitative study of 50 people who lost their job because of mental health problems described feelings of loss, degradation and humiliation, with a sense of waste when 'skills, knowledge and experience are misdirected into menial or unfulfilling work' (Bodman *et al*. 2003 p.2).

These findings demonstrate the urgent need to enhance job retention for employees with recurrent depression because 'preventing people from losing their job in the first place is often seen as easier than finding a new job' (Steadman & Taskila, 2015 p.45). In contrast an RCT evaluating an exposure-based return-to-work intervention delivered by OHPs (Noordik *et al*. 2013) concluded that for employees off sick with common mental health problems 'it is easier to make a change *of* work than *within* work' (p.159). Similarly, other studies found that about 20% people absent from work due to poor mental health may have difficulties returning to their original job (Ekberg *et al*. 2011), such that a job-to-job move or even changing to a new profession may be a good strategy for maintaining employment (Nordström *et al*. 2014).

1.8 THE SOLUTIONS

1.8.1 Current policy and practice

There is a range of possible solutions and a multitude of organisations with an interest in work and disability (Appendix 4). However job retention is under-investigated with too much emphasis on policies and interventions to reduce the cost of welfare benefits by getting unemployed people with chronic conditions to return-to-work, and not enough emphasis on policies and interventions to reduce the rate of 'health-related employment exit' (p.14) by supporting employed people with disabilities to stay-at-work (Gardiner & Gaffney, 2016). Support offered to people with long-term disabilities, such as mental health problems, is often too little too late.

Two distinct approaches towards mental health and employment interventions have been identified (Robinson & Raine, 2010): the individual / consumerist / psychological models vs. the social / structural approach. Different constructs of 'disability' and different ways of looking at depression inform the debate on how to help people with long-term conditions to participate in the world of work (Appendix 5). In the past a biomedical, reductionist or forensic approach was taken to defining and assessing disability, whereas contemporary approaches use a psycho-social or ecological-economic model (Kausto, 2013) . Disability is now seen as multi-factorial and multi-level set in a specific economic, cultural and political context.

Some organisational level interventions are based on the social model of disability which is underpinned by an emancipatory-participatory philosophy (Barnes & Mercer, 1997 p.1-2).

> *The significance of disability theory and practice lies in its radical challenge to the medical or individual model of disability…The latter is based on the assumption that the individual is 'disabled' by their impairment, whereas the social model of disability reverses the causal chain to explore how socially constructed barriers have disabled people with a perceived impairment.*

The social model of disability is supported by the Trade Union Congress (TUC, 2015). It puts the onus on employers to make the workplace more accessible to people with mental health problems by promoting a holistic approach to employee wellbeing.

However the World Health Organisation (Dunstan & Covic, 2006 p.68) supports the bio-psychosocial model of disability which:

> *…has emerged in reaction to the biomedical model's limitations, [and] assumes illness, pain and disability to be products of the interaction between psychological and physical variables, which together are set against a background of social and environmental influences.*

The bio-psychosocial model has been rejected by disability rights campaigners because they claim it has been misused by assessors of sickness and disability welfare benefits to individualise the problem (Shakespeare *et al*. 2017).

Whilst helping clients maintain employment is important because it has been shown to be a 'protective factor' for employees at risk of 'severe intractable' symptoms of depression (Heinz *et al.* 2018), this appears to depend on the quality of the job. The TUC (2017) makes a clear distinction between 'good work' and 'bad work'. The 'Work in Progress' report on improving outcomes for people with depression describes 'good work' as offering structure, focus and a social environment that can support self-fulfilment and provide an important sense of achievement (Trotter, 2013).

1.8.2 At the societal level

Interventions include government policies that aim to 'change cultures and mind-sets across all of society' (DWP, 2016 p.6). Relevant policies cross departmental boundaries such as the Department of Health and Social Care, the Department for Work and Pensions which encompasses the Office for Disability Issues, and the Department for Communities and Local Government which encompasses the Equalities Office (Appendix 6).

Although depression is a major public health concern, most of the economic costs of depression are not related to treatment but to its effect on productivity (Mcdaid *et al*. 2007). Therefore an argument was made for the government in England and Wales to make a massive investment in Improving Access to Psychological Treatment (IAPT) services (Clark, 2011). IAPT is designed to promote early recognition and to provide evidence-based therapies for common mental health disorders, and includes an employment support component.

Other recommended societal level interventions to prevent depression include increasing the capacity and volume of psychiatric care, reducing poverty and economic exclusion, increasing civic participation, promoting physical activity through the design of urban spaces, improving housing quality and neighbourhood environments, restricting the availability of alcohol, and investing in anti-stigma campaigns (Wahlbeck, 2015; Cuijpers, 2015) .

One systematic review (Underwood *et al.* 2007) made a clear distinction between interventions that aim to help people with mental health problems to obtain work and those that aim to help people with mental health problems to retain work. There has been more emphasis on interventions to tackle absenteeism and unemployment due to depression rather than to tackle presenteeism, and there is much more research on employment support interventions for people with severe mental health problems (such as psychosis) than for

those with common mental health problems (such as depression and anxiety), despite the greater prevalence of the latter.

Employment support funded by government tends to use the Individual Placement and Support (IPS) model (Bond, & Kukla, 2011), but 'IPS is not job retention; it's a different thing, different model with its own evidence base' (Steadman & Taskila, 2015 p.45). IPS is focused on finding competitive employment for unemployed people with serious and enduring mental illness such as schizophrenia, bipolar disorder and major depression with psychotic features (Suijkerbuijk *et al*. 2017; Schneider *et al*. 2016), and IPS alone is 'not sufficient' to improve clinical outcomes (Kukla & Bond, 2013). Nevertheless, IPS has been adapted for employees with 'moderate mental illness' i.e. mostly affective disorders that improved significantly more than CAU over 12 months follow-up in terms of self-reported depressive symptoms although the mean scores at baseline suggest that the severity of depression was mild (Reme *et al.* 2019).

Current policy recommendations are relatively superficial. The most important intervention may be to ensure a diverse workforce such that the proportion of employees with mental health problems reflects the prevalence of the population as a whole (i.e. 17.5% of working-age adults (16–64 years old) (Reme *et al.* 2019). Whilst the UK has a minimally regulated flexible labour market with lower wage growth and less job security, other countries use quota and wage subsidy systems that ensures more representativeness (Vanhercke *et al.* 2017).

However concerns have been expressed that if job retention of people with mental health problems and other disabilities improves, this might have a negative impact on the recruitment of other people with mental health problems and other disabilities. Therefore, while 'those in work gain…those without a job find it even more difficult to access the labour market', because a policy to improve job retention 'potentially hinders employment of people who are judged by employers to be susceptible to sickness or disability in the future' (OECD, 2010 p.17). Regardless, eliminating employees with mental health problems from the workforce would be impossible because they have 'such high incidence and prevalence' (Cooper & Llopis, 2013 p.35).

1.8.3 At the organisational level

For employees with depression, supportive working relationships can help them maintain stable employment across the lifespan (Heinz *et al*. 2018). Interventions include reducing work-related stress, promoting mental health in the workplace and improving the inter-personal environment based on the principle that 'maximum impact can be achieved via a

cultural change in workplace relationships and expectations among employers and employees' (Gardiner & Gaffney, 2016 p.8).

Unfortunately, most interventions funded by organisations are designed to change the worker rather than the work. When an employee reports depression, the problem is often located in the individual with less attention paid to psychosocial hazards in the working environment (Leka & Jain, 2010). These hazards are defined as those components of the design and management of work and its organisational contexts that have 'the potential for causing psychological, social or physical harm' (Eurofound & EU-OSHA, 2014 p.11).

The UK has been involved in two main European initiatives to combat psychosocial hazards in the workplace (Oeij *et al*. 2004), and to promote mental health (EU-OSHA, 2011). EU-OSHA recommends a holistic approach including training on mental health awareness for managers and employees, early identification of stress and mental illness, psychological support, and free counselling.

NICE (2009a) has also published guidelines on promoting wellbeing at work, recommending interventions at a strategic level such as creating a 'culture of participation, equality and fairness based on open communication and inclusion' (p.4), and at an operational level such as line management that involves 'delegation, constructive feedback, coaching and mentoring' (p.6). Likewise, the Advisory, Conciliation and Arbitration Service (ACAS, 2019) offers advice for managers to 'spot the signs', 'engage with the employee' and 'keep a watching brief'.

Canada is the first country to agree on a national standard for 'psychological health and safety in the workplace' (Gilbert & Bilsker, 2012 p.2), which comprises a set of voluntary guidelines. The standard targets organisational processes and practices rather than individual mental health problems, and is informed by the social model of disability. Baynton & Fournier (2017 p.15) explain:

> *We hoped to move beyond the idea that mental health was exclusively an individual's responsibility and recognize that the way work environments were managed mattered. We knew that work - just like community and family - had an impact on mental health. How work was organized, how instructions were given, how leaders supported employees, how conflict was resolved, and how people related to each other in work teams all had an impact.*

Several of the recommended organisational level actions are of an inter-personal nature including enhancing 'civility and respect in the workplace', promoting collegiality, supporting and valuing employees, considering employees' opinions, and encouraging employee participation in decision-making (MHCC, 2013a).

Similarly, an Australian guideline (Safe Work Australia, 2014) recommends that to support good mental health in the workplace, organisations should act on discrimination or bullying, raise awareness of mental health and provide training in stress management, inter-personal skills and negotiation, diversity and disability for example.

All of these guidelines emphasise developing positive relationships within the organisation. In addition, 'natural supports' such as induction, routine supervision and appraisal, team building and training, as well as strengthening the informal social support network provided by family and friends can offer protection against relapse for people with mental health problems (Corbière *et al*. 2014) .

Some organisations offer employer-sponsored insurance which can be used to fund psychotherapy, since 'enhanced depression care' has been shown to be cost-effective with significantly improved work outcomes (Wang *et al*. 2006). Other organisations offer employee assistance programmes (EAPs) and occupational health services (OHS), but many employees do not have access to these programmes and services. Likewise few organisations use workers' health surveillance (WHS) to screen for mental health problems. Screening can help to prevent depression in the workplace (Couser, 2008; McDaid, 2008) but OHS are generally only involved with employees who are already absent and do not offer help to people who are at work but struggling due to mental health problems (NWPHO, 2010).

1.8.4 At the individual level

Interventions include employment programmes and healthcare services. Regrettably, employment programmes tend to ignore health, and healthcare services tend to ignore work (Francis *et al.* 2008). Services often work in isolation and tackle either the mental health problem or the employment need discretely. Addressing both is important as there is no systematic evidence that better health alone will deliver better employment outcomes.

1.8.4.1 Barriers to job retention

Without changes to the work environment, some employees may choose to resign for the sake of their mental health. A qualitative study of service-users' and practitioners' experience of a job retention intervention claimed that (Woodall *et al.* 2017 p.7):

> *Whilst it may contradict the intention of retaining employment…the best course of action for service users is sometimes to leave work entirely.*

Thus, even work-focused interventions alone are unlikely to tackle the 'wicked' problems defined above, and may have limited impact because employees with moderate-severe recurrent depression face significant political, economic, healthcare system, institutional,

cultural, organisational, and personal barriers to treatment (Collins *et al.* 2004) and job retention (Lammerts *et al.* 2016).

1.9 EXISTING EVIDENCE

A scoping exercise of meta-analyses, meta-syntheses, and systematic literature reviews published between 2002 and 2012 was undertaken in preparation for this study. Sixteen studies were identified and looked into to find out whether there was already sufficient evidence available to answer the research questions (Appendix 7). Examination of these documents failed to find any psychotherapeutic interventions designed to enhance job retention for employees with moderate-severe recurrent depression. Several reviews did not draw convincing conclusions while others identified significant gaps in knowledge, with the main recommendation being more research at all levels.

For service-users of CMHTs, the Care Programme Approach guidance recommends that problems with employment should be addressed as part of the care plan. However only 27% of service-users said that NHS mental healthcare services 'definitely' gave them any support with finding work or maintaining employment in the previous 12 months (CQC, 2018).

Most national guidelines recommend psychological treatments for depression (Appendix 8) but there is only one clinical guideline for chronic depression (Jobst *et al.* 2016). This document recommends that Cognitive Behavioural Analysis System of Psychotherapy (CBASP) should be offered as a first-line treatment and Interpersonal Psychotherapy (IPT) as a second-line treatment based on a conceptualisation of recurrent depression as causally and dynamically related to inter-personal excesses and deficits, which might make establishing a therapeutic alliance problematic (Weck *et al.* 2013). In any case, more research into treatments for chronic depression is needed (Cuijpers *et al.* 2017).

A recent review provides strong evidence that CBT without 'workplace modifications or service coordination components' is not effective in supporting the return-to-work of employees with mental health problems (Collie *et al.* 2018 p.1), especially if there is an element of coercion or conditionality in terms of eligibility for welfare benefits.

Psychotherapists have asked the question, 'Can a return-to-work agenda fit within the theory and practice of CBT for depression and anxiety disorders?' (Wesson & Gould, 2010 p.27). There needs to be a clear justification for the development of psychotherapeutic interventions with a work-focus, and Wesson & Gould (2010) claim that having return-to-work (or stay-at-work) on the agenda, need not jeopardize the client-therapist relationship when 'work issues are embedded within the formulation' and the treatment plan (p.27). Problems with return-

to-work may be manifestations of, for example, avoidant behaviour, self-blame, negative predictions and assumptions, or represent major obstacles to change that can be targeted in therapy. Ultimately, helping employees with moderate-severe recurrent depression to maintain their employment will require an integrated multi-level approach (MacEachen, 2018).

1.10 AIMS AND OBJECTIVES

Adults with moderate-severe recurrent depression face significant challenges in the workplace that may ultimately contribute to them becoming unemployed. It is therefore ethically defensible for psychotherapists to develop work-focused interventions that have the twin goals of treating depression and enhancing job retention in service-users of UK CMHTs.

Bearing this in mind, the aim of this research is as follows:

> *To design a theory-driven psychotherapeutic intervention that will both alleviate symptoms of moderate-severe recurrent depression and enhance job retention in working people, and to assess the feasibility of evaluating and implementing the intervention in a real-world setting.*

The objectives are as follows:

- To appraise the effectiveness of current psychotherapeutic interventions for moderate-severe recurrent depression that have a positive impact on work outcomes.
- To identify gaps and areas of uncertainty in the current evidence-base in order to validate the development of a new work-focused psychotherapeutic intervention.
- To create a taxonomy to define and describe components of potentially relevant psychotherapeutic interventions.
- To explore the hypothesised mechanisms of change of these psychotherapeutic interventions.
- To model the design of a new intervention and its programme theory based on the findings from the literature review.
- To consult with stakeholders to establish their views on the suitability of the research procedures, to refine the programme theory, and to modify the intervention design to improve its acceptability and accessibility.
- To pilot the new intervention by collecting outcome and process data.
- To develop an outline proposal for a future definitive trial.

The thesis chronicles the development and preliminary evaluation of a new psychotherapeutic intervention and represents the first revolution of a research cycle. It is hoped that the findings will augment the existing evidence base and stimulate further research.

1.11 RESEARCH QUESTIONS

The research questions are:

Q1. What would be helpful in the design of a work-focused psychotherapeutic intervention to treat moderate-severe recurrent depression and to enhance job retention in employed clients of UK CMHTs?

Q2. Which study procedures would be helpful when implementing and evaluating a work-focused psychotherapeutic intervention in a real-world community setting?

Q3: What is the feasibility of evaluating a work-focused psychotherapeutic intervention in a real-world community setting?

Q4. What is the feasibility of implementing a work-focused psychotherapeutic intervention in a real-world community setting?

Q5. What would be helpful in the re-design of a work-focused psychotherapeutic intervention to enhance job retention in UK employees with moderate-severe recurrent depression?

1.12 THESIS STRUCTURE

Chapter 2 reports the findings of a narrative literature review into psychotherapeutic interventions that might enhance job retention in employees with moderate-severe recurrent depression. There are three sections: an effectiveness review, a component analysis, and an integration of theories underpinning relevant and potentially relevant interventions. A gap in the evidence is identified and the research questions are formulated.

Chapter 3 describes, and justifies the choice of, the methods and methodology used in this thesis. The Medical Research Council's guideline for the development and evaluation of complex interventions is summarised (Moore *et al.* 2015; Craig *et al.* 2008; Campbell *et al.* 2000).

Chapter 4 reports on the findings of the pre-intervention and post-intervention stakeholder consultation that informed the modification of the intervention design and refinement of the programme theory. It also reports on the findings of an exploratory quasi-experimental feasibility study that involved piloting, collection of interim outcomes and process evaluation.

Chapter 5 discusses the overall findings and synthesises the results of each stage. The strengths and limitations of the project are discussed, and a critical appraisal of the thesis is offered.

Chapter 6 makes a case for further research to test whether a worksite-based psychotherapeutic intervention for employed people with moderate-severe recurrent depression could improve job retention rates. It involves an integration of data from each stage in order to make recommendations regarding future implementation and evaluation of the new intervention. A dissemination strategy is proposed.

Chapter 7 presents the conclusions arising from the thesis and how this research contributes to knowledge and practice in the fields of group-CBT and vocational rehabilitation.

2 LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 identified a major problem that, given the high prevalence of depression, it is likely that there are many employees in the UK with moderate-severe depression and that relapse or recurrence may be a factor in them losing their jobs. The chapter explained that current solutions for treating depression and enhancing job retention are inadequate, and outlined a range of barriers that might limit the impact of current solutions.

This literature review identifies empirical studies of relevant and potentially relevant psychotherapeutic interventions in order to explore the existing evidence base, and covers the period from 2002 to 2012 prior to the preliminary design stage of the new intervention. Relevant literature published since 2012 is considered in Appendix 9.

2.2 STRUCTURE OF THE CHAPTER

This chapter comprises the following sections:

1. A **description of the methods** used to carry out the search for relevant and potentially relevant literature.
2. An **effectiveness review** of randomised controlled trials (RCTs) that evaluate psychotherapeutic interventions for employees with depression, and that report both clinical and work outcomes.
3. A **component analysis** of a larger selection of relevant and potentially relevant psychotherapeutic interventions in order to establish each intervention's 'form' or 'operational logic'.
4. A **theoretical integration** of explanatory frameworks and supposed mechanisms of change of relevant and potentially relevant psychotherapeutic interventions in order to establish each intervention's 'function' or 'conceptual logic'.
5. An **overview of the findings** from each section, presenting the over-arching principles, core practice components, core theoretical concepts, and plausible mechanisms that were identified, and setting the scene for the next stages of the research.
6. A **Critique of the Literature Review**, and a **Summary**.

2.3 DESCRIPTION OF METHODS

2.3.1 Database Search

A search of relevant databases was carried out to identify RCTs reporting on psychotherapies or psychotherapeutic interventions delivered as primary, secondary and tertiary preventative programmes specifically for depression with a focus on improving job retention or return-to-work in employed people with mental health problems (Appendix 10).

2.3.2 Inclusion and Exclusion

The PICO factors framework was used to formulate the review's inclusion and exclusion criteria (Petticrew & Roberts, 2006). The inclusion criteria were as follows:

- **Population.** Working-age adults with moderate-severe recurrent depression or with long-standing depression plus a high degree of chronicity, complexity and comorbidity causing work dysfunction.
- **Intervention.** Any intervention with a face-to-face psychotherapeutic component (1:1 or group format).
- **Comparison or control.** Any randomised or cluster randomised controlled trial.
- **Outcomes.** Studies that report both outcomes related to work status such as rates of job retention or sickness absence and outcomes related to clinical status such as symptoms of depression or psychological distress.

The literature review excluded quasi-experimental, pilot, or matched-controls studies.

The focus of this review is only on psychotherapeutic interventions that are based on psychological theory and practice, so this review excludes other possible interventions such as occupational therapy or vocational rehabilitation. This review also excluded:

- Interventions based on exercise, massage, relaxation, yoga, meditation, tai chi, or mindfulness.
- Interventions that only reported outcomes related to clinical status.
- Interventions that focus only on unemployed people.

2.3.3 Search Strategy

The review involved several processes recommended by the Critical Appraisal Skills Programme (CASP International Network, 2010). The data extraction and quality assurance processes are described in detail to ensure transparency and replicability (Appendix 11).

Each paper was appraised by the author, and relevant data was extracted and tabulated. Of the 24 studies, only five studies (seven relevant psychotherapeutic interventions) fully met

the criteria and were therefore included in the **effectiveness review**, as shown in Table 1. A further 19 studies (22 potentially relevant psychotherapeutic interventions) were included in **the component analysis** and the **theoretical integration.**

Table 1 - Study relevance

	Highly Relevant	Potentially Relevant
Bakker *et al.* 2007		✓
Blonk *et al.* 2006		✓
Bonde *et al*. 2005		✓
Brouwers *et al.* 2006		✓
Burnand *et al.* 2002	✓	
De Vente *et al.* 2008		✓
Duijts, 2007		✓
Eriksen *et al.* 2002		✓
Knekt *et al*. 2008a, 2008b	✓	
Lexis *et al.* 2011		✓
Limm *et al*. 2011		✓
Nystuen & Hagen, 2003, 2006		✓
Rebergen, 2009		✓
Schoenbaum *et al*. 2002	✓	
Stenlund *et al.* 2009		✓
Takao *et al.* 2006		✓
Tsutsumi *et al.* 2009		✓
van der Klink *et al.* 2003		✓
Van Oostrom *et al.* 2010		✓
van Rhenen *et al.* 2007		✓
Vlasveld *et al.* 2012	✓	
Vuori *et al*. 2012		✓
Wang *et al.* 2007	✓	
Willert *et al*. 2009, 2011		✓
	Effectiveness review	
	Component Analysis / Theoretical Integration	

2.4 EFFECTIVENESS REVIEW

An effectiveness review was carried out of RCTs that evaluated psychotherapeutic interventions for employees with depression and that reported both clinical and work outcomes.

Data extracted included details of the control or comparison intervention, participant demographic information and intervention features including the setting, pre-stated outcome measures including work status and clinical status. The five studies involved seven active psychotherapeutic interventions. Appendix 18 details the main features of these psychotherapeutic interventions and of the control or comparison interventions.

None of these trials was based in the UK. Two were based in the USA, one in the Netherlands, one in Switzerland and one in Finland.

2.4.1 Design

Of the five highly relevant studies, two were multi-centre RCTs, two were single-centre RCTs, and one was a cluster RCT. In total, they included 2,068 participants in seven intervention-comparison pairs. For details of the client groups see Appendix 13.

2.4.2 Outcomes

The five trials used a range of outcome measures in relation to work status, clinical status, and other outcomes such as quality of life (see Table 2). The studies used a range of time intervals for follow-up (see Table 3).

Table 2 - Outcomes of the studies

Study details *Author / date*	Burnand *et al.* 2002	Vlasveld *et al.* 2012	Knekt *et al.* 2008	Schoenbaum *et al.* 2002	Wang *et al.* 2007	
Work outcomes			✓	✓	✓	Work status (i.e. maintained employment)
						Actual or intention to quit / retire / move jobs
			✓		✓	Perceived work functioning / workability / performance
					✓	Working hours as a proportion of contracted hours
		✓				Objective measure: incidence of sick leave
		✓				Objective measure: frequency of sick leave
		✓				Objective measure: duration of sick leave / number of days
		✓				Objective measure: time until partial / full return-to-work
						Self-reported: incidence of sick leave
						Self-reported: frequency of sick leave
	✓		✓			Self-reported: duration of sick leave / number of days
						Self-reported: time until partial / full return-to-work
Clinical outcomes		✓	✓			Improvement: subjective remission
			✓	✓	✓	Improvement: objective remission
		✓	✓			Improvement: subjective recovery
			✓	✓	✓	Improvement: objective recovery
		✓				Time to first response: subjective
						Time to first response: objective
	✓		✓	✓		Severity of psychiatric symptoms / psychological distress / anxiety
						Severity of inter-personal problems
	✓					Admission to hospital (mental health)
	✓					Length of stay in hospital
Other	✓					Objective measure: overall functioning
		✓				Level of work-related stress, job characteristics
						Coping self-efficacy
				✓		Quality of life
				✓		Satisfaction with treatment / received appropriate care
	✓					Adverse effects / treatment failure

Table 3 - Measurement timings

Study details Author/date	3m	6m	9m	12m	18m	24m	36m
Wang *et al.* 2007		✓		✓			
Schoenbaum et al. 2002		✓		✓	✓	✓	
Knekt *et al.* 2008		✓		✓			✓
Vlasveld *et al.* 2012	✓	✓	✓	✓			
Burnand *et al.* 2002	✓						

2.4.3 Critical Appraisal

The quality rating for each research trial was cross-referenced with either Cochrane reviews where the study was included or other literature reviews that used a comprehensive system of appraisal. Criteria and appraisal results are shown in Table 4.

Overall, these studies were judged to be of moderate-high quality and therefore included in this review.

Table 4 - Critical appraisal results

Study details Author / date	Random sequence generation	Allocation concealment	Blinding of outcomes assessors (clinical)	Blinding of outcomes assessors (work)	Incomplete outcome data (clinical)	Incomplete outcome data (work)	Selective reporting	RATED AS MEDIUM-HIGH QUALITY IN COCHRANE or OTHER SYSTEMATIC REVIEW
Wang *et al.* 2007	+	+	-	-	+	+	?	Nieuwenhuijsen *et al.* 2010
Schoenbaum *et al.* 2002	+	-	-	-	+	+	?	Soegaard, 2012
Knekt *et al.* 2008	+	+	-	-	+	-	?	Soegaard, 2012
Vlasveld *et al.* 2012	+	?	+	+	?	?	?	Archer *et al.*, 2012
Burnand *et al.* 2002	?	?	-	+	-	-	?	Nieuwenhuijsen *et al.* 2014 Nieuwenhuijsen *et al.* 2008

2.4.4 Primary Outcomes: Work Status

Primary outcomes from the five studies relating to work status such as job retention, return-to-work, and absenteeism are presented below. Variable maps are available in Appendix 15.

2.4.4.1 Job retention

Two trials with active treatment comparisons (Knekt *et al*. 2008b, Schoenbaum *et al*. 2002) gave results for self-reported job retention. Knekt *et al*. (2008b) found that in a large sample of outpatients (n=326) participants who received Long-term Psychodynamic Psychotherapy (LPP) maintained employment over 36 months after randomisation, but this was no different to the rate of job retention for participants in the two comparison interventions.

At the end of 24 months follow-up (the intervention only lasted up to 12 months) in one trial (Schoenbaum *et al.* 2002) with a large sample of primary care patients (n=938), participants who received Quality Improvement Therapy (QI Therapy) had significantly more days in employment than CAU i.e. an extra 20.9 days (p=0.03; CI: 2.4, 39.3). However later analysis (Sherbourne *et al.* 2004) found that QI Therapy was superior to CAU and to Quality Improvement (QI Meds) up to 18 months for men but not for women who had significantly more days in employment with QI Meds compared to CAU ($p<0.05$). There was no difference in the number of sick days between groups which suggests that the improvement is due to patients unemployed at baseline finding work.

In another study (Wang *et al.* 2007) with a large sample of employees (n=604) pooled results at 12 months showed that there was a small effect and a statistically significant difference in job retention with 7.4% of participants who received a depression outreach-treatment programme based on CBT losing their job compared to 12% in the CAU group ($p\leq0.022$; OR = 1.7; 95% CI: 1.1, 3.3). Participants in the intervention group increased their contracted hours by 0.7 hours per week whereas there was a reduction of 4 hours per week in the CAU group resulting in a medium effect. There was a statistically significant difference in hours actually worked for the intervention group compared to the CAU group ($p\leq0.02$; OR = 2.0; 95% CI: 0.3, 3.7).

2.4.4.2 Absenteeism

Two trials with active treatment comparisons (Knekt *et al.* 2008b; Burnand *et al.* 2002) gave results for self-reported absenteeism. Knekt *et al.* (2008b) found that 16-22% of participants in the three treatment groups had more than 7 days off during the previous 3 months at considerable cost to the employer. Therefore a statistically significant ($p<0.001$) reduction of approximately 9% during follow-up for the LLP at 18 months and for the MPP at 36 months represents a real and substantial saving with no statistically significant change in the SFBT

group. Similarly the average number of sick-leave days during previous 3 months at baseline was 5.5 days. Only the LPP achieved a small effect (d=0.3) with a statistically significant reduction in days off sick at 18 months follow-up of approximately 3 days. Nevertheless this reduction represents a real and substantial saving for the employer.

Burnand *et al.*(2002) found that in a small sample of acute outpatients (n=74) participants in the intervention group (combined psychodynamic psychotherapy plus Clomipramine) who were employed at baseline lost fewer work days during treatment (i.e., until discharge) compared to participants who received Clomipramine alone with a difference of approximately 20 days (p=0.02).

Interestingly, Wang *et al.* (2007) found there was an increase from baseline in the mean number of days taken as sick leave of 1 day in the previous week for participants in the intervention group compared to 1.8 days in the CAU group resulting in a small effect and a statistically significant difference in absenteeism ($p \leq 0.002$; OR = 2.6; 95% CI: 1.0, 4.3).

2.4.4.3 Return-to-work

One trial with a CAU comparison and a sample of employees on sick leave with depression (n=126) (Vlasveld *et al.* 2012) gave results for register-based data on return-to-work and found that participants who received collaborative care based on problem-solving therapy (PST) did not differ from CAU participants in terms of duration until full return-to-work. It is interesting to note that nine employees in the PST group and eight in the CAU group resigned and so were not included in the analysis of RTW data. For employees that maintained their employment nearly two-thirds of the total sample achieved a lasting full RTW by 12 months. However there was a wide variation in the time taken to resume work with a mean of approximately 6 months overall and no difference between groups ($p>0.05$; 95% CI: −0.657 to 0.261). Similarly there was wide variation but no difference between the groups in the number of days off sick during the 12 months follow-up period with a mean of approximately 200 days ($p>0.05$). This finding suggests that regardless of the treatment a substantial proportion of employees either remained on long-term sickness absence or had been off sick for a lengthy period as opposed to cumulative short-term sickness before resuming work.

2.4.4.4 Work functioning, work ability and performance outcomes

Two trials with active treatment comparisons (Knekt *et al*. 2008b; Burnand *et al.* 2002) gave results for work functioning, work ability, and performance. The mean scores on the self-report Work Ability Index (WAI) in one trial (Knekt *et al*. 2008) showed that the sample as a whole had moderate impairment at baseline calculated as between 28-36 points (Tuomi *et al.*

1998). There was an overall statistically significant improvement in the mean scores from baseline of 3.73-5.15 which meets criteria of real change ≥+2 based on prior analyses (Boström *et al*. 2012) with the effect persisting until 7 months in those who received Short-term Solution Focused Brief Therapy (SFBT), and Medium-term Psychodynamic Psychotherapy (MPP), and until 24 months only for the Long-term Psychodynamic Psychotherapy (LPP). The LPP was superior to the MPP at 36 months ($p<0.05$; 95% CI: -4.56, -0.39), and it was also better than SFBT but the difference was not statistically significant. Actual work performance was also better for participants in the LPP intervention between 9-12 months, and between 18-36 months after randomisation compared to participants in the SFBT and the MPP interventions.

The other trial (Burnand *et al.* 2002) found that participants who received combined psychodynamic psychotherapy plus Clomipramine and those who received Clomipramine alone (ADM) showed large improvements in terms of functioning according to mean GAS scores with a statistically significant but small difference in favour of the combined treatment ($p=0.006$). In addition, participants in the combined Psychodynamic Psychotherapy plus Clomipramine group had a small but statistically significant improvement on the 'adjustment-to-work' subscale of the clinician-administered Health-Sickness Rating Scale ($p=0.04$) at the end of a 10-week treatment programme.

One trial with active treatment comparisons (Schoenbaum *et al*. 2002) gave results for role limitations derived from four responses on the self-report Short-Form Health Survey (SF-12) (reported in Sherbourne *et al.* 2001). Participants in QI Therapy showed more improvement than CAU participants in terms of role limitations from 6-18 months, and better improvement than QI Meds from 6-12 months, but the effects were non-significant at 24 and 18 months follow-up respectively. Participants in QI Meds improved more than CAU participants at 12 months.

2.4.5 Secondary Outcomes: Clinical status

2.4.5.1 Remission of depression

Three trials with active treatment comparisons (Knekt *et al*. 2008a; Burnand *et al.* 2002 Schoenbaum *et al*. 2002) gave results for depression. In one trial (Burnand *et al.* 2002) the mean scores at intake on the HAM-D indicated severe depression, with nearly half having experienced a past episode of depression and nearly half having a personality disorder. Nevertheless, over 70% were in employment. There were statistically significantly fewer patients meeting diagnostic criteria for MDD at 10 weeks with only three (9%) in the combined treatment compared to eleven (28%) in the ADM only group ($p=0.04$).

In another trial (Knekt *et al*. 2008a) the whole sample had a mean score of 15.4-15.8 on the HAM-D at baseline (moderate severity) and 17.9-18.7 on the BDI-II at baseline (mild severity) with a high degree of chronicity, comorbidity and complexity. Mean scores indicated that all groups achieved remission within 3 months on the self-report BDI-II with scores showing a reduction overall of 51% which meets criteria for a minimal clinically important difference (MCID) i.e. 17.5% reduction in scores from baseline (Button *et al*. 2015). Both comparison treatments (MPP and SFBT) did so more rapidly from follow-up at 3 months, whereas participants in the LPP intervention only achieved remission from 9 months. However, the effectiveness of LPP continued with further significant reductions in BDI-II scores through to follow-up at 36 months. When comparing the different approaches using the BDI-II at 3 years LPP was superior to SFBT ($p<0.05$; 95% CI: 0.4, 5.5) and to MPP ($p<0.05$; 95% CI: 1.4, 6.2). There was no significant difference in BDI-II scores between the two comparison treatments at any time point. However, the clinician-administered HAM-D mean scores suggest that no treatment achieved remission.

In another trial (Schoenbaum *et al*. 2002) remission was defined as no evidence of 'probable depression'. Of the sample as a whole 65.8% were employed at baseline, and just over a quarter had a lifetime form of depression and just less than half had an anxiety disorder as well as depression. Participants in QI Therapy showed less likelihood of having 'probable depression' using the clinician-rated CIDI-SF than patients in CAU at 6 months with a 10% point difference in prevalence at 6 and 12 months follow-up but the effects were insignificant at 18 and 24 months. There was a statistically significant difference in the rate of 'probable depression' at 24 months between QI Therapy at 31% and QI Meds at 39% ($p=0.04$), but no difference comparing QI Therapy with CAU.

Two trials with a CAU comparison (Vlasveld *et al.* 2012; Wang *et al.* 2007) gave results for depression. One trial (Vlasveld *et al.* 2012) found that at baseline mean scores on the PHQ-9 indicate that the sample as a whole had moderate depression. Just over 50% also had GAD, and just over 15% also had panic disorder as well as depression. Less than half of the total sample achieved remission (i.e. scoring <5 points on the PHQ-9), and there was no difference between treatments in the time until remission.

In the other trial (Wang *et al.* 2007) the mean score of the QIDS-SR showed that the sample as a whole had moderate depression at baseline and mild severity at 12 months. There was no difference in the proportion of participants in the depression outreach-treatment programme achieving remission at 6 months after randomisation, but there was a small effect and a statistically significant difference at 12 months in the proportion of participants achieving remission 26.2% vs. 17.7% (i.e. $\leq$5 on the Quick Inventory of Depressive

Symptomatology: QIDS-SR) in the depression outreach-treatment programme compared to CAU participants (p<0.011; OR = 1.7; 95% CI: 1.1, 2.4).

2.4.5.2 Recovery from depression

In Knekt *et al*. (2008a), mean scores in all treatments showed that the majority of participants achieved recovery using the BDI-II with improvement lasting from remission throughout the 36 months follow-up period, and in addition there was a statistically significant change (p<0.001) overall with a large effect (d >0.8) on both measures. However there was a reduction overall of only 36% on the HAM-D with no treatment showing a clinically significant reduction of 7.9 i.e. 50% (Cusin *et al*. 2009). 43% in the LPP had achieved recovery at 3 years with a 50% reduction in scores. When comparing the different approaches using the HAM-D at 3 years, LPP was superior to SFBT at 3 years (p<0.05; 95% CI: 0.1, 3.5) and to MPP (p<0.05; 95% CI: 0.3, 3.5).

Interestingly, in Burnand *et al*. (2002) both treatments appeared to have a 'marked negative effect' over the 10 week treatment period using the clinician-administered (HAM-D), with mean scores showing more severe depression. However, fewer participants who received combined Psychodynamic Psychotherapy plus Clomipramine experienced 'treatment failure' defined as meeting diagnostic criteria for MDD at 10 weeks. At discharge only two participants in the combined treatment had been admitted to hospital compared to nine in the ADM only group (p=0.04), and they spent statistically significantly fewer days in hospital (p=0.04).

Whilst the sample overall did not achieve remission in the Wang *et al.* (2007) study, pooled results at 12 months show a small effect and a statistically significant difference in symptom severity comparing the outcomes for the depression outreach-treatment programme to the CAU group (p<0.001; OR = -1.0; 95% CI: -1.7, 0.4).

2.4.5.3 Response to treatment

At 3 months in the Vlasveld *et al.* (2012) study, there was no difference in the change in mean scores (p=0.460), although there was a statistically significant difference in response to treatment (i.e. 50% reduction on the PHQ-9) between the groups with half of the PST group and just under a third showing large improvements in depressive symptoms (OR 2.514; 95% CI: 1.035–6.110, p=0.04). This effect was particularly strong for employees with moderate-severe depression at baseline with those in the PST group scoring 'mild' at 3 months, and those in the CAU scoring 'moderate' depression (p =0.002). However, this difference was non-significant at 6, 9 and 12 months follow-up (reported in Vlasveld *et al.* 2013). Whilst the statistically significant difference did not persist after 6 months the result is probably

important at the individual level in terms of more severely affected employees feeling better in a relatively short timeframe. By 12 months, there was a continuing reduction in symptoms but the results showed that there was no difference in the odds of not responding to treatment or achieving remission ($p>0.05$; 95% CI: −0.281 to 1.353). Less than a quarter of the total sample responded to treatment although employees in the PST group responded significantly quicker to treatment in an average time of 5 months compared to 7.8 months in the CAU groups ($p<0.05$; 95% CI −1.684 to −0.027).

In Wang *et al.* (2007), 30.9% of participants in the intervention group achieved recovery i.e. 50% improvement at 12 months compared to 21.9% in the CAU group ($p<0.010$; OR = 1.4; 95% CI: 1.7, 2.5). Interestingly this improvement was only observed at 12 months, not 6 months. This finding suggests that whilst scores of QIDS were lower at 6 months in the intervention group compared to CAU; it takes more than 6 months for this treatment to improve scores on the QIDS by 50%.

2.4.5.4 Improved emotional wellbeing

One trial with active treatment comparisons (Schoenbaum *et al*. 2002) gave results for emotional wellbeing (Sherbourne *et al.* 2001) . Participants in QI Therapy showed better emotional wellbeing than CAU at every time point from 6-24 months follow-up, with no difference between QI Therapy and QI Meds.

Another trial with active treatment comparisons (Knekt *et al*. 2008a) gave results for anxiety and overall emotional wellbeing. All treatments achieved a significant reduction in scores on the self-report SCL-90-ANX at 3 months, with further reductions only for participants in the MPP at 7 months. However, scores for participants in the LPP continued to decrease in the 36 month follow-up period, with better scores than both the short- and medium-term interventions. There was no significant difference in scores between the two comparison treatments at any point. On the clinician-administered Hamilton Anxiety Rating Scale (HAM-A), results were similar, with participants in the MPP scoring better than the LPP at 7 and 12 months, with no significant difference between the two treatments at 36 months. However, participants in the LPP scored better than those in the short-term SFBT intervention at 36 months.

Similarly, for overall emotional wellbeing, all treatments achieved a significant reduction in scores on the Symptom Checklist-90**:** General Severity Index (SCL-90-GSI) at 3 months. Scores for participants in the MPP were better than the LPP at 7, 9 and 12 months, but scores for participants in the LPP continued to decrease over the follow-up period and were better

than the MPP at 36 months. There was no significant difference in scores between the two comparison treatments at any point.

2.4.5.5 Generalisability

The effectiveness of the reviewed interventions may not be generalisable because there was inconsistency in the baseline characteristics of participants. Only two studies included 100% employed people (Wang *et al.* 2007; Vlasveld *et al.* 2012), whilst in the remaining three studies, the sample included some unemployed people (Schoenbaum *et al*. 2002; Knekt *et al*. 2008a; Burnand *et al.* 2002). Also, in some studies generalisability is limited because their samples differ from the client profile of CMHTs in the UK where the new intervention will be piloted. Just one study included only people with moderate-severe depression at baseline (Wang *et al*. 2007), whilst in another study, the sample included 60% of people with moderate-severe depression at baseline (Vlasveld *et al*. 2012, 2013). Furthermore, all these interventions were tertiary preventative programmes based in a clinical setting, i.e. treatment or care management of symptomatic individuals.

Overall, there was marked variability in the methods of evaluating the interventions, which makes it difficult to make sense of the findings taken as a whole, especially in terms of programme theories.

2.4.5.6 Conclusions

In conclusion, a high-intensity psychotherapeutic intervention based on CBT versus CAU impacts on job retention up to 24 months and improved work functioning up to 18 months (Schoenbaum *et al*. 2002). There was a statistically significant difference in the rate of remission of depression at 6 months lasting up to 12 months for clients who received this treatment compared to those who only received CAU, and a statistically significant difference in emotional wellbeing up to 24 months. Likewise, a low-intensity psychotherapeutic intervention based on CBT versus CAU impacts on job retention up to 6 months (Wang *et al.* 2007). There was a statistically significant difference in the rate of remission at 12 months with a clinically significant reduction in depressive symptoms for clients who received this treatment compared to those who only received CAU. Clients who received another low intensity work-focused psychotherapeutic intervention based on PST had a clinically significant response to treatment at 3 months compared to CAU but this statistically significant difference had disappeared by 12 months (Vlasveld *et al.* 2012).

Only the high intensity psychotherapeutic intervention met the standard for recovery from depression with remission lasting 6 months. The two low intensity psychotherapeutic interventions did not impact on recovery from depression.

None of these interventions was specifically designed to enhance job retention in employees with moderate-severe recurrent depression. Therefore, a gap in research and practice has been identified with regard to which psychotherapies and psychotherapeutic interventions might work best for this cohort, and whether psychotherapies and psychotherapeutic interventions should be work-focused. It is not known whether staying-at-work or returning-to-work is a contributory factor in the onset of, or the recovery from, depression. Also, these studies did not provide the answer to the 'what works for whom in what circumstances and in what respects, and how?' (Pawson *et al*. 2004 p.v).

2.4.6 Over-Arching Principles

Realist synthesis (RS) methodology was used to look for explanatory concepts and ideas (Pawson & Tilley, 2004). Data extraction forms can be found in Appendix 16. The RS process focuses on the choices that individuals make influenced by their 'reasoning', their 'reactions', and the 'resources' available to them (Lacouture *et al.* 2015). Through interrogating different studies, some patterns emerged in terms of over-arching principles.

Barriers to effective intervention were outlined in Chapter 1. Interventions included in this review appear to have tackled some of these barriers by using over-arching principles extracted from the data. For the purpose of this thesis, these over-arching principles are seen as structural meta-mechanisms, because they work to bring about a change in social structures and systems by challenging custom and practice or by modifying the power dynamics in healthcare organisations for example.

2.4.6.1 Multi-disciplinary teamwork

Four interventions were based on multi-disciplinary teamwork delivered either as collaborative care, coordinated through an integrated care management approach or via an intensive milieu setting. In one study (Knekt *et al*. 2008a), three interventions were described as single-modal speciality treatments, but subsequent research found that all patients accessed additional help from psychiatric services (Laaksonen *et al.* 2011) suggesting that different practitioners from different disciplines were involved in their care although it may not have been coordinated.

2.4.6.2 Guideline concordance/quality improvement

Three interventions were based on promoting guideline concordance either in terms of optimal treatment for depression (Wang *et al.* 2007; Schoenbaum *et al*. 2002) or in terms of optimal return-to-work procedures in occupational healthcare (Vlasveld *et al.* 2012). These interventions were designed to promote change at the organisational level (i.e. the healthcare system as opposed to the workplace system) in order to promote change at the individual

level (i.e. client / employee). Two of these interventions provided training for low-intensity practitioners (Wang *et al*. 2007; Vlasveld *et al.* 2012), and one used a dissemination and implementation strategy (Schoenbaum *et al*. 2002). Three interventions were either long- or medium-term psychodynamic psychotherapy (Knekt *et al*. 2008a) or informed by psychodynamic psychotherapy (Burnand *et al.* 2002), and one intervention was SFBT (Knekt *et al*. 2008a). Whilst, none of these interventions are first-line recommended treatments for depression, they appear to have been high quality in terms of practitioners' extensive experience, intensive training and supervision.

2.4.6.3 Detection of probable depression

Two interventions aimed to improve the detection of probable depression through screening of workers (Wang *et al*. 2007) or primary care patients (Schoenbaum *et al*. 2002). Routine screening may mitigate the impact of low levels of help-seeking in individuals with depression. The other five interventions were for help-seeking individuals symptomatic of or diagnosed with depression such that detection of probable depression is a given (Vlasveld *et al.* 2012; Knekt *et al*. 2008a; Burnand *et al*, 2002).

2.4.6.4 Early intervention

Two interventions could be classified as 'early intervention' because the symptomatic individuals identified through screening had not already accessed treatment (Wang *et al.* 2007; Schoenbaum *et al*. 2002). The remaining interventions appeared to rely on referrals from other clinicians for employees who had already been diagnosed in primary or secondary care (Knekt *et al*., 2008a; Burnand *et al.*, 2002), or from the workplace for employees who were off sick such that early intervention is beside the point (Vlasveld *et al.* 2012). This suggests that job retention is more likely if employees at risk of relapse and recurrence of depression receive psychotherapeutic interventions before they go off sick.

2.4.6.5 Treatment initiation

Two interventions used a care management approach to 'facilitate entry' into treatment (Wang *et al.* 2007; Schoenbaum *et al*. 2002). In one intervention 'depression nurse specialists' assessed, informed, and motivated clients at regular brief face-to-face meetings (Schoenbaum *et al*. 2002). In the other intervention, generic mental health clinicians fulfilled a similar role (Wang *et al.* 2007). Clients were supported to accept the treatment/s they preferred such as psychotherapy and / or pharmacotherapy, depending on the assessment of their clinical need and state of readiness. For some clients, treatment may have been prescribed as part of a return-to-work plan (Vlasveld *et al.* 2012), whilst clients in the other

four interventions appear to have been help-seeking such that treatment initiation is a given (Burnand *et al.* 2002; Knekt *et al*. 2008a).

2.4.6.6 Treatment completion

One intervention used an outreach approach to maintain engagement in treatment using different media such as a psycho-educational workbook and methods such as 'phone contact to maintain clients in treatment (Wang *et al.* 2007). Clients with persistent depressive symptoms at 2 months who declined in-person treatment were offered low-intensity phone CBT (Wang *et al.* 2007).

2.4.6.7 Tracking of progress

Three interventions used routine monitoring of depressive symptoms as well as treatment adherence (Schoenbaum *et al*. 2002; Wang *et al.* 2007; Vlasveld *et al.* 2012) to assess if there was any improvement or deterioration. Two interventions used systematic case review (Schoenbaum *et al*. 2002, Wang *et al.* 2007) and one involved a web-based tracking system (Vlasveld *et al.* 2012) to identify those not making progress.

2.4.6.8 Preventing drop-out, poor response, unmet need

When practitioners became aware of clients who were not making progress, they had access to speciality consultation and supervision with a psychiatrist (Vlasveld *et al.* 2012; Wang *et al.* 2007) or 'local experts' (Schoenbaum *et al*. 2002). Following case discussion adjunctive treatment or a referral for specialist psychotherapy may be recommended in line with clinical guidelines.

2.4.6.9 Informed clinical decision-making

Improving practitioners' reasoning / reactions is necessary to enhance guideline concordance. Prompts from electronic decision support systems (Wang *et al.* 2007, Vlasveld *et al.* 2012) provided progress updates to care managers, who then provided feedback and algorithm-based recommendations to other clinicians and treatment providers as necessary.

2.4.6.10 Funding for psychotherapy

Increasing resources is necessary to improve access to psychological therapies and interventions. Research funding was provided such that the intervention was provided at a reduced fee to clients (Schoenbaum *et al*. 2002), or free to clients (Vlasveld *et al.* 2012, Burnand *et al.* 2002, Knekt *et al*. 2008a) and purchasers (Wang *et al.* 2007). There was only one work-focused psychotherapeutic intervention (Vlasveld *et al.* 2012) that appears to have tackled the return-to-work challenge for employees off sick with moderate-severe depression. This intervention showed no superiority over CAU provided by OHPs in terms of length of

sick leave over 12 months, despite showing a statistically significant difference in treatment response, i.e. reduction of symptoms > 50% for participants who scored PHQ-9 > 15, i.e. moderate-severe depression over 3 months follow-up.

2.4.7 Conclusion

No psychotherapeutic interventions were found that had been specifically designed to enhance job retention in employees with moderate-severe recurrent depression, and which had been evaluated with an RCT. However, this review found five relevant psychotherapeutic interventions that aimed to treat depression as a primary outcome where the majority or all of the participants were employees with moderate-severe depression (Wang *et al.* 2007, Vlasveld *et al.* 2012), persistent depression (Schoenbaum *et al*. 2002), an acute episode of severe depression (Burnand *et al.* 2002), or long-standing depression plus a high degree of complexity and comorbidity causing work dysfunction (Knekt *et al*. 2008a).

There was only one work-focused psychotherapeutic intervention that aimed to improve return-to-work rates in employees on short-term sickness absence for depression, which was no more effective than CAU (Vlasveld *et al.* 2012). The other psychotherapeutic interventions were person-focused and did not interface with employees' workplaces. Whilst employees managed to stay-at-work, job retention in itself may actually be a risk for recurrence of depression if work-related stress is a factor in relapse. Previous reviews have claimed that psychotherapy that aims to relieve symptoms is not sufficient for effective vocational rehabilitation that aims to provide work-focused care or treatment plus workplace accommodations: '*Both* are necessary: they are inter-dependent and must be coordinated' (Waddell *et al*. 2008 pp.5-6). Therefore, it is important for new psychotherapeutic interventions to be work-focused incorporating job retention strategies such as workplace liaison.

Realist synthesis suggests that the care pathway should incorporate these overarching principles, which will be applied in this present research (Appendix 17).

2.5 QUALITATIVE STUDIES

A related search was undertaken for qualitative studies that might provide data about potential mechanisms of change in a psychotherapeutic intervention to enhance job retention in employees with moderate-severe recurrent depression. Three relevant studies were identified and reviewed.

A large meta-synthesis of stakeholder views on what helps to find and sustain employment for people with a range of mental health problems (Fossey & Harvey, 2010) involved 20 qualitative studies and 518 participants. The study found that people with mental health problems want to work but accept that there may be 'drawbacks to working' such as negative 'interactions and relations' in the workplace. The main personal barrier to job retention was reluctance to disclose mental health problems due to stigma, and the 'energy devoted to hiding illness' (Fossey & Harvey, 2010 p.310). There are also systemic barriers to working such as perverse incentives to remain on sickness or unemployment benefits or to only work part-time.

One recommendation that might help employees to 'continue working through difficult times' was to increase access to 'natural supports in workplaces as potentially enabling people experiencing mental ill-health to retain their jobs without the need for disclosure' (Fossey & Harvey, 2010 p.310). This could be achieved by creating an 'accepting workplace culture', instituting a 'constructive approach to management' based on 'respectful, fair and supportive communication', and encouraging positive relationships between colleagues. Ultimately, it was important to find the 'right kind of work' congruent with the employee's values, needs, and aspirations. The authors were Occupational Therapists (OTs) and addressed their recommendations to OTs.

A qualitative study ran alongside an RCT to 'explore patients' experiences', and involved 17 interviews with people who had completed either a 12-month group cognitive behavioural rehabilitation programme with Qigong, or Qigong alone, and one interview with someone who had dropped out (Fjellman-Wiklund *et al*. 2010). The RCT involved 136 participants and although mean scores showed significant improvements in clinical and work outcomes, there was no difference between the different interventions (Stenlund *et al.* 2009). Participants in both groups described themselves as being like "seekers" or "wanderers" in the healthcare system, but now felt as if they had "come home" (Fjellman-Wiklund *et al*. 2010 p.42), and found being in a group was helpful in 'regaining control of their lives' and for 'recovery' (p.42).

Another small qualitative study into users' experiences of a job retention service in Brighton involved 14 employed people (Cameron *et al.* 2012). The Retain project provided 1:1 support from a case manager and access to a group programme. The project was for employees with enduring mental health problems including depression, bipolar disorder and schizoaffective disorder, with the majority being treated in primary care and a few in secondary care (Cameron *et al.* 2012). The intervention was delivered at the interface level and was based on the Person-Environment-Occupation model. Service-users thought that interventions should help employees improve their self-confidence, communication, problem-solving, and coping skills.

Interestingly, in all of these studies there was a tendency towards silos or 'splitting' with employment specialists and mental health practitioners perceived as separate to the workplace. In Fossey & Harvey (2010 p.310), employees 'preferred…to address problems in the workplace for themselves', and in Cameron *et al.* (2012 p.8) employees 'tended not to perceive Retain as acting as an advocate for them. Instead the project was seen as a support to self-advocacy'. Whilst some interventions were work-focused, the CBR programme did not involve sufficient emphasis on work resumption with only a single meeting at the workplace before return-to-work. Employees on long-term sickness absence probably need a structured approach to rehabilitation with 'strong continuous support' (Stenlund *et al.* 2009 p.302).

Interventions delivered in a group format have advantages in reducing isolation, shame and self-blame (Cameron *et al.* 2009), and in providing inspiration, hope for the future, non-threatening peer support, and community connectedness (Fossey & Harvey, 2010), but they may also encourage dependency and collusion. Without the facilitation of both support *and* challenge, group members may become over-reliant on others' uncritical validation and become 'worried about how they would manage without support from the group and professionals' (Fjellman-Wiklund *et al.* 2010 p.477).

2.6 COMPONENT ANALYSIS

2.6.1 Analysis of Intervention Components

In order to design the new intervention, it is necessary to understand exactly *what* interventions do and *how* they do it, i.e. the operational logic (Astbury & Leeuw, 2010). Due to the limited number of studies in the effectiveness review, this section comprises a comprehensive narrative review and descriptive analysis of the design of relevant and potentially relevant psychotherapeutic interventions evaluated in the RCTs identified by the search. Details of these studies are summarised in Appendix 18.

2.6.2 Data Extraction

As described, 24 studies fully or partially met the inclusion criteria and reported both work and clinical outcomes. The features of each intervention's design are described and critiqued using the Intervention Component Analysis Methodology (Sutcliffe *et al*. 2015).

Programme (or intervention) designers may have provided a rationale for their choice of *core practice components*, but where this is not presented retroductive reasoning is needed to unearth the designers' implicit assumptions about *why* it is supposed to work. In many cases, creative speculation and conjecture (Astbury & Leeuw, 2010) have been used to identify plausible explanations for *what* was done and *how* it was done. Explicit reasons for *why* interventions are supposed to work i.e. conceptual logic (Astbury & Leeuw, 2010) will be addressed in Section 2.7 of this chapter which interrogates the *core theoretical concepts* and explanatory frameworks informing each intervention's design.

2.6.3 Strategic Components

The 24 studies included 29 active psychotherapies and psychotherapeutic interventions which were categorised using the Occupational Health framework into what model of practice it was based on, as well as the level of prevention and the level of intervention, as summarised below. For more detail see Appendix 19.

- **Models of Practice**: Cognitive Behavioural Therapy (CBT), Psychodynamic Psychotherapy (PP), Problem-Solving Therapy (PST), Solution-Focused Brief Therapy/ Coaching (SFBT), Stress Management or Stress Inoculation Training (SMT/SIT), and Staff Support (SS).
- **Level of prevention**: Tertiary, secondary and primary preventative programmes.
- **Level of intervention**: Individual or micro-level, organisational or meta-level, societal or macro-level, and interface level.

2.6.4 Core Practice Components

Scrutiny of each intervention allowed the operational components to be identified and categorised. For more detail see Appendix 20.

2.6.5 Operational Components

2.6.5.1 Focus

Focus is defined according to the issues on which the intervention mainly concentrates i.e. person-focused or work-focused.

Interventions delivered at the individual or interface levels of intervention can still be work-focused if they are designed to help employees cope with redeployment for example.

2.6.5.2 Base for intervention delivery

Base is defined as where the intervention is actually delivered i.e. clinic, worksite, Social Security offices, client's home, or alternative community venues such as church halls or libraries.

2.6.5.3 Intensity

Intensity is defined as the amount of skill and expertise required to treat mental health disorders ranging from mild-moderate to moderate-severe, and from single-diagnosis to complex comorbidity i.e. high-intensity interventions are delivered by qualified and experienced psychologists or psychotherapists, or low-intensity interventions are delivered by generic practitioners other than qualified and experienced psychologists or psychotherapists or non-clinical workers such as Human Resources personnel or peer support volunteers.

2.6.5.4 Format

Format is defined as the method used to deliver psychotherapeutic interventions i.e. one-to-one or a group format.

2.6.5.5 Duration

Duration is defined as the length of time between treatment initiation and treatment completion i.e. short-term refers to < 12 weeks, medium-term >12 weeks < 9 months, or long-term > 9 months.

2.6.5.6 Dose

Dose is defined as how many hours of treatment clients actually receive i.e. a very low dose refers to < 3 hours, low dose >3 hours < 8 hours, medium dose > 8 hours < 24 hours, high dose > 24 hours < 32 hours, or very high dose > 32 hours.

2.6.5.7 Volume

Volume is defined as how many clients can be treated by one practitioner per hour i.e. low-volume interventions are when one practitioner provides the equivalent of one hour of treatment for one client, medium-volume interventions are when one practitioner provides the equivalent of one hour of treatment for between two to four clients, high-volume interventions are when one practitioner provides the equivalent of one hour of treatment for between five to twelve clients, or very high-volume interventions are when one practitioner provides the equivalent of one hour of treatment for more than twelve clients.

2.6.5.8 Frequency

Frequency is defined as how often practitioners have contact with clients for the purposes of treatment i.e. a one-off session, daily, 2-3 times per week, once per week, every 2-3 weeks, or monthly/bimonthly.

2.6.6 Content Components

A content component is defined as the subject matter of therapeutic sessions in terms of *what* was talked about by the therapist and *what* was provided in terms of written information e.g. psycho-education, behavioural skills, emotions/affect regulation, cognitive restructuring, coping strategies, a focus on intra-personal, and/or a focus on inter-personal.

The categorisation of each of these main content components was derived from several sub-categories. For more detail, see Appendix 20.

2.6.7 Process components

A process component is defined as *how* the therapist interacts and communicates with the client or *how* clients interact and communicate with each other e.g. purposeful and planned activities that occur during therapeutic sessions, or *how* the therapy was applied e.g. using homework assignments, keeping a thought diary, eliciting insight e.g. style of teaching-learning, facilitation of peer-to-peer dialogue, in vivo activities and skills practice, relationship with therapist, relationship with group members/significant others, between-session activities, sharing emotional experiences, and/or provision of resources.

The categorisation of each of these main process components was derived from several sub-categories. For more detail, see Appendix 20.

2.6.8 Job retention strategies

A job retention strategy is defined as any content or process specifically offered or undertaken by the therapist in order to enhance the client's ability to maintain their employment e.g. provision of information, a focus on the workplace, support for line

managers / supervisors, liaison with other stakeholders, help getting back to work, supporting employment, and/or promoting employee's career management.

The categorisation of each of these main job retention strategies was derived from several sub-categories. For more detail, see Appendix 20.

Pie charts were used to show how much time was given to each component in each category of intervention (Appendix 21).

It must be noted that some researchers did not publish enough information to ascertain how many (if any) content or process components or job retention strategies were incorporated, and that therefore this review may not reveal the reality of *what* was done and *how* it was done.

2.6.9 Conclusions

Only one intervention used a published and freely available treatment manual (Muñoz & Miranda, 2000) that described the treatment in sufficient detail for adequate replication (Schoenbaum *et al*. 2002). Most of the other interventions were under-specified and a lot of creative speculation and conjecture was required to work out what therapists did, and how they did it. Therefore, this review meticulously and systematically scrutinised 29 potentially relevant interventions that fully or partially met the inclusion criteria. Immersion in the data allowed for a comprehensive range of components to be identified and classified.

The analysis revealed several core practice components that will be reflected in the care pathway and intervention design (Appendix 22).

It is proposed that when these core practice components are enacted through the implementation of a new psychotherapeutic intervention, they might bring about change at the individual level of intervention e.g. the symptomatic employee, through activating new client beliefs and behaviours for example. For clients who take advantage of the OT offer, the intervention might also bring about change at the interface level of intervention e.g. a more depression-friendly approach used by OH or HR personnel involved.

2.7 THEORETICAL INTEGRATION

This literature review set out to establish the *core theoretical concepts* of different psychotherapeutic interventions that explain *why* they might work to enhance job retention in employees with moderate-severe recurrent depression.

2.7.1 Mechanisms of Change

The term 'mechanism' refers to a change-inducing measure by which the intervention has a particular outcome in a particular context. 'Context' refers to the particular conditions, at the individual, organisational, and societal levels for example, necessary for the intervention (or one of its components) to activate the particular mechanism in order to produce particular outcomes patterns. Finally, 'outcomes patterns' refers to the actual effects generated by causal mechanisms in particular contexts (Tilley, 1998 p145). Pawson *et al.* (2004 p.2) explains:

> *Programmes are thus shaped by a vision of change and they succeed or fail according to the veracity of that vision. Evaluation, by these lights, has the task of testing out the underlying programme theories. When one evaluates realistically one always returns to the core theories about how a programme is supposed to work and then interrogates it - is that basic plan sound, plausible, durable, practical and, above all, valid?*

Evaluations that focus on outcomes alone do not provide sufficient information for policy makers, commissioners or clinicians about the potential impact of implementing any intervention in the real world. Programme designers should provide detailed information to aid decision-makers about strategic components such as model of practice, level of prevention and level of intervention, and operational components such as intensity, duration, dose, volume, frequency, format, or content and process components. Doing so also improves knowledge translation in healthcare sciences. It is especially important to identify mechanisms of change because these may have unintended or 'surprising side effects', and to identify active ingredients without which the intervention would be unlikely to achieve its specified outcomes (Sutcliffe *et al.* 2015).

It can be seen that when a study has a clear hypothesis based on a theory underpinning the intervention's proposed mechanism of change, it is possible, when the hypothesis is not upheld or when there are adverse outcomes, to decide whether there has been a programme theory failure or a programme implementation failure. However, even when explicit explanations are spelt out, it is often necessary to 'mine' the document by looking 'below the surface' to elucidate the designers' implicit assumptions about human behaviour which informed *why* they did *what* they did and *how* they did it. Reconstructing programme theory (Leeuw, 2003) often requires careful reading between the lines when only documentary data

is available. It is also necessary to look for confirmatory as well as contradictory data before proposing how existing *core theoretical concepts* could be merged and refined.

2.7.2 Explanatory frameworks

This review provides a brief overview of theories underpinning different interventions (Appendix 23). Each theory, and how it was applied in practice, was interrogated to find out what programme designers believed might influence employees' choices about whether to stay-at-work or return-to-work, particularly in terms of reasoning, reactions and resources.

Mechanisms are not directly visible or knowable, and may be unarticulated or unconscious. Therefore, creative speculation and conjecture are used to identify any plausible 'candidate explanations'. How these mechanisms were elicited is presented in Appendix 24, and how they were codified and mapped is presented in Appendix 25.

2.7.3 Possible Mechanisms

Several possible mechanisms surfaced during this analysis, which allows for some preliminary hypotheses to be proposed (refined by the stakeholder consultation focus groups).

These mechanisms were elicited by asking, 'What did programme designers believe might influence an employee's choices about whether to stay-at-work or return-to-work?' They were categorised under seven provisional headings as described below.

Most authors provided some details about the theory underpinning the intervention design, or cited foundational texts. The analysis revealed that the new psychotherapeutic intervention should promote change via mechanisms at three levels based on core theoretical concepts:

- Work-related changes: individual and organisational
- Psychological changes: behavioural, cognitive, and emotional
- Relationship changes: with self and with others

2.7.3.1 Changes in self: work-related

This review hypothesises that employees may need to feel that they can cope with organisational changes and other career setbacks, they may need to appreciate the benefits of lifelong learning in the workplace, they may need a sense of belonging and job satisfaction, and they may need to establish a work-life balance.

2.7.3.2 Changes in environment: work-related

Some interventions focused on organisational change that might work to enhance job retention in employees with moderate-severe recurrent depression. This review hypothesises that the work environment may need to change by involving employees in improving their

working environment, allowing employees to have more control over their work and the demands made upon them, being clear about what employees are expected to do, providing the necessary resources for them to do their jobs effectively, promoting supportive relationships in the workplace between an employee and their line manager and between an employee and their colleagues, and ensuring employees experience fair and consistent leadership.

2.7.3.3 Changes in self: behavioural

This review hypothesises that employees may need to develop more helpful behavioural patterns, to develop more helpful coping skills, and to be able to set their own goals.

2.7.3.4 Changes in self: cognitive

This review hypothesises that employees may need more knowledge about stress / trauma / depression to develop more helpful thinking patterns, and to be able to reframe stressful events and problems as challenges to be overcome.

2.7.3.5 Changes in self: emotional

This review hypothesises that employees may need to feel better with fewer symptoms of stress / trauma / depression, feel physically calm and psychologically safe and to be able to express and manage their emotions better.

2.7.3.6 Changes in relationship: with self

This review hypothesises that employees may need to have more self-awareness (insight), appreciate their strengths, personal qualities, life experience, and wisdom, be able to see themselves as resourceful, resilient, and responsible, and to believe that they are in charge of their lives.

2.7.3.7 Changes in relationship: with others

This review hypothesises that employees may need to have more inter-personal awareness (outsight), understand how the past affects the present, be able to relate positively, and to experience supportive relationships in therapy.

It is further hypothesised that these mechanisms might form a hierarchy of interventions such that work-related changes should be prioritised over psychological changes because employees are less likely to decide to stay-at-work or return-to-work if these changes have not been implemented at the organisational level. Similarly, psychological changes should be prioritised before relationship changes because employees are less likely to decide to stay-at-work or return-to-work if these changes have not been implemented at the individual level.

2.7.4 Conclusions

The analysis uncovered several core theoretical concepts that will be reflected in the programme theory (Appendix 26). Thus, the new intervention is informed by a theoretical integration of occupational stress, psychological, social / inter-personal, and bio-medical theories. It will particularly target inter-personal deficits and sensitivities because if clients improve their communication and interaction skills it is hoped that they will be better able to access emotional support at work and at home, and that this will protect them against the relapse and recurrence of depression.

It is proposed that when these core theoretical concepts are enacted through implementation of a new psychotherapeutic intervention, they might bring about change at the individual, interface and organisational levels i.e. the contractual partnership between the symptomatic employee and their employer, through activating new client behaviours and reducing psycho-social hazards in the workplace that may improve their clinical status and their work status.

2.8 CRITIQUE OF THE LITERATURE REVIEW

This literature review has several strengths. It is systematic and transparent in outlining each step of the reviewing process such as study retrieval, grading of evidence quality, and synthesis of data, so that its findings should be reproducible. The process conforms to standards set by the Critical Appraisal Skills Programme (CASP International Network, 2010) so that the review is trustworthy and authoritative. The robustness of the findings is further strengthened by a clear description of, and rationale for, the narrative synthesis methodology used to identify probable mechanisms. This should offset any concerns about rigour and increase confidence in the preliminary intervention design and programme theory.

However there are several limitations. A major flaw is that there was no stakeholder involvement in the reviewing process. Nevertheless, the findings informed the discussion guides for the phase two focus groups which involved former service-users, frontline practitioners and managers.

This review was based on a recommended appraisal process but only included studies using an RCT methodology and excluded other studies using a quasi-experimental methodology for example. Whilst this means the review may have missed some non-randomised and matched controls studies that may have provided more detailed information about potentially relevant interventions, RCTs are considered the gold standard and as such there can be greater confidence in the results. Similarly, only articles published in English language peer-reviewed journals were included. Whilst this means that the review may have missed some studies it is likely that the findings would not have been generalisable. None of the included studies was based in the UK, but they were based in the developed world where occupational culture is likely to be comparable.

Very few studies fully met the inclusion criteria. In order to extract information not just on effectiveness, strategic and operational components, and theoretical or explanatory frameworks it was decided to include studies where the sample included a proportion of participants who were unemployed, off sick, or had mild-moderate depression. Whilst these samples are more representative of real-world clinical case loads, there was greater variability in the type of interventions, the methods of evaluating them and the comparators used. In addition, whilst all studies reported several outcomes, some studies focused on clinical status as the primary outcome and some focused on work status. Some of the included studies reported data for clients with different severity of depression, and for clients employed versus unemployed at baseline.

The above heterogeneity made conducting a statistical meta-analysis unfeasible. Therefore, a narrative synthesis approach (Popay *et al*. 2006) was used which pulled together and made sense of data from a variety of studies, and provides a high degree of trustworthiness in the conclusions of this review.

Overall there may have been several sources of bias in the included studies as several important principles were not reported. However, all of the studies had been included in Cochrane or similar high-quality systematic reviews and as such were considered to be of at least moderate quality.

Another weakness in this review is that half of the included studies had small sample size so were probably underpowered to detect a true effect. However three studies had more than 300 participants in total, which suggests that their conclusions are more robust.

Some studies had a high rate of attrition which makes the follow-up data potentially unreliable, and some had short follow-up period so relapse and recurrence were unlikely to be observed. Whilst these issues jeopardise the validity of individual studies, the narrative synthesis approach considers a lack of data completeness.

2.9 SUMMARY

Significant gaps in the literature have been identified and none of the included studies was able to demonstrate unambiguous effectiveness for any intervention in terms of enhancing job retention for employees with moderate-severe recurrent depression. Only one study evaluated group-CBT but the results were aggregated with 1:1 CBT. Several studies included suggestions for further research and methodological considerations, which were born in mind.

Several probable mechanisms were derived from data extracted from studies involving diverse practice models and approaches. Three meta-mechanisms were identified: work-focused mechanisms, cognitive-behavioural mechanisms, and relationship-focused mechanisms. These will form the basis of a preliminary intervention design and programme theory and the initial research proposal.

No conclusive evidence was found for the use of specific mechanisms due to the heterogeneity of psychotherapeutic interventions reviewed, and there was a high degree of disparity in terms of which key ingredients or components were incorporated, which suggests considerable disagreement about whether they might be essential or not. Despite some contradictory findings, it was possible to integrate a selection of these probable mechanisms to propose a framework for theory and practice that underpins a new psychotherapeutic

intervention specifically designed to enhance job retention in employees with moderate-severe recurrent depression. .

This review has established a need for further research and improved practice to enhance job retention in employees with moderate-severe recurrent depression.

This research study is based in several city centre Community Mental Health Teams (CMHTs) for people with moderate-severe and enduring mental health problems such as recurrent depression. An outline of the proposed intervention is now proposed:

- **Strategic and operational components**: it will be a high volume; medium dose; medium-term; tertiary preventative Treatment Programme delivered as weekly sessions in either a 1:1 or a group format, and set in a community venue. The intervention will have an inter-personal focus in concordance with clinical guidance (Jobst *et al.* 2016). It will be delivered at the interface level (for clients who choose Occupational Therapy input).
- **Component factors**: it will be a high-intensity relational CBT intervention involving a skills mix with a psychotherapist who will focus on the clinical treatment of depression and an Occupational Therapist who will focus on job retention strategies. The content will include psycho-education, behavioural skills, emotions and affect regulation, cognitive restructuring, coping strategies, intra-personal issues, and inter-personal issues.
- **Process components**. The intervention will be relational in that, whether it is delivered in a 1:1 or group format, it will incorporate an extensive range of inter-personal therapeutic processes.
- **Job retention strategies.** The intervention will be work-focused in order to incorporate components such as the provision of information, help getting back to work, supporting employment, and promoting the employee's career management. For participants who choose Occupational Therapy input, there will also be a focus on the workplace, advocacy, employment support, and low key liaison with other stakeholders if required.

The new intervention will be called a 'work-focused relational CBT Treatment Programme'. The outline design, as well as the care pathway and research protocol, will be explained in the following chapter. A theory of change diagram can be found in Appendix 27.

3 METHODOLOGY

3.1 INTRODUCTION

This study took place in an NHS secondary mental healthcare service in the UK. When working in the NHS, which is a complex system of practice and often involves a wide range of different professionals and practitioners, it is necessary to use the most appropriate methodology and methods, because clients' problems are likely to have multi-level and recursive causation, and practitioners are likely to be committed to multiple and potentially incompatible solutions. In addition, uncertainty and unpredictability is the natural state of a complex systems like secondary mental healthcare services, such that psychotherapeutic interventions may work for some clients but not others, at certain times, in certain places, and may generate unintended positive and negative effects depending on contextual factors like HR policies and procedures at the organisational level, or government policies at the societal level, which often appear contradictory in terms of their theories of change (Appendix 6).

Therefore research into the feasibility of designing, implementing and evaluating a new psychotherapeutic intervention in practice needs to take into consideration various stakeholder perspectives in order to elaborate the possible mechanisms of change and the contexts in which these mechanisms might be activated to produce the desired outcomes (Pawson & Tilley, 2004). This chapter justifies the choice of a critical realist, mixed-methods approach to answer the five research questions (Section 1.9).

3.2 STRUCTURE OF THE CHAPTER

This chapter comprises the following sections:

1. **Ontological underpinning of the study**: explanation of the author's world view and how this fits with the therapeutic approach.
2. **Epistemological approach**: explanation of the ways that conducting the research might lead to useful solutions to a complex problem.
3. **Methodological approach**: description of the method used to answer the research questions and why the chosen approach is best.
4. **Research Design**: description of the framework used to structure different stages of research and the methods used for each stage.
5. Details of **Ethical and Management Approval**, **Critique of the Methodology,** and a **Summary**.

3.3 ONTOLOGICAL UNDERPINNING OF THE STUDY

3.3.1 Critical Realism

Critical realism combines realist ontology with relativist epistemology, and is interested in generative causality that requires 'uncovering processes whereby social actions arise out of the complex interaction of internally related mental dispositions, meanings, intentions, social contexts and structures' (Ekström, 1992 p.107). In the real world things happen in a 'contingent and indeterminate' way (Walsh & Evans, 2014 p.3), due to the 'reciprocally interactive' nature of causation (Carolan & Clark, 2005 p.3), which makes it difficult to predict how an intervention will work in different contexts with different actors.

When researching the impact of interventions, the critical realist evaluator wants to know not just, 'What works?', but 'What works for whom in what circumstances in what respects, and how?' (Pawson & Tilley, 2004 p.v). Where RCTs can answer the question, 'Does it work?', and feasibility studies are designed to answer the question, 'Can it work?' and 'Will it work' in practice (Orsmond & Cohn, 2015; Bowen *et al*. 2009), they cannot answer the question, 'How and with whom exactly?' (Byrne & Egan, 2018 p.182).

Researchers must abandon their professional silos and black-boxed, taken-for-granted assumptions, in order to search for causal mechanisms 'more expansively and exhaustively' (Walsh & Evans, 2014 p.3). Researchers should investigate how other disciplines; even unrelated disciplines such as literature, history, anthropology, economics, sociology, or politics to make sense of phenomena.

Critical realism recognises many valid ways of exploring social phenomena, including observational, experimental, participatory, or evaluative forms of enquiry. Critical realism goes further in viewing the data derived from interpretative and empiricist research as important in predicting and generating theory, but also holds that social science is concerned with the exploration of deeper layers of reality to explain social phenomena (Wuisman, 2005). Abduction (or retroduction) is a creative form of reasoning used by critical realists to propose generative mechanisms which could best account for observed phenomena. Using a combination of deductive, inductive and abductive reasoning, competing explanations are then compared for their explanatory power (Morgan, 2007).

Critical realist methods explore three overlapping domains of reality: not just the 'empirical' level of reality (i.e. what can be observed or experienced), but also the 'actual' level (i.e. what is known but cannot always be seen or felt), and the 'real' level (i.e. what is hidden in terms of deep social structures, and / or deep physical and psychological processes). Some

aspects of reality possess attributes of 'materiality' such as psychiatric hospitals, and some do not but are nonetheless real such as stigma.

Bhaskar (2013) put forward the idea of reality as 'stratified' such that there are different levels of reality which interact interdependently, and that reality is 'emergent from' and 'rooted in' other levels. In this way the whole is more than the sum of its parts, and reality is irreducible to biological, psychological, or social processes. Recurrent depression is likely to have multi-determinations.

Critical realists emphasise the interdependence of structure and agency, with social structures providing resources and limits, and individuals creatively responding to those circumstances over time. Human agency is always enabled or disabled by social structures such as patriarchy, gender relations, class dynamics, or neo-liberalism, but also by other factors such as biology, evolution, ecology, geography and genetics (Carolan & Clark, 2005). A critical perspective on the current social order (Bhaskar, 2013) is important because workaholism, absenteeism, presenteeism, leaveism, or counter-productive work behaviours may be creative (or destructive) responses to working in highly stressful occupations in a capitalist economy.

Whilst psychology often looks for intra-personal factors such as belief systems, learned behaviour, motives, needs, wants, goals, and habits etc. that influence an individual's decisions and actions, sociology often looks for inter-personal or extra-personal factors such as the views of others, cultural norms, social role expectations and economic constraints. However what people do, say, think and feel is not simply determined by indoctrination or internalisation of the prevailing social structure. If humans are relegated 'to the role of robot without capacity for deliberation' (Morselli, 2014 p.13), then there can be no individual freedom. Rather, seeing human agency and social structure as two distinct things creates a 'false dichotomy' (Morselli, 2014). Thus, a dualism of agency / structure in a relationship of mutual interdependence allows people to change society, institutions, and organisations and vice versa.

Nevertheless change occurs both from the bottom up and from the top-down as these different levels of reality communicate and interact synergistically. Social *structures* influence (perhaps unconsciously) human actors' *agency* such as whether to stay-at-work, go off sick or return-to-work when experiencing low mood. Moreover, human actors' agency and decisions in how they communicate and interact with others in the workplace for example either maintains or transforms social structure (Burkitt, 2016). Therefore, for psychotherapeutic interventions to bring about sustainable change they must consider the

'duality of structure and agency' (Pawson & Tilley, 1997 p.56) with an appreciation of sociology that is as important as psychology and biology.

Thus, the design of a complex intervention should be underpinned by a convincing programme theory. The new intervention should be informed by an understanding of what influences employees' decisions to carry on working or to give up their employment for example. At present stricter sickness absence policies perceived as punitive by employees might work in the sense that they enhance job retention. However when causal mechanisms are investigated through realist synthesis and realist evaluation methodology, it might turn out that fear of job loss is the mechanism responsible for the outcome in this context, and unintended effects of this policy might be an increase in presenteeism, more mistakes and accidents, or a culture of bullying.

The researcher also needs to consider the question of determinism versus voluntarism (Porter, 2015), i.e. whether employees' actions are caused by institutional structures and social relations in the workplace and in the community, or whether their actions are caused by individual volition, arising out of their ability to reason and choose. A non-reductionist approach probably better represents why things happen. It is not a case of either determinism or voluntarism. The free will of individuals is necessarily enabled or disabled by contextual factors or 'pre-existing conditions' (Pawson, 2006 p.25).

The stakeholder consultation stage is meant to elucidate 'a range of mechanisms which sustained the original problem' (Pawson & Tilley, 1997 p.75) in terms of barriers to job retention in depression. It is vital to differentiate 'contextual mechanisms' that might cause depression in employees for example, and 'programme mechanisms' that might cause remission of depression and job retention (Porter, 2015).

There are other reasons why critical realism was chosen as the best approach for this study. Realist synthesis (RS) and realist evaluation (RE) bring to the forefront of the research process what it means to be human, in that it is not just about finding technical solutions to human problems, but finding solutions that make sense to meaning-making entities.

Take the example often given to explain RE, of why CCTV might work. For a start, CCTV is unlikely to stop dogs fouling the pavement, but seems to reduce crime in humans. Of course, dogs cannot understand *what* CCTV does, *how* it works, or *why* it is supposed to work, so it makes no sense to them and therefore does not in any way influence their behaviour. However, *what* CCTV does, *how* it works, and *why* it is supposed to work, makes sense to humans in myriad ways, with greater or lesser amounts of misapprehension. One person may believe that it involves a police officer monitoring the area in real-time with a

remote device, and that if this person breaks the law, the police officer will broadcast a warning over a loud speaker telling him to desist. Another person may believe that it involves a robot recording a film, and if he breaks the law, the robot will issue an automatic fine in a few weeks. The mechanism of change is likely to be different depending on these two peoples' understanding of CCTV: either the mechanism is avoiding the embarrassment of an immediate warning or avoiding the punishment of a future fine. And their beliefs about CCTV may cause them to behave very differently. In addition, their behaviour going forward will also be influenced by the experience of actually being caught breaking the law, when their beliefs about *what* CCTV does, *how* it works, or *why* it is supposed to work are either confirmed or disproved.

This illustration is provided to highlight that programme developers need to know how people understand *what* a psychotherapeutic intervention does, *how* it works, or *why* it is supposed to enhance job retention for employees with moderate-severe recurrent depression. They also need to know how people understand the original problem, as this too will influence their response to any solutions.

Ultimately, the design of a new psychotherapeutic intervention is based on the layered ontology of critical realist philosophy whereby mechanisms in the 'real' domain (such as an employee deciding to disclose mental health problems) are activated in certain contexts (such as during treatment for depression) to generate events and actions in the 'actual' domain (such as an employee's line manager offering emotional support), potentially leading to experiences and perceptions in the 'empirical' domain that can be observed and measured (such as an employee going off sick less than before).

3.4 EPISTEMOLOGICAL APPROACH

3.4.1 Mixed-Methods Epistemology

The mixed-methods approach aims to improve accuracy, produce a more complete picture, compensate for specific weaknesses associated with, and avoid biases intrinsic to, mono-method paradigms (Denscombe, 2008) in recognition that what we take as simply a matter-of-fact truth is often extremely complicated, context-specific and open to interpretation. Real-life problems require multi-level perspectives to develop an understanding of the personal, cultural and social factors creating and maintaining them. Thus the mixed-methods approach is able to capture both hard and soft evidence of clinical improvement such as giving up emotionally unrewarding paid work to become a poet (Appendix 28). (Onwuegbuzie, 2012 p.4) refers to mixed-methods research as the 'radical middle' which is 'consciously local, dynamic, interactive, situated, contingent, fluid, strategic and generative'.

Post-modern approaches to research reject reductionism and dogmatism, acknowledging that our interpretation of data (whether quantitative or qualitative) is both objective and subjective. Our sense of reality is always derived from the synthesis of data from a variety of sources. The benefits of a mixed-methods approach are that it values both objective and subjective sources of knowledge. Privileging one form of knowledge over another creates a false dichotomy. Mixed-methods research takes an 'anti-dualist stance…which involves replacing binaries with continua' (Teddlie & Tashakkori, 2010 p.10) and researchers use a dialectal stance that 'bridge[s] post-positivist and social constructivist world views' (Creswell *et al*. 2011 p.4).

Social constructivists believe that one's ontology (beliefs about being and reality), cosmology (beliefs about the universe) and epistemology (beliefs about knowledge and science) are shaped by language and are culture-specific. In other words, research invents the world as we know it rather than discovers it. In contrast, logical positivists or ontological realists reject metaphysics and believe that there is an objective reality, independent of our interpretation of it, and that true knowledge can only be based on empirical evidence.

The polarisation between qualitative and quantitative approaches to research has been called the paradigm wars. The 'thesis of incommensurability' (Kuhn, 1962) asserts that different research methods are fundamentally incompatible and that combining them will result in confusion and 'epistemological incoherence' (Howe, 1988 p.10). However (Teddlie & Tashakkori, 2010 p.5) claim researchers should reject either / or choices because 'methodological eclecticism' allows them to choose the best tools to answer their questions. (Onwuegbuzie & Leech, 2005 p.382) recommend mixed-methods as an 'interactive and

unifying process'. Epistemological pluralism was chosen as the best approach for this study because it aims to develop a holistic view of what might help employees with depression to maintain their employment.

Moreover, mixed-methods research also embraces deductive, inductive, and abductive reasoning. Abductive reasoning refers to trying to make sense of unexpected events, or when data is incomplete, by relying on intuition, or making an educated guess. It often involves a creative leap of imagination which fits with how critical realism also explores what the data means.

3.4.2 Data Integration

One approach to mixed-methods data integration is the 'model of profoundisation' described as 'blended' (Langdridge & Hagger-Johnson, 2009). This model uses qualitative methods to 'tease out' important aspects of quantitative data especially when there are unexpected results or when there are complex issues and anomalies that cannot be explained by statistical analysis. Qualitative data often provides valuable insights into the feasibility of conducting further research with larger samples.

Likewise, critical realists evaluate the suitability of a research method by how it is used to generate explanatory power. Rather than as a form of validation of different sources of data, triangulation is used to develop a more holistic understanding. (Gallo & Lee, 2015 p.202):

> *May be valuable…in the development of the intervention, during evaluation of the intervention, and after completion of the follow-up and assessment of outcomes...*

In this study, qualitative data were also used to understand how to improve implementation and evaluation of the new intervention in a future trial. Data integration helped to shed light on feasibility factors such as the recruitment strategy, and processes such as how the intervention works and whether any adaptations are needed (Olsen, 2007). Qualitative data can also be used to explain outcomes, to elicit users' feedback on an intervention, to understand moderators and mediators, and to gather information on the clinical significance of an intervention (Gallo & Lee, 2015) (Appendix 29).

3.5 METHODOLOGICAL APPROACH

This study used the MRC guidance for developing, evaluating, implementing and reporting on complex health and social care interventions (Moore *et al*. 2015; Craig *et al*. 2008; Campbell *et al.* 2000). Complex interventions are defined as those that involve several components and a variety of therapeutic activities, with multiple interactions between different practitioners, teams and systems.

Mixed-methods are often employed to investigate features of implementation and evaluation such as standardisation of design and delivery, sensitivity to context, working in complex systems, and understanding the causal chains linking intervention with outcome.

The MRC guidance refers to four phases that informed the four stages of this study to develop and evaluate a work-focused psychotherapeutic intervention:

1. Reviewing the literature
2. Modelling the intervention
3. Piloting the intervention
4. Re-modelling the intervention

The preliminary development of complex interventions starts with a systematic review of existing research and theory, and investigation of current interventions. Chapter 2 identified relevant and potentially relevant psychotherapeutic interventions and highlighted a gap in evidence and practice that pointed to the need for a new intervention. The next step is engagement with and involvement of stakeholders at an early stage in design, then initial testing of feasibility in terms of implementation and evaluation which involves exploring outcomes and processes, and finally modifying and refining the intervention design and programme theory.

It is possible to apply realist principles to all phases of the MRC framework (Fletcher & Murphy, 2016) such that the development of an innovative intervention design goes hand-in-hand with the development of programme theory, and modelling and piloting should be based on the theorised contextual conditions which are necessary for activation of intervention mechanisms and the production of outcomes. Little is known about the 'active ingredients' or components that contribute to improving the outcomes of a work-focused psychotherapeutic intervention for recurrent depression. Understanding how interventions work is a vital first step in building an evidence-based practice. Prior to evaluation of effectiveness, research into new interventions should provide 'proof of concept' which helps to elucidate how and why the intervention achieves its stated aims, and recommendations for implementation.

3.6 RESEARCH DESIGN

The MRC framework suggests that a precursor study should be undertaken to determine if a definitive full-scale trial is warranted and can be undertaken. This study used an established conceptual framework and recommended format for carrying out feasibility studies (Eldridge *et al*. 2016).

Feasibility studies are differentiated from pilot studies, which are a smaller version of the main study used to test 'whether the components of the main study can all work together' (Arain *et al*, 2010 p.5). The main objective of a precursor study is not to test treatment effectiveness but to investigate key areas of uncertainty regarding the implementation and evaluation of an intervention in order to determine the feasibility of conducting a definitive randomised controlled trial in future.

It was intended to run the feasibility study as a single-blind Randomised Controlled Trial (RCT) with a wrap-around qualitative study to capture the views and opinions of former service-users, frontline staff and managers. Unfortunately, due to low referral rates, the feasibility study was run as a single-centre quasi-experimental study with a small purposive sample and a pre-post design. Nevertheless, the study procedures complied with ethical guidelines and there was only one variation from the protocol due to recruitment difficulties.

For generalisability, the feasibility study is set in routine secondary mental healthcare which employs the Care Programme Approach as best practice in coordinating care and treatment for clients with moderate-severe and enduring mental health problems. Running a trial in a naturalistic setting improves ecological validity because out-patient samples in secondary care tend to be heterogeneous with more co-morbidity.

3.6.1 Study Stages

The study was conducted in four stages:

1. The **modelling stage** involved planning focus groups to seek the views of former service-users, frontline practitioners and managers about helpful components of the proposed intervention and features of the research protocol, then adapting the implementation and evaluation plan to suit the community context and local needs.
2. The **piloting stage** involved conducting a single-centre quasi-experimental study to report on several feasibility factors outlined above.
3. The **re-modelling stage** involved analysing written feedback from feasibility study clients and reviewing focus groups to again seek the views of former service-users, frontline practitioners and managers as above.

4. The **data integration stage** involved building, connecting and merging the findings in order to propose an implementation and evaluation plan for further research.

The CReDECI 2 checklist (Möhler *et al*. 2015) was used to ensure comprehensive and transparent reporting at all four stages, and the TiDIER checklist and guidance (Template for Intervention Description and Replication: (Hoffmann *et al*. 2014) was used to ensure that the new intervention could be delivered with fidelity in a future definitive trial.

3.6.2 Stakeholder Consultation Methods

3.6.2.1 Primary aim

To consult with key stakeholders regarding the feasibility of evaluating the intervention and the feasibility of implementing the intervention at two points: pre-intervention planning stage, and post-intervention reviewing stage.

3.6.2.2 Secondary objectives

- To discover the views of users about whether the proposed intervention design and research protocol are acceptable to clients and frontline staff.
- To explore the most appropriate outcome measures for use in any future clinical trial.
- To identify factors that could make an RCT attractive to potential participants including checking the contents of patient information sheets for comprehensibility, reviewing possible therapeutic techniques, and considering ways to reduce attrition.
- To elaborate and refine the probable mechanism framework developed in the literature review before the intervention has started.
- To investigate any contextual factors likely to enable or disable the activation of mechanisms and the production of outcomes.
- To ascertain how to improve the acceptability and accessibility of the new intervention.
- To modify the intervention design and refine the programme theory based on the findings of the planning and reviewing stages.

Stage One used focus groups to provide a structured forum for members to discuss the design of the intervention in the planning and reviewing stages based on their own experience and expertise.

3.6.2.3 Focus groups

Focus groups were used in this study to collect background information, stimulate new ideas, identify problems, gather impressions, and generate hypotheses, learning how participants talk about a topic to make the new intervention more relevant (Stewart *et al*. 2007). The

author chose focus groups as a medium for stakeholder consultation because it seemed that discussion amongst peers is the most effective and efficient way of finding out what users think is helpful in the design of the new intervention. However, there are disadvantages to focus groups such as not hearing each individual's points of view, experiences and opinions as clearly as one might have done with a semi-structured interview conducted on a 1:1 basis (Guest *et al*. 2017).

This drawback is offset by the potential for discussion to uncover more diversity of opinion by virtue of interactive group processes. Moderated discussion can give rise to new ideas and shared understandings, and the discursive nature of focus groups means that knowledge emerges from dialogue within (as participants sit quietly, listen and mull over what others are saying), and between people (as participants join in the discussion).

Focus groups provide a good source of naturalistic information that may not have surfaced otherwise and makes explicit use of peer interaction to fill in gaps in knowledge and to produce data that is different from that gathered by other methods. The discussion shifts from a superficial level to a more profound level as different participants resonate with and react to what others have said. This is due to a group phenomenon whereby participants can influence and affect each other whilst talking together which has the potential to deepen exploration and subsequent understanding of the topic under consideration. Important insights and creative ideas are thought to be evoked by the 'synergy, snowballing, stimulation and spontaneity' related to group dynamics (Catterall & Maclaran, 1997 p.1.3). However it is possible that only one person articulates an idea that is totally original, and that this idea cuts across conventional wisdom or 'custom and practice' in a useful way.

To design the new intervention, it was important to ascertain not just *what* users thought would be helpful, but *how* it would be done (operational logic), and *why* (conceptual logic). Focus groups have an explanatory as well as an exploratory function when the moderator tries to clarify participants' 'logic in addition to their judgements' (Grudens-Schuck *et al.* 2004 p.4).

A focus group should be a 'safe space' (Bergold & Thomas, 2012), so a permissive and non-threatening environment was created that allowed participants to 'relax, open up, think deeply, and consider alternatives' together (Grudens-Schuck *et al.* 2004 p.3). It is important to produce a neutral and informal atmosphere (Puchta *et al*. 2004). A skilled moderator will encourage everyone to contribute to the discussion by asking different types of questions, unpacking answers, probing for deeper understanding, and ensuring that the group does not regress to 'group think' conformity.

Participants could be conceived of as a 'panel of experts', and the range of perspectives elicited from them engaging in a roundtable discussion is ideal especially when the topic is complex. However, it is possible that discussion becomes an exercise in small talk because people often try to find what they have in common rather than what sets them apart. Skilful moderation is needed so that participants can enter into meaningful conversation with each other and so that the discussion does not just collect participants' existing views, but pushes them to wrestle with the issues.

Nevertheless, focus groups are not always appropriate. Krueger & Casey (2000) recommend that they should not be used in exploring sensitive, confidential, or highly contentious issues. In this study, all of the former service-users knew at least one other person because they had already been through a treatment programme together. Therefore it is likely that there was a degree of trust that might not be there when focus groups comprise strangers.

Usually, researchers have specific questions to answer. A discussion guide was used by the moderator to maintain structure and focus. There should be no expectation on the moderator to achieve consensus, educate, resolve conflict, solve problems, or change anyone's mind for example. The moderator's main function is active facilitation of group interaction. The purpose of the group was not decision-making but to investigate issues and elicit perceptions, opinions, beliefs, attitudes, descriptions, evaluations and explanations. Decisions were made about the design of the intervention following primary analysis of the data.

Dissension and disagreement were actively encouraged. Calling for personal feelings and gut reactions that 'come off the top of your head' elicits a variety of natural and uncensored views. Focus groups enable natural quality control of the data and have a high level of face validity because what participants say can be questioned, confirmed, refuted, reinforced or contradicted within the group discussion (Webb & Kevern, 2001).

The moderator discourages 'account clutter' i.e. material that is not useful such as when participants tell rambling anecdotes, qualify their statements with expressions of doubt, or simply give factual information (Puchta *et al*. 2004). It is crucial to ask members to 'go on the record': '[b]y lessening the emphasis on accountability [i.e. there is no right or wrong answers] participants can be encouraged to produce stronger claims with less hedging' (p.31). This can also prevent unproductive arguments. In this study some former service-users had difficulty in expressing themselves coherently due to high levels of anxiety, and the moderator gave them more time to articulate what they wanted to say. Using focus groups to contribute to the study was consistent with the author's fundamental belief in the power of inter-personal processes (such as emancipatory discourse) in generating solutions to practical

problems as well as empowering participants to challenge 'prevailing orthodoxy' (Stahl *et al*., 2011 p.378), and to shape needs-led services. This is also consistent with the principles of co-production i.e. 'doing with' rather than 'doing to' or 'doing for' (Slay & Stephens, 2013 p.14).

3.6.2.4 Focus group recruitment process

The focus groups included 13 former service-users and 15 frontline practitioners and managers, most of whom had experience of receiving / providing group-CBT in secondary mental healthcare or experience of receiving / providing job retention interventions within the last two years (Appendix 30). Recruitment for the pre-intervention stakeholder consultation was achieved by word-of-mouth, or by contacting potential participants by letter/email, and inviting them to contribute to the research (Appendicx 38a). Before consent was obtained, information about the study was given in written form (Appendix 39a or 39b), explained face-to-face, or by sign-posting to a video available on the study website (www.group-CBT.com), and time was made available by the author for questions and answers.

If there is a huge disparity in status between members of the group (including the moderator), this may create a perception of social distance and inhibit some members from joining in on an equal footing. Most participants were known by the author by virtue of previous service contact, and focus groups were selected as carefully as possible so that every member was likely to feel comfortable enough to make meaningful contributions.

Purposive sampling was the best way of ensuring participation from people with the appropriate knowledge and experience who could participate in a lively and thought-provoking discourse. Focus groups do not claim to use representative samples because it is vital to ensure some homogeneity (in background, not attitudes) to promote free-flowing discussion and to reduce the temptation for participants to edit what they want to say which is more likely in a heterogeneous group. In this study, a breadth of views rather than a depth of understanding were looked for.

Using similarity criteria (such as shared experience) to guide the composition of different focus groups (e.g. former service-users in Focus Group A and frontline practitioners and managers in Focus Group B) helped to obtain a cross-section of opinions in a welcoming atmosphere fostered by common interests.

Focus group recruitment continued until saturation of the data had been reached, and no new understandings of the main issues were emerging.

3.6.2.5 Necessary preparations and the format of discussions

Participants were asked to sign a consent form (Appendix 31a) before the discussion. The author (acting as moderator) read a short statement about the purpose of the discussion at the beginning of every focus group (Appendix 32).

The former service-user focus groups (FGA) were asked to consider questions related to possible components of the intervention as well as practical issues about implementing the intervention (Appendix 33). The frontline practitioner and manager focus groups (FGB) were asked to consider questions related to the research procedures and practical issues about evaluating the intervention (Appendix 34). A mixed group (FGC) were asked their opinions regarding the acceptability and accessibility of the Treatment Programme in response to questions about the comprehensibility of the theoretical manual and other resources, and the overall helpfulness of the interventions with reference to users' written feedback and preliminary analysis of outcomes (Appendix 35).

The planning focus groups had a semi-structured format and used open-ended questions to stimulate discussion regarding ideas about the design of a psychotherapeutic intervention which aims to enhance job retention in employees with moderate-severe recurrent depression, and ideas about the research procedures. The initial findings from the literature review were used to develop two discussion guides, one for former service-users, and one for frontline practitioners and managers. Participants also spoke about the experience of working with depression, the impact of depression on work, folk-theories about the causes of depression, and how it might be managed better in the workplace.

The reviewing focus groups comprised participants from the original list who were contacted by post and email to invite them to take part in post-intervention stakeholder consultation. Those that agreed were sent an A5 booklet, well-received in itself as a mini-textbook as opposed to the plan to provide separate handouts. They were also sent other resources such as a DVD with short animated films explaining some concepts, and a CD of mindfulness and progressive relaxation exercises.

In both sets of focus groups the main questions were written on a flip chart to maintain direction, and to facilitate time management so that each topic was given adequate consideration. Participants were encouraged to explain their responses in order to deepen the level of comprehension. Discussions lasted between 1-2 hours, with a break in the middle of the session. Refreshments were provided as a way of creating an informal, friendly and social climate.

3.6.2.6 Data collection

All sessions were both video- and audio-recorded on digital devices to aid transcription. The use of video allowed for the capture of non-verbal behaviour such as nodding or shaking the head as a sign of agreement or disagreement. Stakeholder consultation and primary data analysis using the mind-mapping approach was undertaken sequentially, so that each subsequent discussion guide could be up-dated to allow fuller exploration of themes in later groups. The author used the initial groups for thorough exploration of the topic and subsequent groups for the development of understanding.

It is claimed that focus groups are not just a data collection method, but a research methodology (Jamieson & Williams, 2003). Therefore it was important to involve the focus groups at all phases for verification of the conclusions. In this study the author used a flip chart to record disparate ideas and opinions as they emerged in discussion. Before the end of each focus group, a brief summary of the discussion was written on the flip chart, in collaboration with the participants to verify emerging themes. Field notes were recorded in a reflective journal immediately after each focus group and the author checked these notes by watching the video- and listening to the audio-recording in a single uninterrupted sitting.

Within a few days the field notes were used to construct a Mind Map (Burgess-Allen & Owen-Smith, 2010) which was circulated to participants by email asking them to amend, clarify or correct any misunderstandings, and to add any further thoughts. Any changes were highlighted in a different colour to distinguish the original from the revised map.

3.6.2.7 Data analysis

The mind-mapping data analysis method is useful when timescales are tight (Burgess-Allen & Owen-Smith, 2010; Meier, 2007). In this study there were only a few weeks between the pre-intervention stakeholder consultation and resubmission of the clarifed research protocol so that recruitment for the feasibility study could commence on time. Therefore it was essential to analyse the focus group data as it emerged using a method that was robust yet rapid and that did not require transcription of the audio-recordings.

Mind-mapping has been used to represents themes from focus groups as they arise during joint problem-solving, brainstorming and free-association, often in response to a structure such as a discussion guide. There is usually a central theme from which sub-themes branch off perhaps in two or more directions representing divergent views or different options. Further branches elaborate on the sub-themes with concrete suggestions and examples.

Mind Maps are elegant in their simplicity and represent complex ideas in non-linear format which appears to ‘reflect our natural thinking patterns’ (Burgess-Allen & Owen-Smith, 2010

p.407). They can capture a wide range of perspectives, and reviewing them may help in building consensus where there was previously dissent. Research comparing the mind-mapping approach (Tattersall *et al*. 2011) or listening to audio-recordings of focus groups (Greenwood *et al.* 2017) with traditional methods of qualitative data analysis that require transcription of focus group discussions shows that Mind Maps generate a similar hierarchical framework with codes and categories that matched in most respects (Neal *et al.* 2015).

Secondary data analysis involved a realist evaluation approach in five stages (Crinson, 2001) in order to propose several context-intervention-mechanism-outcome configurations:

1. Transcribing

A full transcription of the audio recordings was undertaken by a trained and qualified administrator. Video recordings of the focus groups were re-played by the author to complete, correct, validate, anonymise, and to ensure an adequate grasp of the data. Transcripts were annotated with observational data if appropriate or necessary.

2. Indexing

Significant excerpts of verbatim transcription were coded using highlighter pens if it appeared to answer the question as to why, with whom, and in which circumstances a new intervention might work (Lacey & Luff, 2009). Process data on three levels (individual, group, and interactional) were noted in relation to the attributes of the individual respondent in order that group aggregated findings can be refined in relation to major sub-groups of service-user (e.g. occupational status), or service provider (e.g. professional role).

Incidence and intensity data were logged with excerpts to preserve context e.g. if a response was repeatedly given by one participant or by many, whether responses were particularly emotional etc. Multiple coding cycles were ongoing to re-organise, recombine and conceptualise the data.

3. Interpretation

Construction of a coding frame was deductive in that it drew upon the analysis of intervention components and explanatory frameworks conducted during the literature review, but was also inductive and open to new codes. Twenty four sub-themes were abstracted from these codes using an inductive approach, and subsequently merged into twelve themes.

4. Theorisation

Themes were a mix of those related to intervention design (i.e. operational logic) and those related to programme theory (i.e. conceptual logic). Participants' words and phrases were coded as a mechanism (an aspect of the psychotherapeutic intervention that might be helpful

in treating depression) or as an enabling context (an aspect of the group format that might be helpful in activating the mechanism).

5. Retroduction

To further develop the programme theory, these themes were collapsed into six mechanisms using a retroductive approach. Mechanisms are often subtle and were discerned by considering how the *resources* provided by the new intervention might interact with clients' *reasoning* to trigger some sort of process (cognitive, emotional, or physiological) that might produce a behavioural change.

3.6.2.8 Reporting of findings

Stewart *et al*. (2007) suggest that for exploratory research, simple description is appropriate. Findings were reported in narrative form for the main questions, grouped according to the major themes and codes, with illustrative quotes. For the analysis of causal mechanisms, graphic forms of presentation are more appropriate to identify links, relationships, relative positions, influences. Potential mechanisms of action reported or inferred by focus group participants are presented in appendices, with supporting excerpts and illustrative quotes.

3.6.2.9 Verification of findings

The credibility of thematic analysis relating to the main research questions was checked by maintaining a coding frame and diary, checking for outliers, testing for correspondence across data sources, and maintaining emotional and incidence context for excerpts and quotes. As far as possible findings were maintained in meaningful 'sequences of discussion' (Webb & Kevern, 2001 p.803) and 'original excerpts from the raw data…related to the group setting to strengthen the plausibility of the analysis' (Jamieson & Williams, 2003 p.279) but also to demonstrate how the moderator facilitated group discussion to develop different themes arising from different questions.

The verification of potential generative mechanisms in the critical realist analysis phase was undertaken separately by two researchers: the author; and another researcher with experience of undertaking and publishing analysis of causal mechanisms. The external researcher worked from anonymised excerpts from the transcripts. The source of explanations was checked, discussed, and compared. Levels of concordance or unique interpretation were reflected upon, although this process was primarily a constructive component of data analysis, rather than solely for verification purposes.

3.6.3 Feasibility Study

3.6.3.1 Primary aim

- To find out whether the implementation of a work-focused relational group-CBT Treatment Programme for employees with moderate-severe recurrent depression is feasible, and if so, whether evaluation of the new intervention in a definitive randomised controlled trial is feasible.

3.6.3.2 Secondary objectives

- To report on i) participant recruitment, ii) characteristics of the resulting sample, iii) utility of outcome measures and data collection methods, and iv) estimated costs of delivering the intervention.
- To report on the interim benefits of the intervention to participants in terms of clinical, occupational and inter-personal outcomes.
- To use the data generated on the difference in outcomes (effect sizes) to inform a power calculation for sample size in any future study.
- To report on a quantitative analysis of i) rates of retention / attrition, ii) adherence, iii) therapeutic alliance, and iv) client satisfaction; and a qualitative analysis of clients' and co-facilitator's written feedback to assess the acceptability and accessibility of the intervention and to identify which elements of the programme they found most helpful / relevant.

3.6.3.3 Study design

Single centre quasi-experimental feasibility study with non-blinded outcome assessment.

3.6.3.4 Setting

Here and There Partnership Foundation NHS Trust (HTPFT) hosted the research. All participants were Trust service-users. The 1:1 assessment sessions took place in an outpatient CBT clinic based at a mental health hospital in There. The relational group-CBT sessions took place in a community library café run by the Local Authority which was accessible with adequate facilities, security arrangements and nearby pay and display parking. There was a large meeting room with projector, white board, flipchart and TV / DVD player.

3.6.3.5 Project timetable and milestones

The feasibility study was scheduled to start in April 2013 and ran over approximately nine months with the relational group-CBT sessions running from September to December 2013. Follow-up was undertaken 3 months later. A schedule of work is available in Appendix 36.

3.6.3.6 Study population

Potential participants were adult service-users of Community Mental Health Teams (CMHTs).

3.6.3.7 Eligibility

Inclusion criteria:

- Aged between 18-64 years.
- Meets the service threshold for moderate to severe recurrent depression (BDI-II > 20).
- Ability to communicate in English.
- Employed either full-time / part-time or off sick from work due to mental health problems.
- Intending to maintain or resume employment.
- Willing to participate in group therapy and abide by group ground rules (Appendix 37).

Exclusion criteria:

- Has an intellectual disability (IQ < 70).
- Has a severe medical illness or physical disability that would significantly interfere with participation in group therapy.
- Has a recent history of inter-personal violence which is contra-indicated for group therapy.
- Has symptoms of an acute psychotic illness (e.g. hallucinations, delusions, mania, paranoia), organic brain disorder (e.g. dementia), anxiety disorder (e.g. PTSD, OCD) or eating disorder (anorexia or bulimia nervosa) as the main presenting problem.
- Current substance misuse as main presenting problem.
- Current, frequent and serious self-harm (requires medical intervention ≥ once a week).
- Has not worked in the previous 12 months.

3.6.3.8 Participant recruitment

Potential participants were identified at the Single Point of Access (SPA), triage of Psychological Therapy Service (PTS) waiting list referrals, formulation meetings, referred by any member of staff, or in response to study posters and other marketing strategies.

Potential recruits were screened on the 'phone to find out if they meet the main inclusion criteria of being employed and depressed. An invitation letter (Appendix 38b) was then sent

to the potential recruit for a 1:1 session to obtain informed consent. The letter included the information sheet (Appendix 39c), study website address, and a BDI-II form.

Eligibility was checked using the BDI-II at the first 1:1 meeting (moderate-severe depression score). The purpose of the study was then explained and questions answered. Once informed consent was obtained an appointment was offered for the first 1:1 assessment session (Appendix 31b). A letter was sent to the client's GP informing them that she was participating in the research study (Appendix 38c).

3.6.3.9 Sample size

It was hoped to recruit enough clients to randomise them to the new intervention or CAU. Ultimately only eight potential participants were eligible and gave informed consent (Appendix 40). However, relevant data was collected to make a power calculation for a future definitive trial.

3.6.3.10 Baseline procedures

Recruits were assigned an ID number and were asked to complete a battery of baseline measures. Results were recorded on the Case Record Form (Appendix 41) using the client's ID number.

3.6.3.11 Staff involved

The group-CBT treatment programme was co-facilitated by the author, a CBT group psychotherapist, and by an OT who had completed a post-graduate programme in Vocational Rehabilitation. Individual sessions for holistic assessment, psychological formulation, and carers' support sessions, were undertaken by the author. Individual sessions for job retention strategies, work-focused consultation and liaison were undertaken by the OT. Service-user volunteers were invited to train as peer support workers to co-facilitate the group programme.

3.6.3.12 Training and supervision

Training in the theory and practice of relational group-CBT was provided by the author to the OT during the 3-month enrolment stage, and as required during the course of the study. Fidelity to the model was promoted by setting aside time before, during, and after each group session for briefing and de-briefing whereby both facilitators provided feedback to the other after each session using a group-CBT competencies checklist (Appendix 42). Quality assurance was similarly provided by a Consultant Psychologist, a specialist in CBT, who provided live supervision through close observation of one group session and scoring fidelity using the same checklist. Clinical supervision for the co-facilitator was provided by the

author on a weekly bases and as required. The author accessed clinical supervision on a monthly basis and as required by the Consultant Psychologist.

3.6.3.13 Outcome measures

Primary outcome measure:

- The Hamilton Rating Scale for Depression (HAM-D 21-item: clinician-rated)

Secondary outcomes measures:

- The Beck Depression Inventory-II (BDI-II 21-item: self-rated).
- The Work and Social Adjustment Scale (WSAS 5-item: self-rated).
- The Coping Self-Efficacy Scale (CSES 26-item: self-rated).
- The Inventory of Inter-personal Problems (IIP 32-item: self-rated).
- The Health and Safety Executive Management Standards Indicator Tool (35-item: self-rated).
- Clinical Outcomes in Routine Evaluation (CORE 34-item: self-rated).
- Agnew Relationship Measure-5 (ARM 5-item: self-rated).
- Quality of Life (EQ-5D 5-item: self-rated).
- Client Satisfaction Questionnaire (CSQ 8-itemt: self-rated).
- Bespoke weekly questionnaire: the proportion (expressed as %) of agreed hours at work in the last week and intention-to-quit (expressed as %).

Information about the outcomes measures is available in Appendix 14.

3.6.3.14 Process data

Qualitative data was collected to evaluate the acceptability of the intervention to users. After each session, clients were asked to complete a Session Review Sheet (Appendix 43), and to give written feedback at the end of the programme on a Final Feedback Form (Appendix 44). These data were coded into themes for qualitative analysis.

3.6.3.15 Data collection and analysis

Timing of data collection: quantitative data was collected at five time-points:

- T = 0 Baseline
- T = 1 Group-CBT session 1
- T = 2 Group-CBT session 6
- T = 3 Group-CBT session 12
- T = 4 12 week follow-up

Follow-up involved collecting data 12 weeks after the end of the group-CBT treatment programme. A letter (Appendix 45) was sent inviting the client to complete the enclosed BDI-II and CORE forms and to return them in the stamped addressed envelope. Clients were also invited to write an update on their progress if desired.

3.6.3.16 Statistical methods

Quantitative data was managed by SPSS (v 14). As this is a feasibility study the analysis focused principally on descriptive data such as recruitment rates, characteristics of participants, attrition from therapy, and estimated costs of providing the intervention. Group scores for the primary and secondary outcomes (mean scores, confidence intervals and effects sizes) were compared at pre-, mid-point, and post-intervention (i.e. baseline, 6 weeks and 3 months follow-up), using non-parametric statistical tests.

By comparing the same client's scores before and after treatment, the study effectively used each client as their own control. Therefore the correct rejection of the null hypothesis (here that the treatment made no difference) becomes much more likely, with statistical power increasing simply because the random between-client variation has now been eliminated.

A pre-post test design generates data in the form of repeated measures from the same sample suitable for a t-test which can be used to compare two scores from the same population. It is feasible with small numbers to compare before and after scores for each individual (i.e. paired scores) as opposed to comparing the mean group scores in an RCT with two different samples serving only one condition each (i.e. unpaired scores). Comparing paired samples (when using a within-groups design) should provide less variation and more statistical power to detect significant effects than comparing unpaired samples (when using a between-groups design).

The independent variables were four different time-points in the form of categorical data: Time 0 (pre-intervention), Time 1 (first session of group programme), Time 3, (post-intervention) and Time 4 (12 weeks follow-up). The dependent variables were continuous clinical scores on a range of measures.

For continuous measures, the choice of a statistical test is also based on how the data is distributed. This sample was a clinical sample so likely to be skewed. Therefore, non-parametric Wilcoxon matched-pairs were chosen in preference to the parametric paired t-test.

A comparison of the changes in various parameters over time was made, and the analysis results are summarised in Chapter 4.

3.6.3.17 Resources required

An economic evaluation was undertaken to estimate the total costs of providing the intervention which involved calculating the direct and indirect costs of providing the intervention using the HFMA (2014) guidance. One approach to health economics is for all resource inputs to be identified, measured and valued to calculate the cost of the output (i.e. recovery). Another approach is to estimate unit costs. This can be done in two ways:

1. 'Bottom-up' (e.g. working out the value of each element of the intervention and then adding on a percentage for overheads); or
2. 'Top-down' (e.g. working out how much is spent on the overall service and dividing this figure by the number of patients referred for any intervention)

Monitor (2012) prefers providers to supply patient-level information (i.e. bottom-up) which details all the resources required to deliver an intervention.

Costs are made up of different expenses such as:

- Pay and benefit costs: mid-point pay scale plus 22% uplift for on-costs (employer National Insurance and pension contributions).
- Non-pay costs: 10% of total staff costs (training and development, office consumables, travel and subsistence, IT and communications equipment etc.).
- Incremental corporate overheads: 30% of total staff costs (HR, finance, payroll, and IT; office furnishings, office space etc.).

The total direct cost was calculated by working out how much each practitioner is paid by the hour (plus 22% uplift for on-costs) multiplied by how much time they spent on direct clinical contact.

The total indirect cost was calculated by working out how much time each practitioner spent on non-clinical activity such as clinical supervision, preparation, brief / debrief, and administration, multiplied by each practitioner's hourly rate.

3.6.4 Data integration

Data integration involved several processes and several points of interface (Fetters *et al.* 2013; Gallo & Lee, 2015) (Appendix 29). Firstly, qualitative data from the pre-intervention stakeholder consultation stage was gathered and analysed, and these findings were used to build the new intervention design and programme theory for testing in a pilot study. Secondly, the pilot study generated quantitative data on processes and outcomes which were gathered and analysed to assess the feasibility of implementation and evaluation in the definitive trial. Thirdly, the results from the pilot study were connected with data from the

pre-intervention stakeholder consultation stage to inform the discussion of the post-intervention stakeholder consultation stage. Lastly, integration of both data sets was achieved by merging the results from the pilot study (quantitative data) with the findings from both stages of stakeholder consultation (qualitative data), and with the written feedback from the pilot study (qualitative data), and then interpreting the merged results.

The joint display method (Guetterman *et al*. 2015) was used to triangulate qualitative data with quantitative data, and as a way of creating a 'dialectic of learning' (Olsen, 2004). The discussion chapter further integrated what was learnt during the study through narrative using the staged approach (Fetters *et al.* 2013), and this led to recommendations for further implementation and evaluation of the new intervention presented in Chapter 6, with an outline proposal for a definitive trial (Appendix 75).

3.7 ETHICAL AND MANAGEMENT APPROVAL

It is crucial for any research to be subjected to proper oversight and governance (De Silva *et al.* 2014) When recruiting participants, the potential costs (which must be made explicit) of taking part in the research must be balanced by the potential benefits.

Although it is impossible to guarantee complete safety due to the nature of group interaction, identified risks can be ameliorated by using exclusion criteria that would prevent selecting people who could pose a risk to others. Group ground rules were discussed with clients and standards of behaviour agreed before they have contact with any other clients. Focus group members and Treatment Programme clients were advised that offensive, insulting, racist, homophobic, or sexist language is unacceptable in group settings. If evidence came to light that anyone's behaviour is putting other people at risk of harm, the matter would be investigated, raised in supervision, and if appropriate the researcher would have had to ask the participant or client to withdraw from the study. Debriefing and follow-up support would be offered through managers of the service.

Sensitive and skilful moderation limited the likelihood of adverse effects. All incidents and any near misses should be recorded and reported.

Research governance processes were put in place prior to conducting the study. The proposal (Appendix 53a): was submitted, and ethical approval and management authorisation for the study was granted by the University of Derby Research Ethics Committee, the NHS Local Research Ethics Committee (LREC) via IRAS, and HTPFT Research and Innovation department.

Administration of the study conformed to standards outlined in The Declaration of Helsinki (World Medical Association, 2013) and Good Clinical Practice (MHRA, 2012). The study was indemnified by the University of Derby.

A Site File of Essential Documents (e.g. Approval / Favourable Opinion of Ethics Committees, Curriculum Vitae, Study Protocol, Insurance Statement, Patient Information Sheets, Delegation of Duties and Signatures form, Case Record Forms, Outcome Measures) was set up.

Participants were informed that they can request details of any future publication of the findings of the study and that their identities will be protected.

The ethics of involving service-users in research projects are considered in Appendix 46.

3.8 CRITIQUE OF THE METHODOLOGY

The methodology has several weaknesses, which may be corrected in future research.

Whilst the choice of mixed methods is an appropriate methodology because the data collected and analysed offers both breadth and depth, the sheer amount of data was overwhelming when it came to analysis which was time-consuming and resource-intensive. The design and re-design process involved several stages of development and preliminary evaluation following the MRC complex intervention guidance. The MRC guidance recommends the use of mixed methods including stakeholder consultation and a feasibility study before any definitive trial. This study undertook both process and outcome evaluation albeit on a very small scale, but this increases the reliability and validity of the data, and its interpretation.

What is unique about this study is that the stakeholder consultation involved several former service-users, frontline practitioners and managers most of whom had experience of receiving / providing group-CBT in secondary mental healthcare or experience of receiving / providing job retention interventions within the last two years. Therefore, they knew what they were talking about when they offered many suggestions and ideas for what would be helpful in the design of the new intervention. The richness of the data also made it possible to explore causal relationships in terms of a plausible theory of change, and to expand the understanding of recurrent depression in the workplace beyond explanations based on uncomplicated linear determinism such as the medical model or occupational stress.

Regrettably, the data derived from the feasibility study and its interpretation is weaker by virtue of not recruiting sufficient participants to randomise to an intervention group and a CAU group. However randomisation processes were in place and involved *a priori* randomisation sequence generation to conceal allocation and to ensure a balance of male/female, white/non-white in intervention and control groups. In future research, the procedure could be carried out by an independent research assistant (RA) blind to which group the client was being allocated. A member of the administrative staff could complete the Screening and Randomisation form which will be kept separate from the Case Record Form. The randomisation procedure and research governance processes are compliant with the Good Clinical Practice guidance (MRHA, 2012).

Although six candidate mechanisms surfaced through analysis of the focus group data, their action could not be verified in this study due to limitations in the methods employed. One major drawback is that written feedback was not detailed enough to confirm that clients had acquired, consolidated and applied the basic CBT concepts and skills underpinning each mechanism. Semi-structured interviews with users (clients and staff) would have been better.

Although objective evidence of the effectiveness of the new intervention is crucial, the subjective experience of the people we care for cannot be ignored. The phenomenology of what it feels like to undergo treatment can have a positive or negative effect on internal emotional states such as motivation, hopefulness, a sense of belonging (with other group members), feeling cared about (by the therapist) and self-belief. These feelings are intangible and we can only really learn about them by asking questions and listening to answers.

Realist evaluation uses a painstaking and meticulous process of data analysis to 'open the black box' of complex interventions. However, observational evidence in the form of video data might have demonstrated that the 'work-focused relational group-CBT Treatment Programme' was the necessary context for the hypothesised mechanisms to be triggered and the desired outcomes to be produced. Without observational evidence, it is impossible to know whether other contingencies might be responsible for changes in clients' behaviour (such as a pay rise).

Nevertheless, a major strength of the study was the high degree of expert-patient involvement in terms of planning and reviewing the intervention in pre- and post-intervention focus groups (Appendix 46). The main justifications for involving service-users are 'arguments such as usefulness, authenticity, credibility, reflexivity, and sustainability' (Bergold & Thomas, 2012 p.17). So whilst these values fit better with NHS providers' mission statements than they do with standards of academic quality, involving service-users in this study was a decision based on a critical approach that aims to reduce the alienation of this group, and to question some of the social and economic structures that contribute to their oppression and exclusion, which may be a causative factor in recurrent depression.

Unfortunately, service-users were not involved at every stage of the research process in a bona fide 'co-learning' partnership (Shippee *et al.* 2015 p.1155) , nor were they 'maximally empowered to make decisions at every stage of the mixed research process' as (Onwuegbuzie & Frels, 2015 p.159) describe in a 'critical dialectical pluralist focus group discussion'. Likewise, community-based participatory research (CBPR) is recommended as a suitable framework for achieving integration in mixed-methods designs (Fetters *et al.* 2013).

The author was drawn to the ethical structure of mixed-methods because it is 'based on creating a more just and democratic society' (Creswell *et al.* 2011 p.4), and mixed-methods is particularly suitable for mental health research due to the effects of social exclusion, oppression, institutional abuse and stigma. Mixed-methods is based on a participatory / social justice framework (Fetters *et al.* 2013) that involves participants in the study, examines the phenomenon of depression through a social justice lens, and aims to bring about

transformative change (individual, organisational, social). This fits with disability and feminist theory whereby the results are framed to elucidate power relations, and reported to advocate social action. Crucially, realist evaluation of the focus group data inadvertently revealed specific workplace contexts such as a disabling organisational culture that could constitute a serious barrier to the production of the desired clinical and work outcomes.

Mixed-methods allow for some tentative suggestions that can be made about the theory and practice of relational group-CBT. The end result is simply a 'highway code' (Pawson *et al.* 2004 p.21): although the findings do not qualify anyone to drive, it may help in showing the direction of travel and in making the journey less risky.

3.9 SUMMARY

This study was a multi-phase mixed-methods study involving an iterative process of co-production it used an exploratory sequential design involving a two-stage stakeholder consultation process (qualitative data analysis) and an embedded pilot study (quantitative data analysis).

The mixed-methods approach is used in order to explore the experience of working with depression, deepening, widening and enriching the insights gained into both problems and solutions. Mixed-methods helps to draw inferences and generate new hypotheses, explain the results, and for a more complete understanding to be reached about the possible active ingredients and mechanisms of the new intervention, and for detailed recommendations to be made about future implementation and evaluation.

4 RESULTS

4.1 INTRODUCTION

This chapter presents the results from the development and preliminary evaluation of a complex psychotherapeutic intervention that aimed to enhance job retention in employees with moderate-severe recurrent depression.

4.1.1 Structure of the Chapter

This chapter comprises four sections which cover the initial stages recommended by the MRC guidance (Moore *et al*. 2015; Craig *et al*. 2008; Campbell *et al.* 2000), plus a critique of the results and conclusions:

1. Results of Stage One (**modelling**), involving two sets of focus groups. The first was used to ascertain the views of former service users to modify the intervention design. The second was used to ascertain the views of frontline practitioners and managers to clarify the research protocol. Further analysis of both sets of focus groups was subsequently undertaken to refine the programme theory.
2. Results of Stage Two (**piloting**), involving the conduct of a feasibility study to report on the results of the outcome evaluation and the process evaluation.
3. Results of Stage Three (**re-modelling**), involving one set of focus groups to ascertain the views of former service users, frontline practitioners and managers about the acceptability and accessibility of the treatment manual and the additional resources, taking into consideration self-report and written feedback from clients in the feasibility study.
4. A **Critique of the Results**, and a **Summary**.

4.2 MODELLING STAGE

The first iteration of the new intervention design and programme theory was based on a component analysis of relevant and potentially relevant psychotherapeutic interventions, and theoretical integration of occupational stress, psychological, social/interpersonal, and biomedical theories that underpinned these interventions (see Chapter 3). Subsequently, an analysis of pre-intervention stakeholder consultation was undertaken; this resulted in the second iteration with a modification to the intervention design and refinement of the programme theory.

4.2.1 Active Ingredients

The first aim was to find out what former service users thought in answer to Research Question 1:

> *What would be helpful in the design of a work-focused psychotherapeutic intervention to treat moderate-severe recurrent depression and to enhance job retention in employed clients of UK CMHTs?*

Four themes were identified: triple foci of therapy, three inter-dependent outcomes, group format, and facilitation of peer interaction. Further details are presented as a Mind Map in Appendix 47.

4.2.1.1 Triple foci of therapy

Former service users thought that it would be helpful if the new intervention focused on (i) presenting problems (such as symptoms of depression), (ii) work issues (such as occupational stress), and (iii) underlying issues (such as trauma, core beliefs and maladaptive coping).

Table 5 – Triple foci of therapy

Theme	Illustrative quote
Presenting problems	To alleviate your depression somehow or try to help you to manage it. Male, Former SU, Engineer 014:FGA2:586
Work issues	Some people that are workaholics, they work because it gets them away from whatever the main issue [is]. Female, Former SU, Staff Nurse 015:FGA3:1095
Underlying issues	That would give you insight into what you think is where the bigger problems are. Female, Former SU, Civil Servant 013:FGA2:404

4.2.1.2 Three inter-dependent outcomes

Former service users thought that it would be helpful if the new intervention had clear aims and objectives related to three inter-dependent outcomes: (i) improvement in depression, (ii) maintenance of employment, and (iii) enhancement of relationships at home and at work. They thought that the main goal of therapy should be to help someone with recurrent depression recover fully, and that remaining in or returning to work could be part of their recovery process.

Table 6 - Three inter-dependent outcomes

Theme	Illustrative quote
Improve clinical status	You can look back on it …and think last week was a bit crap but this week I've improved. Female, Former SU, Parent 023:FGA3:370
Improve work status	It …gives you a snapshot of what's actually happening for that person so quickly we can see how they are working or if they are not. Female, Former SU, Staff Nurse 015:FGA3:464
Improve inter-personal functioning	If they had a better social understanding of their colleagues then they might not take things as personally. Male, Former SU, IT Manager 012:FGA3:913

These outcomes can be objectively and subjectively evaluated using appropriate outcome measures.

4.2.1.3 Group format

Former service users thought that it would be helpful if the new intervention should use a closed-group fixed-term group format and be run as 12 full-day sessions with regular breaks during term-time only from 10am-3pm (so that people with child-care responsibilities could attend), with no more than eight clients and two co-facilitators.

They suggested that each session should have a 'loose structure' so that facilitators could be responsive to material disclosed during the discussion, and so that different activities could be timetabled. They valued different sized groupings such as working in pairs, small groups and large group plenary.

There was broad support for light refreshments to be provided, and that lunchtime should be an unstructured 'social space' to create space for 'small talk' and 'chit chat' which helped them get to know one another.

Service users thought that it would be helpful to invite clients to discuss specific difficult situations and inter-personal incidents at work or home so that the other members of the group could help with new perspectives and new strategies for dealing with stressors.

They approved of enactive techniques such as role-play, and an empty chair to rehearse and practise new skills in the group could be helpful.

Table 7 - Group format

Theme	Illustrative quote
Dose / duration	I think longer sessions because there's probably going to be a lot of material to actually work through. Male, Former SU, IT Manager 012:FGA1:116
Volume / frequency	People need to feel comfortable. They won't open up if there's more than eight people will they? We need to trust each other… Female, Former SU, Parent 023:FGA2:434
Structure of sessions	You can have a loose structure, like you said, you know you have got small group morning, large group afternoon... Female, Former SU, Civil Servant 013:FGA2:362, 396
Adult learning methods	The most important thing is to have variety and activities…we were doing different things all the time and sometimes we were doing individual things and sometimes small group, sometimes large group and that's what I would do as a teacher as well. Female, Former SU, Retired HE Lecturer: 019:FGA2:408
Content components	More along the lines of managing and coping and developing strategies for living with depression. Male, Former SU, Engineer 014:FGA3:1149
Process components	You need people to see things [different] from your perspective otherwise you way as well just sit in a room with people that agree and then you are never going to learn anything, are you? What are you going to learn? Female, Former SU, Bank Worker 024:FGA3:1015
	A small group of two people and then bring it back to the group together. Female, Former SU, Parent 023:FGA2:1096

4.2.1.4 Facilitation of peer interaction

Former service users thought that it would be helpful if the new intervention set up opportunities for peers to interact. They recognised the added value of peer learning, peer feedback and peer support, and of being able to take on the role of 'therapist' to each other.

Some of them supported the idea of recruiting (and if possible paying) a peer support worker and to offer training to help them fulfil their role during the setting up of the group-CBT programme. However, others expressed misgivings about this idea because the role was unclear.

Table 8 - Facilitation of peer interaction

Theme	Illustrative quote
Peer learning	Everyone is learning something from everyone else…there is that opportunity for other people just to give you feedback from other people who learn from that. Male, Former SU, IT Manager 012:FGA2:1094
Peer feedback	We did the little group circles and then you have got to do some feedback and they say, 'Well what do you think?' Female, Former SU, Parent 023:FGA2:26
Peer support	It can help…you can put a hand out and help a fellow sufferer. I feel better for it as well. Male, Former SU, Financial Manager LA, Union Rep 028:FGA4:186

4.2.2 Mechanisms of Change

The findings from a secondary analysis of data from both sets of planning focus groups related to mechanisms of change are summarised below. The data was interrogated for evidence of plausible mechanisms of change for a new psychotherapeutic intervention (as described in Chapter 3).

Twenty four sub-themes were merged into twelve themes, which were subsequently collapsed into six mechanisms that require the acquisition, consolidation and application of basic CBT concepts and relational skills i.e. the ability to ***Realise*** (acknowledge problems), ***Reflect*** (on thoughts and feelings), ***Regulate*** (emotions and behaviour), ***Resolve*** (ambivalence and conflicts), ***Relate*** (to self and others), and ***Retain / Resume*** (stay-at-work or return-to-work). Further details are presented as a Mind Map in Appendix 48.

It is possible that activation of the one or more of the six hypothesised mechanisms might be accelerated and optimised in the context of group psychotherapy via the skilful facilitation of peer interaction. This requires the leader to set up opportunities for peer learning, peer feedback and peer support in order to produce the desired outcomes.

4.2.2.1 Realise

The term ‘realise’ refers to a client being able to recognise that they have depression, work-related stress or inter-personal problems. People often have ‘blind spots’ about themselves or their environment and see things as ‘normal’. Just like in physical illness, mental illness may have few overt signs. Realise is like a ‘light bulb moment’ which allows a client to see what is going wrong for them at the problem or symptom level.

Table 9 - Realise

Theme	Sub-theme	Illustrative quote
Shift in perception: people	Seeing myself differently	People will come up with the same answer or somebody will say something and somebody else will say ‘Oh yeah, yeah that’s one of mine as well’, and it opens people’s minds into thinking ‘Actually I do that’. Female, Former SU, Financial Assistant 016:FGA2:1068
	Seeing others differently	You have to look at yourself first. And when you have done that you realise that actually you are okay yourself. Female, Former SU, Bank Worker 024:FGA3:1063, 1067
Shift in perception: problem	Seeing my problems differently	It became clear to me that for my own health, get out of there… there are times when you just need to be able to get the person to work out actually is this the most important things for you. Male, Former SU, Engineer 014:FGA1:306
	Seeing others’ problems differently	Everyone else thinks that’s a reasonable request for your boss to ask you but you think they are bullying you so you have interpreted it as bullying. Male, Former SU, IT Manager 012:FGA3:995, 1023

4.2.2.2 Reflect

The term 'reflect' refers to a client being able to observe thoughts, feelings and behaviours from a meta-position. It also denotes the process whereby the client gains insight or outsight which is a more profound process of illumination when a client can see the underlying causes of their problems or symptoms, and others' problems or symptoms.

Table 10 - Reflect

Theme	Sub-theme	Illustrative quote
Learning` from each other	Speaking about my experience	I could sit and say what had happened to me. I would be able to say it now, where before I wouldn't have been able to say it. Female, Former SU, Parent 023:FGA2:1148, 1152, FGA3:642
	Listening to others' experience	It would be very heartening for people in the group to see somebody who has gone through it and come out the other end and has got better because I think when you're in that situation you often think you are never going to get better. Female, Former SU, Retired HE Lecturer 019:FGA3:510
Understanding each other	Understanding myself: insight	I can deal with all sorts; deal with anything but the minute something little at home would have happened it would have been all like trauma and everything would have gone to pot. Female, Former SU, Staff Nurse 015:FGA3:851
	Understanding others: outsight	Work is also a social environment as well as a professional one and social relationships at work are for a lot of people very, very important. Because you have got two things going on: social interactions as well as the professional ones. When they get out of kilter you can have problems. Male, Former SU, Engineer 014:FGA3:857, 861

4.2.2.3 Regulate

The term 'regulate' refers to a client being able to tolerate feelings (e.g. emotions, sensations, impulses) triggered by autonomic hyper- and hypo-arousal so that they can stabilise their mood either by themselves or with the help of another person. It also denotes more adaptive coping by dealing directly with a problematic situation or by accepting it.

Table 11 - Regulate

Theme	Sub-theme	Illustrative quote
Managing my mood	Self-regulating	It is very difficult to do because you are so up and down through the day. Male, Former SU, Traffic Manager LA 027:FGA4:146
	Co-regulating	I think you could have shared what you were going through, I felt like I had to hide it and I think a lot of people hide your depression and hide what you are going through. Female, Former SU, Retired Bank Manager 029:FGA4:158
Coping better	Active coping	People could give examples of how they dealt with it, good or bad… because it gives you alternatives that you mull over in your mind…so it gives you options to think about. Female, Former SU, Civil Servant 013:FGA2:1128, 1136
	Passive coping	Be able to...shrug it off in way... If you can't change the management…this is going to be the way it is… Female, Former SU, Staff Nurse 015:FGA3:1039, 1043

4.2.2.4 Resolve

The term ‘resolve’ refers to a client being able to weigh up options, make decisions and take action, and also refers to their dealing with inter-personal conflict through positive competition, collaboration and cooperation. Ambivalence about change needs to be resolved before a client can commit to trying new behaviours so that skills can be acquired, consolidated and applied in a range of other contexts.

Table 12 - Resolve

Theme	Sub-theme	Illustrative quote
Managing my behaviour	Practising skills	You need to learn to, if you focus on yourself…your own this, your own that, then the ways you respond to people…the manager’s not changed, they are the same but you are going to be different so the way they respond to you as this different person it's going to change. Female, Former SU, Bank Worker 024:FGA3:1051
	Goal-setting	It's not all about what’s the world done to me, I need to change. Male, Former SU, Financial Manager LA, Union Rep 028:FGA4:264
Dealing with conflict	Saying what I want and finding a shared solution	Some people when they are very stressed show ratty argumentative, confrontational, if you can recognise that, you might be able to manage the confrontational side of things. Male, Former SU, Engineer 014:FGA2:772
	Hearing what others want and finding a shared solution	I mean I’ve worked with people…when I get to the nitty-gritty of it, actually it’s half a dozen of one and it's half a dozen of the other and I suppose that’s where…you get them to be open and start discussing some other things. Female, OT, Job Ret Specialist, Voc Rehab Service 008:FGB2:258

4.2.2.5 Relate

The term ‘relate’ refers to a client being able to get along better with themselves and with others. For some clients who have experienced inter-personal trauma, the relationship with oneself and relationships with others can be a source of internal and external stress rather than a source of support.

Table 13 - Relate

Theme	Sub-theme	Illustrative quote
Two-way feedback	Giving feedback	I think if you are in this group and you have got a problem…it's there to be challenged basically. Male, Former SU, IT Manager 012:FGA3:1107
	Receiving feedback	It would be nice to have feedback to say ‘I actually tried what we discussed and it didn’t work or I tried this instead’. Female, Former SU, Financial Assistant 016:FGA2:1122
Helping each other	Helping myself	We did have someone in the group, they never spoke did they…you won't help yourself get anywhere like that. Female, Former SU, Civil Servant 013:FGA2:452, 456
	Helping others	Other people give you suggestions how you could have coped with it, it just makes you think differently, you know, so instead of just being stuck on yourself all the time you took it on. Female, Former SU, Parent 023:FGA2:1166

4.2.2.6 Retain / Resume

The term ‘retain’ refers to a client being able to maintain employment when depressed.

Table 14 – Retain

Theme	Sub-theme	Illustrative quote
Staying at work	Disclosing mental health problems or work-related stress	People are very reluctant often to disclose their mental health issues to an employer. Female, OT, Job Ret Specialist, Voc Rehab Service, HTPFT 003:FGB2:134
	Negotiating reasonable adjustments	It's whether that person feels empowered enough to be able to request what they need, the support that they need. Female, RMN, OH 011:FGB3:488
Returning to work	Negotiating phased return	Well when I had what was nearly a breakdown I did go into work specifically every week just to see them, that’s the most I could commit to. Male, Former SU, Financial Manager LA, Union Rep 028:FGA4:516, 520
	Negotiating on-going support	It helps to name the problem. When you speak to the employer it becomes nebulous, talking about feelings, the employer can't get a handle on that. Male, Former SU, Traffic Manager LA 027:FGA4:466

4.2.3 Study Procedures

The second aim was to find out what frontline practitioners and managers thought in answer to Research Question 2:

> *Which study procedures would be helpful when implementing and evaluating a work-focused psychotherapeutic intervention in a real-world community setting?*

The findings from the primary analysis of data from Focus Group B involving frontline practitioners and managers related to the research protocol are summarised here. Five themes were identified: source of referrals, recruitment strategies, obtaining consent, choice of outcome measures, and care pathway. Further details are presented as a Mind Map in Appendix 49.

4.2.3.1 Source of referrals

In terms of the feasibility of evaluating the new intervention in a real-world community setting, frontline practitioners and managers thought that it would be helpful if the author provided clarity about the study's aims and objectives so that referrers could decide if the new intervention might be helpful. They thought that the study should not exclude eligible members of staff from participating if they were under the care of the Trust with moderate-severe recurrent depression, although it was agreed that the study should exclude people who are unemployed. There were concerns about creating extra demand for psychotherapy and extra work for CMHTs because both services were at capacity. Nevertheless, participants thought there was a need for work-focused psychotherapy to enhance job retention.

Table 15 - Source of referrals

Theme	Illustrative quote
Clarify aims & objectives	So it is people who are in secondary care services. Female, Psychologist, HTPFT 006:FGB2:108
Identification of potential participants	Referrals could come from anywhere, a lot of different places, it could be a Supervisor, just struggling with work, or a Manager… Male, Psychotherapist, HTPFT 004:FGB1:214
Be careful not to create extra demand for psychotherapy	It's a big piece of work to talk to people about disclosure and to support them to open up but then if the support isn't in place to manage that then it's almost like you have kind of encouraged people to do something that might leave them feeling quite unsafe. Female, OT, Job Ret Specialist, Voc Rehab Service, HTPFT 003:FGB2:134
Be careful not to create extra work for CMHTs	CMHT staff are so busy at the moment so absolutely overwhelmed with work…with everything else that's going on at the moment it would probably not get the attention that it deserves. Female, OT/Manager, HTPFT 009:FGB3:110

4.2.3.2 Recruitment strategies

Several ideas were put forward about how to recruit clients willing to take part in a research study. Frontline practitioners and managers advised that referrals should only be accepted from the Single-Point-of-Access or from clients already on the caseloads of CMHTs to manage demand on those services.

Table 16 - Recruitment strategies

Theme	Illustrative quote
Screen psychotherapy waiting lists	I think there would definitely be a need…there are a lot of referrals coming through for people who are moderately to severely depressed and struggling to say in work. Female, OT, Job Ret Specialist, Voc Rehab Service, HTPFT 003:FGB1:60
Circumvent the bottlenecks	[CMHT] …are not aware of it…of referring outside of the quota. Male, Psychotherapist, HTPFT 004:FGB1:470-474
	Or self-referral. Male, Psychotherapist/Manager, HTPFT 001:FGB1:216
Attend CMHT allocation meetings in person	They need somebody to go and tell them and just re-emphasise because…they will remember your face and name more so than you just sending out a generic email. Male, Psychotherapist, HTPFT 004:FGB1:474-478

4.2.3.3 Obtaining consent

Frontline practitioners and managers were concerned that unrealistic expectations should not be raised if clients were screened for inclusion and then found to be ineligible. They advised the author to be careful when excluding people who had requested further information.

They also suggested that it might be more feasible to randomise clients to a control group that could involve care-as-usual (1:1 psychological therapy or case management by a care coordinator in the CMHT), or a waiting list. They wondered about the feasibility of asking any clinicians involved in providing CAU to collect outcome data due to time pressures.

Table 17 - Obtaining consent

Theme	Illustrative quote
Be careful not to raise unrealistic expectations	I was thinking they have probably gone through quite a lot before they get to discuss…they have gone through all of that and then you say, 'No'. Male, CBT/Manager, HTPFT 002:FGB3:320-3244
Clarify control conditions	Could you kind of have people in the group and then the other people for 12 weeks of 1:1 but with a [focus on] workplace stress? Female, OT, HTPFT 020:FGB4:406

4.2.3.4 Choice of outcome measures

Frontline practitioners and managers offered suggestions about how to collect clinician-rated outcomes, such as trainee psychiatrists on placement or voluntary research assistants trained and supervised to administer the HAM-D, and that follow-up data could be collected by post at twelve weeks post-treatment.

Table 18 - Choice of outcome measures

Theme	Illustrative quote
Administration of HAM-D	Could you almost use a sidekick there couldn't you, somebody independent? Junior doctor, trainee psychiatrist? Female, CBT/OT, HTPFT 021:FGB3:298
GAF is unacceptable	In Occupational Health…some of my colleagues are general nurses…they wouldn't need these. Female, RMN, OH 011:FGB3:188
	Well that's actually, that's a ridiculous scale… Male, Former SU, IT Manager 012:FGA3:1161

4.2.3.5 Care pathway

Frontline practitioners and managers recommended that the care pathway of the intervention should match the existing one, which meant conducting a thorough diagnostic assessment and psychological formulation. This would need to be undertaken on a 1:1 basis before group psychotherapy. They thought it was important to identify maladaptive 'schemas' or personality traits that might create inter-personal problems in the therapeutic relationship or between members of the group.

Occupational therapists advised that if any clients indicated that dissatisfaction with their employment was a factor in the recurrence of depression, then the fit between the Person x Environment x Occupation could be discussed with them to discover whether a change in role might be beneficial. If so, the therapist could support clients to find alternative employment.

Table 19 - Care pathway

Theme	Illustrative quote
Complete holistic assessment	The assessment that we do carry out…it's very holistic it does take into account work and personal life, any factors that are impacting on health and well-being. Female, RMN, OH 011:FGB3:188
Complete psychological formulation	I think the work-based theme, I would do problems and targets so a problem might be let's say, I'm not assertive I don't know and low self-esteem at work. Sometimes it might be the boss saying do this, do that and taking on everything so it's learn not necessarily to say no but not take on too much… Male, CBT/Manager, HTPFT 002:FGB4:158
Identify underlying personality traits / disorder	People [could]…enter the group with a kind of schema that they would want to explore whilst they are in the group you know, some of the inter-personal dynamics. Female, Psychotherapist/Manager, HTPFT 005:FGB2:300
Clarify components of therapy	We make our sessions very, very long half of the session about psychoeducation half of the session for some psychotherapy. Female, Psychologist, HTPFT 006:FGB4:320
Recruit an Occupational Therapist as the group co-facilitator	I guess maybe targeting OTs for the training needs….It's quite a good learning opportunity…It would be good if you had somebody who knows about workplace issues. Female, OT, HTPFT 020:FGB4:474-486

4.2.4 Changes made

In line with the four themes that were identified, the new intervention was renamed ‘a work-focused relational group-CBT Treatment Programme’ (Appendix 50).

4.2.4.1 Modification of the intervention design

The next iteration in the development of the intervention design incorporates the four active ingredients identified here (Appendix 51).

4.2.4.2 Refinement of the programme theory

The barriers to job retention and the six probable mechanisms identified here were subsequently integrated with the preliminary programme theory. The next iteration in the development of the programme theory incorporates the six new mechanisms with the three original possible mechanisms identified through a realist synthesis of relevant and potentially relevant interventions (Appendix 52).

4.2.4.3 Clarifications to the research protocol

This process resulted in the research protocol being amended and re-submitted to a sub-committee of the LREC and approval was granted for the author to undertake Stage 2 (Appendix 53b).

4.3 PILOTING STAGE

The piloting stage involved testing the new intervention in practice for the feasibility of evaluation and implementation. It was delivered as a treatment programme for eight clients, and was held over six months with a combination of 1:1 and group sessions. Results are reported for individuals and for the group as a whole. Outcome evaluation will cover the preliminary response of clients to the intervention, and any indication of moderation or mediation. It will also address data completeness and make a power calculation for any future trial. Process evaluation will cover recruitment and resulting sample, utility of the outcome measures and data collection methods, successful and safe delivery of the intervention, resources required and ability to implement and evaluate the intervention.

4.3.1 Outcome Evaluation

The aim of the mixed methods quasi-experimental study with a small purposive sample was to find out what happened when the new intervention was piloted in answer to Research Question 3:

> *What is the feasibility of evaluating a work-focused psychotherapeutic intervention in a real-world community setting?*

The results from the feasibility study (outcome evaluation) are summarised below. Statistical data will be presented first, then the descriptive data. Further details can be found in the case vignettes (Appendix 28).

Outcomes related to clinical status were collected using validated and reliable questionnaires (Appendix 14). At baseline, the mean scores were in the severe range for depression, psychological global distress, inter-personal problems and work-related stress. For health-related quality of life, work and social adjustment, and coping self-efficacy, mean scores were in the moderately poor, lower or unhealthy range.

4.3.1.1 Statistical data

The primary outcome was the severity of depression. Data from a single group of subjects was collected, and the aim of the analysis was to compare outcomes for this group at different time-points. Analysis of group scores involved comparing changes over time for the subjects in the study. The specific time-points to be compared were determined in advance of looking at the data. The research was not focussed on exploring correlations between variables. The chosen statistical test was also under investigation.

Depression severity

A comparison of the changes in clinician-rated depression (HAM-D) and self-report depression (BDI II) over time was made (Table 20).

Table 20 - Depression severity

Outcome	Time A	Time B	N	Time A Mean (SD)	Time B Mean (SD)	Change Mean (95% CI)	P-value
HAM-D	T1	T3	5	31 (13, 37)	26 (8, 36)	-5 (-14, 5)	0.22
BDI II	T0	T3	8	36 (16, 47)	16 (1, 44)	-20 (-27, -6)	0.02
	T0	T4	5	34 (16, 36)	12 (2, 50)	-13 (-34, 18)	0.22

The first figures presented are the number of subjects with data at both time-points who were included in the analysis. The next figures are the median and range at the first time-point (Time A) and the second time-point (time B). Also reported are the mean changes in values over time, along with a corresponding confidence interval. Median values were used in preference to the mean values to be consistent with the use of non-parametric analysis methods. Finally, *p* values indicating the significance of the results are also reported.

The results suggested that there was no change in the HAM-D score between T1 and T3. However, for the BDI II, there was a significant change in values from T0 to T3, with scores decreasing by an average of 18 units. However, there was no significant change from T0 to T4, although it is noted that the number of subjects in these analyses was low, and hence there is less statistical power to show a difference. Moreover, this result may have been confounded by an outlier who scored worse at every time point on all the measures. Written feedback at the end of the treatment suggests that this client (Paula) masked her depression at baseline.

Of the clients in skilled jobs, two achieved remission on the BDI-II at post-intervention (Annabel, Naomi), and one at follow-up (Jill). One did not provide follow-up data (Naomi). Of the clients in semi-skilled or unskilled jobs, two had deteriorated at follow-up, one scored worse than baseline (Paula), and one scored worse than post-intervention on the BDI-II (Mandy). Two did not provide follow-up data (Harriet, Betty).

Several line graphs were produced to illustrate these results showing the median value for each parameter over time, along with corresponding 95% confidence intervals using the non-parametric approach to the data analysis (Appendix 54).

Indication of moderation or mediation

A comparison of the changes in various parameters over time was made, and the analysis results are summarised in Table 21. The results suggested that for CORE there was a significant change in values from T0 to T3, with scores decreasing by a median of 30 units over this time. There was no significant change from T0 to T4, although it is noted that the number of subjects in these analyses was low, and hence there is less statistical power to show a difference.

There were significant differences between T1 and T3 for each of CSES, EQ-VAS and IIP32. CSES and EQ-VAS values increased between these time periods, whilst IIP32 values decreased significantly. The median increase in CSES values between these time-points was 62 units. There was also slight evidence that CSES values increased between T1 and T4, but this result did not quite reach statistical significance. There was no strong evidence that any of EQ-5D, W&SAS, HSE and HAM-D varied between T1 and T3.

Inter-personal problems

All of the clients had identified at least one inter-personal problem which matched the top 5-10% of an outpatient sample (Leach *et al*. 2004). This finding suggests that they had serious difficulties in relationships in at least one domain on the IIP-32. At the end of the treatment programme, five clients scored better on the IIP-32; one client in a semi-skilled occupation was no longer over the threshold for caseness (Christine); two clients in skilled occupations scored the same as a healthy general population (Annabel, Naomi); and two clients in unskilled occupations were still at caseness but significantly lower than at baseline (Harriet, Betty). Two clients' scores had not changed and were still at caseness at T3 (Mandy, Paula), and one client's scores had not changed but were below the threshold for caseness at both time points (Jill).

Table 21 - Clinical outcomes

Outcome	Time A	Time B	N	Time A Median (Range)	Time B Median (Range)	Change Median (95% CI)	P-value
CORE	T0	T3	8	87 (23, 107)	45 (14, 92)	-30 (-64, -4)	0.02
	T0	T4	5	77 (23, 88)	32 (5, 105)	-11 (-69, 18)	0.22
CSES	T1	T3	8	37 (10, 40)	128 (26, 198)	62 (30, 108)	0.01
	T1	T4	5	78 (10, 140)	143 (5, 223)	45 (-5, 105)	0.08
EQ-5D	T1	T3	8	0.65 (0.02, 0.81)	0.69 (0.36, 0.81)	0.00 (0.00, 0.50)	0.22
EQ VAS	T1	T3	7	32 (20, 65)	50 (25, 75)	8 (0, 28)	0.02
IIP 32	T1	T3	8	75 (38, 101)	53 (22, 76)	-21 (-42, -1)	0.02
W&SAS	T1	T3	8	27 (11, 30)	20 (8, 28)	-4 (-11, 4)	0.18
HSE	T1	T3	8	105 (70, 161)	117 (81, 144)	8 (-6, 35)	0.12

Table 22 - Inter-personal problems

		Pre-test score (mean)	Post-test score (mean)
031	Mandy	2.0	1.9
032	Jill	1.4	1.5
033	Christine	2.4	1.5
034	Harriet	2.5	1.6
035	Paula	2.0	1.9
036	Annabel	1.1	0.6
037	Betty	3.0	2.2
038	Naomi	2.8	0.9
MEAN		2.5	1.5
SD		0.67	0.53

Quality of life

Table 23 shows the difference between the mean quality of life by the age of the general population (EuroQol Group, 2009) and each client's mean EQ-VAS score. A one-tailed paired t-test comparing scores at T1 and T3 showed that the improvement was a significant (p = 0.032). However, a two-tailed test showed that when comparing mean scores at T1 and the mean of the general population by age, there was a highly significant (p = 0.0001) difference between the clients' quality of life and the general population's quality of life; and when comparing mean scores at T3 and the mean of the general population by age, there was still a significant difference between the groups (p = 0.002).

Table 23 - Quality of life by age

General population	Age Group	
	30-39 years	40-49 years
Mean	86.2	85.1
Standard Deviation	14.6	15.5

The EQ-VAS was used to compare data from a survey of the UK general population and scores from study clients, as shown in Table 24.

Table 24 - Participant quality of life

		Age	Pre-test score	Post-test score
031	Mandy	40	33	60
032	Jill	45	20	25
033	Christine	41	35	60
034	Harriet	41	25	28
035	Paula	49	30	30
036	Annabel	47	65	75
037	Betty	49	40	Missing (use 40)
038	Naomi	36	30	60
MEAN			34.75	47.25
SD			13.7	18.8

Table 25 - Coping self-efficacy scores

		Pre-test score	Post-test score	Follow-up score
031	Mandy	26	115	74
032	Jill	118	184	223
033	Christine	78	115	143
034	Harriet	29	67	Missing (use 67)
035	Paula	10	26	5
036	Annabel	140	198	181
037	Betty	39	140	Missing (use 140)
038	Naomi	35	157	Missing (use 157)
MEAN		59.4	125.3	123.8
SD		44.4	54.1	65.8

Coping self-efficacy

Taken case-by-case, as shown in Table 25, all clients improved from baseline to end of treatment on a subjective measure of coping self-efficacy (CSES). As scores went up on the CSES, scores went down on the BDI-II, which suggests a relationship between the two variables. One client (Paula) who scored worse depressive symptoms at follow-up than at baseline also deteriorated in coping self-efficacy.

Occupational stress

Scores from the HSE questionnaire showed that seven clients scored high (red: urgent action needed) for occupational stress at baseline. Difficult relationships and a lack of managerial and peer support at work caused clients the most stress, with high demands and an unclear role being stressful for two clients. Three clients reported less occupational stress at the end of the treatment programme treatment, and there was no change in the other four clients. Naomi scored green (doing well), Jill scored blue (good but need for improvement), and Paula scored yellow (clear need for improvement). Only Harriet scored green (doing very well) for occupational stress at baseline with no change over the course of the treatment programme.

Data completeness

For the HAM-D, data was complete for 5/8 (62.5%) clients between time-points T0 and T3. Otherwise, for time-points T0 and T3 data was complete (100%) for all clients for seven variables, and for 7/8 (87.5%) clients on the EQ-VAS. The missing data was managed by intention-to-treat analytic strategy (i.e. the last score was carried forward).

For time-points T0 and T4 data was complete for 5/8 (62.5%) clients for three variables (CSES, BDI II and CORE). The missing data was managed by only analysing the complete data sets.

Power calculation

This study was not large enough to test for statistically significant differences in outcomes as at present, there is no data upon which to determine the sample size. Nevertheless, some assumptions were made about the power calculation based on detecting a difference of 4.0 units on the HAM-D total score, a standard deviation (SD) of 8, an alpha level of 5% and a power of 80%. This indicated that the required number of subjects based on these figures would be 45 per treatment group or 90 subjects in total. The proposed sample size for the group programme in this study (n = 16) was too small to test for clinical effectiveness or social outcomes between groups. Therefore, it aimed to establish the feasibility of the new intervention and likely effect size and recruitment potential for future research trials.

4.3.1.2 Descriptive data

Work status

Descriptive data was collected from clients at baseline, at every group session, and at follow-up about their employment status, working hours, reasons for any absences, and intention to quit (Appendix 55). Outcomes related to work status were collected weekly using a bespoke

form designed for this study (Appendix 56). At baseline, three women were off sick, one woman was working in a voluntary job, and one woman was unemployed (both of these women lost their jobs while on the waiting list), and three women were at work.

Of the clients who were on short-term sickness absence due to physical health problems at baseline (T0), by the end of the group-CBT programme (T3), both clients had returned to their part-time contracted hours, with one struggling to attend regularly and reliably (Harriet) and one coping much better at work (Naomi).

One client had not returned to salaried work after long-term sickness absence because of depression, but was working as a self-employed shopkeeper (Christine). One client had returned to her full-time contracted hours from restricted duties having negotiated reasonable adjustments (Jill).

Of the clients who were working their contracted hours at baseline, by the end of the group-CBT programme, one had maintained her contracted hours and was coping much better at work (Betty), and one had maintained her employment but was on short-term sickness absence due to depression (Paula).

Of the clients who had lost their jobs whilst on the waiting list at baseline, by the end of the group-CBT programme, one was still on welfare benefits and looking for work through the Work Programme (Mandy), and one had started a voluntary job (Annabel).

By follow-up (T4), of the clients who were in employment at baseline, no-one lost their job during the intervention. One client had returned to work after long-term sickness absence (Christine). By follow-up, of the two clients who were out-of-work at baseline, one had made little progress due to relapse of depression (Mandy) and one had consolidated her position in a voluntary job, later achieving a paid job (Annabel). The first client was attending the Work Programme as a condition of claiming Employment and Support Allowance and she did not request employment support from the Occupational Therapist, but the second client received two 1:1 sessions with the Occupational Therapist (Appendix 57).

At follow-up, written feedback (Appendix 58) from the client who was an outlier in terms of clinical status and who had been working fulltime at baseline but then went off sick at the end of the treatment programme suggested that she benefitted from the treatment programme because it raised awareness of her unmet needs and supported her in making important decisions about her job (Paula). She had been working full-time at baseline but was on short-term sickness absence at follow-up. However, she had started to write poetry and perform in public. This client did not request employment support from the Occupational Therapist.

Intention to quit was measured on a 5-point Likert scale. Clients who were in employment were asked, 'Do you intend to quit your job?' Analysis of this data suggests that no client had any plans to leave or change their employment scoring 'probably not' or 'definitely not'. Only one client frequently scored 'unsure', and received two 1:1 sessions with the Occupational Therapist (Appendix 57). She continued working in her own shop throughout, and had resumed part-time salaried work by the follow-up (Christine).

Healthcare use/welfare benefits

Outcomes related to healthcare use/welfare benefits were collected weekly (Appendix 59). At baseline, all but one of the participants reported physical health problems. Three participants had long-standing conditions such as asthma, morbid obesity, or Gastro-oesophageal Reflux Disease (GERD). One participant was significantly underweight (with no evidence of an eating disorder). Three participants complained of chronic pain (see case vignettes for more details). One woman who had lost her job while on the waiting list was claiming Employment and Support Allowance.

Rate of physical illness/need for medical consultation

During the group-CBT programme, several clients took time off work for physical illnesses and investigations such as blood tests, an endoscopy, and a routine smear. All of them, with the exception of one client (Jill), made high use of Primary Care services for minor illnesses and symptomatic complaints such as chest and urine infections, thrush, upset stomach, abdominal pain, and a severe rash. One client was admitted to the acute hospital for a routine operation to treat long-standing GERD. One client had investigations for undiagnosed abdominal pain.

During the group-CBT programme, mental health temporarily worsened in two clients with one taking an overdose (without suicidal intent) requiring assessment and treatment in hospital (Christine). The same client had a planned consultation with an occupational health physician as part of return-to-work procedures and was recalled several times by her GP to monitor her mental state and medication compliance. The other client made use of the 24/7 crisis helpline on one occasion (Harriet).

4.3.2 Conclusions

Although these results do not indicate that the new intervention is effective in reducing depressive symptoms and in enhancing job retention, change in clinical and work outcomes was in the right direction for the majority in this small sample, and it can therefore be judged as promising (Orsmond & Cohn, 2015) that merits further evaluation.

4.3.3 Process Evaluation

This section presents the findings from the process evaluation stage, which involved the analysis of descriptive data in assessing several feasibility factors as outlined above. The aim of the mixed methods quasi-experimental study with a small purposive sample was to find out what happened when the new intervention was piloted in answer to Research Question 4:

> *What is the feasibility of implementing a work-focused psychotherapeutic intervention in a real-world community setting?*

The results from the feasibility study (process evaluation) are summarised below. Descriptive data was collected at several time-points in relation to recruitment and the resulting sample, the utility of the outcome measures and data collection methods, the successful and safe delivery of the intervention, and the resources required.

4.3.3.1 Recruitment and resulting sample

Recruitment was planned for September 2011 to April 2011 but, due to higher than anticipated non-response and non-consent rates, it was extended to August 2012. The first strategy was to recruit exclusively from new referrals. Secondly, the study recruited clients who had already been assessed by screening paper referrals and writing to all potential participants because there as there was a long waiting list for CBT in both secondary care and primary care (IAPT). Thirdly, frontline practitioners in both There and Here were approached by email giving them information about the study to elicit direct referrals. Finally, third sector organisations such as MIND in There and Workplace Plus in Here were approached to offer information and seek referrals (see Appendix 60).

Table 26 - Stages of recruitment process

Stage in recruitment process	Numbers
79 potential participants contacted by letter	54 female, 25 male
15 potential participants screened for eligibility	12 female, 3 male
11 potential participants obtained consent	10 female, 1 male
3 potential participants withdrawn after assessment	2 female, 1 male
8 participants treatment initiated	8 female
8 participants treatment completed	8 female

The recruitment process took longer than anticipated and, despite canvassing 79 potential participants in two city-centre sites, only eight finally entered treatment. They were all female, aged between 36-49 years; seven were White-British and one was African-British. This gender, age and ethnic mix does not reflect that of the average UK workforce.

It was not possible to discover why the majority of potential participants did not respond to the initial invitation because consent had not been given for direct contact.

4.3.3.2 Characteristics of the resulting sample

Baseline demographics are summarised in Table 27, and case vignettes give more background information about each client (Appendix 28). Baseline clinical data shows that clients had a high degree of complexity, comorbidity, chronicity and complicating risks (Appendix 40).

Baseline work status shows that all clients were either currently or recently in employment. The inclusion criteria were relaxed so that two clients who had lost their jobs while on the waiting list for CBT were included. Of those working at baseline, five worked in part-time and three in full-time jobs. Two women were in skilled jobs and were professionally qualified. Three women were in low paid unskilled jobs. One woman was in a semi-skilled job and was also a self-employed shop-keeper. One woman was unemployed but previously in an unskilled job, and one woman was volunteering but previously in a skilled job that required specific training. Three women were off sick at baseline.

Half of the sample had no children. One woman had two grown-up sons living at home, and three women had school-age children. All of the mothers were in committed relationships, and only one of them worked fulltime.

Table 27 - Demographic characteristics

Characteristic	Data
Gender	
Male % (n)	0% (0)
Female % (n)	100% (8)
Age: mean (SD)	43.5 (4.42)
Number of children at home: mean (SD)	1 (1.12)
Ethnic Group	
White % (n)	87.5% (7)
Non-white % (n)	12.5% (1)
Marital Status	
Single % (n)	12.5% (1)
Married % (n)	50% (4)
Co-habiting % (n)	37.5% (3)
Divorced or separated % (n)	0% (0)
Accommodation	
Owner occupier % (n)	75% (6)
Secure tenancy % (n)	0% (0)
Private landlord % (n)	25% (2)
Receiving state welfare benefits	
Not claiming benefits	87.5% (7)
Statutory Sick Pay % (n)	0% (0)
Employment Support Allowance % (n)	0% (0)
Disability Living Allowance % (n)	12.5% (1)

Table 28 - Baseline clinical severity

	Number of participants	Mean (SD)	Clinical status
CORE:	n = 8	80 (25)	Severe
BDI-II:	n = 8	35 (9)	Severe
CSES:	n = 8	60 (47)	Unhealthy range
EQ-5D:	n = 8	8.8 (1.7)	Moderately poor
EQ VAS:	n = 8	34 (15)	In lower range
IIP-32:	n = 8	73 (22)	Most severe range
W&SAS:	n = 8	23 (8)	Moderately severe
HSE:	n = 8	105 (27)	Low-moderate occ. stress
HAM-D:	n = 5	28 (9)	Severe

Table 29 - Baseline work status

Status	Data	Skilled etc.
Full time paid % (n)	3	1 skilled, 2 unskilled
Part-time paid % (n)	3	1 skilled, 1 semi-skilled, 1 unskilled
Voluntary work % (n)	1	1 skilled
Looking after family home % (n)	0	
Long-term sickness absence % (n)	0	
Unemployed % (n)	1	1 unskilled

4.3.3.3 Utility of the outcome measures and data collection methods

The primary outcome was severity of depression. This was measured using a self-report scale (BDI-II) and a clinician-rated scale (HAM-D). The BDI-II was useful and completed fully by all clients at T0-T3, but three clients did not return it at follow-up (T4). Questionnaires were sent by post including an SAE, with two text reminders at weekly intervals up to 4 weeks. There was some missing data at follow-up with just over half of clients returning questionnaires by post.

The HAM-D was undertaken by telephone by two independent research assistants. The HAM-D was useful and completed fully on the occasions that the research assistants managed to speak to the client. However this proved difficult due to the limited availability of the research assistants (one morning per week), and they were unable to contact several clients who were at work or otherwise unable to complete the assessment on the telephone. It was decided not to use the HAM-D at T4.

The secondary outcome was job retention. Amount of hours worked, intention-to-quit and time off sick were measured by self-report every session. The questionnaire was user-friendly and provided clear, descriptive data for people who were employed. However, this was not an appropriate measure for one client who was unemployed and one client who was under-employed (doing a few hours of voluntary work each week).

Other self-report measures were useful and completed fully as above, although one client expressed frustration at having to fill in questionnaires, which she did not believe truly reflected how she was feeling or functioning.

4.3.3.4 Delivery of the intervention

Evaluation of the successful and safe delivery of the intervention for clients was undertaken by analysing statistical and descriptive related to client retention, attendance, adherence (homework), and number of adverse events.

4.3.3.5 Client retention, attendance, and adherence

A measure of successful delivery is reliable and regular attendance for treatment appointments. There was a 100% client retention rate as all clients who initiated treatment completed treatment (Appendix 61).

The group programme was well attended with the mean number of sessions = 10.63 (SD 1.87), and the mean number of clients per session = 7.08 (SD 0.95). All clients attended $\geq$ 10 sessions, and one client who travelled over 25 miles attended 6 sessions. The reasons for missed sessions appeared to be unrelated to the intervention.

A review of every client's goal review forms shows that out-of-session assignments were completed by most of the clients. Whilst some clients struggled to attempt all of their goals, everyone attempted at least one goal every week.

4.3.3.6 Adverse events

A measure of safe delivery is the number and seriousness of adverse events. There was one adverse event when one client took an overdose (without suicidal intent) and was admitted to the general hospital. However, she was discharged the following day and attended the next group session with no ill effects.

There were other unexpected events such as the sudden death of the niece of one client, and a major crisis in one client's family life when her partner threatened to end their relationship. Two clients made disclosures for the first time about childhood sexual abuse, which caused stress within their families of origin. Two clients regularly abused alcohol, which was beginning to impact negatively on their work and home lives.

Crisis prevention involved offering between-session contacts and planned individual sessions (Appendix 62).

4.3.3.7 Resources required

It was feasible to provide the intervention in terms of the resources required such as CBT, group psychotherapeutic and occupational therapy expertise and time. The intervention required suitable space which was found in the community, and suitable equipment was available at no extra cost. Sufficient administrative capacity was available within existing budgets because all of the clients had been accepted into the psychology or psychotherapy service, whilst two voluntary research assistants helped with data management and analysis.

The total direct, indirect, non-pay and overhead costs were calculated (Appendix 63). The mean direct cost per client was calculated as £4,552.76 with mean total costs per client £6,457.12.

4.3.4 Conclusions

The study procedures complied with ethical guidelines and were carried out as planned with the only variation from the protocol being due to recruitment difficulties. It had been intended to run the research as a pragmatic RCT but only eight participants consented to take part so the protocol was modified to a quasi-experimental pre-post design. Nevertheless the randomisation processes were feasible and compliant with the Good Clinical Practice guidance (MHRA, 2012).

Recruitment of participants willing to participate in evaluating the effectiveness of a work-focused relational group-CBT treatment programme was not feasible in the allocated timeframe because the sample was not large enough to randomise and was not representative of the working-age population.

The most effective recruitment strategy was making direct contact with CMHT practitioners so that the author could explain the study and describe the intervention.

Overall, the choice of outcome measures and the methods of collection were feasible and gathered a wealth of descriptive and statistical data. However 'phone administration of the HAM-D was problematic because RAs often could not get hold of clients. Only five clients returned follow-up questionnaires. These were sent by post, which may not be the best data collection method.

This study shows that it is feasible to implement the new intervention in practice with the proviso that recruitment should be undertaken via face-to-face meetings with referrers, and that more time and resources need to be dedicated to recruitment. The Treatment Programme was delivered without problem, and there were high rates of client retention, attendance, and adherence. Only one minor adverse event was reported, although some clients experienced

serious negative life events during the treatment programme. However the costs of delivering the intervention are high.

4.4 RE-MODELLING STAGE

The second iteration of the intervention design and programme theory was piloted to test the feasibility of evaluation and implementation in practice. Subsequently, analysis of users' views and post-intervention stakeholder consultation was undertaken. This resulted in the third iteration with a modified intervention design and refined programme theory.

The aim was to find out what the clients, co-facilitators, frontline practitioners and managers, and former service users thought in answer to Research Question 5:

> *What would be helpful in the re-design of a work-focused psychotherapeutic intervention to enhance job retention in UK employees with moderate-severe recurrent depression?*

There are five sources of data:

- **Therapeutic alliance** questionnaires requested from clients after each session and at the end of the treatment programme.
- **Client satisfaction** questionnaires requested from clients after each session and at the end of the treatment programme.
- **Clients' written feedback** from post-session review forms and at the end of the programme.
- **Co-facilitator's written feedback** from the middle and at the end of the programme.
- **Post-intervention stakeholder consultation** undertaken after the 12-week follow-up of clients in the feasibility study.

4.4.1 Therapeutic Alliance

The Agnew Relationships Measure (ARM-5) was used after each session to collect data about any problems clients were experiencing in undergoing therapy, especially with regard to the therapeutic relationship and confidence in the treatment. Analysis of statistical data from the ARM-5 suggests that each client was highly satisfied with the working alliance (Appendix 64).

4.4.2 Client Satisfaction

Statistical data from the CSQ after the final session suggests that clients were highly satisfied with their overall treatment. The CSQ-8 asks clients to rate their level of satisfaction with the service they have received overall and whether they would recommend the programme to a friend (Appendix 64).

4.4.3 Clients' Written Feedback

Evaluation of how and why the intervention could be re-designed was undertaken via primary analysis of clients' written feedback (post-session and post-programme) (Appendix 58).

4.4.3.1 Post-session

After every session, clients were asked to provide written feedback about their experience of the session. There were two questions related to acceptability:

- What did you find helpful/relevant today?
- What did you find unhelpful/irrelevant today?

Written feedback at the end of each session suggests that, by and large, the new intervention is acceptable to users. Analysis of clients' responses revealed eight themes regarding what was helpful and/or relevant (see Table 30). There were very few negative comments. Analysis of clients' responses revealed five themes regarding what was unhelpful and / or irrelevant (see Table 31). See Appendix 58 for more details.

4.4.3.2 Post-programme

At the final session, clients were asked to provide written feedback about their experience of the whole course. There were five questions related to acceptability:

- Name one positive thing that stands out in your mind about the programme.
- Name one negative thing that stands out in your mind about the programme.
- Is there anything that you think should be included in the programme?
- Is there anything that you think should be removed in the programme?
- Please give any other feedback which could contribute to a re-design of the programme.

Analysis of clients' responses revealed six themes regarding positive and negative aspects of the treatment programme (Appendix 58), and ideas for re-designing it are shown in Table 32.

4.4.3.3 Follow up

At follow-up, clients were asked to provide written feedback about how they were getting on in the form of a letter if they wished to. Five women provided an update on their progress in terms of mental and physical health, work, relationships at home and contact with other group members. Three women expressed appreciation for the help they received. Their responses provide some evidence for the helpfulness and relevance of the programme.

Four women reported feeling better mentally, and two women reported their physical health had improved. However, Paula was really struggling with low mood which affected her

motivation, whilst Annabel's motivation had been a problem (although she had got back on track) (see Table 33).

Three women continued to make progress at work, but Mandy was still trying to find work. However, Paula was off sick and finding it difficult to return-to-work (see Table 34).

Three women reported a better relationship with their partners. However, one client's father-in-law had died suddenly, which caused her much distress. She did not say if she was getting on with her partner any better. She also wrote that she finds continuing contact with other group members unhelpful, whereas another client found it helpful and indicates that she would like to attend a long-term group to maintain her mental wellbeing (see Table 35).

Table 30 - Helpful/relevant themes

Theme	Illustrative quote
Disclosure	Being able to admit my addiction.
Feelings	Talking to others about how I feel.
Feedback	Feedback in small group to remind me that others would have found my job difficult to do.
Discussion	Discussing issues, different points of view.
Sense of universality	Sharing problems with other group members and knowing I'm not on my own.
Hearing others' stories	I found it all deeply moving and quite anxious, I hate to see people upset but sharing is so important.
Awareness of self and others	A really good session, it made me think about my relationships with others or lack of them.
Inter-personal problem-solving	The 'yes/no' debate, I feel I am much better at considering the other's point of view even if I don't agree.
New ideas	Every session I pick up something helpful.
In-session and between-session goals	Discussing goals.
Joining in	Getting out of the house and talking with others.

Table 31 – Unhelpful / irrelevant themes

Theme	Illustrative quote
Problem with equipment	The bad recording was difficult to follow and irritating.
Difficulty concentrating or understanding	I think I went off in my mind more this week and not able to concentrate as much.
Content not suitable	I don't panic so this [panic induction exercise] didn't apply to me but it did to others.
Timing of session	Needed a bit of a break in the morning session.
High expressed emotion in the group	Another member's reaction towards another, too much for me to handle.

Table 32 - Clients' experiences of the treatment programme

Theme	Illustrative quote
Most people found being in a group and talking together about problems was positive.	I've been able to talk about my problems (especially in small group), which is a good base on which to resolve things, you only get out what you put in
	Sharing experiences with other service users.
For one person the resolution of conflict in the group was ultimately positive.	Even the group member who I find difficult has been an important part of the learning…it was uncomfortable at the start but that was part of the point.
Some participants appreciated the style of facilitation.	The way [the leader] worked with the group to involve everyone, whilst controlling input from those who were prone to go off subject.
	The balance and speed were good for me…I liked the balance of theory with practical.
For one person the need to participate fully was positive.	Not being allowed to hide.
Things that participants found unacceptable	I found some of the slides quite complicated and I think there is a lot of jargon. A bit more plain English explanation might help.
	The book we were working from was very dry, and read more like a manual for professionals in psychotherapy than for patients.
	Too many goals to achieve each week….Going over goal programme twice.
	Very repetitive.
	More help when in a crisis.
Suggestions for re-designing the programme	It would be good to revisit some of the theory from the earlier weeks and discuss what coping strategies are working and how people were adapting these
	Twelve weeks wasn't long enough, CBT gives the knowledge on how to change our reactions to situations but trying to do this in twelve weeks and keeping up with the changes we try to make until they become natural responses is hard with just 12 weeks support.

Table 33 - Changes in clinical status

Client	Illustrative quote
Mental health: positive	I have cut down on the self-harm. Not doing it as often and not as much. I'm just too damn old. Trying not to be so stupid. Slowly getting there I think. I am very well still. I still only have one voice in my head and it's a much nicer voice now. It doesn't expect me to be perfect; I don't expect me to be perfect. In general some things are difficult to put into practice but I feel like I've made steady progress and will continue for the foreseeable future. I no longer isolate myself and I have more ups than downs which is good for me!
Physical health: positive	On a health note I've started running and am being more mindful of what I eat. So far this year I've lost nearly 1 stone and can run 5K now. I've just had carpal tunnel surgery, it feels much better.
Mental health: negative	Everything else is in a downward spiral. Finding it increasingly difficult to make myself do anything. I am not sure if I believe I have made massive progress and I was very down in January which was probably down to winter blues and the anniversary of my leaving my last job… I have picked up since then but find it quite easy to put off doing things I don't want to face.

Table 34 - Changes in work status

Client	Illustrative quote
Work: positive:	Work is still busy but I'm really enjoying what I'm doing and am getting positive feedback. I actively check how things are going so the feedback is good and I'm far more able to ask for help and support if I need it. I am now almost back to full-time work and it has been tough but I'm beginning to enjoy [it] more, which is building up my confidence and sense of humour! The biggest step forward I suppose is that I actually applied for a paid job at [a garden centre] which came up just as I joined them as a volunteer… I did get an interview but didn't get the job…I finally have a paid job – hope you are proud!
Work: negative	Off work sick. Should have gone back last Friday but couldn't do it.

Table 35 - Changes in inter-personal functioning

Client	Illustrative quote
Relationships at home	Paul and I still talk a lot more that we did and I share more about how I'm feeling. Philip remains financially supportive and I feel much more at ease with this than I used to do. Too much if I really think about it… It's been a particularly trying time for me. Firstly we had the upset and grief of the loss of Rose's father. It was a terrible thing to have to deal with. As for progress, Jim and I are 95% better than before. We understand each other for the first time thanks to him being involved in my therapy. Because of this, we are happier as a couple and a family. Relations with my parents have been up and down since I last saw you…due to tensions still present between me and my parents since I told them about the abuse. I only ever wanted to get rid of the secret.
Contact with other group members: negative	I've tried to maintain contact with some other group members but I've found it difficult as I have no interest in their problems (can't listen to it) so I've been isolating myself again. I need some time to get my head around my own problems.
Contact with other group members: positive	I have found it quite helpful to keep in touch with the other girls in the group and to have met up with a few of them. It is nice to be able to keep the link with the others as we don't have to explain our situation and we went through a personal experience together.

4.4.4 Co-facilitator's Written Feedback

The occupational therapist provided written feedback at T2 and T3. Analysis of her responses revealed five themes regarding any problems or difficulties she had encountered in delivering the programme, elements that she thought were most effective, and ideas for re-designing it as shown in Table 36 (Appendix 65).

Table 36 - Co-facilitator feedback

Theme	Illustrative quote
Successful delivery of the programme	There were no problems in delivering the programme as it was supervised and planned well and consequently any potential problems were discussed in advance of the session.
Development of skills	The group has helped me to develop my skills in encouraging individuals to talk by asking reflective questions.
Development of knowledge	It has enabled me to recognise more widely group dynamics and explore non-verbal interactions in more depth.
Benefits of peer interaction	Clients were able to work together to identify problems and solutions using interventions / conversations guided by the course facilitators proved far more effective than had it been the course leaders identifying the issues.
Ideas for re-design	Having some sessions that were solution-based but specific about individuals' management of issues at work and ways to resolve them would also have been beneficial.
	I think it could have been led for a longer period of time…a review session 6-8 weeks post group may be beneficial in future programmes.

4.4.5 Post-intervention Stakeholder Consultation

There were two 3-hours mixed Focus Groups C held on one day which involved three frontline practitioners and five former service users who were asked their opinions regarding the acceptability and accessibility of the treatment manual and the additional resources. Several themes emerged in response to the following questions and with reference to users' written feedback and preliminary analysis of outcomes (Appendix 35):

- To what extent do the ideas presented in the manual make sense?
- To what extent are they helpful in terms of learning how to cope with depression?
- To what extent where the additional resources helpful?

4.4.5.1 Suggested improvements

Acceptability

The synthesised findings from the primary analysis of qualitative data arising from all stages of this study for the purposes of modifying the intervention design and refining the programme theory are summarised here.

Two themes were identified that might improve acceptability: make it more interesting and stimulating, and focus on coping over the long-term. Further details are presented as a Mind Map in Appendix 66.

i. Make it more interesting and stimulating

One client in the feasibility study 'liked the balance of theory with practical' content, whereas another thought there was 'a lot of jargon'. Paying attention to the presentations was a problem for a different client in the feasibility study who struggled to focus one week because she 'went off in my mind more this week and not able to concentrate as much'. Another client found some of the content around panic 'didn't apply to me'. However, former service users, frontline practitioners and managers in FGC gave positive feedback about the manual, which they found engaging in some ways and explained the concepts quite well.

Absorbing and processing information was thought to be especially difficult for people with depression. However, when the intervention process components were described, such as the use of experiential exercises, adult learning techniques and small group discussion, participants were reassured that the concepts were effectively explained and elaborated.

Table 37 - Make it more stimulating and interesting

Theme	Illustrative quote
Introduce new concepts	Although I've learned quite a lot from when I went through my therapy, there were new concepts and new ideas in there. Male, Former SU, Financial Manager LA, Union Rep 028:FGC2:134
Use case scenarios	I found it really informative and lots of really good stuff…there's lots of good examples and stuff like that, and illustrations and analogies. Male, CBT/Manager, HTPFT 002:FGC1:40
Use experiential teaching techniques	One of the activities could be either by drawing or using the stone things that we did to map out the things that are causing you stress. Female, Former SU, Civil Servant 013:FGA2:400

ii. Focus on coping over the long-term

Concern was also expressed by some service users about the possibility of clients feeling worse or not making progress either during or after the intervention, which might result in people 'going back to square one'. This was thought to be more likely if people 'opened a can of worms' in terms of disclosing distressing events from their past, or in terms of people being confronted about their behaviour. However, when the assessment, formulation and treatment-planning processes were described, such as personalised problems and targets, crisis and relapse prevention plans, participants were reassured that the programme was sufficiently containing and supportive.

One client from the feasibility study suggested that 'it would be good to revisit some of the theory from the earlier weeks and discuss what coping strategies are working and how people

were adapting these; what was working and why which might help those still looking for the right one', and the OT who co-facilitated the group thought that the process of change might need 'a longer period of time and continued to benefit the clients further and a review session 6-8 weeks post group may be beneficial in future programmes'.

Two former service users picked up on the written feedback of one client from the feasibility study who suggested that it would be better if she had got more help in a crisis. It was thought essential that the new intervention should be containing and supportive, and should provide up-to-date information about 24/7 crisis services.

Table 38 - Focus on coping over the long-term

Theme	Illustrative quote
Warn people it might make them feel worse at first	You get worse before you get better… Because I had to face it, without any, without like cheating, you know, [safety] behaviours and things. Male, Former SU, unemployed, volunteer HTPFT 030:FGC1:923
Revisit skills	There isn't an alternative, but sometimes you just wish that you were a computer and you could turn it off. Female, Former SU, Financial Assistant 016:FGC1:852
Provide crisis support	How to recognise…the signs maybe that things are getting out of hand and…what the best things to do, what sort of support would be appropriate. You know, that kind of thing, it can work in a crisis. Male, Psychologist/Manager, HTPFT, Union Rep 007:FGC1:764

<u>Accessibility</u>

The synthesised findings from the primary analysis of qualitative data arising from all stages of this study for the purposes of modifying the intervention design and refining the programme theory are summarised here.

Three themes were identified that might improve accessibility: make it more understandable, deliver it at the worksite, and make it peer-led. Further details are presented as a Mind Map in Appendix 66.

i) Make it more understandable

Participants in the focus groups gave positive feedback about the manual because it was 'informative', a 'treasure trove', and explained the concepts quite well, 'in words that people could understand'. Another former service user said, 'to find all that resource in one place was really good'.

The main criticism of the manual was that there was too much information, using words such as ‘dense’, ‘technical’, ‘dry’, ‘over-complicated’, ‘academic’, and ‘confusing’. All of the participants were concerned that if the concepts were presented just as a textbook or as didactic ‘chalk and talk’ teaching session, then people would be ‘turned off’ and would ‘not engage’ with the ideas. Similarly, one client in the feasibility study found ‘some of the slides quite complicated…a bit more Plain English explanation might help’.

Formers service-users valued theoretical knowledge that could help them understand why they were depressed. One said, ‘to understand what depression is, and that it’s not you. And once you understand that part, the exercises and things like that, that’s in, start to show you why’, and another said, ‘just seeing it written there, what had caused these problems, just seeing it there, in black and white…that’s what it’s about’. The need for knowledge about depression was further endorsed by another former service user who said, ‘I thought it was very helpful and I’d read about it, but seeing it [in the DVD] made it more accessible, that information, and it helped, it kind of gave a sense of hope’, and another said,

> *I think it’s just more because I understand more about what my problems are and I can express them easier….It’s more, I don’t know if like I can be more assertive and calm and be able to think about it a little better…But now it’s just, I don’t know, even if I’m feeling at my lowest, I can be calm about it and sort of just explain what’s going on.*
>
> Male, Former SU, unemployed, volunteer HTPFT
> 030:FGC1:995

Practitioners in the focus groups expressed frustration with a lot of self-help books that they recommend to clients because they all had different and potentially confusing concepts, and one OT said, ‘it would be much easier, all kind of being on the same page’, which suggests that there is a need for a unifying model for use with clients in secondary care.

Most frontline practitioners and managers were interested in the underpinning theoretical framework and how it integrated different models such as learning theory, attachment theory and emotional regulation theory. One said, ‘The way you’ve pulled it together is really good. It’s really…it’s quite exciting, really’. However, they questioned how much needed to be spelt out in detail, but could see the value of the manual as a training resource for group facilitators because they might need to understand the conceptual logic of the programme more so than service-users.

Table 38 - Make it more understandable

Theme	Illustrative quote
For clients	I think everything…makes sense. Male, Former SU, IT Manager 012:FGC2:354
For practitioners	I think because there are so many different guides out there but similarly, I think it can be quite confusing as well so if we stuck to the same thing [it would] make things easier. Female, RMN, OH 011: FGB4:34

ii) Deliver it at the worksite

One former service user in the focus groups introduced the idea that the intervention could be 'delivered in the workplace' as a Training Programme perhaps as part of the health and safety strategy for staff. He suggested that Treatment Programmes are 'remote' from the workplace and to some extent 'separates [employees] an awful lot from the daily life of their work' if the only way to access therapy is when employees are symptomatic and off sick. This means that learning is not necessarily 'integrated' in the workplace. In addition, Training Programmes are less 'frightening' compared to 'group therapies' delivered in 'institutional' settings.

One former service user in the planning focus groups also thought that although:

> *…there are health and safety workers but they are only looking at physical health and whether it's a dangerous environment physically, there should be health and safety workers who are emotionally trained and who are responsible for checking people's feelings and how, you know how they are feeling in their workplace.*
>
> Female, Former SU, Retired HE Lecturer
> 019:FGA4:206

She blamed 'untrained managers' for 'so much misery in workplaces', and thought they needed more training. Another former service user said training 'the person that's not depressed as well', the 'middle manager' or those 'in an executive role' or with a 'higher responsibility' might help them to understand better stress and mental health which might have a positive impact on the person themselves as well as their subordinates.

Another service user agreed that it could act to prevent mental health problems if delivered to a 'relatively healthy population' or to a 'self-selecting' population who needed extra support to cope with stress. However, there were concerns about confidentiality and reluctance 'to start disclosing stuff in front of work colleagues' because of the lack of 'anonymity'.

Some of these ideas are supported by concerns raised in the planning focus groups. Unexpectedly, frontline staff and managers focused on whether the group could be accessed by employees of the NHS Trust because they perceived a high demand with the staff counselling service 'inundated' with referrals. Two OH practitioners corroborated the perception of high stress and stress-related absenteeism in public services such as the NHS or Local Authorities speaking of 'a huge amount of people off sick'. In addition, one manager highlighted lack of disclosure as a potential barrier: 'I guess there's a hell of a lot of people within this organisation who have got mental health problems and they don't come forward'. Delivering the new intervention at the worksite for all employees might extend its reach because disclosure would not be necessary.

In response to the concern that staff working in public services might not want to disclose work-related stress, one practitioner stated. 'It's why we run reflective practice groups within our Trust; I mean that is … trying to reduce stress, most of the things talked about is [stress]'.

However, concerns were expressed by one frontline manager about stigma and that therefore how the programme was 'named' was important. If employees perceive it as 'therapy', they may feel as if this suggests they have a 'fundamental deficit' so that help may have to be delivered under 'another guise'. He anticipated problems in staff volunteering to undertake a Treatment Programme if it meant they needed a formal referral through mental health services because 'I could not see my staff coming forward to take this up if it involved a CPA process'. For a start, accessing a Treatment Programme would require disclosure which he termed following 'the confessional sort of pathway so to speak' or 'through a conventional route because then you have a diagnosis', both of which are significant barriers for employees accessing help for work-related stress and mental health problems.

Other practitioners and managers expressed concern that staff might feel uncomfortable accessing group therapies because of the likelihood that they would be treated alongside colleagues or service users and a perception that they have different needs to service users. One manager thought that it 'would be different with staff I suppose so again I don't know whether the same thing looking at them because actually, it's different isn't it, if it's for staff', and two OH practitioners also thought that a 'sticking point' was staff not wanting to join with service users in a group-based intervention because it 'could cause an issue, for both parties'.

However, one practitioner thought that employees might find that a Treatment Programme delivered in the workplace might actually reduce some barriers. One service user saw the value in employees gaining understanding about work-related stress and mental health

problems alongside managers. The planning focus groups also emphasised the need for everybody in the workplace including line managers to receive training to raise awareness about the difficulties that someone with mental health is likely to encounter in getting along and getting ahead at work, and to develop 'emotional intelligence' and 'soft skills' which might improve the culture of the organisation as well.

Table 40 - Deliver it at the worksite

Theme	Illustrative quote
Could reach more people	If it's all in one go then it separates them an awful lot from the daily life of their work, so it's not actually given in the workplace. Male, Former SU, Traffic Manager LA 027:FGC2:254
Some workers will not disclose / share	Obviously when I was in a group with, once again, we don't know each other, there is anonymity. I would reveal that, but to work colleagues, there's no way. Male, Former SU, Financial Manager LA, Union Rep 028:FGC2:298
Might prevent work-related stress	We're starting to do a lot of work with teams now …so we're actually going in and recommending that managers carry these out [HSE assessments] with their staff members and then we will come in once the results have been numerated and then we can look at the main problem areas and figure out ways to sort of address those. Female, RMN, OH 011:FGB4:58
Could come under 'health & safety'	I think if it's delivered in the workplace, we get presentations on health and safety; we get presentations on stress awareness. This becomes another part of that, de-stigmatises it. Makes people think about trying to catch it early, when they start to feel this and recognise it in themselves, and look for help early. Male, Former SU, Traffic Manager LA 027:FGC2:262
Everyone in the workplace needs more knowledge and skills about mental health	But managers being trained how to deal properly with workers…I mean I just see so much misery in work places which is unnecessary because of untrained poor managers….. Female, Former SU, Retired HE Lecturer 019:FGA3:1027

iii) Make it peer-led

If the new intervention was re-designed as a Training (and staff support) Programme, it could be delivered by employees who have experienced therapy for mental health problems and trained in co-facilitation because they will better understand how stressed employees are feeling and their ambivalence about seeking and accepting help.

Some of the former service-users agreed that a peer support worker 'could be very valuable, you will get quite different conversations between a [peer] support worker and the group' whilst others were concerned that:

…that kind of thing could get on my nerves, people sat there telling their bloody stories and how wonderful everything is… I've heard it all before… I'm sick of hearing this and that. I just want to sort myself out… not everybody wants to sit there and want to hear everybody's bloody story. No offence. It's not personal.

Female, Former SU, Bank Worker
024:FGA3:652

Nevertheless, the majority agreed that in a group-based intervention, a peer could be 'just somebody who is fulfilling a different role', and that 'it can help; you can feel better as well. You can put a hand out and help a fellow sufferer. I feel better for it as well'.

Two service-users wanted to be involved as peer facilitators in delivering the intervention because they might be able to use their experience of depression, stress and trauma to benefit others.

Table 39- Make it peer-led

Theme	Illustrative quote
Others can identify / trust more in a peer	I would like to give back what I've suffered because I think you have to go through something like I did to really understand it. I think they would offer more support because they would understand better. Female, Former SU, Parent 023:FGA3:540
Might be good for one's own recovery	I think a group where you have got people that have got these things in common validate each other's experiences in a way that sometimes Clinicians, Doctors, Nurses, all respected….but that they might not you know they sort of see symptoms and missing the negative stuff where your peers can recognise and validate your experiences and that is a very important thing. Male, Service user representative, HTPFT 025:FGA4:180

4.5 CRITIQUE OF THE RESULTS

Although the participation of former service-users and frontline staff was a central element in the overall study, the research is limited in tackling issues of power and control, and issues of inequality and discrimination, in healthcare and in the workplace since the focus is mainly on the psychological treatment of individual clients. Nevertheless, psychotherapists should be aware of how these issues may affect people with recurrent depression, and how they impact on employment.

The feasibility study had a small sample, and a within-groups single-case research design with a paired t-test was used to compare paired samples with the client acting as their own control. Small samples, even (n = 1), are sufficient in a single case experimental design with repeated and frequent measures.

Another strong point of this study is that it collected outcome data about possible mediator variables such as coping self-efficacy and quality of life. Case vignettes were provided to add context to the quantitative data.

The focus groups were informed by an appropriate theoretical and practical understanding of the methodology. This led to effective setting up and running of eight planning focus group involving 28 participants and two reviewing focus groups involving eight participants. Skilled moderation generated animated discussion which provided the author with rich data. In addition, focus groups are often used in service development projects, and are therefore compatible with the aims of a practice doctorate.

This piloting phase was undertaken thoroughly, employing critiqued evidence on effective cognitive-behavioural treatment of recurrent depression (Jobst *et al*. 2016), up-to-date clinical guidance (NICE, 2009), and applying current MRC guidance (Moore *et al*. 2015; Craig *et al*. 2008; Campbell *et al.* 2000). Recruitment was partially successful in that information was gathered that could inform a potentially successful strategy for a future RCT i.e. direct referrals from a clinician with whom there is an established relationship such as a Care Coordinator or Consultant Psychiatrist.

Attrition was low once clients had been engaged in the treatment which supports the use of different outreach and crisis contingency strategies.

The results are presented comprehensively and transparently and comply with the CReDECI reporting recommendations (Möhler *et al*. 2015).

Quantitative data was analysed using an appropriate statistical test, and the results were reported in full. Qualitative data was also presented in the form of written feedback to evaluate the acceptability and accessibility of the intervention to clients and the co-facilitator.

4.6 SUMMARY

Overall, it is feasible to implement and evaluate the new intervention in practice as a Treatment Programme. Re-designing the intervention and modifying the programme theory so that it could be delivered upstream by peers as a Training (and staff support) Programme informed by relational group-CBT at the worksite might make it more acceptable and more accessible.

5 DISCUSSION

5.1 INTRODUCTION

Many employees in the UK experience moderate-severe depression during their working lives and some will be at risk of relapse and recurrence (see Chapter 1). Current interventions are inadequate in helping them maintain employment. No studies into psychotherapeutic interventions specifically designed to enhance job retention in employees with moderate-severe recurrent depression were identified in the literature review (Chapter 2). Thus, this research had two main aims: to design a theory-driven psychotherapeutic intervention that would alleviate symptoms of moderate-severe recurrent depression and enhance job retention; and to test the feasibility of implementing and evaluating the new intervention in a real-world setting. The design process used MRC guidance as best practice in developing and evaluating complex interventions.

5.1.1 Structure of the chapter

This chapter discusses the study findings relating to the original research questions in five sections.

1. The **modelling stage**: considering the findings from stakeholder focus groups regarding what might be helpful in terms of the intervention design (Active Ingredients) and the programme theory (Mechanisms of Change).
2. The **piloting stage**: considering possible reasons for the difficulty in recruiting a representative sample. It then examines the choice of outcome measures; data collection methods, and missing data; and the resources required. It explores different explanations for the new intervention's high treatment completion and session attendance rates. The study outcomes are interpreted in terms of what the preliminary responses of clients signify with regard to 'what works for whom in what circumstances and in what respects, and how?'(Pawson & Tilley, 2004 p.v).
3. The **re-modelling stage**: considering what might be helpful in improving the new intervention taking into consideration users' and stakeholders' views. Subsequently, a modified intervention design and a refined programme theory are proposed to improve acceptability and accessibility.
4. The chapter will conclude with a **Critique of the Discussion** by appraising how the findings add to the existing literature. It will then weigh up the limitations and strengths of the overall study. The chapter ends with a **Summary**.

5.2 MODELLING STAGE

The reporting of complex interventions has frequently been criticised because there is a lack of information about *what* interventions do, *how* they do it, and *why* are they supposed to work (Mikkelsen & Rosholm, 2018). The development of complex interventions demands clear specification of the intervention design and the programme theory (Moore *et al*. 2015).

Importantly, this study consulted widely with several former service-users, frontline practitioners and managers, most of whom had experience of receiving/providing group CBT in secondary mental healthcare, or experience of job retention interventions within the last two years. Therefore they offered informed suggestions and ideas relating to the design of the new intervention.

5.2.1 Active ingredients

Primary analysis and interpretation of the data from focus groups involving former service-users resulted in a list of active ingredients.

5.2.1.1 Triple foci of therapy

Former service-users suggested the new intervention should target presenting problems such as symptoms of depression, work problems such as occupational stress, and underlying problems such as past trauma, in recognition of the fact that clients in secondary mental healthcare often have multiple disorders, multiple problems, potentially high risks, and complex comorbidities.

5.2.1.2 Three inter-dependent outcomes

Former service-users suggested the new intervention should improve clinical status, work status and inter-personal functioning, and although they thought treating depression should be the priority, they also thought that these outcomes were inter-dependent.

5.2.1.3 Group format

Former service-users suggested the new intervention should use a group format to create an enabling context for acquiring, consolidating and applying basic CBT concepts and skills. They suggested a fixed-term closed group, delivered as twelve full-day sessions over a period of three months, with no more than eight group members and two co-facilitators.

5.2.1.4 Facilitation of peer interaction

Former service-users suggested the new intervention should facilitate peer interaction, with the leader setting up opportunities for clients to take on the ‘therapist’s role’ for each other in reciprocating pairs, to practice skills in triads, and to ‘open up’ in small groups.

5.2.2 Conclusions

Most of these active ingredients are unique to the new intervention. None of the relevant interventions included in the effectiveness review (see Chapter 2) focused explicitly on all three problems, and none explicitly aimed to improve all three outcomes. Only one study included CBT delivered in a group format (Schoenbaum *et al*. 2002), but results were aggregated with 1:1 CBT. The manual of the GCBT intervention (Muñoz & Miranda, 2000) showed that there was limited time for group discussion or peer interaction.

5.2.3 Mechanisms of change

The planning focus groups provided data that were mined for evidence of what would be helpful in the design of a new psychotherapeutic intervention using a realist evaluation approach. Six 'candidate mechanisms' of change that might enhance job retention in employees with moderate-severe recurrent depression were made visible and subsequently operationalised. Activation of one or more of the six hypothesised mechanisms could be accelerated and optimised in the context of group psychotherapy via the skilful facilitation of peer interaction. This requires the leader to create opportunities for peer learning, peer feedback and peer support.

Taking on the role of peer facilitator was envisaged by some former service-users who wanted to use their experience of stress, trauma, and depression, and learning how to manage it, to help others. Moreover, service-users thought that their peers were a more credible source of learning, feedback and support because they shared the experience of trying to maintain employment while depressed.

5.2.3.1 Realise

Clients discussed how their symptoms impact their home, social and work lives. Opportunities were set up for group members to become more self-aware, and resources were provided, such as exploratory, expressive and experiential exercises (Appendix 67).

5.2.3.2 Reflect

Clients were asked to record 'here and now' situational triggers and how they responded in terms of 'inner me' experience (thoughts, feelings) and 'outer me' expression (verbal and non-verbal behaviour), and how others responded. In pairs, clients were encouraged to ask probing questions rather than just agree with how their partner interprets situations, and this process may have revealed different perspectives on themselves, others and the world. Resources were provided such as the 'Double Donut' and 'Telling my Story' exercises (Appendix 67).

5.2.3.3 Regulate

A non-threatening and secure context was created by asking clients to abide by group guidelines such as zero tolerance of offensive language (Appendix 37), and by gradually exposing group members to potentially triggering inter-personal situations in vivo, such as activities involving joint exploration and expression. Group members took turns to speak and to listen, assuming the role of therapist in reciprocating pairs, focusing on their partner, and offering each other emotional support in small groups. They were also encouraged to share their thoughts and feelings, and to understand, accept, validate, and soothe each other. Resources were provided such as 'animal metaphor' cards (Appendix 67), and the provision of audio-recordings of progressive muscular relaxation, abdominal breathing, mindfulness meditation, and videos explaining basic neuroscience.

5.2.3.4 Resolve

Clients helped each other to review and plan goals in pairs at the beginning and end of each session. Group members were asked to use a coaching approach to reinforce every small step and to report back in plenary what their partner had learned. Group members were also expected to express a range of views, explore similarities and differences, correct misunderstandings, and seek mutual understanding. Resources were provided such as the 'Yes/No debate' exercise and prescribed within- and between-session targets such as 'asking for help'; 'disagreeing with someone'; 'saying sorry'; or 'accepting a compliment' (Appendix 67).

5.2.3.5 Relate

Clients made personal disclosures and listened to others as a way of deepening relationships within the group, commenting on what others said and did, and letting others know what impact they were having. Resources were provided such as Gestalt-type activities e.g. 'empty chair', role-play, re-scripting, writing 'letters' to significant others, therapeutic journaling, 'The Hot Seat' exercise, as well as in vivo training in the twelve building blocks of 'good conversation' (Appendix 67).

5.2.3.6 Retain

Each client was prescribed a weekly job retention goal as part of their care plan. Clients could also access 1:1 Occupational Therapy which involved employment support and low-key liaison with the workplace. Occupational analysis could be undertaken if required to assess what needed to change in terms of 'the worker, their work, and the workplace' (Cameron *et al*. 2012). Resources were provided such as the book '*Overcoming your Workplace Stress: a self-help guide'* (Bamber, 2011).

5.2.4 Conclusions

The most likely explanation for the findings related to mechanisms of change is that realist evaluation allowed the researcher to dig deeper into former service-users' views. This involved identifying resources that need to be supplied as part of the new intervention and identifying a reasoning process whereby clients might choose a different way of thinking, saying, doing.

They also emphasised the importance of peers in recovery. The literature suggests that promoting self-help in a peer-support group as a form of indirect autonomy-respecting help (Ellerman, 2007) may be more efficacious than providing direct autonomy-eroding help through 1:1 psychotherapy, for example. The idea is that 'helping people help themselves' has influenced the 'people-powered health' movement recommended as a self-management strategy for chronic conditions such as recurrent depression (De Silva, 2011).

Describing an 'experts-by-experience' approach to mental health in the workplace, (van Haaster, 2013 p.43):

> *There is an increasing attention for self-help and mutual support in recovery. Service-users are taking responsibility for their own health and lifestyles and are not so dependent on the demands of professionals. Service-users rely more and more on their own knowledge and expertise.*

Involving unqualified people to help each other is supported by research into the comparative effectiveness on depression outcomes of peer-led interventions delivered by volunteers or paid lay people, which shows that they can be as effective as interventions delivered by paraprofessionals (Bellamy *et al*. 2017; Vally & Abrahams, 2016; Parmenter *et al*. 2015; Fuhr *et al*., 2014), and by qualified psychologists or psychotherapists (Bryan & Arkowitz, 2015). Peer support interventions can achieve a reduction in depressive symptoms superior to CAU, and comparable to group-CBT (Pfeiffer *et al*. 2011; Bryan & Arkowitz, 2015).

There are several theories about how peer support benefits people with depression. For example, Dennis (2003) found that there are direct effects such as decreasing isolation; increasing the exchange of health and self-management information; a buffering effect that reduces the impact of stressors; and a mediating effect of providing positive role models. Similarly, a qualitative study found that the quality of the communication and interaction amongst peers offered them a form of 'healing' that they did not get from formal services such as psychiatry or psychotherapy, mainly because practitioners do not reveal if they have ever experienced mental health problems (Behler *et al*. 2017). In some cases, the group helped users become 'informed consumers' of services; in others the group was 'an adequate substitute' for specialist services because it was more consistent and open-ended.

In conclusion, the most likely explanation for these findings is that former service-users were able to talk about their experience of participating in CBT groups, and were able to explain what aspects were most helpful.

5.3 PILOTING STAGE

Piloting provided a wealth of outcome and process data. Many lessons were learned and the challenges of running a research study in the real world of clinical practice were identified. This section discusses how these findings can be understood and addressed in the conduct of a definitive trial.

5.3.1 Difficulty recruiting a representative sample

It had been hoped to recruit at least 16 clients, with half allocated to the new intervention group and the other half to a control CAU group so that the randomisation procedures could be tested, but this was not possible. Demand was lower than expected and there were no direct referrals at first.

This section will discuss what influences clinicians' decisions to refer or not, and what might therefore account for the low rate of recruitment.

5.3.1.1 Factors influencing clinicians' decisions to refer

A culture resistant to research has been identified in mental health services perhaps because research is a low priority when services are being cut (Borschmann *et al.* 2014 p10). Clinicians may refer only clients they think might benefit from psychotherapy (Collins & Corna, 2018), and this may be subject to unconscious bias, such as not referring fewer men (Talbot *et al*. 2014). Clinicians may have negative attitudes to psychotherapy (Denman, 2007), and prefer to treat some clients with ADM and supportive counselling (Stavrou *et al*. 2009).

5.3.1.2 Factors influencing clients' decisions to participate or not

There are several possible reasons why clients did not take up the offer of therapy after assessment, including objections to randomisation or the study design; changes in their circumstances; starting other treatment; and changes in their symptoms (Knekt *et al.* 2008) . The literature suggests that some clients would never consider taking part in research; some think they are ineligible, or that they do not need therapy; or that there are disadvantages to taking part in depression trials (Hughes-Morley, 2017). Clients may be put off by lengthy leaflets (Locock & Smith, 2011); some may not be able to access necessary travel expenses or childcare (Woodall *et al*. 2010); or may have had previous negative experience of CBT (Barnes *et al*. 2012). Some may have preferred a different modality (Seidler *et al*. 2018; Liddon *et al*. 2018), while others will try anything to relieve their suffering (Simmonds *et al*. 2013), and some participate in research for altruistic reasons (Tallon *et al.* 2011).

In most cases, clients prefer 1:1 psychotherapy over group psychotherapy (Haugh *et al.* 2019; Strauss *et al.* 2015), due to worries about confidentiality, fear of being criticised, or of losing control in front of other people (Piper, 2008). Positive attitudes towards group-based interventions are influenced by expectations such as knowing that others have similar problems, hearing many different ideas and opinions, and receiving feedback from others that enhances self-understanding (Shechtman & Kiezel, 2017).

Some studies have been able to recruit equal numbers of men and women (Gelhart *et al*. 2002), but men may be reluctant to participate in psychotherapy due to masculine gender norms such as stoicism, and coping strategies such as self-reliance (Seidler *et al*. 2016). Group-based interventions may be challenging for men due to a sense of shame (House *et al.* 2018). In mental healthcare services, men are over-represented at management levels and under-represented in the direct provision of care. This raises the question of whether 'feminised' services are 'likely to be off-putting for men' (Morison *et al*. 2014).

5.3.2 Conclusions

The most likely explanation for the findings related to recruitment is that clinicians and clients need to be convinced that participating in a research study is likely to benefit both client and/or service. Clients on the waiting list were under no pressure from referring clinicians to participate, and it was probably easier to persuade clients when they were seen face-to-face for assessment in the CMHT.

5.3.3 Choice of outcome measures, data collection methods, and missing data

Overall, the study procedures were tolerated. No problems were encountered in collecting self-rated measures during the intervention, but collecting and interpreting the clinician-rated primary outcome measure was more problematic. Data completeness was high during the Treatment Programme, but was compromised by three women not returning follow-up data.

This section will discuss differences between the depression instruments considered in this section, use of 'phone administration and difficulties collecting postal questionnaires.

5.3.3.1 Difference between HAM-D and BDI-II

For the group as a whole, there was no change in the HAM-D mean score from baseline and end of treatment. However, there was a significant change in the BDI II mean score values. There are several possible reasons for the discrepancy. The independent outcome assessors (OAs) were graduate voluntary psychology assistants with limited experience in mental health. Unfortunately, the planned online training in HAM-D administration was not available. Thus, the discrepancy may have been because the OAs did not receive adequate

training in administering the instrument. Inter-rater reliability is better with training (Rosen, *et al*., 2008), and ideally raters should be trained clinicians (Hamilton, 1960).

Alternatively, the HAM-D was designed to pick up a change in somatic symptoms (Hamilton, 1960), whereas the BDI-II was designed to pick up change in affective and cognitive symptoms (Beck *et al*. 1961). Lower scores on the HAM-D may have been due to clients' physical health problems manifesting more on the HAM-D.

Then again, the discrepancy may have been because clients under-reported on the self-rated BDI-II, perhaps because the data collection process involved the author directly. Previous research has shown that the influence of social desirability often leads middle-aged and older people to 'fake good' on self-report measures of mood and personality (Soubelet & Salthouse, 2011).

The HAM-D scores may have been inaccurate due to 'phone administration. However, other research shows that 'phone assessments can yield data equivalent to face-to-face assessments for depression (Rohde *et al*. 1997). It is possible that mean scores on the BDI-II may have been confounded by an outlier who scored worse at every time point on all the measures. The literature suggests that some clients who score lower levels of distress on self-rated instruments at baseline because of 'perceptual difficulties in the face of their own psychic strain', score higher levels of distress at the end of treatment because therapy has helped them to 'recognise their own symptomatic complaints better' (Haase *et al.* 2008 p.622).

5.3.3.2 Phone administration

There was a high rate of missing data for the HAM-D. There are several possible reasons for the problems in collecting data over the 'phone. Clients were not at home, or may have found OAs ringing them inconvenient or intrusive, especially if other family members were present. However, other research shows that collecting questionnaire data over the 'phone is acceptable (Simon *et al.* 1993; Aneshensel *et al*. 1982). In any case, the administration of the HAM-D is time-consuming and may have been burdensome to clients (D'Avanzato & Zimmerman, 2017).

5.3.3.3 Postal questionnaires

Only five clients returned questionnaires at 12 weeks follow-up. The loss to follow-up increases the risk of selection bias. There are several possible reasons for the difficulty in collecting this data. Clients symptoms may have improved (Nakash, 2007), or they may have relapsed (Higgins & Green, 2011). The literature suggests that for pregnant women with depression, those who were educated, single or with difficulties in their relationships showed a higher degree of commitment to complete all study procedures, while those who were

unemployed or with low educational attainment were less likely to provide follow-up data (Lara *et al.* 2010).

Clients may have different motivations for returning postal questionnaires. The literature suggests that clients might be 'reluctant' or 'unhappy' non-responders (Nakash, 2007), giving various reasons for not returning the questionnaire, such as being 'forgetful', 'lazy' or 'disorganised'. Clients are often unaware that follow-up data is important (Kearney *et al*. 2018). Alternatively, researchers may have lost sight of participants' lived experience and the reality of the problems they were facing (Richard *et al.* 2017 p.8) and that thus postal questionnaires may not be the best way of gathering follow-up data. 'Phone calls (Claassen *et al*. 2009) and home visits (Lara *et al*. 2010) have been shown to maximise data completeness in some longitudinal studies.

5.3.4 Conclusions

In conclusion, the HAM-D captures different but important information on the BDI-II. Although it is possible to administer the HAM-D over the 'phone, this needs to be done flexibly at the client's convenience. Three clients disengaged from the study, possibly because the Treatment Programme had ended, or they did not realise the importance of follow-up data.

5.3.5 Resources required

It was possible to outline the resources required and the direct costs of delivering the Treatment Programme, and to collect data about healthcare utilisation and prescription medication (for mental health disorders), and receipt of welfare benefits.

The direct costs of delivering the intervention were relatively high. This section will discuss the resources required in comparison to the costs of other treatment programmes in primary and secondary mental healthcare, and how this might limit the feasibility of the new intervention. Consideration will be given to what additional data should be collected for assessment of cost-effectiveness in any further research.

5.3.5.1 Direct costs

The mean total cost per client was estimated at £6,457.12 (Appendix 63), which compares to £2,895 per average course of treatment for people with mild-moderate symptoms in IAPT (Radhakrishnan *et al.* 2013), and £4,418 for a complete course of 1:1 CBT (16 sessions plus 2 booster sessions) as a mono-therapy for people with moderate-severe depression in secondary mental healthcare (Koeser *et al*. 2015).

The reason that the new intervention was so expensive was that it was multi-modal and delivered by a Cognitive Behavioural Therapist and an Occupational Therapist. It also provided a high and concentrated dose of therapy. Many clients in CMHTs need a high dose (usually delivered over a longer period), and most clients remain on the caseloads of CMHTs for between 1-5 years (CQC, 2017). However, there is a risk of dependency and sometimes termination of longer-term psychosocial intervention in CMHTs proves difficult (Koekkoek, *et al*. 2019). The risk of dependency is mitigated in a fixed-term group-based intervention such as the Treatment Programme that relies on peer effects.

Establishing more symmetrical roles between practitioners and clients, encouraging clients take on the therapist role in reciprocating pairs (Bonavigo *et al*. 2016), and using time-limited interventions (Koekkoek *et al.* 2019) reduces the risk of dependency. Likewise, using a 'patient activation' approach by which clients learn how to better manage chronic health condition can reduce demand for NHS services (Hibbard & Gilburt, 2014).

However, the literature suggests that involving two practitioners is labour-intensive, and senior NHS managers worry about the upfront costs and demands on staff when resources are stretched 'within fragile financial infrastructures' (Herschell *et al*. 2009). Likewise, one of the major 'blocks' to implementation, according to the Structured Assessment of Feasibility (SAFE) tool, is the requirement for additional human and material resources (Bird, *et al.* 2014) (Appendix 68). Other blocks are that training is required to deliver the new intervention; it is time-consuming to provide; and it is quite complex. Facilitators would require additional monthly supervision sessions; and more than one member of the multidisciplinary team (MDT) would be involved in providing the intervention, although no professionals not in the standard MDT are required. Despite several 'enablers', most blocks to implementation were scored as 'yes' or 'partial', which suggest limited feasibility for the new intervention in NHS secondary mental healthcare services.

Equally, driving down the cost by reducing the dose and shortening the length of the Treatment Programme as a whole might make an intervention cheaper, but not necessarily more cost-effective, as it is possible that interventions are not long enough or focused enough may raise re-referral and readmission rates. The literature suggests that providing a high dose of therapy lessens the 'revolving door' phenomenon that occurs when clients relapse (Bouras *et al*. 2018; Lousada *et al*. 2015). Others argue that using a stepped-care approach makes the best use of limited resources (Fenger *et al*. 2011), although assessing clients' need and complexity is not straightforward (Delgadillo *et al*. 2017; Goddard *et al*. 2015).

5.3.5.2 Indirect costs

Estimating cost-effectiveness in a future trial would require clients to give consent for researchers to collect data on indirect costs. This study shows that clients are willing to share information about how much contact they had with other healthcare practitioners for physical and mental health problems, which was surprisingly high. The literature suggests that clients receiving CBT may incur a higher spend on other health services compared to clients receiving TAU, perhaps because they are encouraged to take better care of their physical health as well as their mental health (Holman *et al*. 2011).

Some of these contacts were probably unnecessary 'monitoring' visits (Lin *et al.* 2018), which is responsible for wasted capacity and duplication in the healthcare system. A collaborative care approach (Shah, 2017) is recommended in NICE depression guidelines (NICE, 2009b) and might eliminate waste. A single-site multi-modal approach was recommended for work-focused psychotherapeutic interventions, and this might overcome difficulties with inter-disciplinary communication (Robinson & Raine, 2010; Cameron *et al*. 2012b).

5.3.6 Conclusions

The most likely explanation for the findings related to the resources required is that co-facilitation is costly but necessary, as is a high dose of therapy. Clients did not seem to mind sharing information about indirect costs. Concurrent mental healthcare provided by GPs and OHPs may confound the impact of the results, so needs to be addressed as a contextual factor.

5.3.7 High treatment completion and session attendance rates

It was possible to deliver the new intervention with zero attrition and high adherence. Where practitioners in the planning focus group assumed that clients with depression would find full-day sessions unacceptable, in practice clients were able to tolerate a high and concentrated dose of therapy.

Although the sample was small, the finding that all clients persisted with treatment despite various barriers (Barrett *et al.* 2008), contradicts the pooled results from a review comparing outcomes for 1:1 CBT and group-CBT (Hans & Hiller, 2013) which found that overall approximately 25% of all participants dropped out of CBT. The attrition rate was twice as high for 1:1 CBT compared to group-CBT, and the researchers hypothesised that this might be because group-CBT programmes generally have fewer sessions. However, another study found that the type and format of therapy do not affect drop-out rates (Swift & Greenberg, 2012). These results also compare favourably to other psychotherapeutic interventions where attrition rates are high. For CBT outpatients in 1:1 psychotherapy drop-out is approximately

40% (Bados *et al.* 2007); 25% for chronically depressed clients (Arnow *et al.* 2007); and 50% for group-CBT for mood disorders (Oei & Kazmierczak, 1997).

This section will discuss the range of factors influencing clients' decisions to attend.

- *Client factors*

Client demographics associated with significantly lower drop-out rates include clients who are female, more educated, and married or in a committed relationship, whilst the client's race or employment status does not predict drop-out (Swift & Greenberg, 2012). Younger people tend to miss more psychotherapy appointments, and tend to drop-out more, whilst older married or cohabiting people are more likely to complete treatment (Fenger *et al.* 2011). Low socio-economic status, low educational attainment and unemployment consistently predict both drop-out and no-shows, whilst people on sick leave tend to show up more for appointments, perhaps because they do not have to take time off work to attend (Fenger *et al.* 2011).

Clients with more chronic forms of depression are more likely to complete psychological or pharmacological treatment, possibly in the hope that it will bring relief (Fournier *et al.* 2009). People with mild levels of distress and those with high levels of distress miss more sessions than those with moderate levels of distress (Fenger *et al.* 2011). However, researchers have questioned whether high levels of treatment adherence may mask an unhelpfully submissive and compliant relationship with service-providers (Chase *et al.* 2012). Even though these clients seldom miss appointments and do not drop-out despite feeling there is 'no perceived benefit', the majority are only superficially engaged (p.581)

- *Practitioner factors*

A strong therapeutic alliance helps to maintain clients in therapy, and trust between individual clients and the therapist may be strengthened by incorporating four 1:1 ideographic formulation sessions. These sessions also allowed for a personalised care plan to be developed, considering comorbidities. The literature suggests that retention is often due to a 'good fit' between the client and the intervention, and that a 'one-size-fits-all' approach is unhelpful (Carroll & Nuro, 2002).

- *Intervention factors*

It might be that none of the clients dropped out because the new intervention adhered to recognised best practice in secondary mental healthcare services. The care pathway complied with the Trust's Care Programme Approach (CPA) policy and included holistic assessment, risk management, crisis contingency, relapse prevention and discharge planning.

On the other hand, the use of various engagement, motivational, and commitment strategies may have been responsible for the high treatment completion and session attendance rates in this study. Case tracking allowed for early detection of any increase in distress, self-harm or suicidality, or problems in the therapeutic alliance (Whipple *et al.* 2003). The literature suggests that providing feedback to therapists about clients at risk of treatment failure can help to maintain clients in therapy (Rubel *et al*. 2015). Moreover, an outreach approach was used to address leader-member and member-member problems by working through 'rupture-repair' cycles (Safran *et al.* 2001). The author also reminded clients about upcoming sessions and positively reinforced their attendance. Clients were encouraged to text if they were likely to be late or absent. After any missed sessions, they were contacted by text and gently encouraged to attend the next session, and offered a 'phone call if needed.

The literature suggests that text messages improve attendance at clinical appointments including initial psychotherapy and ongoing psychiatry appointments (Schwebel & Larimer, 2018; Boksmati *et al*. 2016). Conversely, DNA rates for both IAPT assessment and ongoing appointment are lowest in the 'phone with reminder' group compared to the 'letter only' group or 'phone call only' group (Pennington *et al.* 2012).

The new intervention set aside time for clients to bond and for a sense of 'group cohesion' to develop. In group psychotherapy, the leader is responsible for creating a climate of openness, safety, and belongingness (Burlingame *et al.* 2018). Some groups support psychological well-being if they are perceived as 'a safe haven and secure base' because this improves members' sense of attachment security (Mikulincer & Shaver, 2017).

5.3.8 Conclusions

The most likely explanation for the findings related to treatment completion and session attendance rates are that risk of drop-out was identified early through various methods of case tracking; different strategies were used to enhance engagement; group cohesion was created by the skilful facilitation of peer interaction; and the therapeutic alliance was strengthened by incorporating 1:1 sessions before and during group sessions.

5.3.9 Preliminary response

Group scores suggested that the new intervention might be an effective treatment for moderate-severe recurrent depression in some employees. However, not everyone benefitted. In-depth information about each client is presented as case vignettes (Appendix 28).

This study used a critical realist approach (Pawson & Tilley, 2004) to clarify prognostic factors (who is most at risk) and prescriptive factors (what intervention or component is best for which client). Variance in outcomes may reveal important contextual factors that may

moderate the effect of the new intervention on outcomes. This section will discuss potentially enabling and disabling contexts. It will also consider the range of factors influencing clients' response.

5.3.9.1 Enabling contexts

- *Client factors*

The four women who achieved remission were in stable, committed relationships, and this context may have had a beneficial effect both on their mental health and their capacity to work. The literature suggests that, for women, being married or cohabiting is associated with a better outcome in therapy (Meyers *et al*. 2002; Thase *et al*. 1992), and better job satisfaction and engagement at work (Burnett *et al*. 2012).

All clients' scores on the Coping Self-Efficacy Scale (CSES) improved during the Treatment Programme, although only three clients reached the 'healthy' range. The literature suggests that baseline scores on the CSES $\leq$104 predict non-response to CBT for depression, especially for clients with more severe depressive symptoms at baseline (Stiles-Shields *et al*. 2015). However, the usefulness of CBT skills at the end of treatment is associated with higher coping self-efficacy and is a better predictor of outcome in CBT for depression (Miner *et al.* 2015). This finding raises an important question as to whether improvement in coping self-efficacy is the pivotal mechanism of change in relational group-CBT.

It could be that some clients appeared to get better because they attended sessions and participated fully in the exercises and activities. Adherence was also assessed by examining every client's goal review forms, which showed that at least one out-of-session assignments was completed by most clients. Between-session goals were supplemented with in-session goals to overcome potential difficulties with homework, as highlighted by former service-users in the focus groups. Goals were personalised because quality rather than quantity of homework is an important moderator of outcome (Kazantzis *et al.* 2016). The literature suggests that assignments that particularly target skill acquisition are not just a way of changing behaviour, but a way of changing beliefs (Kazantzis *et al.* 2016), and that clients who undertake more between-session assignments in CBT show better outcomes (Flach *et al*. 2015).

- *Practitioner factors*

It could be that some clients appeared to get better because both co-facilitators had worked with CMHT clients for several years. Those that improved may have done so because the co-facilitators used a multi-modal theoretically integrated approach based on an ideographic formulation of each client's problems. The literature suggests that therapists in secondary

mental healthcare need to be highly flexible and experienced to deliver 'practice de facto psychotherapy integration' (Krebs *et al*. 2018), and CBT therapists need 'technical eclecticism' (Norcross *et al*. 2019). Likewise, new conceptual models of psychotherapy suggest it is important to adapt interventions to clients' needs (Norcross *et al*. 2019; Hayes & Hofmann, 2017; Constantino *et al*. 2013).

Another explanation is that both co-facilitators were adequately supervised and adhered to the agreed model using a competency checklist adapted from Scott (2012). Fidelity was monitored by live supervision when a CBT consultant sat in on a group session as an observer, and by the co-facilitators briefing and de-briefing each other before, during and after group sessions with the checklist. The literature suggests that quality assurance of group-based interventions can be achieved by video-recording sessions and rating therapists' behaviours using a validated scale with high inter-rater to identify strengths and weaknesses in the facilitator's competences during the supervision process (Folmo *et al*. 2017). Having two co-facilitators has additional benefits in terms of clinical governance, because they can observe verbal and non-verbal communicative dynamics (leader-member and member-member) in order to mitigate unhelpful interactions (Vandenberghe & Leite, 2018; Hoekstra, 2014).

- *Intervention factors*

The positive response may have been because the new intervention involved close collaboration between a Cognitive Behavioural Therapist and an Occupational Therapist. The literature suggests training OTs in CBT enhances how they apply the Person-Environment-Occupation model in practice and supports collaboration between mental health professionals (Slepecky *et al*. 2017). Extending the skill-set of both practitioners may have been a positive spin-off of joint-working. However, this contrasts with the findings from several studies evaluating the impact of OT on work resumption and depression. At present, the evidence supporting the inclusion of Occupational Therapy Interventions (OTIs) as part of rehabilitation for people with depression is weak (Désiron *et al*. 2011). OT has been used as an adjunctive treatment alongside CAU for employees off sick with work-related mild-moderate depression (Schene *et al*. 2007), and 'highly impaired' employees off sick with work-related moderate-severe depression (Hees *et al*. 2013). Supplementary OT with its on-the-job support showed effectiveness in terms of fulltime work resumption in less impaired employees (Schene *et al*. 2007), and part-time work participation in more impaired employees (Hees *et al*. 2013). The addition of OT with its focus on functioning (Schene *et al*. 2007), and 'work-related coping and self-efficacy' (Hees *et al*. 2013) did not accelerate recovery in less severely depressed employees (Schene *et al*. 2007), but was associated with

longer sustainable remission in more severely depressed employees (Hees et al. 2013). It was concluded that (Schene *et al.* 2007 p.351):

> *The addition of OT to good clinical practice does not improve depression outcome, [but] improves productivity without increasing work stress and is superior to TAU in terms of cost-effectiveness.*

Thus adjunctive OT does not accelerate recovery, but does accelerate work resumption.

- *Organisational factors*

The four women who achieved remission were in skilled or semi-skilled jobs, and this occupational context may have had a beneficial effect both on their mental health and their capacity to work. One possibility is that employees in secure employment and those who have 'good work' (TUC, 2010) are supported in their recovery and less likely to relapse following therapy. The literature suggests that it is important to help clients maintain employment because it has been shown to be a buffer or 'protective factor' for employees at risk of 'severe intractable' symptoms (Heinz *et al*. 2018).

Five women asked for 1:1 employment support and low-key liaison from the OT, and all had a positive work outcome. Most clients reported a degree of occupational stress at baseline, and there was no strong evidence that overall scores on the HSE changed significantly from baseline to end of treatment (see case vignettes). Nevertheless, three of these women maintained their employment in the same job. One client did not ask for help from the OT despite reporting red (urgent action needed) for occupational stress in her job as a part-time social worker at baseline. It is possible that this client did not access OT because she did not believe this would change the organisation she worked for or the nature of the job, which is known to be highly stressful and high turnover (Bowyer & Roe, 2015).

5.3.9.2 Disabling contexts

- *Client factors*

The four women who had a limited or negative response to the new intervention were in unstable relationships (one partner was abusing alcohol; another was unwilling to commit), or with no partner. These contexts may have had a deleterious effect both on their mental health (Whisman, 2001) and their work performance (Burnett *et al*. 2012). The literature suggests that dissatisfaction and discord in marital relationships are associated with worse depression (Whisman *et al*. 2002), and vice versa (Najman *et al.* 2014; Whisman & Uebelacker, 2009). Being single is also a risk factor for a limited or negative response to psychotherapy (Gelhart *et al.* 2002).

Of the clients in unskilled jobs, two had deteriorated with one scoring worse than baseline, and one scoring worse than post-intervention. The literature suggests that between 5-10% of clients receiving psychotherapy deteriorate (Hansen *et al*. 2002), and using the CORE-OM it was found that more than half of the clients receiving psychotherapy in a naturalistic secondary care setting remained unchanged, and about 7% got worse (Mechler & Holmqvist, 2016). Other research suggests that certain socio-demographic factors interact with the length of psychotherapy to predict clinical outcomes (Joutsenniemi *et al*. 2012).

An alternative explanation for this finding is that neither client fully recovered. The literature suggests that risk factors for relapse are experiencing residual symptoms at the end of treatment and having prior episodes of depression (Buckman *et al*. 2018; Bockting *et al.* 2015). For clients who have completed a course of CBT for prior episodes of depression, residual symptoms predicted both short-term relapse and long-term recurrence (Wojnarowski *et al.* 2019). In a study of clients who had completed a 16 or 20-week course of CBT for depression, 9% of those who fully recovered, and 52% of those that partially recovered, relapsed during the 12-month follow-up period (Thase *et al.* 1992). Similarly, age was found to be a predictor of a slower recovery in psychotherapy for depression (Thase *et al.* 1997) . The clients in this study were aged 36-49 years, so a longer duration was probably necessary.

An alternative explanation is that in communities that score high on indices of urban or rural deprivation, residents who present to their GP in distress are often diagnosed with depression and prescribed medication or referred for 'talking therapies' (DeStress Project 2019). These two clients may have been referred to mental health services because the cause of their distress was medicalised and attributed to depression rather than to the 'injustices caused by on-going economic, social and health inequalities' (p.4). Their persistent and residual symptoms may have been poverty-related, and the literature suggests that social care may be more appropriate than healthcare in these contexts (Fenger *et al*., 2011).

Alternatively, a negative response or non-response to treatment may be due to misdiagnosis (Scott, 2018). The heterogeneity of depression means that people reporting similar symptoms are given the same diagnosis even though there are obvious differences in how they experience the illness. It is possible that these two clients had undiagnosed personality disorders, which are independently associated with worse clinical and functional outcomes on completion of treatment (Goddard *et al*. 2015). Another risk factor for relapse is ongoing chronic stress, which both women reported throughout the Treatment Programme and at follow-up. The literature suggests that relapse is more likely when a client with residual symptoms experiences a severe post-treatment negative life event (Harkness *et al*. 2014). Clients in this study reported both 'acute antecedent stressors' such as physical illnesses, pain

and bereavement as well as 'chronic ongoing stressors' such as family conflict, poverty, and discrimination (Tennant, 2002). They also reported a range of 'childhood stressors' such as abuse and neglect. Research shows that when depressed clients live with acute stressors, alleviation of symptoms might be quicker than for clients living with chronic stressors, although both are associated with more frequent relapse and recurrence (Tennant, 2002).

- *Intervention factors*

One explanation for the finding that some clients appeared to get worse is that whilst all of them attending 10 or more sessions and participated fully in within-session exercises, they may not have undertaken the between-session assignments. The literature suggests there are often significant barriers to CBT homework completion (Callan *et al*. 2012) which is one of the contextual factors associated with partial or non-response to CBT (Federici *et al*. 2009). It may be that although the new intervention provided a high and concentrated dose of therapy, the two women who only partially responded and the two women who got worse, probably required a longer duration and/or higher dose of therapy to achieve statistically significant and clinically meaningful change. Clients who have responded to treatment but not fully remitted may subsequently relapse and seek further psychotherapy (Buckman *et al*. 2018), and some clients frequently re-refer themselves which may be due to 'complex environmental, historical, psychological problems' (Cairns, 2014). However, according to the dose-effect model, clients need a higher dose of therapy. The literature suggests some clients need >10 hours of therapy per week over approximately 8 weeks to achieve clinically significant changes (Haase *et al.* 2008).

Alternatively, these two clients may have been resistant or avoidant. The literature suggests that some clients do not do well in psychotherapy (Lambert, 2007) and reach a stalemate where the positives and negatives of being in therapy 'cancel each other out' (De Smet *et al.* 2019 p.7). This situation often presents as non-improvement on the BDI-II when the client feels unable to change because of a sense of the impossibility of anything ever changing, and an ongoing stressful environment, for example (De Smet *et al.* 2019). Likewise, avoidance is a causal factor for non-response in psychotherapy across depressive and anxiety disorders (Meier, 2014). Clients high in avoidance often report intense negative affect across sessions, and are likely to need a longer duration (or higher dose) of therapy (Meier, 2014).

- *Organisational factors*

Employees who are in part-time, insecure jobs, those who have 'bad work' and those who are unemployed are unsupported in their recovery and more likely to be non-responders or to relapse. The literature suggests that in some cases employment may be associated with worse outcomes compared to unemployment (Gelhart *et al*. 2002).

One client was dismissed from her job due to mental health problems while on the waiting list for CBT and was claiming disability benefits at baseline. This client did not access OT, perhaps because she was already receiving employment support through the Work Programme as a condition of her ESA. The other client was working part-time as a cleaner on a permanent contract in an NHS community unit for the elderly. By the end of treatment, she had maintained her employment with only one episode of STSA due to an upset stomach. However, by follow-up she was off sick due to depression and struggling to return to work. It is not clear why this client did not ask for help, but a possible drawback to involving an OT to provide 1:1 employment support and low key liaison with the workplace was that clients who opted for this component had to disclose their mental health problem to their employer, which some may have been unwilling to do. In one study, only 21% of more than 400 people with depression had ever disclosed it or asked their manager for help (Heinz *et al*. 2018).

- *Societal factors*

Another possible contextual factor is that both women were vulnerable by virtue of poverty due to low-paid work or unemployment and inadequate or insecure housing (see case vignettes). The literature suggests that psychotherapy cannot address 'structural factors', complex social problems and vulnerabilities that are not under the client's control, and therefore different interventions or more comprehensive treatment packages may be required (Knapstad *et al*. 2018; Waldegrave, 2009; Holland, 1992) (Appendix 69).

Another factor in one client's continuing unemployment could be the generosity of the social security system in terms of the value of disability benefits, because this influences how likely it is that someone in poor health will leave the workforce permanently (Reeuwijk *et al*. 2017). Likewise, there might have been a perverse incentive for the other to go off sick because she worked as a cleaner for the NHS, which offers better sick pay than most businesses (Boorman, 2009). The literature suggests that large workforces report the highest sickness levels, and the UK public sector (e.g. NHS and local authorities) tend to have higher rates of sickness absence with more stress and higher incidence of mental health problems reported than the private sector (Bevan & Mahdon, 2006).

Better outcomes may have been achieved if the OT component was not an optional extra. In the OT literature, a model of political practice for OTs (PPOT) (Pollard & Kronenberg, 2008 p.3) constructs work an opportunity for 'doing, being, becoming and belonging' that many people with mental and physical disabilities are denied, and addresses inequalities that 'arise from the injustices that surround the conditions of human occupation'.

5.3.10 Conclusions

The most likely explanation for the findings related to clients' preliminary response is that for clients whose self-rated depressive symptoms improved after they completed the Treatment Programme, the new intervention was helpful, met their needs, and addressed their problems to a satisfactory extent. This was because co-facilitators used an integrated and transdiagnostic approach, provided a high dose of therapy, and encouraged adherence to between-sessions assignments. For clients whose self-rated depressive symptoms deteriorated from the start of the Treatment Programme, or after completing it, they may have needed a higher dose or longer course. Or it may be that the new intervention was unhelpful, did not meet their needs, and did not address their problems to a satisfactory extent.

For clients who had a positive work outcome, employment support and low-key liaison provided by an OT may have been a useful component of a work-focused psychotherapeutic intervention. However, it seemed to have limited impact on occupational stress. For clients who did not access OT, it is possible that neither client was motivated to change her work status.

5.4 RE-MODELLING STAGE

Following the piloting stage, data analysis was undertaken to reveal what users and stakeholders thought might be helpful in re-modelling the new intervention.

5.4.1 Improving acceptability

The findings suggest that the new intervention was acceptable to most clients. Descriptive data derived from three measures of acceptability: treatment completion rates, therapeutic alliance, and client satisfaction. This was combined with an analysis of users' written feedback about their overall experience of the Treatment Programme.

5.4.1.1 Treatment completion rates

The new intervention achieved a 100% treatment completion rate. A recent network meta-analysis that used drop-out rates as a proxy for the acceptability of different delivery formats of CBT for depression found that there was no significant difference between 1:1, group and 'phone formats (Cuijpers *et al*. 2019) . Likewise, a meta-analysis evaluating the acceptability of Group Behavioural Activation Therapy found that it had a lower drop-out rate than comparable 1:1 psychotherapies for depression (Simmonds-Buckley *et al*. 2019). Nevertheless, even though group-based interventions appear to be acceptable, it is important to know why clients did or did not find them helpful.

5.4.1.2 Therapeutic alliance

This study used the ARM-5 to collect data at the end of every group session about the therapeutic alliance. Clients reported a positive bond and partnership with the co-facilitators and confidence in the treatment. ARM-5 scores reveal that all sessions and all clients scored above the 20th percentile, which represents a 'green flag' for working alliance (Appendix 64). This might be explained by the attention paid to each individual in terms of providing up to four 1:1 sessions for assessment and formulation to develop a personalised care plan.

5.4.1.3 Client satisfaction

Statistical data from the CSQ was collected after the final session and this suggested that clients were highly satisfied with their overall treatment. The mean score on the CSQ was 27.0 (SD 1.93), which compares well with the mean CSQ-8 score of 28 (SD 4.8) in a similar study evaluating group therapy for people with low mood and depression (Mcclay et al. 2015). This finding might be explained by the fact that the questionnaire was completed at the end of the Treatment Programme. Clients might have had mixed feelings towards therapy, but morale was possibly higher than usual because they had organised a 'goodbye' party and exchanged small gifts and cards. Another potential risk of bias was that neither the ARM-5 nor the CSQ-8 was anonymous, which may have influenced scoring.

The literature suggests that clients who do not improve or who deteriorate might still be highly satisfied with their experience in psychotherapy (Werbart *et al*. 2015), and some clients who show little or no change often rate their own progress as high (Rubel *et al*. 2015).

5.4.1.4 Written feedback

Written feedback suggests that some of the hypothesised mechanisms of change may have been activated (Appendix 70). A synthesis of quantitative and qualitative data suggests that the acceptability of the new intervention appears to depend on an optimum balance between content and process. This requires skilful facilitation of peer interaction so that 'theory' (CBT concepts) and 'practice' (CBT skills) can be integrated for the purpose of catalysing cognitive and behavioural change.

- *Positive aspects*

i. Peer interaction

In relational group-CBT, the leader's behaviour aims to give rise to three group-specific therapeutic processes: peer learning, peer feedback and peer support. This requires using a structured-directive group leadership style to set up opportunities for peer interaction, such as experiential learning activities and goal-planning/goal-reviewing pairs. These peer-based processes are thought to create an enabling inter-personal context in which the six hypothesised mechanisms might be activated, i.e. acquisition, consolidation and application of basic CBT concepts and skills.

The literature suggests that clients value 'inter-personal exchange and support' (Schuster *et al*. 2018), and in IAPT clients appreciate 'smaller groups with people with similar issues' (Newbold *et al.* 2013). Group-based interventions add value compared to 1:1 interventions by virtue of increasing social contact and reducing isolated, and by creating an opportunity for mutual sharing that normalises and de-stigmatises symptoms (Newbold *et al*. 2013). Sharing personal stories can generate deep emotional connections between members. Clients in a group for divorced women described a sense of 'sisterhood', affirmation, validation, and personal growth. A similar bonding process was reported in a group for women with post-natal depression, which helped clients to normalise their experience by 'getting to know each other' and by 'sharing their darkest thoughts…not being alone any more' (Scope *et al.* 2012 p.6). They also found 'counselling one another' helpful because they were able to be honest and 'not made to feel guilty' as they might with a professional. Peer interaction allows clients to compare themselves to other group members. When they identify with those who have similar problems and severity of symptoms, clients feel more comfortable and 'normal', whereas if they feel different, they feel undeserving of a place in the group (Noble *et al*.

2006). They can be motivated by witnessing other group members progress, which gives them hope (Kimball *et al.* 2009).

In traditional GCBT, peer interaction is generally used to provide a 'cheerleading', inspirational and validation function based on the assumption that clients want to help each other as de facto therapists (Whitfield, 2010). It can also be used to create a sense of social identification and social connectedness (Cruwys *et al.* 2014), or to change attitudes through processes such as normative social influence and cognitive dissonance (Cruwys *et al*. 2015) . In other models of group psychotherapy, all peer interaction takes place in the large plenary group without dividing the group into reciprocating pairs or smaller subgroups. The leader's behaviour acts to promote a safe regression so that clients can make the 'unconscious conscious', whereby manifest symptoms can be understood as latent conflicts via the leader's interpretations and translations (Foulkes, 1959). Talking together without any agenda gives rise to a dream-like shared space with clients free-associating in response to each other's silences, words, and non-verbal signs and signals. Inter-personal processes such as emotional resonance and mirroring arise from more spontaneous forms of communication, and this allows clients to connect at a deep emotional level, with minimal intrusion from the therapist. In inter-personal groups, discussion is similarly encouraged using an unstructured-nondirective leadership style (Yalom, 1995) and is the vehicle for group-specific therapeutic 'curative factors' such as group cohesion, ventilation of affect, social identification, altruism, universality, and vicarious learning.

In behavioural models of group psychotherapy based on learning theory such as Focused Brief Group Therapy (FBGT) (Whittingham, 2015; Lotz, 2013) peer interaction is used as an inter-personal laboratory wherein skills can be acquired, consolidated and applied. Other approaches have been adapted from a 1:1 format such as the Group Cognitive Behavioural Analysis System of Psychotherapy (G-CBASP) (Michalak *et al*. 2015; Sayegh *et al.* 2012), and Functional Analytic Group Therapy (FAGT) (Vandenberghe & Leite, 2018; Hoekstra & Tsai, 2010). In FBGT and FAGT, targeted behaviours are clearly identified following a thorough assessment of inter-personal problems. Using close observation of group interaction, desired behaviours are modelled, shaped, and positively reinforced. Clients' difficulties will usually emerge naturally 'during unplanned interaction in the group', and undesired behaviours are 'blocked' in order to extinguish them. The 'spontaneous responses' of group members to each other are vital (Vandenberghe & Leite, 2018). The leader's behaviour gives rise to an individual-psychotherapy-in-a-group culture. An unstructured-nondirective leadership style promotes discussion of clients' 'daily life issues and struggles as well as their experience of the group' (p.234), and as such the group requires fewer resources

and less preparation. However, leaders require additional training as the techniques are quite complex.

In contrast, in G-CBASP the main therapeutic strategy is Situational Analysis (SA) (Michalak *et al.* 2015). SA requires group members to complete a Coping Survey Questionnaire describing a recent incident that caused them inter-personal distress, and then the therapist works on a 1:1 basis with each client in turn, comparing the actual outcome with their desired outcome. Other group members are invited to contribute different perspectives to promote an 'active, problem-solving and inter-personal focus', with the aim of helping clients shift from a hostile and submissive pattern of communication to a more friendly and assertive pattern of communication. The therapist's stance is one of 'disciplined personal involvement' (DPI) (McCullough, 2007), which has been operationalised as a 'pronounced personal-authentic stance towards the participants throughout the treatment' to give 'immediate feedback on the impact their behaviour has on others' through 'contingent personal responsivity' (CPR) (Michalak *et al.* 2015 p.954). These interventions are thought to re-establish the Person x Environment connection, broken by depressive inter-personal withdrawal and avoidance.

A Transference Hypothesis (TH) is developed based on a Significant Other History (SOH) that anticipates possible inter-personal problems that might emerge between group members as well as between individual clients and the therapist. Subsequently, the Inter-personal Discrimination Exercise (IDE) is used by the therapist to help the client notice that not everyone behaves towards her as she expects (Michalak *et al*. 2015). In this, way unhelpful associations are gradually extinguished and the client's behavioural repertoire can be extended. A structured-directive group leadership style limits open-ended discussion by focusing on the SA, and as above fewer resources and less preparation may be required, but again leaders require additional training.

ii. Psycho-educational information

In relational group-CBT, the main component is the leader-led pre-determined syllabus for each session, comprising psycho-educational information related to the six mechanisms, as well as client-led material such as their relationship problems at home/work, which emerge in response to the various presentations, expressive and exploratory exercises, goal-planning/-reviewing, and small group discussions. The literature suggests that psycho-educational groups for depression may be enough to improve prognosis through anti-depressant medication compliance (Tursi *et al.* 2013), and to reduce sickness absence (Pedersen *et al.* 2015). Psycho-educational groups for bipolar are no more effective than facilitated peer support groups, but they are more acceptable (Morriss *et al*. 2016).

In traditional GCBT, a major advantage of more content and less peer interaction is that leaders are able to stay focused and get through the psycho-educational material without being distracted by having to deal with difficult dynamics between group members, and that group members can focus exclusively on their own problems. In addition, sessions can be manualised and are therefore easier to implement with high fidelity to the model. However, several disadvantages of relying heavily on psycho-educational content have been identified. If leaders do not encourage peer interaction but only work with one group member at a time, other clients become bystanders and some may get no individual attention at all. In addition, if content is conveyed using didactic methods of presentation, clients could become bored and drop out; or if clients miss a session, they may find it difficult to catch up.

Another potential drawback of focusing more on content than process is that there is usually not enough time for clients to acquire, consolidate and apply skills in-session, so practice is usually negotiated as between-session assignments, but some clients experience major obstacles in undertaking skills practice at home or at work, and also in recording and reporting accurately what happened in the following group session. Likewise, an emphasis on content also means leaders may feel under pressure to keep to a tight timetable and curtail free discussion between clients, meaning there may not be a time for in-depth exploration.

In other models of group psychotherapy, no psycho-educational information is provided. Content is client-led as group members talk about their problems at home/work in their own time with the occasional prompt from the leader. In psychoanalytic (Foulkes, 1959) and inter-personal groups (Yalom, 1995), the content is also group-centred as clients are encouraged to address relationship problems with the leader and other group members, reflect on group dynamics, and make links between 'there and then' and 'here and now' relationships.

iii. Structure

In relational group-CBT, a structured-directive group leadership style is used to split the group into different-sized groups for discussion and to set up various exercises. The literature suggests that there is a higher drop-out from peer support groups due to a lack of structure with a nondirective leadership style and no agenda, whereas psycho-educational groups are more acceptable because they are structured with a directive leadership style and an agenda including a taught introduction to each session, skills practice, and an emphasis on goals and future plans (Morriss *et al.* 2016). Structured groups have a 'workshop-like character', which suits some clients who would be put off by traditional unstructured group psychotherapy that may be beset by 'undesired group dynamics', such as one group member monopolising the discussion (Newbold *et al*. 2013; Schuster *et al*. 2018). Whilst it is important to clients that

everyone contributes ('nobody just sat there': Luke, 2011 p.67), some clients in IAPT express a preference for group therapy because there is less pressure to talk (Newbold *et al*. 2013).

In traditional GCBT, sessions tend to be psycho-educational (Scott, 2012), and despite attempts to integrate awareness of group dynamics and phases of group development into CBT groups (Bieling *et al.* 2006; Satterfield, 1994), in practice this is often neglected as content is still prioritised over process (Spitz & Tschuschke, 2008). The literature suggests that clients may feel 'emotionally short-changed' in brief psycho-educational groups where the leader's role is solely to impart facts and information (Lothstein, 2014 p.233). If leaders focus on therapeutic techniques rather than therapeutic relationships, there is a risk that this may be a sterile and isolating experience. Clients in structured groups ask for 'more time for talking' rather than 'doing things' (Schuster *et al*. 2018 p.9). In a similar vein, relationships between group members are contrived and do not form 'naturally', and this may hinder phenomena such as denial, splitting, and projective identification (Foulkes, 1959), as well as subtly thwarting transformational 're-enactments' through the 'corrective recapitulation of the primary family group' (Yalom, 1995 p.1).

In other models of group psychotherapy, an unstructured-nondirective leadership style promotes open, honest and uncensored discussion. The lack of an agenda in Group Analysis is valued by some clients, especially when they feel supported by other group members and when they experience the therapists 'as parents providing safety and care' (p.91), and are able to 'stay with' their feelings (O'Beney *et al*. 2019 p.88). This 'weathering' process ultimately helps them gain new learning, which leads to change in terms of 'managing emotions' and 'asserting their needs in more productive ways' (p.92).

There are several advantages of an unstructured-nondirective leadership style in group psychotherapy. The lack of structure allows for a different way of talking that promotes inter-subjectivity between group members, allowing discussion to be highly creative, transgressive, uninhibited, free-flowing, and playful, like a Bakhtinian form of dialogue that encourages polyphony of diverse voices and a multiplicity of perspectives occurring simultaneously. De Mare (2018) describes a distinctive dynamic that occurs in a median group of about 20 people, which he called *koinonia:* a sense of fellowship, community, and impersonal friendship.

One argument against a structured-directive group leadership style is that too much structure and direction may be counter-productive if group members feel micro-managed. A lot of group activity or 'busyness' may function as an unconscious social defence blocking awareness of painful feelings and impeding emotional catharsis (Yalom, 1995).

iv. Skills practice / prescribed goals

In relational group-CBT, the main process component is learning the art of 'good conversation' (Appendix 71) to ensure that each client has time to talk; to create degrees of privacy by working in reciprocating pairs and small subgroups; and the opportunity to make things more public in plenary sessions. Another important process is prescribing within- and between-session goals. The literature suggests that completion of homework is related to outcome in CBT, and both quantity and quality of homework are important predictors of recovery in depression (Kazantzis *et al.* 2017). Compliance is enhanced by providing feedback (Macrodimitris *et al.* 2010). In group-based interventions, clients report feeling motivated to complete homework because of the support and reinforcement of others (Schuster *et al*. 2018) , and they gain confidence as they take responsibility for helping themselves and others (Newbold *et al*. 2013).

In traditional GCBT, clients might be asked to formulate a goal for themselves (Fehm & Mrose, 2008), or they might all be asked to pursue the same goal (Neimeyer, 2016; Rees *et al*. 2005). The literature suggests that homework is more effective if therapists and clients collaborate (Cooper & Law, 2018). Thus, goals may be unrealistic if leaders do not have time to collaborate with group members on a 1:1 basis. In one survey of therapists' experience of setting homework, it was found that over 50% of therapists developed the task alone (Helbig & Fehm, 2004). In the new intervention, clients were prescribed goals based on their ideographic formulation as well as observation of their interaction in the group.

- *Negative aspects*

i. Side effects

Peer interaction may be curtailed in some group-based interventions because it is unpredictable and difficult to regulate, and some clients may be harmful to others. Clients report negative experiences in group-based interventions because peer interaction is 'demanding' (Schuster *et al*. 2018), or they may feel ambivalent about fully opening up (Newbold *et al*. 2013). The literature suggests that not all clients benefit from group psychotherapy (Burlingame *et al*. 2006; Ogrodniczuk *et al*. 2003), with some showing non-response, some deterioration, and some adverse events or side effects (Roback, 2000). Observation of group sessions reveals behaviours associated with improvement or deterioration. Clients who initiate discussion, express controversial views, over-disclose in the early stages based on the expectation that group therapy requires 'sharing deep personal information' are likely to do worse than clients who wait to be invited to contribute to discussion, are more cautious and 'sit on the fence', for example (Hoffmann *et al.* 2009) .

When clients disclose very distressing events, this may lead to actual and vicarious traumatisation in other group members (Smokowski *et al.* 2001), and there is a possibility of 'emotional contagion' rather than empathy (Bacha, 2019). Other damaging experiences reported include clients feeling ignored, rejected, intruded upon or attacked by the therapist; clients experiencing 'feedback overload' or being confronted by other group members; confidentiality being broken by other group members; or clients assuming or being ascribed a 'deviant group role', such as the scapegoat or the identified patient (Lieberman *et al*. 1973).

Moreover, clients from minority socio-cultural groups including the LBGT community may not do as well as other clients in group therapy (Chen *et al.* 2008), and they are more likely to report lasting bad effects from both 1:1 and group therapy (Crawford *et al*. 2016). Group-based interventions with homogenous membership have the benefit of creating group cohesion 'around similar culturally relevant life experiences' (Cardemil *et al*. 2010 p.191).

Some practitioners doubt the value of peer interaction. Oei & Browne (2006) describe a short-term group-CBT programme where the 'development of strong bonds' between members is not encouraged, and as such there appears to be less sharing of the Self and more reliance on the Self. Similarly, the 'Stress Control' course is designed for a large group with little or no peer interaction (White, 2007). The manual includes the following: 'Will I have to talk in front of other people? NO. 'Stress Control' is not a group therapy. Not many people in this country would be happy to talk about their problems in front of others' (p.3).

ii. Homework

One client complained about too many goals. The literature suggests that clients with depression encounter serious obstacles when completing homework assignments depending on whether it is a 'cognitive' or a 'behavioural' task (Helbig & Fehm, 2004). Therapists reported problems in over 70% of clients in agreeing homework tasks, and that just under 40% of clients actually completed the homework because it was too difficult; they had no opportunity/time to do it; they were afraid/unwilling (Helbig & Fehm, 2004). Lack of motivation, procrastination, or low self-efficacy are obstacles (Leahy, 2002; Garland & Scott, 2002), but lack of therapist skill or deterioration in the client-therapist relationship may also affect clients' willingness to undertake between-session assignments (Callan *et al*. 2012).

In the new intervention, clients were encouraged to negotiate during goal-planning section with a partner in reciprocating pairs. However, some clients might have poor negotiation skills, so that they might agree too many goals to please others and/or to avoid conflict.

5.4.2 Conclusions

The high acceptability of the new intervention was possibly due to skilful facilitation of peer interaction balancing content and process. Psychological regression, dependence, and other potentially disturbing and damaging phenomena were checked by focusing on relationship problems in the real world of home/work using the Double-Donut exercise (Appendix 67). Relationship distress in the group was managed safely by encouraging clients to give each other strengths-based constructive feedback. High acceptability might also have been due to sessions being structured with lots of activities. Some clients might not talk much at all in unstructured-nondirective groups because they have to compete with others to find their voice and speak out, and these groups may have silences that some people can find extremely persecutory (Ladany *et al*. 2004; Hill *et al*. 2003; Gans & Counselman, 2000). When leaders are more directive they can deliberately set up different partners in different pairings and small subgroups, and this means that everyone gets to work with everyone else. Misunderstandings and irritations can often be ironed out as clients perceive each other's real strengths and qualities, as well as weaknesses and flaws. Silences can be used deliberately as reflective spaces and quiet times for writing a journal, for slowing down the pace of the group's interaction, or for extra individual support.

Encouraging clients to contribute to the therapeutic group process has the potential to be more democratic and empowering, especially for those who have experienced inter-personal abuse. This approach shares some features of a therapeutic community where group members spend long periods of time in each other's company, and are expected to make collective decisions about how the community runs (Campling, 2001; Haigh, 2013). The purpose is to generate a sense of 'responsible agency' and 'belongingness' (Pearce & Pickard, 2013).

5.4.3 Improving accessibility

The findings synthesised from multiple data sources (but predominantly from the reviewing stakeholder consultation stage) suggest that it would be helpful if the new intervention was simplified so that it can be delivered by peer facilitators at the worksite, as a universal intervention for all employees, rather than an indicated or targeted intervention for only those with symptoms of, or at risk of, depression. There is a precedent for transforming a Treatment Programme into a Training (and staff support) Programme. The only GCBT intervention (Muñoz & Miranda, 2000) reviewed in Chapter 2 resolves the problem of balancing content and process by having two separate programmes using the same manual: it can be delivered as a ***training programme*** in a 'psychoeducation mode' led by peers, or as a ***treatment programme*** in a 'psychotherapy mode' led by two qualified practitioners.

The literature suggests that primary or secondary preventative interventions, interventions for chronic and treatment-resistant depression, and those that prevent relapse are particularly needed to reduce the worldwide disease burden of depression (Cuijpers 2017). Low-income clients and those living in poverty need psychotherapeutic interventions to be more accessible (Goodman *et al.* 2013; Santiago *et al*. 2013), and accessibility is an important measure of implementation success in NHS services (Rycroft-Malone *et al*. 2017).

Service-users' suggestions are consistent with several studies showing that it is also possible to prevent depression by increasing access to, and using innovative methods of delivering, psychotherapeutic interventions (Wahlbeck, 2015; Wahle *et al*. 2017; Cuijpers *et al*. 2015). A review of universal interventions (i.e. at primary prevention level) based on CBT found that they can be effective in the prevention of depression (Tan *et al*. 2014). Moreover, there have been calls for more upstream and midstream preventative interventions to tackle downstream health problems that can become chronic if not targeted earlier (Coote, 2012).

Most people with depression do not receive treatment. The World Health Organization has called for more research into the barriers to treatment, and for the design of interventions to increase access to treatment, especially those who are most socio-economically disadvantaged (Evans-Lacko *et al*. 2018). Treatment Programmes delivered at tertiary preventative level in clinical settings may be inaccessible for the majority of the working population, whereas Training Programmes delivered at primary preventative level at the worksite can extend the reach of psychotherapeutic interventions and at an earlier stage, ideally before employees go off sick with depression.

To close the 'treatment gap' for depression by designing new psychotherapeutic interventions, the WHO has defined three healthcare accessibility factors: physical, economic, and information accessibility (Appendix 72).

5.4.3.1 Physical accessibility

Taking time off and getting to therapy appointments are barriers to treatment initiation and persistence in working people. In the vocational rehabilitation literature, most universal or secondary preventative programmes in the workplace are delivered at the individual level using a group format. One example is Mental Health First Aid (MHFA), a group-based mental health literacy course. While this is not a treatment for depression, when delivered at the worksite it appears to achieve positive clinical outcomes for employees with depressive symptoms (Kitchener & Jorm, 2004). The widespread adoption of MHFA by organisations is a good example of how to scale up a low-intensity psychotherapeutic intervention. Unfortunately, work outcomes have not been collected in any research so far.

The rolling out of MHFA shows that, rather than delivering psychotherapeutic interventions in clinical settings, the workplace is being transformed into a source of public health prevention and promotion (DWP, 2009). Upstream public health initiatives are likely to have more impact at population level. Many experts agree that the workplace, 'where a large proportion of the adult population can be reached' (Dietrich *et al*. 2012 p.1) is an ideal setting to deliver preventative interventions targeting depression, because (Tan *et al.* 2014 p.1):

> *60% of the world's population [are] engaged in some form of employment and 60% of their working hours [are] spent at the workplace, [and thus] there is potential to reach a substantial number of people in a reliable and predictable manner.*

Likewise, the workplace is 'one of the most important settings for mental health promotion' (Czabała *et al.* 2011 p.70), and delivering interventions at the worksite is (Martin *et al.* 2009 p.1):

> *...both logistically attractive, since [it] provides access to a large proportion of the adult population, and [is] a socially responsible corporate strategy.*

In Europe, eight countries collaborated in the ProMenPol project which took a lifespan approach to the promotion of mental health targeting schools, workplaces and older peoples' residences as the 'predominant context within which [most people] live their lives' (Kuhn, 2010 p.6).

Moreover, recruiting peer facilitators to deliver the new intervention at the worksite is backed by four decades of research into psychotherapies for depression, which recommends that future research should not be about creating new models and formats since most are equivalent in effectiveness, but rather tackling the disease burden by 'training people to become lay counsellors in a *sustainable* way' (Holmes *et al*. 2018 p.38) and scaling up interventions so that they can reach more people (Cuijpers, 2017). Effective dissemination usually involves increasing the impact of interventions by replicating them in similar settings with similar populations, and/or in different settings with different populations (Shiell-Davis *et al*. 2015).

Furthermore, the literature suggests that low-intensity, high-volume interventions may improve access for people with mild mental health problems (Hollon & Williams, 2016), and peer-support workers often provide psychotherapeutic interventions for those with more chronic and severe mental health problems (Davidson *et al*. 2012; Repper & Carter, 2011). Re-modelling the new intervention for delivery at the worksite is supported by one review that found that universal CBT-based interventions that focus on promoting adaptive coping delivered in a group format in the workplace are effective in reducing depressive symptoms (Yunus *et al*. 2018). These interventions might improve employee engagement and

empowerment, and ultimately reduce turnover in all staff, but especially employees at risk of relapse and recurrence of depression.

Likewise, a universal Training (and staff support) Programme is compatible with the recommendations of several national and international guidelines in terms of the need to develop mentally healthy workplaces (LaMontagne *et al*. 2014; MHCC, 2013; OECD, 2012; Leka *et al*. 2010; NICE, 2009a). One large systematic review explored whole-system approaches to maintaining healthy workplaces in healthcare settings and recommends that interventions should engage staff at all levels (Brand *et al*. 2017). Similarly, a Cochrane review of preventative staff support intervention in healthcare settings found low-quality evidence that booster sessions and longer-term interventions might produce more sustainable positive effects (Van Wyk & Van Wyk, 2010). Another large systematic review of international guidelines on workplace mental health (Memish *et al.* 2017) found that prevention is not as high a priority as detection and treatment, and recommendations for preventative interventions tend to be delivered at the individual rather than at the organisational level. (Moore & Evans, 2017 p.133) warn that:

> *Behaviour change interventions focus primarily, or exclusively, on psychological processes, and hence address the most proximal surface influences on behaviour…[with a] resultant tendency for many interventions to be minimally disruptive of the problems they seek to address; an imbalanced focus on the individual having encouraged a preoccupation with mechanisms that have minimal leverage, whilst rendering invisible those that are actually important to sustaining the problem.*

A counter-argument is that whilst the workplace enables greater access because workers can attend either group or 1:1 sessions in work time, ensuring a high degree of compliance (Flaxman & Bond, 2010), some workers may prefer a non-workplace based service, that is independent, impartial and confidential, because there may be fears about hidden agendas (Higgins *et al.* 2012), and if individual-level interventions are used in isolation this may be perceived as the organisation trying to 'fix' the employee (Flaxman & Bond, 2010).

5.4.3.2 Information accessibility

Two clients' written feedback suggested that 'very dry' information could be presented in a less complicated way. Likewise, participants in the reviewing focus groups suggested that the conceptual framework of the new intervention needs to be easier to understand. A major benefit of simplifying the new intervention is that it improves information accessibility, whereby the psycho-educational material is presented in interesting and thought-provoking ways in the manual and group sessions, using user-friendly language. This is also helpful because peer facilitators are likely to be unqualified volunteers.

The need for simplification is also supported by research into the adoption and spread of novel interventions that suggests that implementation may be more successful if interventions are designed using a 'disruptive (or frugal) innovation' approach. (Barry, 2016 p.4), recommends that change in education, health and social care is likely to require: 'new networks and new organisational cultures and involving new players [that] displaces older systems and ways of doing things'. Improving healthcare does not always mean that new interventions should be 'more high-tech, more sophisticated, more complex' (Kelland, 2012 ref webpage). Hwang (2009 p.515) asks, 'How is it possible that healthcare only seems to get more expensive, less convenient, and less accessible?' Whilst complex interventions by definition tend to require a large number of difficult tasks performed by those delivering or receiving the intervention, the 'disruptive innovation' approach suggests that implementation would be more likely to succeed if interventions are simplified.

Experts have called for innovation in mental healthcare services by simplifying and scaling up psychotherapeutic interventions so that they can be delivered by lay counsellors, (Kazdin, 2017; Patel *et al*. 2011) and non-specialist paraprofessionals (Ekers *et al.* 2013). This form of delivery has the potential to reduce the worldwide disease burden of depression (Cuijpers, 2015, 2017). The literature suggests that low-intensity psychotherapeutic interventions provided by non-psychologists can be effective in shortening the length of time employees with depression take off sick (Doki *et al*. 2015). In public health, peer facilitators such as 'grandmothers' are often used to provide basic psychotherapeutic interventions in low- and middle-income countries (Chibanda, 2018; Chibanda *et al*. 2011) and these could also close the treatment gap in high-income countries (Esposito & Perez, 2014). In a study examining the feasibility of 'an all-volunteer workforce', 15% of participants were willing to volunteer to support their peers to lose weight, and three times as many people would attend a free peer-led group than an expert-led paid group (Kraschnewski *et al.* 2014).

Moreover, an overview of the effectiveness of psychological therapies stepped care service delivery models in depression found that the addition of complex components to treatment does not improve outcomes (Ekers & Webster, 2013). Parsimony and fewer 'moving parts' (p.180) improve the quality of wider dissemination when implemented by generic practitioners. Simplification also improves replicability of the new intervention, which is another important measure of implementation success as it enhances quality assurance and makes delivering the intervention with fidelity more likely (Kirchner *et al*. 2017; Hawe, 2015).

5.4.3.3 Economic accessibility

Some former service-users reported that their employer offered stress management training and other mental wellbeing initiatives, but none of them specifically mentioned Employee Assistance Programmes (EAPs). In the UK, organisations are incentivised through the tax system to fund EAPs, which usually offer free short-term counselling. However, the tax exemption does not include treatment, and in any case, short-term counselling may be inadequate for employees with moderate-severe recurrent depression. Thus, another barrier might be the cost of therapy (if mental healthcare services have long waiting lists, employees' only option may be to pay for private therapy).

If organisations are going to permit (and pay for) psychotherapeutic interventions delivered at the worksite, they need to be convinced of a positive impact on productivity and mental wellbeing. The business case for organisational investment in employee mental wellbeing relies on how mental health problems can affect the workplace in terms of an 'increase in error rates, poor decision-making, loss of motivation and commitment, tension and conflict between colleagues' (Bauman *et al.* 2010 p.3). Similarly, looking after staff health and wellbeing can improve efficiency, productivity and organisational performance, as well as reducing sick pay, staff turnover and recruitment costs (MIND, 2011a). There might also be 'non-commercial benefits to organisations from health and wellbeing activity, such as improved management-staff relations' (Sainsbury *et al*. 2012 p.4).

5.4.4 Conclusions

Delivering a universal Training (and staff support) Programme informed by relational group-CBT at the worksite is more accessible than an indicated Treatment Programme, and could contribute to organisational health and wellbeing, and wider public health.

5.5 CRITIQUE OF THE DISCUSSION

5.5.1 Original contribution to knowledge

The new intervention design is unique because it is fully specified and manualised based on a classification system developed to identify helpful components of relevant and potentially relevant psychotherapeutic interventions, in consultation with stakeholders. Likewise, the programme theory is unique because it is based on a theoretical integration of occupational stress, psychological, social/inter-personal, and bio-medical theories. None of the other relevant and potentially relevant interventions reviewed in Chapter 2 clearly specified their hypothesised mechanisms of change.

Since this research was completed, a 'checklist to improve reporting of group-based behaviour-change interventions' has been developed (Borek *et al*. 2015 p.1). Several of the components (see 2.6) are similar to what was identified as important in this study, but the checklist only examined the reporting of group-based weight-loss interventions. The main difference is that the new intervention was specifically designed as a treatment for moderate-severe recurrent depression and that clients experience cognitive, emotional, physiological and behavioural symptoms requiring more complex multi-modal psychotherapeutic interventions to bring about reliable and clinically significant change.

This study has been able to identify the potential benefits of group members talking together, and this is an important finding because discussion in GCBT may be encouraged to a greater or lesser extent, but without as yet an evidence-based rationale. Defining the purpose of peer interaction and how best to facilitate it is essential, because it may have powerful salutogenic or iatrogenic effects.

5.5.2 Limitations and strengths

Empirical studies focused on employed service-users of CMHTs in the UK are lacking, so this study was highly relevant to a marginalised community. It followed MRC guideline for developing, evaluating, implementing and reporting on complex health and social care interventions, and followed recommended procedures to ensure the findings were robust. The first phase involved a thorough component analysis being undertaken to identify essential ingredients of a new psychotherapeutic intervention. An integration of the theories underpinning relevant and potentially relevant interventions allowed for modelling of the new intervention. However, caution is necessary because the search strategy involved only four databases and thus there may be publication bias. Moreover, some studies of relevant or potentially relevant psychotherapeutic interventions may have been missed because the exclusion criteria may have restricted the breadth of eligible research.

The second phase requires pre-intervention consulting with stakeholders. However, they were a convenience sample which means their views may not be typical and it is unlikely that anyone who had previously found group-CBT to be unhelpful would volunteer to take part. A detailed and nuanced account was developed about the problems that employees with depression face in continuing to work, and this allowed for the identification of solutions in terms of how to change a disabling organisational culture. However, it is unlikely that all biases were eliminated because some participants' contribution may have been influenced by knowing the researcher as a colleague or as a therapist, with the possibility of a social desirability bias.

The third phase tested the feasibility of evaluation and implementation in the real world of clinical practice. A major limitation was recruitment shortfall, resulting in a small sample of middle-aged women, which reduces representativeness and increases the possibility of methodological weaknesses in terms of the statistical analysis. However, whilst small samples reduce external validity, in this study the data has been supplemented with case vignettes. A definitive trial would need much larger samples to improve statistical power and increase confidence in the findings. Another major limitation was that not enough qualitative data was collected to explore acceptability in depth, for example, and the author was involved in delivering the intervention such that its generalisability is uncertain.

The fourth phase requires post-intervention consultation with stakeholders, and this study involved two focus groups to consider the acceptability and accessibility of the new intervention. A wealth of data was generated, but the conclusions need to be treated as partial due to a very small sample. Nevertheless, the findings regarding the hypothesised mechanisms of *peer learning, peer feedback, peer support* were supported by the wider literature on group psychotherapy process research. However, it should be noted that the findings may not be generalisable because the context for the feasibility study may be very different to other clinical, worksite, or community contexts.

In conclusion, despite the limitations outlined above, the findings are encouraging, have strong face validity, and provide a convincing rationale for further research.

5.6 SUMMARY

This chapter has presented a robust argument in support of further research into the effectiveness of a work-focused relational group-CBT Treatment Programme, and for the modified and refined Training (and staff support) Programme to be field-tested at the worksite. It demonstrates how the intervention design and programme theory were developed through an iterative process of co-production following MRC guidelines. This chapter shows

how the research set out to answer specific questions regarding what enhances job retention in employees with moderate-severe recurrent depression, comparing and contrasting the mechanisms identified and operationalised in the new intervention with other forms of group psychotherapy. Ultimately, work-focused psychotherapy alone is unlikely to have much impact on helping service-users maintain their employment if changes are not also made at organisational, healthcare system, and societal levels.

6 RECOMMENDATIONS FOR FURTHER RESEARCH

6.1 INTRODUCTION

Mixed-methods data integration using the joint display method was undertaken to pull together different threads and themes from the other stages, in order to recommend future implementation and evaluation of the new intervention.

6.1.1 Structure of the chapter

This chapter presents recommendations for further research based on the many lessons learned during the conduct of this study in three sections.

1. Recommendations for **Future Implementation** of the new intervention considering the implications of the first three stages of the study in terms of how barriers to implementation might be overcome when planning a full-scale definitive randomised control trial.
2. Recommendations for **Future Evaluation** of the new intervention and how this study advances current thinking around trial design and conduct in studies which span mental healthcare and vocational rehabilitation settings.
3. An evidence-based **Dissemination Strategy** for future implementation and evaluation. The chapter end with a **Summary**.

6.2 FUTURE IMPLEMENTATION

Further research into the effectiveness of the new intervention in a definitive trial requires that the intervention design and programme theory are explicit. This study designed a new work-focused psychotherapeutic intervention based on the over-arching principles, core practice components and core theoretical concepts extracted from relevant and potentially relevant psychotherapeutic interventions. It is possible to make some tentative recommendations for the theory and practice of relational group-CBT in terms of w*hat, how,* and *why* (Appendix 73. The Tidier Checklist was used to describe changes made to create two interventions (Appendix 74).

6.2.1 The Treatment Programme

The triple focus involves a holistic assessment to understand each client's problems, so that an ideographic formulation can be developed, requiring up to four 1:1 sessions before the group sessions. The facilitation of peer interaction emphasises that clients are expected to contribute to each other's recovery, necessitating transparency about the need to attend reliably and participate fully. The group format involves full-day sessions, balancing content

(psycho-educational information) with process (peer interaction and interactive learning activities) and led by co-facilitators trained in evidence-based teaching methods. Group members should be treated as responsible, resilient and resourceful adults with a wide range of life experience, personal qualities, and strengths that can be brought into play in group sessions, requiring co-facilitators to take a democratic, inclusive and empowering attitude. Some mechanisms depend on such things as the ability to realise and reflect which requires a personalised care plan for each client.

Positive peer interaction is vital in creating an enabling context and co-facilitators need to be trained in group facilitation skills using a structured-directive leadership style. Co-facilitators should be aware of the risk inherent in involving clients in each other's treatment, and should intervene proactively when necessary, necessitating access to mobile 'phones to send text messages and authorisation to use an outreach approach. The new intervention should incorporate a range of engagement, commitment and motivational strategies to maintain clients on the care pathway (Appendix 50), led by co-facilitators who have undergone specialist training in enhancing client adherence in group-based interventions. Prescribed goals should be sensitive to each client's preferences, strengths and weaknesses, and obstacles that might arise during treatment.

Psychotherapists should treat depression using a social justice framework that takes into consideration systemic and structural barriers to employment for people with chronic mental and physical conditions. This requires equality and diversity training and multicultural competence in CBT to ensure the needs of clients from different racial backgrounds, social classes, gender or sexual orientation, and those with disabilities are given equal weight to those of the dominant group (Hays, 2009).

6.2.2 The Training (and staff support) Programme

The new intervention was re-modelled as a universal Training (and staff support) Programme informed by relational group-CBT. It comprises a compulsory trauma-informed educational/experiential workshop run over four full-day sessions, plus optional open-ended, peer-led base groups with no more than eight employees, set up and run by volunteer peer facilitators (Appendix 74). To improve physical accessibility, the new intervention should be delivered at the worksite.

To improve information accessibility, the new intervention should be simplified for delivery by peer facilitators via a participants' handbook for clients and four PowerPoint slides for co-facilitators (see Client / Facilitator Manual). Training and ongoing supervision by a CBT or an OT with skills in group facilitation to monitor quality assurance is also required.

Finally, to improve economic accessibility or affordability, the new intervention should be demonstrably cost-effective and delivered at the interface between the individual and the organisation.

6.3 FUTURE EVALUATION

This study aimed to make a case for a future 'proof of concept' study at a demonstration site. It has established that a mixed-methods approach is feasible, and that outcome evaluation could be achieved with a Randomised or Cluster Randomised Controlled Trial. An outline proposal for a definitive trial was developed based on the power calculation undertaken following the piloting stage (Appendix 75).

6.3.1 Research design

In this study, a within-groups single-case research design with a paired t-test was used to compare paired samples, with the participant acting as their own control. This design can help to identify mechanisms of change and is particularly suitable for behavioural health research. Similarly, this method of data analysis in applied research overcomes some of the criticisms of RCTs where data is aggregated and compared between groups such that individual differences in response to intervention effects are averaged out (Machalicek & Horner, 2018). The RCT methodology is best suited to evaluating interventions for physical diseases and disorders where the pathology is objectively defined, and is less suited to evaluating interventions for subjective health complaints.

6.3.1.1 Recruitment

To run a definitive trial in a clinical setting, the sample would need to be larger and more representative. Accessibility of new interventions should be improved and different strategies should be used to improve referral and uptake, with an option for self-referral. It might also be possible to 'cut out the middle man' by building relationships with key referrers (Borschmann *et al.* 2014 p.10), rather than rely on waiting lists. It is likely that uptake of psychotherapeutic interventions, especially group-based interventions, requires persuasion to help users overcome barriers such as inaccurate preconceptions, fear and resistance. More time would be required to engage potential participants, preferably at intake, bearing in mind possible barriers to recruitment of men and members of minority groups. Researchers would need to gain permission to attend CMHT allocation meetings, for example. More resources would be needed, such as attractive and inclusive marketing material.

6.3.1.2 Choice of outcome measures, data collection methods, and missing data

To optimise data completeness, different methods should be used to recover clinician-rated and self-rated follow-up data. Loss to follow-up in mental health trials may be mitigated by close collaboration between the research team and the routine treatment team (Furimsky *et al.* 2008), explaining why the study is important (Lara *et al*. 2010), and 'raising and maintaining interest of research participants across the lifespan of the study' (Richard *et al*. 2017 p.8), involving peer support workers to help maintain participants' enthusiasm for the study and their understanding of why it was needed. Clients may be more likely to return questionnaires if they are offered small financial incentives (Brueton *et al*. 2013). Other strategies include using tracking measures, and community involvement in the study design achieves the best follow-up rates (Robinson *et al*. 2015), as does making time for clients to complete questionnaires during therapy sessions (Carroll, 1997).

Researchers might need to make study procedures more user-friendly; to establish and maintain rapport with each client throughout the study, to seek consent from clients to visit them at home and to factor extra time to collect this data. Clients should be offered a choice, such as meeting either in a clinic or at their home, or setting up online questionnaires. Telephone assessments could be booked in advance (including evening or weekend appointments). Alternatively, offering attention-only booster sessions on a monthly basis for up to one year may help clients to maintain their progress as well as provided an opportunity to gather follow-up data.

Using a mixed-methods approach will help to collect and analyse both quantitative and qualitative data to examine how mediator variables interact with moderator variables. For example, in this study, as scores went up on the CSES, scores went down on the BDI-II, which suggests a relationship between the two variables. Another interesting observation was that there were four women in the feasibility study who were in unskilled low-income jobs, and the new intervention seemed to have less effect on depression in these women that those in semi-skilled and skilled jobs. The results should be disaggregated by the type of work clients do, whether skilled or unskilled, and whether this moderates the outcome of the new intervention in terms of both clinical and work outcomes. Further research should evaluate whether effectiveness is moderated or mediated by the level of occupational skill, or whether the intervention should be modified to make it more relevant to participants in unskilled jobs.

More attention should be paid to physical health in order to explore the relationship between the intervention and the occurrence of somatic symptoms, especially whether the inter-personal group process was in any way responsible for an increase in stress-related somatisation that emerged during the Treatment Programme (Linden, 2013; Lopresti, 2017).

More information is required from clients about how they experience other group members' disclosures of past trauma and current negative life events during group sessions. Likewise, it would be interesting to know whether clients' low quality of life on the EQ-VAS (Visual Analogue Scale) was moderated by physical and/or mental health problems, or inter-personal problems, for example.

6.3.1.3 Resources required

It is important to demonstrate that the Training Programme could deliver financial benefits to the organisation. Two practitioners should be given protected time to co-facilitate group sessions, requiring researchers to convince commissioners and senior managers that the costs of co-facilitation are justifiable.

Estimation of cost-effectiveness in a future trial would require clients to give consent for researchers to collect data on indirect costs. These include healthcare system costs such as psychotropic medication, auxiliary psychotherapy, out-patient or inpatient mental healthcare (Laaksonen *et al.* 2011), and physical healthcare costs (Layard & Clark, 2015); organisational costs such as productivity losses due to absenteeism and presenteeism (Maljanen *et al*. 2016), work ability and task completion (Murphy *et al*., 2018); societal costs such as welfare benefits (Layard & Clark, 2015); and costs to the client such as travel, lost leisure time, and unpaid help required to compensate for neglected household chores (Maljanen *et al*. 2016).

Gathering these data is more intrusive and could limit uptake of the new intervention if clients are unwilling to consent. However, if the new intervention was funded by the employer it might be possible to collect important work outcomes such as productivity, and absenteeism rates using HR register data. Researchers would need to explain to clients in a transparent and unambiguous way why this information is needed and how their confidentiality will be protected.

6.3.1.4 Assessment of clients

For further evaluation of the new intervention, more data should be gathered about clients' psychiatric history, past service use and previous help-seeking. Also, taking into consideration clients' high scores on the IIP-32 (Appendix 14), it might be useful to assess 'Expressed Emotion' in significant others, and if they are also depressed. In addition, the Impact Message Inventory (IMI) and the Inventory of Inter-Personal Strengths (IIS-32) (Appendix 14) could be used to identify what impact the client has on others, and what their inter-personal strengths are at baseline and post-intervention. Validated screening tools should be used to identify personality disorder traits such as the Standardised Assessment of Personality–Abbreviated Scale (SAPAS) (Appendix 14)

All except one client in the feasibility study reported physical health problems at baseline and there was a high rate of reported infectious and inflammatory illnesses. All clients had experienced childhood adversity, abuse and/or neglect. In further research, it might be useful to screen for physical health problems and trauma at intake, and to ascertain whether the physical health problems were sequelae of trauma, or whether the mental health problems are sequelae of physical health problems.

Whilst not all clients opted for 1:1 employment support and low key liaison from the OT, it may be helpful for all clients to undergo a full occupational analysis to determine what needed to change, because clients might have a lower risk of relapse if they negotiated reasonable adjustments. This would require more resources in terms of OT capacity to visit the workplace, for example. In addition, it might be helpful to complete an environmental assessment in the workplace with consent and to use a measure of counter-productive work behaviours (Spector *et al*. 2006) or self-assessment of work behaviour (Junkins, 1981),which may reveal how clients' mental health problems manifest in the workplace.

6.3.2 Realist evaluation

Realist evaluation uses 'a case-based (i.e. configurational) and not a variable-based [i.e. correlational] orientation' (Van Belle *et al.* 2016). Therefore, in order to test whether the hypothesised mechanisms are responsible for improving clinical and work outcomes and under which contextual contingencies they might be activated, it will be necessary to conduct a comprehensive process evaluation to probe participants' experience in more detail. An iterative process of fine-tuning will ensure that the new intervention can be modified in response to interim findings.

Some tentative suggestions have been made for the development of a theory and practice of relational group-CBT, especially whether the skilful facilitation of peer interaction activates the hypothesised mechanisms of change. New research questions should focus on identifying the potentially different therapeutic factors and different inter-personal processes in a structured-directive group, which has an equal balance of content and process compared to a non-relational psychoeducation group or a relational unstructured-nondirective analytic or inter-personal psychotherapy group. Empirical evidence for the role of inter-personal processes in group-CBT requires further research to verify the action of the core components, active ingredients, therapeutic factors, and mechanisms of change. There are several validated and reliable instruments to measure therapeutic factors (Appendix 76), which could be used to explore whether group-specific mechanisms of change do indeed accelerate and optimise change compared to non-specific mechanisms activated in CAU, such as 1:1 psychotherapy or vocational rehabilitation.

Any further realist evaluation should also aim to answer questions regarding whether the mechanisms of change can produce the predicted clinical and work outcomes, and identifying different patterns of change (Brand *et al.* 2019). This study has clarified the potential benefits (cognitive, behavioural and emotional) of peers talking together in groups. However, analysis of video data could better identify behaviours that demonstrate and verify the effects of peer learning, peer feedback and peer support in terms of group culture. This would require extra ethical approval and client consent. Teaching clients the twelve building-blocks of good conversation and setting up opportunities for them to practice these skills could be tested in terms of whether it improves patterns of communication in the group sessions, and whether it improves scores on the CSES or the IIP-32, for example. Valid and reliable measures of client adherence in terms of using the twelve building-blocks in-session and between-session need to be developed. Statistical methods might show that these group-specific factors mediate the relationship with clinical outcomes, such as remission from depression, and with work outcomes, such as job retention. This would entail coding clients' and facilitators' verbal and non-verbal behaviours, and data could be interpreted using methods such as discourse or conversational analysis.

6.3.2.1 Semi-structured interviews

One lesson learnt was that the outcome measures used in this study might be too narrow to capture the unexpected effects of the intervention, such as joining a creative writing group and performing poetry (Paula). Future research should gather qualitative data about what influences decisions to go off sick, to resume work, or to resign in employees with depression. Semi-structured interviews could help to spot contextual factors such as barriers and enablers of implementation, which would explain why the same intervention may produce different outcomes in different contexts (Pawson & Tilley, 1997). It would also be interesting to find out how clients had changed, what component of the intervention they thought had contributed to the change, what had changed outside the intervention such as the work environment, negative life events and/or attitudes of other health professionals, and whether they felt any of these changes to be positive or negative regardless of objective/subjective measures of depression.

It would be useful to have a better understanding of clients' careers and work trajectories and to understand more about clients' perceptions of their work. In addition, further research might investigate how clients who have experienced trauma function in the workplace, what sorts of events trigger distress at work, and how the range of problems they report interacts with absenteeism, job performance, and relationship satisfaction, for example through gathering both subjective and objective data from a range of sources.

Members of the wider multi-disciplinary team, such as psychiatrists, community mental health nurses, GPs, and OHPs, could be asked to identify barriers to adoption and how to increase the new intervention's acceptability and accessibility. Data collection and analysis could involve in-depth multiple case study methods with semi-structured interviews and focus groups to access 'insider accounts', which are useful in providing diverse explanations for the impact of interventions and their unintended effects (Wells *et al*. 2012). They can also add to the evaluation of internal validity and generalisability.

6.3.2.2 Non-participant observation

Qualitative data from fieldwork may be useful to identify unanticipated causal pathways and unintended consequences. An observer-rated rather than a self-rated method that has been used in psychotherapy process research could be used to code minute-by-minute verbatim transcripts of the therapy sessions (Starrs & Perry, 2018). Methods such as inter-personal process recall (IPR) (Meekums *et al*. 2016) can be used to uncover potentially out-of-awareness thoughts and feelings that occur during group sessions.

6.3.2.3 Document analysis

Documents such as therapists' assessment and discharge letters, clients' self-assessment of their progress on monthly care plans, as well as their weekly goal-planning and goal-reviewing forms could be analysed using realist methods to identify possible mechanisms of change. These documents contain a wealth of data that might be useful in gaining a deeper understanding of the mechanisms of change. In addition, co-facilitators completed a reflection prompt sheet based on a group-CBT competency framework after each session that could be used to examine therapist-level factors.

6.3.2.4 Fidelity to the model

Dissemination and replication of new complex interventions and behavioural therapies require standardisation through the development of a manual, training protocols and integrity procedures (Carroll & Onken, 2005; Carroll & Rounsaville, 2007). A manual conveys the *what*, *how* and *why* so that accurate replication of the new intervention in a future trial is more likely, optimises fidelity to the model, or alternatively provides a baseline from which to adapt the model in local contexts. In addition, group-CBT competencies need to be identified and a scale developed that takes into consideration the structured-directive approach so that fidelity could be properly assessed. Video data could be analysed to define how group-CBT competences are performed by therapists in practice and their immediate impact on peer interaction.

6.4 DISSEMINATION STRATEGY

The original LREC proposal outlined a dissemination strategy which involved publication of parts of this thesis on the www.group-CBT.com website, and in peer-reviewed journals, and will be used in conference presentations. The author has set up and is co-chair of a Group-CBT Special Interest Group (SIG) through the British Association of Behavioural and Cognitive Psychotherapies (BABCP) and contributes to training workshops for practitioners in primary, secondary and tertiary mental healthcare services.

To ensure optimal implementation of the new intervention as an organisational level training programme, an evidence-based framework should be used. Systematic reviews and critical syntheses of models used in dissemination and implementation research have been produced to provide guidance for researchers to inform study methodology, as well as intervention design and execution (Moullin *et al*. 2015; Tabak *et al*. 2012; Meyers *et al*. 2012).

There are several evidence-based process models and determinant frameworks (Nilsen, 2015) for successful implementation of organisational interventions in health and social care (Hanson *et al*. 2016). These usually recommend a series of steps to improve implementation outcomes such as fidelity, reach, acceptability, penetration, savings, maintenance and sustainability which are undertaken before, during and after the introduction of any training programme or complex intervention.

A category of implementation model was sought that emphasises dissemination and implementation equally, that intends to achieve positive individual, organisational and community outcomes, and that lays out a clear operational procedure in step-by-step detail. Recommended models were subsequently investigated in terms of which organisational contexts they had been used in such as health and / or social care services (Hanson *et al*. 2016) .

The Quality Implementation Framework (QIF) (Meyers *et al*. 2012; Flaspohler *et al*. 2012) which is a refinement of the Interactive Systems Framework (Wandersman *et al.* 2008), was chosen as the implementation theory for any future study of the new intervention. Subsequent evaluation of the QIF has resulted in a toolkit (QIT) which identifies the six components of an implementation strategy by which an intervention is most likely to succeed in bringing about sustainable change.

For practical purposes the author integrated the QIT with an empirically-supported 7-step strategy specifically designed for the implementation of worksite lifestyle interventions (Wierenga *et al*. 2016) (Appendix 78).

6.5 SUMMARY

This chapter has presented the knowledge gained from undertaking the study in terms of how to improve the feasibility of implementation and evaluation of the new intervention. Integration of data from all stages of the study using a mixed methods approach has also allowed for a comprehensive dissemination strategy to be developed for further research.

7 CONCLUSIONS

This research aimed to answer five questions (see 1.9). It used the Medical Research Council's complex intervention guidance to inform different stages of the study.

The literature review established that a psychotherapeutic intervention to enhance job retention in CMHT service-users with moderate-severe recurrent depression had not yet been evaluated in an RCT.

Five RCTs that evaluated a range of psychotherapeutic interventions and reported both work outcomes (e.g. sickness absence rates) and clinical outcomes (e.g. depressive symptoms) (see 5.2) were identified that focused wholly or partially on this client group. Only one of the interventions was delivered in a group format but results were aggregated with the same intervention delivered in a 1:1 format. Results indicated that overall, some people responded better and quicker to psychotherapeutic interventions, and more people achieved remission compared to CAU. In most cases, the advantage of psychotherapeutic interventions was short-lived unless people received long-term psychotherapy. Additionally results indicated that many people did not achieve clinically significant change across treatments. Most psychotherapeutic interventions were associated with a small effect on job retention compared to CAU, with fewer people losing their jobs. A smaller proportion of people took time off work with an overall reduction in the number of sick days, faster work resumption, and more hours worked in the intervention groups.

Realist synthesis revealed several over-arching principles (see 2.46) and several core theoretical concepts (see 2.6).

The first iteration of the intervention design was developed through a component analysis of a larger selection of potentially relevant psychotherapeutic interventions to discover *what* these interventions did, and *how* they did it. The analysis revealed several core practice components including strategic, operational, content, process components and job retention strategies (see 2.5).

The programme theory was developed through a review of each intervention's explanatory framework to discover *why* they were supposed to work. The analysis revealed several core theoretical concepts that are activated in practice (but only in specific workplace contexts) including work-related, psychological and relationship mechanisms of change (see 2.6).

The second iteration of the intervention design and programme theory was achieved through a process of stakeholder consultation. Focus groups were used to find out what former service-users, frontline practitioners and managers thought might be helpful in both treating

depression and enhancing job retention. Ideas were also gathered about which study procedures might be helpful when implementing and evaluating a work-focused psychotherapeutic intervention in a real-world community setting.

Realist evaluation revealed six plausible context-intervention-mechanism-outcome configurations which were operationalised as a relational group-CBT Treatment Programme (see 4.2).

The piloting stage addressed feasibility, and the major problem was recruiting sufficient numbers of participants to randomise (see 4.3.2). Otherwise the new intervention was delivered safely and successfully as planned, although it was comparatively expensive. Quantitative data suggest that the new intervention is promising in terms of remission or recovery. However, there was a problem in collecting follow up data, and of those that returned questionnaires two participants had deteriorated on self-report depressive symptoms (see 4.3.1). Importantly, no-one lost their job during the study period although two clients had done so while on the waiting list. Qualitative data suggest that the intervention was acceptable to all users (see 4.4).

The third iteration of the intervention design and programme theory was achieved through further stakeholder consultation which involved consideration of the clients' manual and written feedback from clients to identify how to improve acceptability and accessibility of the new intervention (see 4.4.5). This culminated in a proposal for a primary organisational level Training (and staff support) Programme to be delivered at the worksite by peer facilitators.

The next stage of the research process will be a definitive trial, and an outline proposal was developed following the pilot stage (see Appendix 77). Further implementation and evaluation of the Treatment Programme or the Training (and staff support) Programme will be informed by some tentative suggestions regarding the theory and practice of relational group-CBT (see Appendix 73), and by recommendations for research (see 5.5).

The research contributes to knowledge and healthcare in the fields of group-CBT and vocational rehabilitation. It used a transtheoretical approach to conceptualise the new intervention and a transdisciplinary approach to deliver it in a real-world community setting. It used a participatory approach by involving former service-users in several planning and reviewing focus groups. These features are unique compared to other studies of work-focused CBT.

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APPENDICES

Nicola Walker

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APPENDIX 1: GLOSSARY

FORMER SERVICE-USER

The term 'former service-user' refers to a client who has completed a group-CBT programme.

CLIENT

The term 'client' refers to a participant in the pilot group-CBT treatment programme.

PARTICIPANT

The term 'participant' refers to any person who has consented to take part in the study or any other research study.

VOCATIONAL REHABILITATION (VR)

VR is an over-arching concept with the broad aim of establishing, maintaining or restoring occupational function e.g. preparing disadvantaged young people and those with disabilities for work, helping people with health problems who are in work to sustain employment, and helping people who are off-sick to get back to work (Frank, 2016). An important report on VR by (Waddell et al. 2008) concentrating specifically on people with 'common health problems' which although potentially manageable (italics in original), are associated with significant impairment. VR encompasses a range of work-focused interventions such as employment support, job retention and return-to-work. Strategies to achieve VR have been described as 'top-down' i.e. societal level interventions such as government policy or population-wide awareness campaigns, and 'bottom-up' i.e. organisational and individual level interventions such as occupational health care or psychological therapies (Frank, A.O. and Sawney 2003).

INDIVIDUAL PLACEMENT AND SUPPORT (IPS)

In the past the main VR options for people with chronic psychiatric disorders were 1) sheltered workshops, 2) transitional programmes e.g. Clubhouse, 3) social enterprises, 4) voluntary work and 5) supported employment (Corbiere and Lecomte 2009). There are two main conflicting approaches to VR and finding work for the 'hard-to-employ': Treat First or Work First (also referred to as 'Train then Place' or 'Place then Train' schemes). An example of the latter option is Individual Placement and Support (IPS) which has been shown to be twice as effective in helping people with severe mental health problems find and keep work (Burns et al. 2009) compared to traditional VR. IPS is a tailored 1:1 recovery-oriented employment support intervention (Bond, G.R. and Drake 2014), and enables uptake of employment in people who may be out-of-work, or

on long-term sickness / disability benefits, due to a serious mental illness (SMI) such as schizophrenia, bipolar affective disorder, and psychotic depression. It is based on a set of principles such as a rapid job search for competitive employment with time-unlimited support and ongoing professional development. IPS has been adapted as a fixed-term intervention called IPS-LITE (Burgess et al. 2011) and evaluated in a RCT with 120 participants (Burns et al. 2015), achieving similar occupational outcomes to IPS-as-usual with improved cost effectiveness. It has also been adapted for unemployed people with affective disorders in a RCT with 60 participants (Bejerholm et al. 2017), achieving similar occupational outcomes to IPS-as-usual, with improved clinical effectiveness.

There is a large body of literature about IPS which is beyond the scope of this thesis to review, and is irrelevant because IPS is mainly used as a tertiary level return-to-work intervention. The focus of this thesis is to develop a tertiary level stay-in-work intervention, so this thesis will search for, and critique, the job retention literature with a specific focus on integrated interventions for moderate-severe recurrent depression which aim to improve both clinical and occupational outcomes.

JOB RETENTION (JR)

Job retention has been defined in a temporal sense as the 'capacity to sustain competitive employment for at least two consecutive years, working at least six months per year and at least 10 hours per week' (Anthony 2011). A more comprehensive definition was given in a report commissioned by the Health and Safety Executive (James et al. 2003) which states that job retention is a VR intervention to help people with mental or physical health problems or disabilities to stay-in-work. The report identifies three categories of once healthy employees who may require job retention interventions:

1) Workers who have acquired a condition that has the potential to affect their work performance in the future if their health deteriorates

2) Workers who able to attend work but whose work performance is being affected by a health problem or disability

3) Workers who are not able to attend work due to a health problem or disability

A 'cycles of vulnerability' framework is used to describe how rehabilitation needs to be a dynamic process responsive to the fluctuating nature of many chronic conditions. In this way people with mental or physical health problems or disabilities can be maintained in employment through workplace surveillance, early identification of mental or physical health problems or disabilities, proactive sickness absence management, functional assessment, and negotiation of

adjustments or accommodations for example (James et al. 2003). The report recommends a 'joined up' approach with open communication and collaboration between all the different professionals and systems involved e.g. psychology, human resources, occupational health, trade unions and general practitioners. At a societal level, rehabilitation and job retention will be influenced by external factors such as employment and equality law, as well as welfare compensation schemes and personal injury litigation for workplace-acquired mental or physical health problems or disabilities.

In a longitudinal cohort study with 347 participants (Ellison et al. 2008) interruption in employment was mostly associated with relapse of mental health problems, with 33% of participants stated that the support of a psychiatrist or psychotherapist helped them to maintain professional- or managerial-level employment over a four year period, and being in psychotherapy also predicted job retention.

RETURN-TO-WORK (RTW)

Return-to-work has been defined as 'a set of workplace processes designed to facilitate the reintegration…..of persons who are on sick leave from work, either on a short-term or long-term basis, and who retain an attachment to a specific employer' (ISSA 2013 p.9). However in the contemporary research context the term 'return-to-work' most often refers to the transition from unemployment to employment in people who are out of work and on welfare benefits due to chronic sickness or disability, with no attachment to an existing employer. These interventions should perhaps be termed more 'back-to-work' (Frank and Thurgood 2006) for the sake of clarity. Sickness absence in the UK is defined as less than 4 weeks for short-term sickness absence and as more than 4 weeks for long-term sickness absence (NICE 2009a)(Clinical 2009), although cumulative short-term absences or multiple spells linked to a specific condition (such as depression) are included in the recommendations for managing long-term sickness absence as well. In addition 'return-to-work' is used inconsistently in research studies with regard to outcome. It may refer to a partial resumption of work on a phased return, or redeployment to a different role, or time taken to achieve complete reintegration, in the person's previous role at their full contracted hours and equal earnings. For the purpose of this study, return-to-work applies only to short-term sickness absence of less than 4 weeks in employed people with moderate-severe recurrent depression.

APPENDIX 2: THE OCCUPATIONAL HEALTH FRAMEWORK

The Occupational Health framework also describes three broad categories of preventative interventions:

Table 1 - The Occupational Health Framework

PRIMARY PREVENTION	**SECONDARY PREVENTION**	**TERTIARY PREVENTION**
HEALTHY INDIVIDUALS NO SYMPTOMS	**AT RISK OR SHOWING EARLY SIGNS**	**HIGH RISK SYMPTOMATIC**
Proactive	**Ameliorative**	**Reactive**
Universal Interventions	**Targeted / Selected Interventions**	**Indicated Interventions**
Prevention of the initial onset or occurrence of disease or mental disorder.	Early detection and management of emerging sub-clinical problems in the early stages before they progress to diagnosable disease or mental disorder.	Treatment of symptoms, and lessening the negative impact of existing disease or mental disorder by reducing complications and restoring function.
Stressor-directed prevention i.e. by modifying the work environment or job to reduce risks.	Response-directed prevention i.e. by modifying how the worker responds to job stress, by training in stress management or coping skills.	Symptom-directed prevention i.e. by modifying symptomatic behaviour, addressing associated disability or incapacity, recovery-focused, aiding return-to-work and rehabilitation, providing workplace adjustments, limiting severity or chronicity, preventing relapse or deterioration.

(Adapted from Żołnierczyk-Zreda (2002) and LaMontagne, Keegel and Vallance (2007)

APPENDIX 3: INFORMATION ABOUT DEPRESSION

3.1 DIAGNOSIS OF DEPRESSIVE DISORDER OR DEPRESSION

Depressive disorders are characterised by sadness or low mood usually with marked loss of interest or pleasure. There are often other symptoms such as disturbed sleep, changes in appetite, loss of energy, either agitation or slowness of movements, poor concentration or indecisiveness, feelings of worthlessness or excessive and inappropriate guilt, and sometimes suicidal thoughts or suicidal acts (ICD-10). For depression to be diagnosed there is a requirement for evidence of clinically significant distress or impairment in social and occupational function.

Table 2 – Symptoms of depression from NICE guideline (2009)

Key symptoms are:

1) Persistent sadness or low mood, and/or
2) Marked loss of interest or pleasure

At least one of these, most days, most of the time for at least 2 weeks

If any of the above present, ask about associated symptoms:

3) Disturbed sleep (decreased or increased compared to usual)
4) Decreased or increased appetite and/or weight
5) Fatigue or loss of energy
6) Agitation or slowness of movements
7) Poor concentration or indecisiveness
8) Feelings of worthlessness or excessive or inappropriate guilt
9) Suicidal thoughts or acts

Then ask about the duration and associated disability, past and family history of mood disorders, and availability of social support.

Symptoms which suggest moderate-severe depression include:

- Inadequate or incomplete response to two or more interventions
- Recurrent episode within 1 year of last one
- History suggestive of bipolar disorder
- The person with depression or relatives request referral
- More persistent suicidal thoughts or active suicidal plans
- Self-neglect
- Psychotic symptoms
- Severe agitation

Sub threshold depressive symptoms:	Fewer than 5 symptoms of depression
Mild depression:	Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor impairment
Moderate depression:	Symptoms or functional impairment between 'mild' and 'severe'
Severe depression:	Most symptoms and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

3.2 RECURRENT DEPRESSION

Researchers reached consensus on the terms to be used in depression studies (Rush et al. 2006); (Frank et al. 1991). 'Full remission' is the term used when the patient is asymptomatic. 'Partial remission' describes the patient's condition when most symptoms have disappeared but with some minimal or residual symptoms still in evidence. 'Recovery' is when the patient has been virtually asymptomatic for between 2-4 months (Keller et al. 1983; Frank et al. 1991). 'Relapse' is a return of enough symptoms to meet diagnostic criteria. 'Recurrence' is any new episode after a period of full remission or recovery.

Recurrent Depression (RD) is diagnosed when there have been repeated episodes of depression with no evidence of mania (e.g. euphoria, excitement, over-activity). Some people are fully recovered between episodes, some people experience only a partial recovery, and some people develop a chronic form of depression as they age. Usually this form of depression is associated with early onset (Kessler and Bromet 2013), co-morbid personality pathology (Drachmann Bukh et al. 2011), and a remitting-relapsing course (American Psychiatric Association, 2013).

Treatment resistant or refractory depression is diagnosed when there has been no (or only a partial) response to at least two trails of either pharmacological or psychological therapy. It is thought that comorbidity, duration and severity of each episode of the illness are predictors of chronicity with associated disability. However there may be other reasons for non-response such as sub-therapeutic doses, early discontinuation, patient non-adherence, intolerable adverse effects, and wrong diagnosis or formulation (Serretti and Fabbri 2014). Lack of response to treatment can be considered using staging models or methods which characterise depression according to its seriousness, longitudinal development or a treatment history, and current features (Ruhé et al. 2012; Cosci and Fava 2013).

By thinking of depression as a progressive illness with several phases (prodromal, acute, residual, recurrent and chronic), treatment choices could be based on prognostic factors as much as by symptomatic presentation. The heterogeneity of depression means that people reporting similar symptoms are given the same diagnosis even though there are obvious differences in how they experience the illness.

3.3 INCIDENCE

The incidence (new cases) of depression is difficult it is to calculate accurately, because the metrics and the data interpretation methods chosen may be biased due to the vested interests of different groups such as pharmaceutical companies, the medical professional, business organisations, Trade Unions, the State, and charities representing patients (Hidaka 2012). Methodological issues such as differences in sampling, methods of clinical assessment and

problems in translation (Ballenger et al. 2001) may be responsible for cross-cultural variances. Nevertheless there is debate about whether more people are actually suffering from depression, or whether there are simply more people disclosing symptoms of depression. An increase in people seeking help will probably result in higher rates of diagnosis, anti-depressant prescribing, and referral to mental health services with associated increased healthcare costs.

Disagreements may also be due to the contrasting stances towards health taken by different institutions for example, 'health as a right' versus 'health as a commodity' (Ney 2010). Institutions representing medicine may support a view of health that increases physicians' power for example. Institutions representing business may support a view of health that reduces the costs of sickness absence for example. Institutions representing patients may support a view of health that gives them more choice and control over their care for example.

Most epidemiological studies report on depression as a single entity, rather than as different subtypes. UK incidence rates have been estimated using information from a variety of databases (see Table 3).

Once people are labelled as 'depressed', they may be more likely to self-report problems with low mood when questioned. However, other cultural influences may come into play, such as levels of stigma and discrimination towards people with mental health problems, and reluctance to acknowledge mental symptoms (Weissman et al. 1996). In addition, people may be reluctant to take time off work for mental health problems when there is a recession due to fear of losing their job (Barnes et al. 2008; Chandola 2010).

Depression is one of the most common mental health problems in the UK according to the Adult Psychiatric Morbidity Survey (Lubian et al. 2014) which found that about 3.8% of respondents met criteria for depression (an increase from 2.6% in 2007). It has been estimated that between 4-10% of people in England are likely to experience a depressive disorder in their lifetime (McManus et al. 2009). It is therefore probable that many employed people will experience a depressive disorder at some point in their working lives, which may have an impact on their work performance and / or attendance, and may threaten job security and job retention in the longer term. Short-term sickness absence and long-term disability due to mental health problems have serious direct and indirect costs for individual employees, workplace organisations and society as a whole. It is therefore important to understand the negative effect that depression has at these three different levels, and how to mitigate these effects.

Table 3 – Sources of information re incidence

DATABASES	METRICS	ASSESSMENT TOOLS
• Quality Outcomes Framework • The Adult Psychiatric Morbidity Survey • Health Survey England • Clinical Practice Research Datalink including the General Practice Research Database (Wallace et al. 2013) • Understanding Society, the UK Household Longitudinal Study • National Wellbeing Programme • UK Bio Bank	• Prescribing of anti-depressant medication • Number of GP consultations for depression • Duration of certified sickness absence for depression • Use of specialist mental health services for depression • Number of hospital admissions and inpatient bed-days for depression • Expenditure of mental health treatments for depression • Sickness or disability welfare benefit claims for depression • Numbers of people diagnosed with depression • Death rates from suicide • Self-reported health status	Examples of semi-structured clinical interviews: • Structured Clinical Interview for DSM Disorders (SCID) • Hamilton Rating Scale for Depression HAM-D • Center for Epidemiologic Studies of Depression Scale (CES-D) Examples of self-report measures: • Beck Depression Inventory (BDI) • Montgomery-Asberg Depression Rating Scale **(**MADRS) • Patient Health Questionnaire (PHQ-9) • Hospital Depression and Anxiety Scale (HADS)

3.4 PREVALENCE

Prevalence 'varies according to gender and social and economic factors' (National Collaborating Centre for Mental Health 2011 p.23). Longitudinal studies show that depression has the largest increase in prevalence (i.e. total cases) for all psychiatric disorders (Compton et al. 2006; Murphy et al. 2000) with younger people more likely to develop depression, and at a younger age. Estimates vary significantly because it is difficult to calculate using the 'incidence x average duration' equation owing to depression tending to be an episodic or recurrent illness following a remitting-relapsing course (Kramer et al. 1980).

The incidence and prevalence of depression in the UK is possibly underestimated because of the way symptoms (as opposed to diagnoses) are reported by General Practitioners (Edwards et al. 2016). So whilst the most recent Adult Psychiatric Morbidity Survey found that mixed anxiety and depression is the most commonly diagnosed disorder, and Health Survey England showed that 25% of all adults have been diagnosed with a common mental health problems, most usually depression, a further 18% of respondents stated that they had suffered from symptoms of anxiety and depression but had never been diagnosed.

3.5 SEVERITY

Assessment of the severity of depression in recent outcome studies was based on either a semi-structured clinical interview or a self-report measure. The former include the Structured Clinical Interview for DSM Disorders (SCID), the Hamilton Rating Scale for Depression HAM-D, and the Center for Epidemiologic Studies of Depression Scale (CES-D) for example. The latter included the Beck Depression Inventory (BDI), the Montgomery-Asberg Depression Rating Scale **(**MADRS), the Patient Health Questionnaire (PHQ-9) and the Hospital Depression and Anxiety Scale (HADS) for example.

A tool has been developed by NICE (2009) to standardise assessment of depression in the UK. It uses the diagnostic criteria of DSM-IV, and the level of severity is based the number of symptoms the client presents with, as well as other psychosocial factors.

Treatment options depend on severity, and include:

- General advice and active monitoring (sub-threshold)
- More active treatment in primary care (mild)
- Referral to mental health professionals (moderate)
- Urgent referral to specialist mental health services (severe)

3.6 COURSE

The majority of people with depression experience another episode leading some clinicians to ask whether it should be managed as a chronic disease (Andrews 2001). This would involve longer-term treatments, which in depression is usually pharmacological although there is an absence of evidence for the effectiveness of anti-depressant medication (ADM) (Uher and Pavlova 2016). The course of recurrent depression is characterised by on average 5-9 separate episodes over the lifetime, and at least 50% of people who recover from the initial episode of depression go on to have at least one more episode (Gelenberg et al. 2010). This study also found that for people who had a history of two episodes of depression, nearly 80% experienced further recurrence. It has been found that even during remission from depression some people may experience residual symptoms in the mild range, and that these people are at more risk of relapse (Judd et al. 1998).

Table 4 - Sources of information re prevalence and course

SOURCE	INFORMATICS
Gelenberg et al. 2010 using worldwide data.	Lifetime prevalence of depression has been calculated as up to 25% in women and 12% in men
WHO 2008 using worldwide data.	Rates vary from 3% in Japan to 17% in the USA
Gilmour, H. and Patten 2007 using data from representative sample of Canadian workers. Kessler et al. 2006 using data from representative sample of US workers.	In the workplace, 12-month prevalence rates range from 4% to 6.4%
King et al. 2008 using data from unselected general practice attendees in six European countries.	At any one time 13.9% of women and 8.5% of men
Klein and Kotov 2016 using data from 142 outpatients selected from consecutive admissions to USA clinics.	Of people attending outpatient mental health services with depression, the proportion of this population having recurrent depression rises to between 36-50%
Murphy, J.A. and Byrne 2012 using data from over 8000 households of adults between the ages of 16 and 85 years in the 2007 Australian National Survey of Mental Health and Wellbeing.	Lifetime prevalence of recurrent depression in community samples is 4-5% of adults, and 30% of people in the general population diagnosed with a depressive disorder have recurrent depression
Smith et al. 2013 using data from UK Biobank differentiating 'probable' depression when relying on 'less stringent' self-report compared to 'actual or confirmed diagnoses' made by formal assessment.	Probable recurrent major depression (moderate) 12.2% with females to males ratio of approximately 7:3
	Probable recurrent major depression (severe) 7.2% with females to males ratio of approximately 6:4
The Quality Outcomes Framework UK	6.5% for the period 2013-2014 in UK adults over 18
Data from Clinical Commissioning Groups across UK	Wide variation between from 3.1% to 12.4%
Labour Force Survey (Health and Safety Executive 2015)	Prevalence of work-related stress, anxiety and depression of 1380 per 100,000 workers, with an incidence rate of 740 per 100,000 workers.

3.7 PROGNOSIS

Many people with depression have a poor prognosis. If the criteria used to identify the disorder are broadened to include dysthymia, and if the follow up is extended, a large cohort study in the Netherlands shows that the majority of people do not have an episodic disorder from which they can make a full recovery, but have a chronic and disabling disorder (Verduijn et al. 2017).

3.8 MORTALITY

A recent prospective cohort study in Switzerland found that people with current unremitted depressive disorders were three times as likely to die as people who had never suffered from depression (Lasserre et al. 2016), and the GAZEL cohort study in France with a 20 year follow up period showed that people with a history of sickness absence for serious mental illnesses

including depressive disorders have increased mortality from somatic diseases (in other words excluding suicide) after adjusting for socio-demographic factors such as gender, age, occupational status, smoking, alcohol use, and body mass index (Lemogne et al. 2013). There were over 6000 suicides per year in the UK between 1981-2018 (ONS 2019), of which 90% are likely to have a psychiatric diagnosis with depressive disorder making up 60% of cases (Arsenault-Lapierre et al. 2004).

3.9 AETIOLOGY OF RECURRENT DEPRESSION

The cause of recurrent depression is probably different to the cause of episodic depressive disorders, such that even though they share a similar symptom profile they may be two different categories or discrete subtypes rather than different dimensions of the same disorder (Klein and Kotov 2016). Furthermore, there is significant comorbidity between Post Traumatic Stress Disorder and Recurrent Depression (Kessler et al. 1995), as well as personality disorders and substance abuse (Hölzel et al. 2011), which suggests a similar aetiology. Taking a developmental perspective shows that people with an early-onset, chronic form of depression have often experienced trauma, neglect and adversity in childhood (Cicchetti, D. and Lynch 1993; Negele et al. 2015). It is likely that people who have experienced these 'psychological insults' (McCullough et al. 2011) will develop cognitive, behavioural, emotional and interpersonal difficulties in adulthood such as enduring, treatment-resistant and unremitting mental health disorders (Hovens et al. 2012; Garcia-Toro et al. 2013; Tunnard et al. 2014).

3.10 PSYCHOSOCIAL RISK FACTORS

There may also be different risk factors for onset than for recurrence (Burcusa and Iacono 2007). For example, whereas gender (being female) and marital status (being single) confers a risk for the index episode, they do not for recurrence (Burcusa and Iacono 2007). Several risk factors have been identified for recurrent depression with a younger age of onset for the first episode that also tended to have a longer duration (Hölzel et al. 2011). In addition, individuals who go onto develop a long-lasting and life-long form of depression show a family history of depression, as well as low levels of social integration and high levels of negative social interaction (Hölzel et al. 2011).

People with chronic depression exhibit more symptoms of depression at baseline, as well as comorbid anxiety and personality disorders. They show greater impairment of social and occupational functioning. Compared to the non-chronic population, there is more likely to be a family history of psychopathology, parental substance misuse, childhood adversity, maltreatment, inadequate parenting and poorer early home environments (Klein and Kotov 2016). Other important variables that predict recurrence are age of the first episode (with younger age of onset

correlated to more risk). Also in adults, severity (manifested as suicidal thoughts / attempts, psychomotor agitation and sleep disturbance), but not duration, of the first episode is associated with greater probability of recurrence.

Researchers have proposed that recursive processes such as stress generation, depressogenic cognitive styles, negative emotionality, maladaptive coping strategies, deficits in problem-solving or rejection-eliciting interpersonal behaviours may be responsible for the self-perpetuating nature of recurrent depression (as opposed to the self-limiting nature of episodic depression (Klein and Kotov 2016). It has also been demonstrated that people with recurrent depression generate stress through contributing to dependent negative life events.

These maintenance factors could be a target for psychological interventions, such as helping people develop new coping strategies and problem-solving skills for example. In addition, since low levels of social support predict, and high levels of social support protect against, recurrence, another target could be improving people's ability to access social support both at home and at work.

When focusing on recurrent depression, about 26.5% of all patients with depression develop a chronic course (Rubio et al. 2011), with a median duration of approximately 20 years (Gilmer et al. 2005). Six psychosocial risk factors for recurrence have been identified (Hölzel et al. 2011; Riso et al. 2002) i.e. younger age at onset, longer duration of depressive episode, family history of mood disorders, comorbidity, low levels of social integration, negative interpersonal interaction, lower severity of depressive symptoms, and psychosocial stressors.

APPENDIX 4: ORGANISATIONS FOR WORK & DISABILITY

Table 5 – Organisations for work and disability

Access Ability	http://www.accessability.org.uk/access-to-work/ An employer-facing website created by providers of DWP's Work Choice and Access to Work programme plus **Access to Work helpline** Telephone: 0800 121 7479
ACAS	The Advisory, Conciliation and Arbitration Service
ACW	The Association for Counselling at Work (workplace division of BACP)
AOHNP (UK)	Association of Occupational Health Nurse Practitioners
@WORK PARTNERSHIP	https://www.atworkpartnership.co.uk/ The At Work Partnership – OH publications & conferences
BASE	British Association for Supported Employment
BIS	Department for Business, Innovation and Skills
BOHRF	http://www.bohrf.org.uk/ The British Occupational Health Research Foundation
BOHS	The Chartered Society for Worker Health Protection
BSRM	www.bsrm.co.uk The British Society of Rehabilitation Medicine
CBI	Confederation of British Industry
CESI (2001-2016)	http://www.cesi.org.uk Centre for Economic and Social Inclusion Merged with the National Institute of Adult Continuing Education to form a new organisation, the Learning and Work Institute.
CIPD	Chartered Institute of Personnel and Development
CMSUK	Case Management Society UK
COT	College of Occupational Therapists
CWH	www.councilforworkandhealth.org.uk The Council for Work and Health
DH	Department of Health
DRC	Disability Rights Commission
DRUK	Disability Rights UK
DWP	Department of Work and Pensions
EMAS	Employment Medical Advisory Service (part of HSE)
ERSA	Employment Related Services Association
ES	The Ergonomics Society
EU-OSHA	The European Agency for Safety and Health at Work
FfW Europe	www.fitforworkeurope.eu Fit for Work Europe (for MSDs)
FOM	www.fom.ac.uk Faculty of Occupational Medicine
GREAT PLACES TO WORK INSTITUTE	https://www.greatplacetowork.co.uk/ Great Place to Work Institute
	http://www.healthmanltd.com/ They own Maximus and also deliver Fit for Work
HEALTH@WORK	www.healthatworkcentre.org.uk Independent charity
HSE	Health and Safety Executive
HWWB	Health and Wellbeing at Work
HEALTHY WORKING WALES	http://www.healthyworkingwales.wales.nhs.uk/
HWUK	www.healthyworkinguk.co.uk (no longer available) Provided for GPs by The Royal College of GPs
IES	Institute of Employment Studies

IOEM	https://www.birmingham.ac.uk/schools/haps/departments/ioem/index.aspx The Institute of Occupational & Environmental Medicine
IOSH	http://www.iosh.co.uk/ Institution of Occupational Safety and Health
L&WI	https://www.learningandwork.org.uk/ Lifelong learning
MAXIMUS	https://www.maximusuk.co.uk/ Delivers health related assessments including Work Capability Assessments.
MHEEN	Mental Health Economics European Network
MHFAENGLAND	https://mhfaengland.org/ Mental Health First Aid
MIND UK	Independent charity (mental health)
NEF	The New Economics Foundation
NHS EMPLOYERS	NHS Employers
	www.workplacehealthandwellbeing.co.uk NHS Plus (2001-2013)
NICE	National Institute for Health and Care Excellence
NMHDU (2009-2011)	National Mental Health Development Unit
OCS (2010- present)	Office for Civil Society
OECD	The Organisation for Economic Co-operation and Development
ODI	The Office for Disability Issues (part of DWP)
PEROSH	Partnership for European Research in Occupational Safety and Health
PHE	Public Health England (part of DH)
POOSH	http://www.poosh.org/ Professional Organisations in Occupational Safety and Health
ENMHP (PROMENPOL 2007-2009)	European Network for Mental Health Promotion (Promoting and Protecting Mental Health)
RADAR	The Royal Association for Disability and Rehabilitation
RCOT	https://www.rcot.co.uk/ The Royal College of Occupational Therapists
REMPLOY	Owned by the DWP
RETHINK	Charity (serious mental illnesses)
RF	Richmond Fellowship
SCIE UK	Social Care Institute for Excellence
SCMH	www.centreformentalhealth.org.uk www.impactondepression.co.uk (no longer available) Sainsbury Centre for Mental Health
	www.healthyworkinglives.com Scottish Centre for Healthy Working Lives
SEQOHS	https://www.seqohs.org/ Safe, Effective, Quality Occupational Health Service Sets standards and offers a voluntary accreditation scheme for occupational health services in the UK and beyond.
SHIFT (2007-2011)	Department of Health's anti-stigma campaign
SEU, SETF (1997-2010)	The Social Exclusion Unit, The Social Exclusion Task Force
SOHP	Society for Occupational Health Psychology
SOM	The Society of Occupational Medicine
WF	www.theworkfoundation.com The Work Foundation
TIME TO CHANGE	www.time-to-change.org.uk Department of Health's anti-stigma campaign (2007-2015)
TUC	The Trade Union Congress
UKRC	United Kingdom Rehabilitation Council
UKCES (Gov)	United Kingdom Commission for Employment and Skills

WALES	www.wellbeingthroughwork.org In work support service
WHO	The World Health Organisation
	www.benefitsandwork.co.uk
	www.health4work.nhs.uk Occupational Health advice line
VRAUK	www.vra-uk.org Vocational Rehabilitation Association UK

Table 6 – Types of organisations

Research bodies and academic institutions	British Occupational Health and Research Foundation
	Sainsbury Centre for Mental Health
	The Work Foundation
	Learning and Work Institute
	Institute of Employment Studies
Professional bodies	British Society of Rehabilitation Medicine
	Association of Occupational Health Nurse Practitioners
	College of Occupational Therapy
Independent think tanks	Reform Foundation
	Resolution Foundation
	Progress
Pressure groups, charities, other not-for-profit and campaigning organisations	Trade Union Congress
	Council for Work and Health.
	Chartered Institute of Personnel and Development,
	Vocational Rehabilitation Association UK
	British Association for Supported Employment
	Depression Alliance
	Rethink
	MIND
	Disability Rights UK

APPENDIX 5: DIFFERENT WAYS OF LOOKING AT THE PROBLEM & POSSIBLE SOLUTIONS

Table 7 – Possible theories and interventions

Theoretical perspective	Possible interventions
Socio-political	**Societal level**: policies to create a more equal, diverse and humane society putting people before profit.
Ethnographic	**Societal level**: policies to decrease stigma, and increase help-seeking for mental health problems.
Institutional-cultural	**Societal level**: implementation of trauma-informed principles into the workplace.
Occupational stress	**Organisational level**: environmental modifications to reduce stress in the workplace.
Social constructivism	**Organisational level**: re-definition of depression as a shared problem occurring between people to be solved by collective understanding and action.
Systemic	**Interface level**: processes to improve communication between all stakeholders in the workplace.
Inter-personal	**Interface level**: training to improve civility and collegiality in the workplace.
Bio-medical	**Individual level**: psychiatric care and / or prescription of anti-depressant medication.
Evolutionary	**Individual level**: psychoeducation on how to regulate emotions and autonomic nervous system.
Stress diathesis	**Individual level**: psychoeducation about how to cope with triggers.
Cognitive and behavioural	**Individual level**: psychological therapies and psychotherapeutic interventions to modify unhelpful beliefs / behaviours.
Psychodynamic	**Individual level**: psychological therapies and psychotherapeutic interventions to resolve unconscious intra- and inter-personal conflicts.

APPENDIX 6: RELEVANT GOVERNMENT POLICIES 2007-2014

6.1 INTRODUCTION

Over the last 20 years, there has been a broadly non-partisan agreement to tackle a financial 'black hole' in UK government public spending. The main fiscal pressures are related to:

Demographic changes such as increased life expectancy that is associated with higher demand for health and social care.

More people leading unhealthy lifestyles which are linked to a cluster of comorbid non-communicable long-term conditions and chronic diseases such as hypertension, cardio-vascular disease, hyperlipidaemia, chronic obstructive pulmonary disease, type II diabetes, stroke, end stage renal disease, chronic pain, fatigue and depression. Poor health is also linked to a reduction in work capability and subsequent worklessness.

Sharply rising expenditure on unemployment, sickness and disability benefits, with increasing on-flows (payments started) and negligible off-flows (payments ended) specifically in relation to assessed long-term incapacity for work. New claimants for mental health problems are mainly middle-aged people, but there are increasing numbers of relatively young people too, which means that once awarded the benefit people could be in receipt of it potentially for life (OECD 2010; Kaltenbrunner Bernitz et al. 2013), thereby creating a significant disincentive to work.

These are the main drivers for recent welfare reforms, mental health and employment strategies, sickness absence and job retention policy, health and wellbeing at work policy, disability policy and equality law, which have a direct and indirect impact on job retention for working people with moderate-severe recurrent depression.

Several government departments have contributed towards these laws, strategies and policies over the last 10 years. Departments that have commissioned research into work and mental health, funded a range of pilots and programmes, and developed policies relevant to job retention for people with moderate-severe recurrent depression include the Department of Work and Pensions, Department of Health, Department of Business, Innovation and Skills, and The Office for Disability Issues. Other prominent state-funded non-departmental public bodies that have had a part to play in policy development include the Health and Safety Executive, and the National Institute of Health and Care Excellence (NICE). Department ministers and political decision-makers in the UK are lobbied by, and influenced by, various organisations (see table 1).

At an international level the European Commission, International Labour Organisation, World Health Organisation, and Organisation for Economic Development and Cooperation for example

have published reports that feed into UK government's disability, mental health and employment strategies.

Business bodies such as the Confederation of British Industry may have a vested interest in shaping policy regarding the employment of people with depression, as do private companies such as Maximus, Ingeus, Atos and Remploy who have a direct role in implementing government return-to-work programmes.

6.2 Welfare Reform

Welfare reform is one of the ways consecutive governments have tried to reduce the budget deficit. Increasing the value of benefits may have had an unintended consequence of more people leaving work permanently before full retirement age perhaps due to a perverse incentive (Banks et al. 2015). Our current sickness and disability welfare system was shaped in the early 1970s. Firstly, 'earning replacement benefits' were introduced to provide an income for people unable to work due to sickness (e.g. Statutory Sick Pay, Employment Support Allowance). Later 'extra-costs' benefits were established to provide financial support for people with disabilities who incurred additional expenses for personal care and transport (e.g. Disability Living Allowance, Personal Independence Payment). 'Horizontal equity' between people with disabilities and those without was the guiding principle (Burchardt 1999), and this still informs welfare policy today.

Previous Labour governments (1997-2007; 2007-2010) based their 'welfare to work' strategy on the principle 'work for those that can, security for those who cannot' (Department of Social Security 1998), and the Coalition (2010-2015) and current Conservative (2010-present) governments have built on previous policies to tighten access to sickness and disability 'extra-costs' benefits by using the Work Capability Assessment. Two powerful narratives are being used to challenge the so-called culture of welfare dependency and perhaps justify cuts such as the idea that people in poverty should not be 'written off' (DWP, 2008), that they are 'trapped on benefits' (DWP 2010), and that 'work must pay' i.e. receipt of benefits should not de-incentivise work, and employed people should never be worse off than those on welfare (DWP 2010). These narratives have been disputed (Lindsay, C. and Pascual 2009), and there is also concern about the divisive language used such as 'shirkers' versus 'strivers' i.e. people who could work and claim benefits fraudulently versus people with aspirations to work hard and support themselves financially, and the 'creeping conditionality' by which entitlement to benefits is restricted, and as such undermines the basic assumption of entitlement or 'welfare rights' (Dwyer 2004). Another controversial narrative, which is gaining some traction, relates to the 'welfare-induced', 'employment-resistant' character of the 'underclass' (Perkins 2016), which argues that benefit dependency changes recipients' personality traits with evidence of low conscientiousness and low agreeableness.

These narratives will also influence the job retention and return-to-work decisions made by employed people with recurrent depression.

To achieve its policy objectives the current Conservative government is further investing in employment support, return-to-work, and job retention and progression programmes (e.g.)….These interventions rely on the State taking an 'activating stance' (OECD 2014) whereby the anyone unable to work due to health problems is also seen as a citizen with a deepening and widening obligation (DWP 2008) to 'contribute to society by means of paid labour' (van Hal et al. 2013), and although financial help will be provided there is an expectation that the sick person will try to get better. This strategy 'emphasises altering attitudes and behaviour, moving people from and dependence to an interdependence mind-set in which personal and collective responsibility is the norm' (Cooper, C & Llopis, 2013 p20).

Furthermore, concern has also been expressed (OECD 2010) that because psychiatric disorders are usually diagnosed by virtue of self-reported distress (as opposed to physical evidence of pathology as in medical diseases), it is possible for people to exaggerate their symptoms for the purposes of primary gain (an internalised motivation to avoid work) and secondary gain (an externalised motivation to avoid work) (Warren 2011). Malingering is the concept used to describe this activity (Els et al. 2011), and it is perhaps an unspoken assumption of people who claim sickness benefits due to mental health problems (Shapiro et al. 2010).

Nevertheless, once an individual has taken on the 'sick role', at the expense of giving up other socially-valued identities (Shapiro et al. 2010), absence from work and exemption of other duties and responsibilities are legitimised (Lederer et al. 2014), although there is also an obligation to seek professional help to recover, and once recovered for normal roles and duties to be resumed (van Hal et al. 2013).

Over this period, Invalidity Benefit (IB) is being replaced by Employment Support Allowance (ESA). All new claimants will be assessed for Universal Credit (UC) and existing claimants will be migrated across to UC. Disability Living Allowance (DLA) is being replaced by Personal Independence Payment (PIP).

The assessment of disability has been taken over by the grant-making institutions (such as insurance companies in some countries and the DWP in the UK), because it is hoped that fewer people will be signed off as unable to work as they are by their family doctors. Nevertheless, in other countries, workplace disability prevention services are funded by the State such that a request for sickness benefits automatically triggers a concurrent request vocational rehabilitation (Pomaki et al. 2010; Frank, A.O. and Sawney 2003). Once people are on disability benefits further treatment is paradoxically precluded (Fenger et al. 2013), which has led some Conservatives

ministers to call for psychotherapeutic interventions for depression and anxiety to be mandatory with sanctions applied for those who refuse (Ross 2014). This view underpinned two pilot studies designed to test the feasibility of running psychotherapeutic interventions in Job Centres (Callanan et al. 2015; Mehul Kotecha et al. 2015), and in spite of concerns expressed by psychotherapists and The Work Foundation (Steadman and Taskila 2015), there are plans to co-locate some IAPT services in Job Centres as part of a phased roll out (Duffin 2015).

6.3 Mental Health and Employment Strategy

Mental health strategies such as New Horizons (Labour: 2009), No Health without Mental Health (Coalition: 2011) and Five Year Forward View (Conservative: 2016), all aim to improve access to treatment and to address rising health inequality in the UK (Marmot Review: 2010), such that there should be 'parity of esteem' between physical and mental health.

Policies acknowledge that comorbidity is common in the population on sickness benefits, and different types of conditions interact in complex and unpredictable ways. So it is important for services to work in a more integrated way, but also to share a conceptual understanding of chronic health conditions (i.e. by using a bio-psychosocial formulation).

Different interventions have been implemented at societal, organisational and individual levels to improve mental health literacy (Dunt et al. 2011), to raise awareness of mental health problems (Dimoff et al. 2016), to enhance attitudes towards people with mental health problems in the general public (e.g. Mental Health First Aid training: Hadlaczky et al. (2014), and to tackle discrimination through anti-stigma campaigns; eg. Shift,Time to Change (Henderson et al. 2017). Again these strategies have perhaps had unintended consequences such that whilst new cases of depression for example may have been identified early, more everyday problems (including work difficulties) have been medicalised (OECD 2010), more people labelled with mental health disorders, leading to potentially less self-efficacy and more illness perception in the general population (Aylward et al. 2013; Macinnes et al. 2014).

The Labour government invested in the Improving Access to Psychological Therapies programme (Clark 2012) to increase the provision of evidence-based treatment for common mental health problems, with the aim to stem the tide of people leaving work with depression and anxiety, and ultimately to reduce the welfare bill. The Coalition government extended the remit of IAPT: 'Talking Therapies: a four-year plan of action' (Department of Health 2011), and set 'Waiting Time Standards' for mental health services (Department of Health 2014).

These initiatives aim to treat the disorder, at the same time as providing in-work employment support for employees with mental health problems as a way of mitigating the risk of job loss (Macinnes et al. 2014). However, providing psychological therapies and interventions might be at

odds with the more directive and work-focused interventions delivered by the Department of Work and Pensions through subcontract to companies, where the staff delivering the support have little if any training in mental health issues or understanding of the complex nature of recurrent depression (Kennedy et al. 2019). Nevertheless, the need to help people with depression stay-at-work and return-to-work is self-evident.

6.4 Sickness Absence and Job Retention Policy

Public sector health and social care organisations have higher than average sickness rates at 8.3 days per employee compared to 5.7 days in the private sector (Murphy 2016). This disparity has been a target for government with attempts to make the NHS an 'exemplar employer'. The Boorman report (2009) recommended that in order to improve staff health and wellbeing in the NHS as the country's biggest employer, 'high priority should be given to ensuring managers have the skills and tools to support staff with mental health problems' (p13). The introduction of staff wellbeing initiatives alongside stricter sickness absence policies and procedures by NHS employers appears to have resulted in lower sickness absence rates in the NHS, now at historically low levels (NHS Digital 2018), such that the gap in sickness rates between the public and private sectors has narrowed over the past 20 years (Office for National Statistics, 2014).

Across sectors, there has also been massive investment in Occupational Health services in response to the Black report (2008) with the independent Fit for Work scheme providing access to OH assessment and advice for small and medium enterprises as well as for GPs. The service aims to help with sickness absence management to improve return-to-work and job retention. The government has also tried to influence all health professionals to consider vocational rehabilitation in their consultations with patients (Frank and Thurgood 2006), Healthcare Professionals' Consensus Statement (HWWB 2008). In addition, there has been a major change in the role of GPs who now use a 'fit note' instead of a 'sick note' to certify the health reasons for absence (Royal College of Physicians 2012).

6.5 Health and Wellbeing at Work Policy

Different governments' industrial strategy and employment policies have had the twin goals of increasing the nation's employment rate (thus raising tax revenues), and decreasing employee sickness absence rates (thus keeping more people in stable work). This is especially important with increasing longevity in the UK, and as a result the Coalition government has made plans to raise the retirement age meaning that people will be expected to work into their late 60s before they can claim the State pension (Beattie 2013), and also applies to parents who are encouraged to work more hours with new flexible working regulations (HM Government 2010).

The narrative in this case is that work is good for health, and being out of work is bad for health e.g. 'employment and health form a virtuous circle' (Independent Mental Health Taskforce 2016 p.16), such that job retention is seen as a legitimate and ethical target for psychotherapeutic interventions. However there is another equally valid discourse that is perhaps not being articulated as clearly i.e. that mental health problems may be caused by working in 'toxic environments' (Kunyk et al. 2014), and people are expected to work as 'willing slaves'(Bunting 2011). One commentator claims that depression is 'a sane response to a crazy world' (Menand 2010), and a form of escape (Kitanaka 2016).

However when someone goes off sick with stress it is often due to a wrong career choice 'such as teachers unable to maintain order in the classroom' (Cooper, C & Llopis, 2013 p8). To facilitate a change of job Black (2008) recommended the introduction of a new brokering service (Universal Job Match) in Job Centres for anyone absent for more than 20 weeks although this has never been fully implemented. However the Coalition government deregulated certain aspects of employment law (such as long-standing rights and protections) because they were thought to stifle entrepreneurship and the efficient working of labour markets as well as to discourage workers from 'moving from job to job for fear of risking employment protections they have acquired over time' (Department for Business Innovation and Skills 2013 p.8), which may resolve a poor job fit and prevent long-term sickness absence.

To tackle other reasons why people may wish to avoid work, governments across the developed world are now considering factors such as 'social capital' i.e. quality of relationships in the workplace, and decent income (North West Public Health Observatory 2010), 'mental capital' i.e. employee health and wellbeing (Beddington 2008). Traditional 'health and safety at work' departments have been transformed into 'health, safety and wellbeing at work' departments (Black 2008), with a new emphasis on reducing psychological risks as much as physical risks in the workplace.

The Coalition and Conservative governments have used a nudge approach to encourage businesses to demonstrate 'corporate responsibility' which is based on philanthropic ideals (Department for Business Innovation and Skills 2014), and involves treating the workforce well amongst other things, hopefully improving staff morale and reducing absenteeism. However a national survey of psychosocial working conditions concluded that there has not been any improvement in the UK (Health and Safety Executive 2012). The business case for employers providing 'good work' i.e. with opportunities for personal development and promotion, flexible working, a degree of control, involvement in key decisions, fair wage, and where there is equality and a lack of discrimination (Liimatainen, M.R. and Gabriel 2000; NWPHO, 2010) and for looking after staff health and wellbeing has been made by demonstrating that this will improve

productivity and organisational performance, as well as reduce sick pay, staff turnover and recruitment (Mental Health Network 2010; Shapiro et al. 2010).

Also it has been pointed out that mental health problems can affect the workplace in terms of a lack of innovation (Ryan et al. 2005), increased error rates, poor decision-making, loss of employee motivation and commitment, tension and conflict between colleagues (Bauman et al. 2010), with significant non-commercial benefits of organisational investment in wellbeing programmes such as better morale and better relationships between management and staff (Sainsbury et al. 2012).

MIND (2010) claims that, 'inexpensive, simple measures to support staff mental wellbeing can save up to 30% of the costs of absenteeism', with another cost-benefit analysis showed that treatment costs are 'more than offset by savings', which whilst the savings were not immediate, they 'were more than fully realized well within our employer analyses' 5 year time horizon' (Wang et al. 2006 p1350).

The workplace is being now recognised as the 'primary extra-familial social context' by which the employee may gain a sense of personal worth, belonging, identity and job satisfaction (Cockshaw and Shochet 2007). At the same time the boundary between work and home life or leisure time has become blurred due to technology such as smart 'phones and new practices such as home working (Demerouti et al. 2014). Concepts such as 'organisational connectedness' (the employee's perception of what others at work think of him/her), 'affective commitment' (the employee's attitudes towards, and appraisal of the organisation) and 'social identification' (feeling part of the organisation) are aspects of employee wellbeing (Cockshaw and Shochet 2007). Organisational connectedness when the individual worker feels 'accepted, respected, included and supported' by others at work is positively associated with their overall resilience and wellbeing, and is more significant than the other two aspects.

Despite the evidence supporting the promotion of employee's health, safety and wellbeing, there has been little extra workplace regulation in the UK, rather governments have tried to influence organisations to reduce psychosocial risks (e.g. bullying and harassment policies), to take better care of people with potential or actual health problems (e.g. workers health surveillance, early intervention, employee assistance programmes), and to help them to stay-at-work when they have been ill or have acquired a disability (e.g. enhanced depression care and proactive disability management programmes).

These schemes have had limited success on job retention and there is now more emphasis on providing interventions which aim to help employees build up their personal resilience to stress in

the workplace caused by organisational change for example, and develop self-efficacy to cope with stress caused by negative life events outside work.

Governments have been called on to do more in terms of making stress management standards mandatory as they are in the Scandinavian countries (Cooper, C & Llopis 2013), and removing the 'so-called' individual opt-out clause to the Working Time Regulation and expanding the Information and Consultation regulations (Brinkley 2015), which would enhance employee wellbeing.

Regardless, employment law (concerning unfair dismissal and employment tribunal procedures) was changed by the Coalition government making it easier for employers to dismiss people, and to have exclusion clauses in employment contracts limit the employer's liability relating to stress arising from organisational change such as redundancy, redeployment, transfer and dismissal, which further undermine workers' rights (Hepple 2013).

6.6 DISABILITY AND EQUALITY POLICY

The social care modernisation agenda included the transformation of community-based adult mental health services, local authority day centres, sheltered workplaces and residential training colleges for people with disabilities (Social Care Institute for Excellence 2007). These institutions have been shown to reinforce stigma and ostracism (National Mental Health Development Unit (NMHDU 2009), and did little to achieve competitive employment for service-users (Modini et al. 2016).

Budgets have instead been used for more widespread implementation of the Individual Placement and Support model, the Access to Work Scheme (which provides help towards the cost of reasonable adjustments), as well as financing the Workplace Mental Health Support Service (which provides job retention programmes through practical support but not psychotherapeutic interventions). It can be seen that the distinction between out-of-work employment support and in-work employment support for people with mental health problems is being addressed by these initiatives (Macinnes et al. 2014).

The Equality Act was passed in 2010 with the aim of preventing people being discriminated against in the workplace by virtue of their mental health problems for example. The Coalition and current Conservative governments have used the Paralympics Legacy, and the concepts of 'social justice' and 'civic participation' (Boardman 2011), to develop a disability strategy which aims to help people with congenital and acquired disabilities, as well as those with chronic illnesses to 'fulfil their potential' rather than being abandoned to 'languish on benefits' (Macleod 2010). The DWP commissions the 'Work Choice' programme for people with 'complex barriers to work', which provides intensive support, but it was only able to find work for 58 people with serious

mental health problems in Great Britain in the year 2011-2012 (Department for Work and Pensions 2013) compared to a NHS Trust that placed 239 people in one year, which suggests Work Choice needs modification. There is concern that the State has become 'disabling', and should be an 'enabling' State by raising expectations, although many suspect that there is an ulterior motive to assisting more people with disabilities to join the labour market (Patrick 2011) .

Regardless the concept of 'fit for work' is open to interpretation, especially when there is widespread confusion about the differences between disease, impairment, handicap, disability, sickness, and incapacity (Aylward et al. 2013). Different conceptual paradigms have been used to determine fitness for work, traditionally biomedical, pathogenic or clinical models (Martin et al. 2015). These models propose that 'an illness is caused by some identifiable physical pathology, and that symptoms of illness…are directly attributable and proportional to that underlying pathology' (Dunstan and Covic, 2006 p.67), and that therefore 'work disability will be resolved either by the relief of pain or by the curing of the physical pathology' (p.68).

In contrast the social model of disability takes a multifactorial and ecological view (Lederer et al. 2014), and proposes that impairment of function is often due to the inadequacy of environments designed for able-bodied people, and to the negative attitudes of others and their behavioural responses (Aylward et al. 2013). Neither the medical or social models make allowance for psychological factors in determining the level of disability. Aylward et al. (2013) states that, 'the problem is that focusing on disease and its *treatment* often leads to neglect of the person and the *management* of the health problem' (p.74).

Therefore, the bio-psychosocial model has been proposed which takes into account individual, organisational, environmental and societal factors which create disability, and thereby constitute barriers to employment. The bio-psychosocial model of disability is the theoretical foundation for the International Classification of Functioning, Disability and Health (World Health Organization 2001), and is often used to determine fitness for work i.e. Work Capability Assessment, whereby impairment is measured by using 'descriptors' to assess levels of functioning rather than by using symptom-based scales (McManus et al. 2012), since disability will vary between individuals with the same diagnosis depending on their personal adaptation, thus reversing the question: 'What makes some people develop long-term incapacity?' but rather: 'Why do some people with common health problems not recover as expected?' (Aylward et al. 2013). The answer may be due to psychological factors.

Nevertheless, even the bio-psychosocial model does not necessarily differentiate between stable and unstable disabilities (Chamberlain et al. 2009). The former due to static conditions such as blindness and cerebral palsy which are predictable in their effects, and the latter due to progressive and fluctuating conditions which often show day-to-day variation in their effects, such

as many chronic mood disorders. (Chamberlain et al. 2009) defines 'work instability' where there is a mismatch between the person's functional capacity and the demands of the job, and 'work disability' where there is a cessation of work.

For job retention, it would be important to identify and intervene at the 'work instability' phase perhaps when performance is beginning to suffer or after a series of short-term absences. Disability in relation to moderate-severe recurrent depression for example is more difficult to determine, and a review of assessment instruments found there were none specifically for mental health problems (Spanjer et al. 2011). The WCA uses the following descriptors which may identify the emotional and behavioural impairments commonly seen in people with recurrent depression:

- Making self understood
- Learning tasks
- Initiating and completing personal action
- Coping with change
- Coping with social engagement
- Appropriateness of behaviour with other people (uncontrollable aggressive or disinhibited behaviour)

People often referred to secondary care mental health services with depression comorbid with what are termed medically unexplained symptoms, symptom-defined illnesses, subjective health complaints, somatisation or somatoform disorders, or functional somatic syndromes (Waddell et al. 2004; Rask et al. 2015), are often assessed as 'fit for work' under the bio-psychosocial framework. Campaigners are worried that their symptoms will be seen as 'all in the mind' when they believe that their health condition has an organic, physical cause and do not see it as a psychological illness (Pring 2017)..

In any case, the causes of long-term work disability cannot be seen in isolation, because it results from a complex interaction between three different systems i.e. the healthcare system, the workplace system and the 'financial compensation system' (Briand et al. 2007).

Other policies have also been utilised to improve diversity and inclusivity especially in relation to employment. Critics dismiss the idea that work is the 'glittering salvation' which will combat the social exclusion of people with disabilities (Thorburn, 2012), or that work is a route out of poverty (Macinnes et al. 2014) because 'reducing disability benefit caseloads is not the *same thing* as increasing employment' (p.43).

APPENDIX 7: META-ANALYSES & SYSTEMATIC REVIEWS

Sixteen meta-analyses, meta-syntheses and systematic literature reviews were identified as a result of the search outlined in Chapter 1. Only one investigated labour market outcomes for employees who received interventions that aimed to treat Major Depressive Disorder (Timbie et al. 2006). All the studies in this meta-analysis were based in Primary Care, and interventions included drug therapy, collaborative care and psychological therapy. Only one intervention included outpatients with 'chronic depression' and they were treated with anti-depressant medication, not psychotherapy. None of the interventions was work-focused. Meta-analysis found that some patients achieved a moderate improvement in terms of clinical symptoms compared with CAU or placebo, but only a small improvement in terms of labour supply effects (e.g. return-to-work) compared to CAU or placebo.

Another systematic review evaluated the evidence for interventions that aimed to improve the occupational health in depressed people (Nieuwenhuijsen et al. 2009). This systematic review searched for interventions that were 'worker-directed' (i.e. individual level) as well as 'work-directed' (i.e. organisational level) interventions, but no work-directed interventions were identified. Whilst all interventions aimed to treat depression with drug therapy, psychotherapy or enhanced depression care, only one intervention was work-focused with adjuvant Occupational Therapy added to usual outpatient care. Of those patients who received psychotherapy or a psychotherapeutic component, two studies were based in Community Mental Health Teams (i.e. Secondary Care for patients with moderate-severe depression), although one was not an RCT, and three studies were based in Primary Care. The review found no evidence for or against psychological interventions in helping employees with depression to return-to-work.

Six reviews included some tertiary level clinic-based treatments for employees identified as symptomatic with common mental health conditions including depressive disorders (Dibben et al. 2012; Seymour, L. & Grove 2005; Seymour, L. & Grove 2005; Soegaard 2012; Waddell et al. 2008) or adjustment disorders with symptoms including reactive or situational depression, anxiety, or worry (Arends et al. 2012).

One meta-synthesis examined workplace-based interventions for common health problems including depression concentrated mainly on work outcomes such as absenteeism and staff turnover (Hill et al. 2007). This meta-synthesis was therefore not relevant.

Nine reviews focused only on workplace-based interventions such as stress management (Bhui et al. 2012; Czabała et al. 2011), reduction of absenteeism (Czabała et al. 2011), prevention of disability due to mental health conditions and prevention of depression in the workplace (Dietrich et al. 2012; Pomaki et al. 2012; van Oostrom et al. 2009), management of depression in the

workplace (Furlan et al. 2012) promoting mental health and wellbeing (Martin et al. 2009; Graveling et al. 2008). These reviews were therefore not relevant.

Work-focused psychotherapy is recommended for employees with common mental health problems of mild-moderate severity in three recent reviews. Tertiary level CBT-based interventions with a work-focus and problem-solving return-to-work strategies have a strong effect on clinical outcomes, and a moderate effect on occupational outcomes such as absenteeism and productivity (Joyce et al. 2016), and high intensity psychological therapies, access to clinical treatment and support in navigating the disability management system is the best way to enhance job retention for example (Wagner et al. 2016). However neither review makes specific recommendations for moderate-severe recurrent depression. The other review found no convincing evidence that CBT-based interventions were any more effective than CAU in helping employees' return-to-work, although the majority of included studies were not work-focused (Nigatu et al. 2016). Two reviews included some studies involving employees with mixed severity mental health problems (Doki et al. 2015; Dewa et al. 2015), and one review was focused only on employees with depression (Nieuwenhuijsen et al. 2014). They all recommend delivering work-focused psychotherapeutic interventions, or integrating a psychologically-informed approach into occupational healthcare.

Table 8 – Meta-analyses and systematic reviews

Study	**Type**	**Client group**	**Intervention**	**Outcome**
Arends et al. 2012	CR	Symptomatic (adjustment disorders)	Workplace-based and clinic-based, primary, secondary and tertiary prevention, individual interventions	Return to work
Bhui et al. 2012	MA	At risk, symptomatic (anxiety, depression)	Workplace-based, primary, secondary, and tertiary prevention, individual and organisational interventions	Stress, mental health, absenteeism
Czabala et al. 2011	SR	ALL	Workplace-based, primary prevention, individual and organisational interventions	Stress, coping, mental health, job satisfaction, absenteeism
Dibben et al. 2012	NR	Symptomatic (common health conditions)	Workplace-based and clinic-based, tertiary prevention, individual, interface and organisational interventions	Work status, health
Dietrich et al, 2012	CR	At risk, symptomatic (depression)	Workplace-based, secondary prevention, individual and organisational interventions	Return to work
Furlan et al. 2012	SR	Symptomatic (depression)	Workplace-based, tertiary prevention, individual and organisational interventions	Work disability, sickness absence

Graveling et al. 2008	NR	Well, at risk	Workplace-based, primary and secondary prevention, individual and organisational interventions	Mental wellbeing
Hill et al. 2007	MS	At risk, symptomatic (common health conditions)	Workplace-based, secondary and tertiary prevention, individual and organisational interventions	Staff turnover, sickness absence and return to work, plus general health outcomes
Martin et al. 2009	MA	ALL	Workplace-based, primary, secondary, and tertiary prevention, individual, interface and organisational interventions	Depression, anxiety
Nieuwenhuijsen et al. 2008	CR	Symptomatic (depression)	Workplace-based, tertiary prevention, individual and organisational interventions	Work disability, sickness absence
Pomaki et al. 2012	SR	Symptomatic (common mental health conditions)	Workplace-based, tertiary prevention, individual, interface and organisational interventions	Work disability, sickness absence
Seymour & Grove 2005; Seymour, 2010	NR	Well, at risk, symptomatic (common mental health conditions)	Workplace-based and clinic-based, primary, secondary, and tertiary prevention, individual, interface and organisational interventions	Work status, mental health
Soegaard et al. 2012	SR	At risk, symptomatic (mental disorders)	Workplace-based and clinic-based, primary, secondary, and tertiary prevention, individual, interface and organisational interventions	Work disability, sickness absence
Timbie et al. 2006	MA	Symptomatic (major depressive disorder)	Clinic-based, tertiary prevention, individual interventions	Work status, depression
Van Oostrom et al. 2009	CR	Symptomatic (musculoskeletal disorders, mental health problems, other health conditions)	Workplace-based, tertiary prevention, individual, interface and organisational interventions	Work disability, sickness absence
Waddell et al. 2008	NR	Symptomatic (musculoskeletal, cardio-respiratory, mental health conditions)	Workplace-based and clinic-based, tertiary prevention, individual, interface and organisational interventions	Work status, health

APPENDIX 8: RECOMMENDED PSYCHOLOGICAL THERAPIES FOR DEPRESSION

Nine guidelines and one update were identified. Recommendations regarding effective psychological therapies for moderate-severe recurrent depression were identified as well as the strength of evidence supporting their implementation.

Table 9 - Recommended Psychological Therapies for Depression

Country/date	Author/Title
United Kingdom 2009	National Institute for clinical excellence (NICE 2009). Depression in adults: The treatment and management of depression in adults.
United Kingdom 2012	Depression in Adults: Evidence Update April 2012 www.evidence.nhs.uk/evidence-update-13
Scotland 2010 (updated 2012)	Network, S. I. G. (2010). Non-pharmaceutical management of depression. A national clinical guideline. *SIGN publication*, (114).
America 2010 (updated 2015)	American Psychiatric Association. (2013). Treatment of patients with major depression and practical guideline 3rd edition.
Singapore 2012	Singapore Ministry of Health. (2012) Depression. Singapore: Singapore Ministry of Health.
Malaysia 2007	Hum LC, Siong ANW, Ebenezer E, Kassim A, Wah LT, Yahya B. (2007) Clinical practice guideline: management of major depressive disorder. Putrajaya: Ministry of Health Malaysia.
Canada 2009	Guideline for the management of Depressive Disorder in Adults (2009) Canadian Network for Mood and Anxiety Treatments CANMAT
Australia/NZ 2009	Australian, R., & New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. (2009). Australian and New Zealand clinical practice guidelines for the treatment of depression.
Spain 2008 (updated 2014)	Working Group on the Management of Major Depression in Adults. Clinical Practice Guideline on the Management of Major Depression in Adults. Madrid. National Plan for SHN of the MHCA.
Europe 2016	Jobst et al (2016) European Psychiatric Association Guidance on psychotherapy in chronic depression across Europe.

8.1 RECOMMENDED PSYCHOLOGICAL THERAPIES FOR RECURRENT DEPRESSION

Based on the highest quality evidence, (Jobst et al. 2016) recommends that people with chronic depression should be offered Cognitive Behavioural System of Psychotherapy (CBASP) as a 1st line treatment, with Interpersonal Psychotherapy (IPT) as a 2nd line treatment. This recommendation is based on a conceptualisation of recurrent depression as being causally and dynamically related to interpersonal excesses and deficits, which might make establishing a therapeutic alliance problematic (Weck et al. 2013). Many people with recurrent depression have experienced interpersonal trauma, childhood maltreatment and adversity in childhood (Nanni et al.

2012). Different aetiological models assume that recurrent depression has a common cause with maladaptive personality traits such as neuroticism, that these traits may act as a precursor of recurrent depression, or that both depression and personality traits lie on a continuum or spectrum of psychopathology (Klein et al. 2011). Models which assume a direct causal relationship suggest that maladaptive personality traits predispose individuals to recurrent depression, or that maladaptive personality traits mediate the experience and expression of depression leading to relapse and recurrence. In contrast, some models assume that recurrent depression impacts on the personality either concomitantly as a result of mood states, or consequentially as a result of scarring.

Regardless of the cause, people with chronic or recurrent depression frequently experience interpersonal problems, and thus relational psychotherapies are likely to be most effective (Jobst et al. 2016). CBASP uses an interpersonal problem-solving technique called Situational Analysis which aims to teach friendly, direct and assertive communication and interaction. People with chronic depression learn adaptive responses to specific relational triggers through a process of "disciplined personal involvement" whereby the therapist provides honest feedback about the personal impact of maladaptive interpersonal coping styles, which promotes an improved person x environment connection (McCullough 2006). Another CBASP technique is called the "transference hypothesis" by which the therapeutic relationship elicits a maladaptive response to specific relational triggers which is then corrected in vivo by a process of stimulus discrimination.

8.2 RECOMMENDED PSYCHOLOGICAL THERAPIES FOR MODERATE-SEVERE DEPRESSION

This brief review only investigated recommendations for psychological therapies alone, or in combination with pharmacological treatment and did not investigate recommendations for anti-depressant medication alone or somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), vagal nerve stimulation (VNS) and deep brain stimulation (DBS).

Nevertheless, most guidelines recommend that ADM be combined concurrently or sequentially with psychological therapy in the treatment of severe depression, as well as active support and advice on self-management. Most guidelines also advise that in the most severe cases, it is especially important that psychological therapists are competent, and "are experts in the applied therapy" (Spain 2008 p14). For people who fail to respond to ADM, psychological therapies can be added as a "crossover" treatment (CANMAT, 2009).

The two main psychological therapies recommended as a first line treatment for people with moderate-severe depression in most of the guidelines are Cognitive Behavioural Therapy (CBT)

and Interpersonal Psychotherapy (IPT), although CBT acts quicker and is more effective in patients with severe depression. CBT is the preferred psychological treatment for moderate, severe or resistant depression, and for patients with recurrent depression and who have a prior history of relapse or residual symptoms, despite treatment (Spain 2008). NICE (2009a) suggest that therapy should consist of 16-20 sessions with 2 sessions per week for the first 2-3 weeks and then weekly with a follow up period of 3-4 sessions for up to 3-6 months. The SIGN (2010) guideline recommends Behavioural Activation as a first line treatment and the Spanish guideline states that "whenever CBT is offered to more severe patients, techniques based on Behavioural Activation should be given priority" (p.15). RNZCP (2004) also recommends structured Problem-Solving Therapy as a first line treatment for moderate-severe depression.

Most guidelines recommend that ADM be combined concurrently or sequentially with psychological therapy in the treatment of severe depression, as well as active support and advice on self-management. Most guidelines also advise that in the most severe cases, it is especially important that psychological therapists are competent, and "are experts in the applied therapy" (Spain 2008 p.14). For people who fail to respond to ADM, psychological therapies can be added as a "crossover" treatment (CANMAT 2009).

Second-line treatments recommended for patients with less severe symptoms are Psychodynamic-Interpersonal psychotherapy (APA 2010; Singapore 2012), Behavioural Activation (BA) (NICE 2009a; SIGN 2010; CANMAT 2009), Behavioural Couples Therapy (BCT) or marital therapy (NICE, 2009; APA 2010; Spain 2008), Family Therapy (APA 2010), Problem-solving Therapy (APA 2010; SIGN, 2010), Cognitive Behavioural Analysis System of Psychotherapy (for people with recurrent depression suffering an acute episode) (CANMAT 2009), Computer-assisted CBT, and Telephone-delivered CBT (CANMAT 2009), and Structured Exercise Programmes (SIGN 2010).

Group-CBT is recommended for persistent sub-threshold depression at Step 2 (low intensity) (NICE 2009a) and for people with depression and chronic physical health problems at Step 3 (NICE 2009b). It should be based on a structured manual such as "Coping with Depression" and delivered by at least two trained and competent practitioners. The group should have no more than 8-10 participants and the course should run for 12-16 weeks including follow up. In a recent evidence update, (NICE, 2013) called for further research on the value of peer support and Group-CBT at step 2 (and other steps) in view of its potential clinical- and cost-effectiveness.

Longer-term interventions are advised for patients if the depression is severe or in patients with comorbid personality disorders (Singapore 2012), or when the patient is making progress and extending therapy has been agreed between the patient and practitioner (NICE 2009a). Treatment

options for people with depression and comorbid personality disorders may include psychodynamic therapy (Singapore 2012; RNZCP, 2004).

Some guidelines make clear which therapies do not have sufficient evidence of effectiveness and therefore cannot be recommended such as guided self-help for patients with severe major depression, or participation in support groups either alone or in combination with other therapeutic measures. (Spain 2008), counselling, couple-focused therapy or family therapy (SIGN 2010), Acceptance and Commitment Therapy, Motivational Interviewing, Mindfulness-based Cognitive Therapy, Emotionally Focussed Therapy and Psychodynamic Therapy for treatment of acute phase Major Depressive Disorder (CANMAT 2009).

8.3 OTHER RECOMMENDED INTERVENTIONS

8.3.1 Stepped, phased or staged care

Some international guidelines use a stepped care system by which the least intrusive but most effective treatment is offered in the first instance, only "stepping up" to more intensive or more specialist services if clinically indicated. Decision-making relies on accurate assessment of risk, symptom severity and the level of psychosocial dysfunction. Some guidelines encourage the use of screening tools such as the self-report PHQ-9 whilst others prefer clinicians to rely on a detailed history using a semi-structured interview or mental state examination plus their own judgement in order to diagnose. RNZCP (2004) suggests diagnosis of subtype is vital as different subtypes require different management. Several guidelines use algorithms to illustrate different care pathways, and to help clinicians to choose appropriate evidence-based treatment options based on Yes/No questions (NICE 2009a; RNZCP 2004).

Some guidelines use a phasing system to decide what treatment to offer (mainly in terms of pharmacotherapy), by which the mental illness is assessed as in an acute, continuation or maintenance phase (Malaysia 2007; APA 2010; Singapore 2012; CANMAT 2009; RANZCP 2004), with the treatment plan based on what stage the patient is at. The clinical staging model proposes that as some mental illnesses progress over time, they have profound and irreversible physical and psychological effects which need to be taken into account when deciding on whether active treatment is offered or not. No guideline for depression recommends treatment based on the stage of illness and active treatment should therefore always be considered regardless of how long the patient has been suffering.

Some guidelines refer to "first line", second line" and "third line" treatments depending on the level of evidence ("first line" being highest quality), although treatments with better levels of evidence may be downgraded to lower lines of treatment due to issues such as side effects or risk status (CANMAT 2009; Spain 2008). The RANZCP (2004) guidelines recommend that most

people with uncomplicated depression, regardless of severity, should be treated in primary care, with either ADM or CBT/IPT.

The NICE (2009a) guidance, identify 4 steps (p16).

- Step 1: recognition, assessment and initial management
- Step 2: persistent subthreshold depressive symptoms or mild-moderate depression
- Step 3: persistent subthreshold depressive symptoms or mild-moderate depression with inadequate response to initial interventions, and moderate-severe depression
- Step 4: complex and severe depression

Most of the guidelines cover treatment for all levels of severity, but the SIGN (2010) guideline specifically excludes people with clear indicators of severe depression or with significant psychological comorbidity (such as personality disorder) (SIGN 2010).

When the pathway involves stepped care (NICE 2009a; RANZCP 2004), assessment is usually made in primary care with onward referrals to specialist mental health services (secondary care) indicated for people presenting with more chronicity and psychosocial complexity as well as those with treatment-resistant and treatment-refractory depression, and those with severe depression (NICE 2009a). Specialist care usually involves coordinated multidisciplinary teamwork.

Most guidelines advise that a referral should be made immediately if serious suicidal risk becomes apparent, if the patient develop any psychotic symptoms, or if there is serious self-neglect. Advice is given on how to ask people with depression about whether they have thought about, or made plans, to harm themselves, and how to assess whether the person is aware of sources of help and has access to social support (NICE 2009a). NICE (2009a) advise to consider more frequent direct or telephone contacts if suicide risk increases and referral to a Crisis Resolution and Home Treatment Teams or inpatient care when risk of suicide or self-harm increases significantly.

Consultation should be sought with a specialist, and referral if required for people who have a comorbid medical condition when the use of ADM might be contra-indicated (NICE 2009a). If the depression is associated with a chronic physical health problem which causes functional impairment, referral may be made to secondary care mental health services (NICE 2009a) with the possibility of using the collaborative care model (NICE 2009b).

8.3.2 Collaborative care

Proponents claim that collaborative care enables patients with depression to be treated more effectively in primary care, as it aims to provide an integrated treatment plan with specialist mental healthcare practitioners and the general practitioner working together. It is based on the

principles of chronic disease management due to the long-term nature of some conditions such as severe and recurrent (remitting-relapsing) depression. Collaborative care uses a care manager (possibly a mental health nurse or social worker embedded within the primary care setting) to provide support through partnership-working and liaison with the patient's GP. Collaborative care also involves caseload consultation by a psychiatrist who may also offer clinical supervision to either or both the GP and the care manager. Interventions include systematic diagnosis and outcome tracking, patient education, support for self-management, brief counselling (using CBT and problem-solving therapy techniques), telephone monitoring, and proactive follow-up to prevent relapse. Recent studies of collaborative care (e.g. ProCEED, CADET and TIDES trials) have demonstrated significantly lower costs than TAU and high levels of patient satisfaction. However the NICE depression guideline (2009a) only recommends collaborative care in specific circumstances. Relevant studies were not included in the revised edition because the samples were too heterogeneous, and fit better in the separate guideline depression in adults with a chronic physical health problem (NICE 2009b).

8.3.3 Psycho-education

Most international guidelines recommend offering information about depression to sufferers and their families based on a biopsychosocial model (NICE 2009a), whereas some advice is based on a biomedical formulation of depression such as, "depression should be explained as a medical illness that is associated with changes in neurochemicals and brain functioning" (Singapore, 2012 p7) . Some recommend psycho-education as "a universal component", mainly in relation to providing information about symptoms, course of the illness, likely response to treatment, possible side effects of medication, and risk of relapse (CANMAT 2009; APA 2010).

8.3.4 Advice on lifestyle and self-management

Most international guidelines suggest offering advice on lifestyle such as sleep hygiene, good nutrition, reduced use of tobacco and alcohol (NICE 2009a; APA 2010), adequate exercise, reducing stress, (Singapore 2012), keeping active, increasing experiences of mastery and pleasure, and maintaining social contacts (CANMAT 2009).

8.3.5 Patient choice

Patient informed choice is acknowledged as important, (NICE 2009a), in so far as people who decline first line therapies may be referred for counselling 6-10 sessions over 2-3 months or short-term psychodynamic psychotherapy 16-20 sessions over 4-6 months (NICE 2009a). They must be advised that these therapies are only recommended for mild-moderate depression because there is uncertainty about their effectiveness in moderate-severe depression.

8.3.6 Social support, carers' involvement

Most guidelines recognise that family members and carers are often a good source of information, as well as a valuable ally in terms of helping to manage risks by being vigilant for signs of deterioration in the patient's mood and encouraging them to adhere to treatment (NICE 2009a). They need good quality information about depression, as well as advice on how best to support the patient's recovery (NICE 2009a; APA 2010; Spain 2008). They may also be involved in decisions about treatment plans with the patient's consent (NICE 2009a; APA 2010; Singapore 2012). Carers can be offered support for themselves and a carer's assessment if appropriate (NICE 2009a)

NICE (2009a) is the only guideline that recommends social support through be-friending if necessary for people with long-standing moderate-severe depression as an adjunct to psychotherapy and/or pharmacotherapy.

8.3.7 Follow-up, booster, relapse prevention

Relapse prevention is a key element of the care pathway so that once psychological therapies have been completed, patients who have had moderate-severe depression may require continuation or booster interventions (NICE 2009a; RNZCP 2004; CANMAT 2009). Some guidelines advised that patient should continue with ADM, as well as CBT (NICE 2009a), Behavioural Activation and Cognitive Behavioural Analysis System of Psychotherapy (CANMAT 2009) or mindfulness-based cognitive therapy (for those who are well but have previously experienced several episodes of depression (NICE 2009a; SIGN 2010; CANMAT 2009).

8.3.8 Vocational rehabilitation

NICE (2009a) is the only guideline that recommends vocational rehabilitation for people who have lost their job due to chronic moderate-severe depression. SIGN (2010) found no evidence that return-to-work programmes alleviated symptoms of depression.

8.4 SUMMARY

In summary none of these national guidelines oppose the use of a work-focused relational group-CBT programme for the psychological treatment of people with moderate-severe recurrent depression if it is offered as part of an integrated care pathway which includes components such as crisis resolution, carer involvement, vocational rehabilitation and relapse prevention.

APPENDIX 9: STUDIES PUBLISHED SINCE 2012

9.1 RESEARCH UPDATE

The original literature review searched for, and critiqued, randomised controlled trials evaluating psychotherapeutic interventions which reported both clinical and work outcomes. Only one study which included a GCBT programme met inclusion criteria (Schoenbaum et al. 2002). However the results for clients who received CBT in a group format were aggregated with the results for clients who received CBT in a 1:1 format, and although the study reported work outcomes, neither intervention was work-focused. Only one of the reviewed interventions was work-focused based on Problem Solving Therapy, but it was designed to promote return-to-work, rather than job retention, and the sample consisted entirely of employees who were on long-term sick leave due to depression (Vlasveld et al. 2013).

9.1.1 Work-focused CBT interventions

Since completion of this study an updated search for recent reviews and randomised controlled trials with more stringent inclusion criteria found only a few relevant studies evaluating the effectiveness of work-focused CBT interventions for depression. Two randomised controlled trials including mainly clients off sick with mild symptoms of common mental disorders (CMDs) were retrieved and reviewed. The first study was based in Norway, and the intervention was described in a supplementary protocol which provided sufficient details to allow replication (Reme et al. 2015). Whilst the intervention was work-focused, with up to 15 sessions of 1:1 CBT delivered by psychotherapists, the Individual Placement and Support (IPS) component was delivered separately by employment specialists. The second study was based in Denmark, and the intervention involved 16 sessions of 1:1 CBT plus an optional workplace component delivered by the same clinical psychologist (Dalgaard et al. 2017). Only 10% of clients opted for the workplace component which involved one or two meetings between themselves, their line manager or Human Resources manager, with or without the clinical psychologist being present to support the client in negotiating reasonable adjustments or in addressing other stressors such as role ambiguity or high workload.

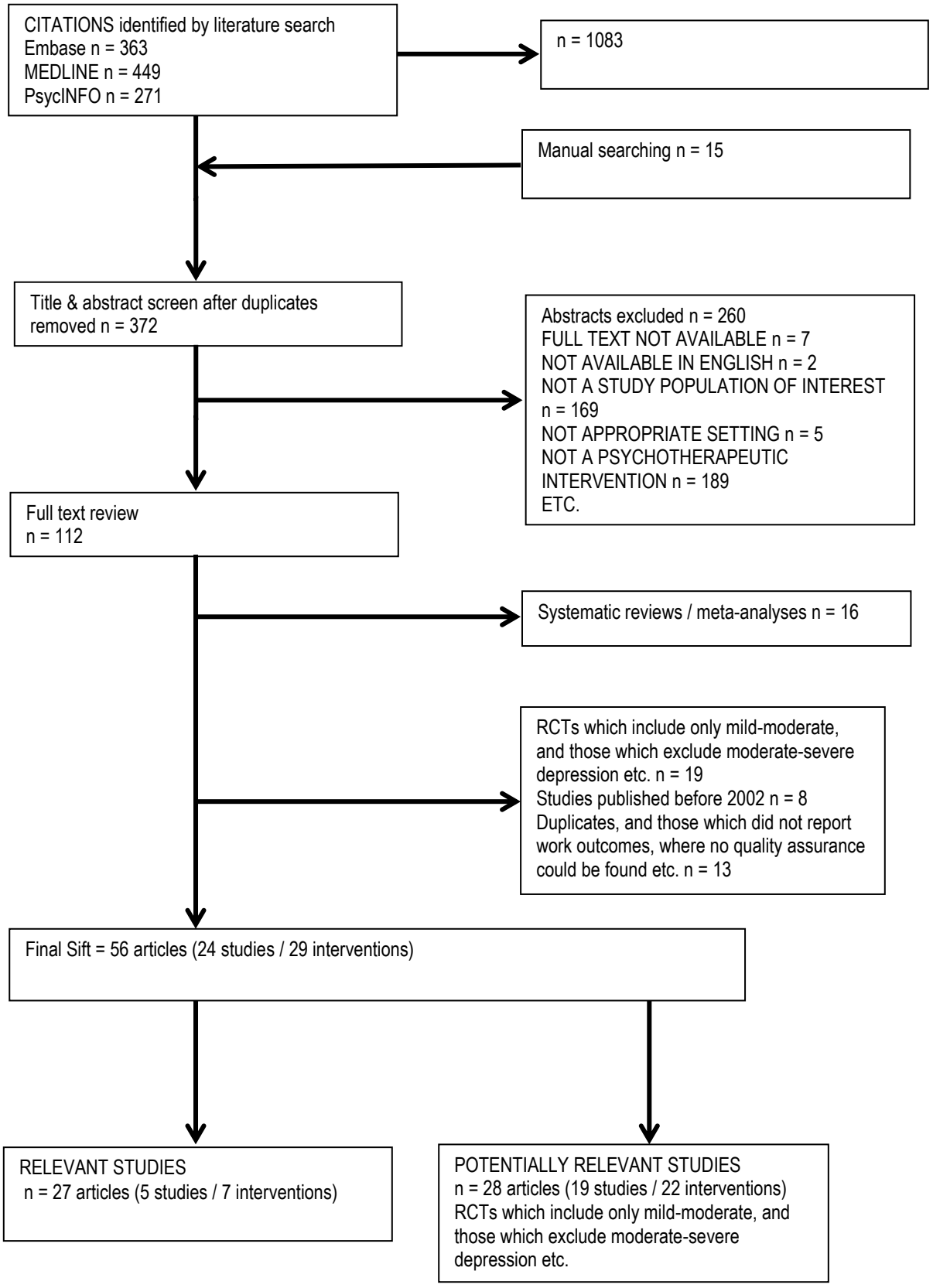
Two non-randomised studies were retrieved and reviewed. One included clients off sick with mild-moderate depression (Brenninkmeijer et al. 2019), and the other included clients off sick with moderate-severe depression (Ito et al. 2019). The first study was based in The Netherlands, and details about the intervention were sparse. However a previous study was cited which describes how psychotherapists delivered 12 CBT sessions in a 1:1 format over 6 months, integrating the work-focus into almost every session and into homework assignments (Lagerveld et al. 2012). The second study was based in Japan, and details about the intervention were also

sparse. Eight weekly 2½ hour GCBT sessions with 4-5 clients in each group were delivered by a clinical psychologist and another member of the psychology team. The Treatment Programme consisted of four main components: behavioural activation, problem-solving, and cognitive therapy plus return-to-work strategies which focused on improving relationships in the workplace, cognitive function, and physical fitness.

Summary

In contrast with new intervention, most of the interventions found through the update search focused on return-to-work rather than job retention, and only one of the studies included some employees at work (Reme et al. 2015). The samples in most of the studies focused on clients with mild-moderate CMDs, and only one included employees with moderate-severe depression (Ito et al. 2019). Only one intervention was described in detail with a clear rationale given for different components (Reme et al. 2015). None of the interventions were delivered in a community setting, as they were all delivered in clinical settings, with only one involving limited contact with the workplace (Dalgaard et al. 2017). None of the studies were based in the UK with employed clients accessing CMHTs.

APPENDIX 10: LITERATURE SEARCH DIAGRAM



APPENDIX 11: LITERATURE REVIEW SEARCH STRATEGY

A search was undertaken of EMBASE, PsycINFO, Cochrane Database and Google Scholar focusing on empirical studies published in English, and using a combination of terms such as:

Meta-analysis with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Systematic review with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Review with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Controlled trial with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Trial with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Compare OR comparison with depressed OR depression OR depressive OR mental OR mood OR affective with work OR workplace OR worksite OR job OR occupational

Limitations were only empirical studies of adults (18-65 years), published in English, using methodologies such as meta-analysis, meta-synthesis, systematic literature reviews, controlled or randomised controlled trials.

The database search identified 1083 records from 2002-2012. A search of secondary references and additional sources such as unpublished studies, conference proceedings and contact with researchers identified a further 15 records.

Studies were excluded if they did not include a psychotherapeutic intervention delivered face-to-face by qualified psychologists or psychotherapists, or by unqualified practitioners who had received training in delivering the intervention. Therefore studies were excluded if they were based on approaches such as Occupational Therapy or Intensive Case Management without a psychotherapeutic component. Online, email or telephone-based interventions, and purely organisational interventions were excluded.

Studies were excluded if the main aim was work-directed fir example to reduce sick leave or to improve return-to-work rates.

Studies were excluded if they focused on for example health promotion (primary prevention) or stress management (secondary prevention), unless for example the prevention or relapse prevention of depression was an explicit aim of the intervention e.g. universal programmes.

Studies were excluded if the subject was a physical health condition such as pregnancy, stroke or cardiac rehabilitation, traumatic brain injury, epilepsy, amputation, musculoskeletal problems, acquired hearing or seeing impairments or a psychiatric condition such as schizophrenia, psychosis, bipolar affective disorder, post-natal depression, social anxiety disorder, alcohol or substance misuse, or learning difficulties and cognitive impairments associated with a condition such as autism, ADHD or Alzheimer's.

Studies were excluded if they focused on unemployed people with depression.

Duplicates and records that were clearly irrelevant were removed. This left 112 records that were screened for inclusion.

For the full search strategy for each database see Appendix 11 and reasons for exclusion see Appendix 12.

A two-stage procedure was used to identify eligible studies. Firstly, all records were filtered using the title and abstract. If it was uncertain whether the study was relevant, the full-text paper was retrieved for a more detailed review.

Aside from the sixteen meta-analyses and systematic reviews described in chapter 1, the first-stage screening process identified 56 records (24 studies / 29 interventions).

APPENDIX 12: WHY STUDIES WERE EXCLUDED

Table 10 - First stage

Eliminate studies which are not RCTs n = 18	
1. Barkham & Shapiro (1990)	Non-randomised pilot study
2. Bond & Bunce (2000)	Mediation analysis
3. Firth & Shapiro (1986)	Published before 2002 - pilot pre-post test
4. Grossi & Santell (2009)	Pilot / Quasi-experimental
5. Kagan et al. (1995)	Published before 2002 - pilot study
6. Karlson et al. (2010)	Matched controls
7. Kobayashi et al. (2008)	Matched controls
8. Landsbergis & Vivona-Vaughan (1995)	Published before 2002 - matched controls
9. Lander et al. (2009)	Matched controls
10. Millear et al. (2008)	Matched controls
11. Munz et al. (2001)	Matched controls
12. Netterstrøm & Bech (2010)	Non-randomised
13. Reynolds (1997)	Published before 2002 - quasi-experimental design
14. Rose et al. (1998)	Published before 2002 - matched controls
15. Shimazu et al. (2003, 2006)	Pilot / Matched controls
16. Slaski & Cartwright (2003)	Matched controls
17. Tsutsumi et al. (2005, 2009)	Quasi-experimental study
18. Umanodan et al. (2009)	Non-randomised

Table 11 - Second stage

Eliminate studies published before 2002 n = 8	
1. Cecil & Forman (1990)	Published before 2002 - work outcomes not reported
2. De Jong & Emmelkamp (2000)	Published before 2002 - intervention had no effect on job dissatisfaction or absenteeism
3. Iwi et al. (1998)	Published before 2002 - work outcomes not reported
4. Jones & Johnston (2000)	Mean BDI score indicates minimal-mild depression at baseline
5. Mynors-Wallis et al. (1997)	Published before 2002 - no quality assurance
6. Peters & Carlson (1999)	Published before 2002
7. Reynolds et al. (1993)	Published before 2002 - work outcomes not reported
8. Sallis et al. (1987)	Published before 2002

Table 12 - Third stage

Eliminate studies duplicates, and those which did not report work outcomes, where no quality assurance could be found etc. n = 13	
1. Ahola, et al. (2012)	Same study as Vuori et al. (2012) evaluating differential response
2. Flaxman & Bond (2010)	Work outcomes not reported
3. Gardner et al. (2005)	No quality assurance
4. Godard et al. (2006)	No quality assurance
5. Harpole et al. (2003)	Older adults
6. Kitchener & Jorm (2004)	Work outcomes not reported
7. Mino et al. (2006)	Work outcomes not reported
8. Nickel (2007)	Not peer reviewed
9. Nystuen & Hagen (2006)	Same intervention as Nystuen & Hagen (2003)
10. Sherbourne et al. (2001, 2004, 2008)	Follow up study based on Schoenbaum et al. (2002)
11. Uegaki et al. (2010)	Cost effectiveness study for Bakker et al (2007)
12. Wells et al. (2000, 2004)	Follow up data on Schoenbaum et al. (2002)
13. Żołnierczyk-Zreda (2002)	Work outcomes not reported

Table 13 - Fourth stage

Eliminate RCTs which include only mild-moderate, and those which exclude moderate-severe depression etc. n = 19	
1. Bakker et al. (2007)	The 'Minimal Intervention for Stress-related mental disorders with Sick leave (MISS)'
2. Blonk et al. (2006)	High intensity versus low intensity CBT for self-employed people
3. Bonde et al. (2005)	Work-focused counselling by a social worker - only 4.2% 'psychiatric disorders' in intervention group
4. Brouwers et al. (2006)	Only 'minor mental disorders'
5. de Vente et al. (2008)	Participants with major depression were excluded
6. Duijts et al. (2008)	Only 'psychosocial health complaints'
7. Eriksen et al. (2002)	Only 'subjective health complaints'
8. Lexis et al. (2011)	Mean BDI-II score indicates minimal-mild depression at baseline
9. Limm et al. (2010)	Mean HADS score indicates minimal-mild depression at baseline
10. Nystuen & Hagen (2003)	Only 'non-severe psychological problems'
11. Rebergen et al. (2009)	Only common mental health disorders (CMHDs)
12. Stenlund et al. (2009)	Only employees with 'burnout'
13. Takao et al. (2006)	Scale used was not validated / reliable, only employees with 'minor stress complaints'
14. Tsutsumi et al. (2009)	Only employees with 'minor psychiatric morbidity'
15. Van der Klink et al. (2003)	Only 'adjustment disorders'
16. van Oostrom et al. (2010)	Mean 4DSQ indicates mild depression
17. van Rhenen et al. (2007)	Comparing stressed and non-stressed employees using a cut-off of distress, a cut-off point of 0.32 on the 4DSQ-Distress subscale
18. Vuori et al. (2012)	Mean BDI-II score indicates minimal-mild depression at baseline
19. Willert et al. (2009, 2011)	Employees with 'a severe psychiatric condition or history of repeated psychiatric conditions were excluded; mean score on Perceived Stress Scale under cut off for 'high perceived stress'

APPENDIX 13: DETAILS OF FIVE STUDIES INCLUDED IN THE EFFECTIVENESS REVIEW

13.1 KNEKT ET AL (2008): SAMPLE 326

The mean scores of the WAI showed that the sample had moderate impairment at baseline calculated as between 28-36 points (Tuomi et al. 1998). There was an overall statistically significant improvement in the mean scores from baseline of 3.73-5.15 which meets criteria of real change $\geq$+2 based on prior analyses (Boström et al. 2012) with the effect persisting until 7 months in the SFBT and the MPP, and until 24 months only in the LPP. The LPP was superior to the MPP at 36 months ($p<0.05$; 95% CI: -4.56, -0.39), and it was also better than SFBT but the difference was not statistically significant.

Between 16-22% of participants in the three treatment groups had more than 7 days off during previous 3 months at considerable cost to the employer. Therefore a statistically significant ($p <0.001$) reduction of approximately 9% during follow-up for the LLP at 18 months and for the MPP at 36 months represents a real and substantial saving with no statistically significant change in the SFBT group.

Similarly the average number of sick-leave days during previous 3 months at baseline was 5.5 days. Only the LPP achieved a small effect ($d = 0.3$) with a statistically significant reduction in days off sick at 18 months follow up of approximately 3 days. Nevertheless this reduction also represents a real and substantial saving for the employer.

The whole sample had a mean score of 15.4-15.8 on the HAM-D at baseline (moderate severity) and 17.9-18.7 on the BDI-II at baseline (mild severity) with a high degree of chronicity, comorbidity and complexity. Over 3 years follow up there was a statistically significant change ($p <0.001$) overall with a large effect ($d >0.8$) on both measures. However there was a reduction overall of only 36% on the HAM-D with no treatment showing a clinically significant reduction of 7.9 i.e. 50% (Cusin et al. 2010). However 43% in the LPP had achieved recovery at 3 years with a 50% reduction in scores. When comparing the different approaches using the HAM-D at 3 years, LPP was superior to SFBT at 3 years ($p<0.05$; 95% CI: 0.1, 3.5) and to MPP ($p<0.05$; 95% CI: 0.3, 3.5). BDI-II scores showed a reduction overall of 51% on the BDI-II which met criteria for a minimal clinically important difference (MCID) i.e. 17.5% reduction in scores from baseline (Button et al. 2015), and mean scores indicated that all groups achieved remission within 3 months. When comparing the different approaches using the BDI-II at 3 years LPP was superior to SFBT ($p<0.05$; 95% CI: 0.4, 5.5) and to MPP ($p<0.05$; 95% CI: 1.4, 6.2).

13.2 WANG ET AL. (2007): SAMPLE 604

Overall the mean score of the QIDS-SR showed that participants had moderate severity depression at baseline and mild severity at 12 months. So whilst the sample overall did not achieve remission pooled results at 12 months show a small effect and a statistically significant difference in symptom severity comparing the outcomes for the intervention group to the CAU group ($p<0.001$; OR = -1.0; 95% CI: -1.7, 0.4). There was a small effect and a statistically significant difference in the proportion of participants achieving remission 26.2% vs. 17.7% (i.e. $\leq$5 on the QIDS-SR) in the intervention group compared to CAU participants ($p<0.011$; OR = 1.7; 95% CI: 1.1, 2.4). In addition 30.9% of participants in the intervention group achieved recovery i.e. 50% improvement at 12 months compared to 21.9% in the CAU group ($p<0.010$; OR = 1.4; 95% CI: 1.7, 2.5).

Pooled results at 12 months show that there was a small effect and a statistically significant difference in job retention with 7.4% of participants in the intervention losing their job compared to 12% in the CAU group ($p\leq0.022$; OR = 1.7; 95% CI: 1.1, 3.3). Interestingly, there was an increase from baseline in the mean number of days taken as sick leave of 1 day in the previous week for participants in the intervention group compared to 1.8 days in the CAU group resulting in a small effect and a statistically significant difference in absenteeism ($p\leq0.002$; OR = 2.6; 95% CI: 1.0, 4.3). Nevertheless participants in the intervention group had increased their contracted hours by 0.7 hours per week whereas there was a reduction of 4 hours per week in the CAU group resulting in a medium effect and a statistically significant difference in hours actually worked for the intervention group compared to the CAU group ($p\leq0.02$; OR = 2.0; 95% CI: 0.3, 3.7).

13.3 BURNAND ET AL. (2002): SAMPLE 74

The mean scores at intake on the HAM-D of a small sample (n = 74) indicated severe depression, with nearly half having experienced a past episode of depression and nearly half having a personality disorder. Nevertheless, over 70% were in employment. Both groups showed a clinically significant improvement on the HAM-D (i.e. reduction of mean scores > 50% (Cusin et al. 2009) over the 10 week treatment period in terms of severity of depressive symptoms with no difference between groups ($p< 0.001$). However there were statistically significantly fewer patients meeting diagnostic criteria for MDD at 10 weeks with only 3 (9%) in the combined treatment compared to 11 (28%) in the ADM only group ($p=0.04$). In addition patients in the combined treatment had a small but statistically significant improvement in adjustment to work on the HSRS ($p=0.04$).

At discharge only 2 patients in the combined treatment had been admitted to hospital compared to 9 in the ADM only group (p=0.04), and they spent statistically significantly fewer days in hospital (p=0.04). Similarly, both groups showed large improvements in terms of functioning according to mean GAS scores with a statistically significant but small difference in favour of the combined treatment (p=0.006). In addition patients in the combined treatment who were employed at baseline lost fewer work days during treatment than those in the ADM only group with a difference of approximately 20 days (p=0.02). Overall this represents a substantial cost saving at individual, organisational and societal levels.

13.4 VLASVELD ET AL. (2012): SAMPLE 126

At baseline mean scores on the PHQ-9 indicate that the sample of 126 employees on sick leave had moderate depression. Just over 50% also had GAD, and just over 15% also had panic disorder as well as depression. At 3 months there was no difference in the change in mean scores (p = 0.460), although there was a statistically significant difference in response to treatment (i.e. 50% reduction on the PHQ-9) between the groups with half of the PST group and just under a third showing large improvements in depressive symptoms (OR 2.514; 95% CI: 1.035–6.110, P= 0.04). This effect was particularly strong for employees with moderate-severe depression at baseline with those in the PST group scoring 'mild' at 3 months, and those in the CAU scoring 'moderate' depression (p = 0.002). Whilst the statistically significant difference did not persist after 6 months the result is probably important at the individual level in terms of more severely affected employees feeling better in a relatively short timeframe. By 12 months, there was a continuing reduction in symptoms but results showed that there was no difference in the odds of not responding to treatment or achieving remission (p>0.05; 95% CI: −0.281 to 1.353). Less than half of the total sample achieved remission (i.e. scoring <5 points on the PHQ-9), and there was no difference between treatments in the time until remission. Less than a quarter of the total sample responded to treatment although employees in the PST group responded significantly quicker to treatment with an average time of 5 months compared to 7.8 months in the CAU groups (p<0.05; 95% CI −1.684 to −0.027).

It is interesting to note that 9 employees in the PST group and 8 in the CAU group resigned so were not included in the analysis of RTW data. For employees that maintained their employment nearly two thirds of the total sample achieved a lasting full RTW by 12 months. However there was a wide variation in the time taken to resume work with a mean of approximately 6 months overall and no difference between groups (p>0.05; 95% CI: −0.657 to 0.261). Similarly there was wide variation but no difference between the groups in the number of days off sick during the 12 months follow up period with a mean of approximately 200 days (p>0.05). This finding suggests that regardless of the treatment a substantial proportion of employees either remained on long-

term sickness absence or had been off sick for a lengthy period as opposed to cumulative short-term sickness before resuming work.

13.5 SCHOENBAUM ET AL. (2002): SAMPLE 938

In a sample of 938 participants 65.8% were employed at baseline, and just over a quarter had a lifetime form of depression and just less than one half had an anxiety disorder as well as depression.

At the end of 24 months follow up (the intervention only lasted up to 12 months) patients who received QIT had significantly more days in employment than CAU i.e. an extra 20.9 days ($p = 0.03$; CI: 2.4, 39.3). However later analysis (Sherbourne et al. 2004) found that QIT was superior to CAU and QIM up to 18 months for men but not for women who had significantly more days in employment with QIM compared to CAU ($p<0.05$). There was no difference in the number of sick days between groups which suggests that the improvement is due to unemployed patients at baseline finding work.

Patients in QIT showed less likelihood of having 'probable depression' using the clinician-rated CIDI-SF than patients in CAU at 6 month with a 10% point difference in prevalence at 6 and 12 months follow up but the effects were non-significant at 18 and 24 months. There was a statistically significant difference in the rate of 'probable depression' at 24 months between QIT at 31% and QIM at 39% ($p=0.04$), but no difference comparing QIT with CAU.

APPENDIX 14: OUTCOME MEASURES

The schedule for assessment is shown in the Case Record Form (Appendix 31).

There is one primary outcome measure.

14.1 THE HAMILTON RATING SCALE FOR DEPRESSION (HAM-D 21-ITEM)

14.1.1 Description

This scale (Hamilton 1960) is a clinician-rated semi-structured interview and is considered to be one of the "gold standard" instruments for measuring severity of depression. The HAM-D is multi-dimensional and consists of 21 sections including mood, guilt, suicide, insomnia, work and activities, psychomotor retardation, agitation, anxiety, somatic symptoms, loss of weight, hypochondriasis and insight. It has recently been approved to measure change in clinical trials of antidepressants (Bech et al. 2014).

14.1.2 Psychometric properties

The HAM-D has high inter-rater reliability of 0.80-0.98 when experienced clinicians use it (Moberg et al. 2001). When inexperienced clinicians or novices use it reliability decreases to 0.57-0.73. However with training inter-rater and test-retest reliability can be significantly improved, even among people given minimal training, 000 and 0.81 respectively (Istriana et al. 2013). It was chosen for this study because an online training package with video-simulation was available to train clinicians in its use (Rosen et al. 2008). In the event this was problematic and the well-established interview guide was used to train research assistants to administer the HAM-D over the 'phone. The interview took on average 35 minutes to administer.

Internal consistency ranges from 0.48 to 0.92 (Hamilton 2000). A recent review of the psychometric properties of the HAM-D found that it has adequate reliability (Bagby et al. 2004). Construct validity has been estimated to range from 0.65 to 0.90 (Cusin et al. 2010).

14.1.3 Scoring

The total score is obtained by summing the score of the first 17 items, (0-4) with higher scores representing greater severity of depression.

14.1.4 Clinical cut-offs or normative data

Scores can range from 0-54, with cuts off as follows:

MILD = 7-17

MODERATE = 18-24

SEVERE > 24

REMISSION = $\leq$ 7

RESPONSE = a decrease of 50% from baseline (Masson, S.C. and Tejani 2013).

MCID = 27% reduction from baseline (Masson, S.C. and Tejani 2013).

There are 8 secondary outcome measures:

14.2 THE BECK DEPRESSION INVENTORY II (BDI-II 21-ITEM)

14.2.1 Description

This scale is self-rated and is also considered to be another "gold standard" used extensively in research of depression. It measures severity in the past week covering diagnostic criteria of major Depressive Disorder in the DSM IV of sadness, pessimism, poor motivation, self-denigration, loss of interest, anhedonia, feelings of guilt, punishment and worthlessness, suicidal thoughts and plans, irritability, social withdrawal, fatigue, problems with concentration, changes in appetite, worry and loss of libido. Each multiple choice question is scored on a 4-point scale from 0 = symptom not present to 3 = symptom very intense).

14.2.2 Psychometric properties

Construct validity is high with factor analysis showing clear differentiation between cognitive-affective depression and somatic-vegetative depression (Wang, Y.P. and Gorenstein 2013).

The BDI-II has been found to have an internal consistency of 0.91 and reliability of 0.92 (Beck et al. 1996). Test-retest reliability has been measured between 0.73 and 0.93 (Wang, Y.P. and Gorenstein 2013).

14.2.3 Scoring

The total score is obtained by summing the total score of all items with higher scores representing greater severity of depression.

14.2.4 Clinical cut-offs or normative data

Scores can range from 0-63, with cuts off as follows:
NOT/MIMIMAL = 0-13

MILD = 14-19

MOD = 20-28

SEVERE = 29-63

REMISSION $\leq$ 9

RESPONSE = 50% reduction from baseline

MCID = 30% reduction from baseline (Masson, S.C. and Tejani 2013)

14.3 THE WORK AND SOCIAL ADJUSTMENT SCALE (WSAS 5-ITEM)

14.3.1 Description

This scale is self-rated and measures impaired functioning with 5-item rating how much problems affects the person's ability to carry out the activities such as ability to work, look after the home, participate in social and leisure activities, close relationships. Its use is recommended in IAPT services (Zahra et al. 2014).

14.3.2 Psychometric properties

Internal consistency ranges from 0.70 to 0.94, inter-rater reliability ranges from 0.81 to 0.86, test-retest reliability reported as 0.73 (Mundt et al. 2002).

14.3.3 Scoring

The total score is obtained by summing the scores of all items with higher scores representing greater severity of functional impairment.

14.3.4 Clinical cut-offs or normative data

Scores can range from 0-40, with cuts off for significant functional impairment but less severe clinical symptomatology in the range 10-20, moderately severe or worse psychopathology above 20.

14.4 THE COPING SELF-EFFICACY SCALE (CSES 26-ITEM)

14.4.1 Description

This scale is self-rated and measures participants' perceived ability to manage their problems, threats and challenges, as well as to what extent they feel they have control over their lives. It uses an 11-point Likert scale, where 0 = "cannot do at all" to 10 = "certain can do". Factor analysis revealed that there are three types of coping: problem-focused, emotion focused and seeking social support.

14.4.2 Psychometric properties

Internal consistency has been reported to range between 0.79 and 0.94 (Chesney et al. 2006; Colodro et al. 2010) with test-retest reliability ranging between 0.49 and 0.80 (Chesney et al. 2006).

14.4.2 Scoring

The total score is obtained by summing the scores of all items with lower scores representing poorer perceptions of self efficacy.

14.4.2 Clinical cut-offs or normative data

Scores can range from 0-260, with a mean score of 163.72 (SD = 38.93) in participants described as 'healthy' in a community sample in the UK, with a significantly lower mean score of 149.64 (SD = 44.48) found in participants described as "unhealthy" (Colodro et al. 2010).

14.5 THE INVENTORY OF INTERPERSONAL PROBLEMS (IIP 32-ITEM: SELF RATED)

14.5.1 Description

This scale is self-rated and measures participants' perceived difficulties in relationships. There are 32 items, and it uses a 5-point Likert scale, where 0 = "not at all" to 4 = "extremely". Confirmatory factor analysis (0.90 to 0.96) revealed 8 types of interpersonal problems reported by psychotherapy out-patients (Barkham et al. 1996).

Initially 8 factors were identified:

1. Hard to be sociable
2. Hard to be assertive
3. Hard to be supportive
4. Hard to be involved
5. Too aggressive
6. Too open
7. Too caring
8. Too dependent

These were found to form 4 bipolar factors each pairing combining a "hard to be…" with a "too…" problem: 1) problems relating to competition (hard to be assertive vs. too aggressive), 2) socializing (hard to be sociable vs. too open), 3) nurturance (hard to be supportive vs. too caring), and 4) independence (hard to be involved vs. too dependent) (Barkham et al. 1996 p22-23).

14.5.2 Psychometric properties

Reliability (alpha coefficients) ranged between 0.71 to 0.89 (Barkham et al. 1996). The IIP-32 is reported to be "robust and highly internally reliable" (reported at 0.81) by McEvoy et al. (2013 p.268) with adequate internal consistency in out-patient and non-clinical samples (Barkham et al. 1996). Test-retest reliability ranges from 0.56 to 0.81.

14.5.3 Scoring

The total score is obtained by summing the scores of all items with higher scores representing greater severity of functional impairment.

14.5.4 Clinical cut-offs or normative data

An effect size for completers of 0.73 show that the IIP-32 is sensitive clinical change in cognitive behavioral group therapy for depression (McEvoy et al. 2013). The IIP-32 can also distinguish

between an asymptomatic community sample (general population mean for the whole scale 0.98) and a patient sample (out-patient mean for the whole scale 1.51) (Barkham et al. 1996). Another study found that the IIP-32 the mean score for the whole scale in patients with anxiety and depression (equivalent to "caseness") was 1.69 (McEvoy et al. 2013).

14.6 The Health and Safety Executive Management Standards Indicator Tool (35-item)

14.6.1 Description

This scale is self-rated and measures participant's experience of their working conditions over the last 6 months. There are 35 items and it uses a 5-point Likert scale, where 1 = "never" to 5 = "always". Confirmatory factor analysis has been performed to show that the tool has good discriminant validity and internal consistency (between 0.78-0.89) across 7 subscales which map onto six risk factors for occupational stress.

1. Demands
2. Control
3. Managerial support
4. Peer support
5. Relationships
6. Role
7. Change

14.6.2 Psychometric properties

Overall scale reliability is reported to be 0.92 (De Vellis 2003). It has been found to be a "psychometrically robust instrument" (Edwards et al. 2008 p.8).

14.6.3 Scoring

The UK Health and Safety Executive (2010) provides an analysis spreadsheet to help score the data across the 7 dimensions, and it can also be used to provide a unidimensional overall score. The tool can detect response inconsistency with reverse-coded questions. Higher scores represent better working conditions.

14.6.4 Clinical cut-offs or normative data

The tool is mainly used as a survey to provide organisations or distinct professions with aggregated data about levels of occupational stress across the workforce. There are four recommendations based on a traffic light system based on a representative sample of UK employees (Cousins et al. 2004).

In this study the questionnaire was used to provide information about individual's work-place stress and therefore scores were compared before and after the intervention.

Table 14 – HSE Stress Indicator Tool Traffic Light System

	TOTAL **MEAN**	
Red:	<3.36	Urgent action needed (scores below 20% in relation to benchmark data)
Yellow:	≥3.36-<3.55	Clear need for improvement (scores are below average 50% but not below 20%)
Blue:	≥3.55-<3.73	Good but need for improvement (scores are better than average 50%, but not at, above or close to 80%)
Green:	≥3.37	Doing very well, need to maintain performance (scores are above or close to 80%)

14.7 CLINICAL OUTCOMES IN ROUTINE EVALUATION (CORE 34-ITEM)

14.7.1 Description

This scale is self-rated and was designed to be administered before and after therapy in order to evaluate the outcome. It measures clinically relevant emotional problems over the last week. There are 34 items and 4 dimensions: subjective well-being (4 items), problems/symptoms (12 items), functioning (12 items), and risk/harm (6 items). The scale uses a 5-point scale ranging from 0 = "not at all" to 4 = "most or all of the time".

14.7.2 Psychometric properties

Internal consistency 75-94 (Barkham et al. 2005).

High internal (0.92-0.94) and test-retest reliability (0.64-0.91) (Evans et al. 2000).

14.7.3 Scoring

The level of current psychological global distress is calculated by averaging the mean score of each dimension giving a rating from "healthy" to "severe" giving a total score between 0-4. The CORE-OM has good sensitivity to change for practitioners to assess meaningful improvement over the course of therapy and provides 2 measurements are important: reliable change and clinically significant change. According to Gray & Mellor-Clark (2007 p.3):

> *Reliable change is change that exceeds that which might be expected by chance alone or measurement error; it is represented by a change of 0.5 or more in the total clinical score. Clinically significant change is indicated when a client's CORE score moves from the clinical to the non-clinical population.*

This equates to a total CORE score of around 1 or below (Connell et al. 2007).

14.7.4 Clinical cut-offs or normative data

National UK norms have been calculated with a large sample (Barkham et al. 2001):

Table 15 – Cut-offs for CORE-OM

CORE-OM		
TOTAL	Female	Male
Minimal	0.00-1.28 (16%)	0.00-1.18 (16%)
Moderate	1.29-2.49 (56%)	1.19-2.49 (58%)
Severe	2.50-4.00 (28%)	2.50-4.00 (26%)
RISK SUBSCALE		
Clinical	0.31-4.00 (59%)	0.43-4.00 (54%)
Non-clinical	0.00-0.30 (41%)	0.00-0.42 (46%)

A more recent study (Connell et al. 2007) recommended rounding the clinical cut-off score down to 1.0 for both sexes because this clinical cut-off distinguishes non-distressed asymptomatic individuals from the general population from patients.

14.8 AGNEW RELATIONSHIP MEASURE-5 (ARM 5-ITEM)

14.8.1 Description

This scale is self-rated and measures five dimensions of therapeutic alliance (bond, partnership, confidence, openness and client initiative. The scale has 5 items and uses a 7-point Likert scale ranging from "strongly disagree" = 1, to "strongly agree" = 7.

14.8.2 Psychometric properties

The ARM-5 has adequate internal consistency 0.77-0.87, good construct validity such that it shows substantial correlations with gains in therapy (Cahill et al. 2012), and strong convergent validity with the Working Alliance Inventory (Stiles et al. 2002).

14.8.3 Scoring

The potential range is from 5-35.

14.8.4 Clinical cut-offs or normative data

The National Audit of Psychological Therapies (Farquharson 2011) recommends the following scoring format:

Red $\leq$ 19

Amber 20-27

Green $\geq$ 28

14.9 Quality of Life (EQ-5D 5-item)

14.9.1 Description

This scale is self-rated and is a criterion standard for health-related quality of life. Part 1 consists of 5 questions with 3 possible answers ("no problems" = 1, "some problems" = 2 and "severe problems" = 3). The dimensions are 1) mobility, 2) self-care, 3) usual activities, 4) pain/discomfort, and 5) anxiety/ depression. Part 2 consists of a vertical graduated visual analogue scale VAS (thermometer) to measure health status, which ranges from 0% (worst imaginable health state)-100% (best imaginable health state. There is also an optional set of demographic questions (McDowell, I. and Newell 1996; Bowling 2005).

14.9.2 Psychometric properties

The EQ-5D has good construct validity (Bowling 2005) and is very responsive to improvement in depression (especially severe) and anxiety (Peasgood, T., Brazier, J. and Papaioannou 2012). Test-retest reliability is high (0.86-0.90) (Bowling 2005).

14.9.3 Scoring

There are 243 combinations (3 to the power of 5), which are described as a 5-digit number (with no numerical value) e.g. 11111 indicates the optimum health state, and 33333. The EQ-5D descriptive system can be converted to an index score.

14.9.4 Clinical cut-offs or normative data

The index score for moderate depression ranges from 0.46 to 0.7 and for severe depression ranges from 0.27 to 0.47 (Sobocki et al. 2007; Mann et al. 2009; Carpenter et al. 2011). The EQ-VAS is a visual analogue score which asks participants to mark on a scale of 0-100 where 0 = 'worst imaginable health', and 100 = 'best imaginable health' (Dolan 1997; Feng et al. 2014).

14.10 Client Satisfaction Questionnaire (CSQ 8-item)

14.10.1 Description

The CSQ-8 has been used in some relevant recent studies. Client satisfaction for a group intervention in primary care counselling was 25.3 (SD 5.8) (Eriksson et al. 2013) out-patient collaborative care for depression 24.4 (SD 3.5) (Richards et al. 2013), and for a life skills programme for people with low mood and depression as 28.0 (SD 4.8) (McClay et al. 2015).

14.10.2 Psychometric properties

The CSQ-8 is a shortened version of the CSQ-18 which has high internal consistency with high scores correlating with changes in self-reported symptoms (Attkisson, C.C. and Zwick 1982).

14.10.3 Scoring

From 0 (highly dissatisfied) to 32 (highly satisfied).

14.10.4 Clinical cut-offs or normative data

In a recent UK study evaluating group therapy for people with low mood and depression (McClay et al. 2015), the mean CSQ-8 score was 28 (SD 4.8).

14.11 BESPOKE WEEKLY QUESTIONNAIRE

14.11.1 Description

A bespoke questionnaire was designed for the study to record the proportion (expressed as %) of agreed hours at work in the last week and intention-to-quit (expressed as %).

14.12 OTHER POSSIBLE INSTRUMENTS

In future research the following instruments may be useful:

- Impact Message Inventory (IMI) (Kiesler & Schmidt, 2006)
- Inventory of Inter-Personal Strengths (IIS-32) (Hatcher & Rogers, 2012)
- Standardised Assessment of Personality – Abbreviated Scale (SAPAS) (Moran et al. 2003)

APPENDIX 15: VARIABLE MAPS

15.1 VARIABLE MAP ONE

Table 16 – Variable Map 1

Psychotherapeutic intervention vs. CAU

Study details Author / date		OUTCOME	3m	6m	9m	12m	18m	24m	36m
WANG	WORK	Job retention (days employed)		✓✓		✓	✓	✓	
		Absenteeism (fewer days absent, shorted duration)							
		Return-to-work (time until partial / full RTW)							
VLASVELD		Work functioning / work ability / performance		✓		✓	✓		
SCHOEN BAUM	CLINICAL	Remission of depression		✓	✓	✓✓			
		Recovery from depression				✓			
		Response to treatment	✓			✓			
		Improved emotional wellbeing		✓		✓	✓	✓	

KEY: ✓ = better than care-as-usual comparison X = worse than baseline

Summary

In summary, a high intensity psychotherapeutic intervention based on CBT versus CAU impacts on job retention up to 24 months and improved work functioning up to 18 months (Schoenbaum, et al. 2002). There was a statistically significant difference in the rate of remission of depression at 6 months lasting up to 12 months for clients who received this treatment compared to those who only received CAU, and a statistically significant difference in emotional wellbeing up to 24 months. Likewise, a low intensity psychotherapeutic intervention based on CBT versus CAU impacts on job retention up to 6 months (Wang et al. 2007). There was a statistically significant difference in the rate of remission at 12 months with a clinically significant reduction in depressive symptoms for clients who received this treatment compared to those who only received CAU. Clients who received another low intensity work-focused psychotherapeutic intervention based on PST had a clinically significant response to treatment at 3 months compared to CAU but this statistically significant difference had disappeared by 12 months (Vlasveld et al. 2012).

Only the high intensity psychotherapeutic intervention met the standard for recovery from depression with remission lasting 6 months. The two low intensity psychotherapeutic interventions did not impact on recovery from depression.

None of these interventions were specifically resigned to enhance job retention in employees with moderate-severe recurrent depression. Therefore, a gap in research and practice has been identified with regard to which psychotherapies and psychotherapeutic interventions might work best for this cohort, and whether psychotherapies and psychotherapeutic interventions should be work-focused. It is not known whether staying-at-work or returning-to-work is a contributory factor in the onset of depression or the recovery from depression.

These studies did not provide the answer to the "what works for whom in what circumstances and in what respects, and how?" question (Pawson, R. and Tilley 2004).

15.2 VARIABLE MAP TWO

Table 17 – Variable Map 2

Psychotherapeutic intervention vs. Active treatment

Study details Author / date		OUTCOME	3m	6m	9m	12m	18m	24m	36m
KNEKT	WORK	Job retention (days employed)		✓		✓	✓		
		Absenteeism (fewer days absent, shorted duration)	✓			✓	✓		
		Return-to-work (time until partial / full RTW)							
SCHOEN BAUM		Work functioning / work ability / performance	✓	✓		✓	✓	✓	✓
	CLINICAL	Remission of depression	X					✓	✓
		Recovery from depression							
BURNAND		Response to treatment							
		Improved emotional wellbeing							✓

KEY: ✓ = better than active treatment comparison X = worse than baseline

Summary

In summary a high intensity psychotherapeutic intervention based on CBT versus ADM impacts on job retention up to 18 months and improved work functioning up to 12 months (Schoenbaum et al. 2002). There was a statistically significant difference in the rate of remission of depression at 24 months for clients who received this treatment compared to those who only received ADM. Likewise, a high intensity long-term psychotherapeutic intervention based on PP versus two other psychotherapies impacts on absenteeism with a statistically significant difference in the number of days absent and the duration of sick leave between 12-18 months and improved work functioning between 18-36 months (post-randomisation) (Knekt et al. 2008). There was a statistically significant difference in the rate of remission and emotional wellbeing at 36 months for clients who received this treatment compared to those who only received medium-term PP and short-term SFBT.

In contrast a low intensity psychotherapeutic intervention based on PP versus ADM impacts on absenteeism with a statistically significant difference in the number of days absent and the duration of sick leave and improved work functioning at 3 months (discharge) (Burnand et al. 2002). However, both treatments had a "marked negative effect" on depression scores using the clinician-administered (HAM-D), with mean scores showing worse severity of depression at 3 months (discharge).

Psychotherapeutic interventions appear to achieve better outcomes compared to ADM in terms of job retention, absenteeism and work functioning. Long-term high intensity psychotherapeutic interventions appear to achieve better outcomes compared to medium- and short-term high intensity psychotherapeutic interventions. Anti-depressant medication appears to achieve equivalent outcomes to psychotherapeutic interventions in terms of clinically significant reduction in depressive symptoms and recovery from depression lasting more than 6 months.

As above, there a gap in research and practice with regard to what might help people with moderate-severe recurrent depression maintain their employment.

APPENDIX 16: DATA EXTRACTION FORMS OVER-ARCHING PRINCIPLES

Table 18 – Multi-disciplinary teamwork

Full reference			
THEORY AREA 1: **Multi-disciplinary teamwork**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 19 – Guideline concordance/quality improvement

Full reference			
THEORY AREA 2: **Guideline concordance/quality improvement**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 20 – Detection of probable depression

Full reference			
THEORY AREA 3: **Detection of probable depression**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 21 – Early intervention

Full reference			
THEORY AREA 4: **Early intervention**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 22 - Treatment initiation

Full reference			
THEORY AREA 5: **Treatment initiation**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 23 - Treatment completion

Full reference			
THEORY AREA 6: **Treatment completion**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 24 - Tracking of progress

Full reference			
THEORY AREA 7: **Tracking of progress**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 25 - Preventing drop-out, poor response, unmet need

Full reference			
THEORY AREA 8: **Preventing drop-out, poor response, unmet need**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

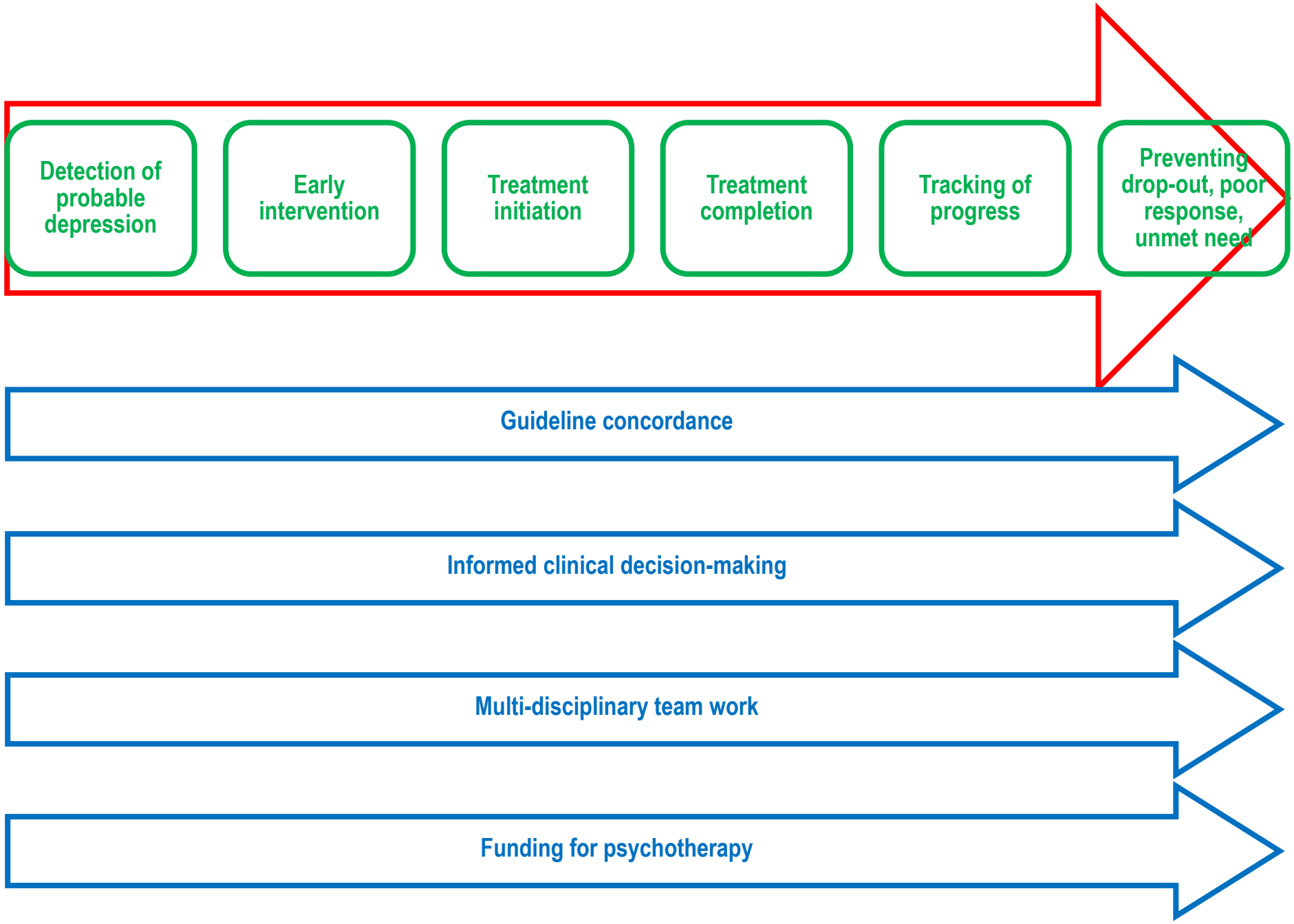
Table 26 - Informed clinical decision-making

Full reference			
THEORY AREA 9: **Informed clinical decision-making**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Table 27 - Funding for psychotherapy

Full reference			
THEORY AREA 10: **Funding for psychotherapy**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

APPENDIX 17: OVER-ARCHING PRINCIPLES DIAGRAM



APPENDIX 18: RCTS: RELEVANT & POTENTIALLY RELEVANT PSYCHOTHERAPEUTIC INTERVENTIONS

Table 28 – Primary preventative interventions

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Eriksen et al. 2002 Norway Worksite	Intervention **n = 98** a) Control **n = 166** b) Comparison **n = 94** c) Comparison **n = 114**	Employees at work (post offices and postal terminals)	Universal stress management training versus Primary prevention	LOW Delivered by non-psychologists: "professional instructors" trained in the different interventions	SHORT-TERM Over 12 weeks MEDIUM Dose = 24 hours	HIGH Twelve x two hour weekly sessions (group format)	a) No intervention b) Combined Integrated Health Programme (includes PE and an ergonomic examination in the workplace) versus c) Physical exercise only	No differences in frequency and duration of sick leave over 12 months follow up.	No effects on subjective health complaints or work-related stress for any intervention over 12 months follow up.
Limm, Gundel, et al. 2011 Germany Worksite	Intervention **n = 75** Control **n = 79**	Lower or middle management employees (99% male) at work (international manufacturing plant)	Universal stress management training Primary prevention	HIGH Delivered by two qualified and experienced medical / psychotherapy practitioners	MEDIUM-TERM Over 8 months MEDIUM Dose = 21 hours	HIGH 24 x 45 minute sessions comprising 2 x consecutive full day workshops plus 4 x 45 minute booster sessions	Waiting list	Statistically significant small increases in working hours compared to WL over 12 months follow up.	Statistically significant reductions in perceived stress reactivity compared to WL over 12 months follow up. Statistically

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
						(group format)			significant improvement in stress, anxiety and depressive symptoms with no difference between groups over 12 months follow up.
Takao et al. 2006 Japan Worksite	Intervention **n = 24** Control **n = 22**	Line managers (supervisors in sake brewery)	Universal job stress education plus counselling skills Primary prevention	LOW Delivered by line managers	SHORT-TERM 2 x single training sessions for line managers LOW Dose = 4 hours	HIGH External facilitators (i.e. occupational physician and two clinical psychologists) provided 2 workshops. (the training was provided in a group format and the intervention was provided in 1:1 format)	Waiting list	Statistically significant improvement in self-reported job performance but only in young white collar subordinates, whilst there was a statistically significant decrease in self-reported job performance in the same cohort of the	Statistically significant reduction in psychological distress but only in young white collar male subordinates compared to WL over 3 months follow up.

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
								WL over 3 months follow up.	
Tsutsumi et al. 2009 Japan Worksite	Intervention **n = 35** Control **n = 45**	Employees at work (assembly line workers)	Universal participatory team-based problem-solving intervention Primary prevention	LOW Delivered by non-psychologists: Research team provided ½ day training for "volunteer in-house facilitators" + line manager education workshop	MEDIUM-TERM 9 months MEDIUM Dose = approx. 12 hours	HIGH In-house facilitators provided 3 workshops (group format)	No intervention	Statistically significant increase in self-reported job performance compared to CG here there was a statistically significant decrease over 12 months follow up.	Statistically significant reduction in emotional distress compared to CG where there was statistically significant deterioration in emotional distress over 12 months follow up.
Vuori et al. 2012 Finland Worksite	Intervention **n = 324** Control **n = 292**	Employees at work (mixed employment)	Universal resource-building group intervention Primary prevention	LOW Delivered by non-psychologists: Research team provided 4 day training for in-house facilitators	SHORT-TERM Over one or two weeks HIGH Dose = approx. 24 hours	HIGH In-house facilitators provided 3-5 workshops either full or half-days (group format)	Received printed information about career and health-related issues	Statistically significant reduction in intention to retire compared to CG over 7 months follow up.	Statistically significant reduction in depressive symptoms and increase in mental resources compared to CG, with most benefit in employees with elevated levels of depression or

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
									exhaustion and younger employees over 7 months follow up.

Table 29 – Secondary preventative interventions

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Duijts 2007 Netherlands Worksite	Intervention **n = 76** Control **n = 75**	Employees at risk of future sickness absence (health care / educational sectors)	Targeted coaching Secondary prevention	LOW Delivered by non-psychologists: work coaches	MEDIUM-TERM Over 6 months MEDIUM Dose = approx. 8 hours	LOW Between 7-9 x one hour sessions which included two x 3-way facilitated meetings between the employee and their line manager (1:1 format)	Waiting list	No differences in incidence of self-reported sickness absence at 12 months follow up. Statistically significant reduction in duration of sickness absence compared to WL over 1 year follow up. **ADVERSE EFFECTS** Statistically	Statistically significant improvement in health, psychological distress and burnout compared to WL at 12 months follow up.

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
								significant difference with increased perceived job insecurity and less training opportunities in the coaching intervention and no increase in the WL.	
Lexis et al. 2011 Netherlands Worksite	Intervention **n = 69** Control **n = 70**	Employees at risk of future sickness absence (banking company)	Targeted psychotherapy with cognitive behavioural therapy and problem-solving components Secondary prevention	HIGH Delivered by clinical psychologists who had received 2 days training plus 1 day booster session	Not reported LOW / MED Dose = 5-9 hours	LOW An initial 7 x 45 minutes with the option of a further 5 sessions if necessary following review of progress (1:1 format)	CAU: Delivered by OHP only if requested	Statistically significant shorter sickness absence duration compared to CAU over 12 months follow up.	Statistically significant reduction in depressive symptoms compared to CAU over 12 months follow up.
van Rhenen et al. 2007 Netherlands Worksite	Intervention (stressed employees) **n = 127** Comparison	Employees either at risk (stressed) or non-stressed (telecom company)	Targeted Stress Inoculation Training (SIT) Secondary	Not reported probably delivered by OHPs LOW	SHORT-TERM Over 8 weeks LOW Dose = 4	HIGH Four x one hour sessions (group format)	Physical Exercise and Relaxation programme	**ADVERSE EFFECTS** Statistically significant shorter period until the onset	Statistically significant reductions in psychological complaints, burnout and

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
	(non-stressed employees) **n = 237**		prevention		hours			of a new sickness absence but no longer duration following the intervention for the cohort of stressed employees in SIT compared to CG over 12 months follow up.	fatigue over 6 months follow up (reported in Van Rhenen, 2005).
Willert et al. 2009, 2011 Denmark Psychotherapy department	Intervention **n = 51** Control **n = 51**	Employees either at work or off sick (work-related stress) (mixed employment)	Targeted stress management training Secondary prevention	HIGH CBT delivered by clinical psychologists	SHORT-TERM Over 3 months MEDIUM Dose = 24 hours	HIGH Eight x 3 hour sessions (initially weekly then fortnightly) (group format)	Waiting list	Statistically significant reduction in self-reported absenteeism compared to WL over 16 weeks follow up (reported in Willert et al. 2011)	Statistically significant reduction in perceived stress and improvement in coping via positive reframing compared to WL over 3 months follow up (reported in Willert et al. 2009)

Table 30 – Tertiary preventative interventions

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Bakker et al. 2007 Netherlands Primary care clinic	Control **n = 206** Intervention ***n = 227***	Employees off sick (mental health problems) (mixed employment)	Indicated Minimal Intervention for Stress-related mental disorders with Sick leave (MISS) based on PST Tertiary prevention	LOW Delivered by non-psychologists: General Practitioners who had received 2 sessions x 3 ½ hours plus 2 follow up sessions = 11 hours	Not reported VERY LOW Dose = ½ - 1 hour	HIGH Up to 3 consultations of between 10-20 minutes (1:1 format)	CAU: delivered by GP	No difference on length of sick leave compared to CAU over 12 months follow up.	Statistically significant reduction in psychological distress, anxiety and depressive symptoms in both groups with no difference between groups over 12 months follow up.
Blonk et al. 2006 Netherlands a) worker's home or workplace b) clinical setting	Intervention **n = 40** a) Control **n = 42** b) Comparison **n = 40**	Self-employed off sick (psychological complaints)	Indicated combined intervention (CI) CBT techniques plus workplace assessment and adjustments versus Tertiary prevention	LOW Delivered by non-psychologists: "labour experts" trained in brief CBT-informed stress management HIGH b) Delivered by psychologists	SHORT-TERM 3 weeks LOW Dose = 5-6 hours b) approx. 6 weeks MEDIUM Dose = 8 ¼ hours	LOW a) 5-6 x 1 hour sessions twice a week (1:1 format) b) 11 x 45 minute sessions twice a week (1:1 format)	a) Control: 2 brief sessions with GP b) CBT	Improved return-to-work rates of CI compared to CBT over 10 months follow up.	Statistically significant reduction in psychological distress in both interventions with no difference between all groups over 10 months follow up.

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Bonde et al. 2005 Denmark OH clinic	Intervention **n = 92** Control **n = 92**	Employees off sick (including MH problems)	Indicated low cost rehabilitation support based on "systemic thinking theory" SFBT with workplace liaison plus CAU Tertiary prevention	LOW Delivered by non-psychologists: social (support) workers	SHORT-TERM Average period of intervention approx. 3 months LOW Dose = 2 ½ - 4 ½ hours	LOW Average contact time = 2.2 x 1-2 hours each time (approx. monthly) (1:1 format)	CAU: return-to-work counselling programme without workplace liaison	No difference on the likelihood of gainful employment after 1 year or on the duration of sick leave.	Statistically significant improvement in perceived health and social functioning with no difference between groups over 15 months follow up.
Brouwers et al. 2006 Netherlands Primary care clinic	Intervention **n = 98** Control **n = 96**	Employees off sick (mental health problems) (mixed employment)	Indicated problem-solving plus graded activity Tertiary prevention	LOW Delivered by non-psychologists: social (support) workers who had received a 3-day training course plus two follow-up sessions	SHORT-TERM Over 10 weeks LOW Dose = 4 hours	LOW Five x 50 minutes sessions (1:1 format)	CAU: delivered by GP	No difference in return-to-work rates over 18 months follow up.	Statistically significant improvement in depressive and anxiety symptoms with no difference between groups over 18 months follow up.
Burnand et al. 2002 Switzerland	Intervention **n = 35** Control **n = 39**	Employees off sick (long-term) with depression (> 75% of	Indicated combined psychodynamic psychotherapy	LOW Delivered by mental health nurses who had received 6	SHORT-TERM Over 10 weeks	Not reported Probably 1:1	Clomipramine alone with support	Statistically significant fewer lost work days during	Statistically significant lower rate of admission to hospital and

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Outpatient psychiatric clinic		sample)	plus Clomipramine Tertiary prevention	months training and on-the-job experience in psychodynamic psychotherapy over 2 years	Dose is not reported, treatment involved "intensive nursing in a specialised milieu"			treatment for participants in work at intake compared to same cohort in CG over approx 10 weeks.	days in hospital at discharge compared to CG over approx 12-24 weeks. **ADVERSE EFFECTS** Both treatments had a "marked negative effect" on depression scores using the clinician-administered (HAM-D), with mean scores showing worse severity of depression.
De Vente et al. 2008 Netherlands OH clinic	Intervention **n = 28** a) Control **n = 26** b) Comparison	Employees off sick (work-related stress) (postal and telecom services)	Indicated stress management training (1:1 format) versus Tertiary	HIGH CBT delivered by clinical psychologists	SHORT-TERM Over 3 months MEDIUM Dose = 12-24 hours	LOW 12 sessions x 1 hour (1:1 format) HIGH 12 sessions x 2 hour (group	a) CAU: regular visits to GP, OHP and / or no more than 5 sessions with a social worker psychologist	No difference in return-to-work rates over 10 months follow up.	Statistically significant improvement in stress, depressive and anxiety symptoms with no

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
	n = 28		prevention			format)	b) Indicated stress management training (group format)		difference between all groups over 4 months follow up. Statistically significant improvement in depressive symptoms in IG compared to CAU only for people with low depressive symptoms at baseline over 4 months follow up.
Knekt et al. 2008a, 2008b Finland University psychotherapy department	Intervention **n = 128** a) Comparison **n = 101** b) Comparison **n = 97**	Employees either at risk of future sickness absence or off sick (long-term mental disorder)	Indicated long-term psycho-dynamic psychotherapy versus Tertiary prevention	HIGH Delivered by clinical psychologists or psychotherapists	MEDIUM-TERM SFBT: no more than 8 months MEDIUM Dose = approx. 12 hours MEDIUM-	LOW SFBT: no more than 12 sessions every 2-3 weeks (1:1 format) Medium-term psycho-dynamic psychotherapy : 20 weekly sessions	a) Medium-term psycho-dynamic psychotherapy versus b) Short-term Solution Focused Brief Therapy (SFBT)	Statistically significant improvement in work ability in medium-term PP and SFBT compared to long-term PP, with no difference between them at 7 months.	Statistically significant improvement in self- and clinical-rated scores for anxiety, depression and global symptoms with medium-term PP more effective than

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
					TERM Psycho-dynamic psycho-therapy: no more than 6 months MEDIUM Dose = approx. 20 hours LONG-TERM Psycho-dynamic psycho-therapy: up to 36 months VERY HIGH Dose > more than 80 hours in 12 months	(1:1 format) Long-term psycho-dynamic psychotherapy: 1-hour sessions 2-3 times a week for up to 3 years (1:1 format)		However, long-term PP showed greater improved work ability at 3 years follow up. Statistically significant reduction in number of sick leave days in previous 3 months compared to medium-term PP and SFBT at 3 year follow up. No change in proportion of participants in employment or education i.e. job retention in any group over 3 years follow up.	long-term PP at 12 months follow up but long-term PP more effective than both CGs at 3 years follow up (reported in Knekt et al. 2008b).
Nystuen and Hagen 2006	Intervention **n = 45**	Employees off sick (mental health	Indicated Solution Focused Brief	HIGH Delivered by four clinical	SHORT-TERM Over 8 weeks	HIGH Eight x 3-4 hour weekly	CAU: psychotherapy or other	No differences on length of sick leave over	Statistically significant improvement

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Norway Social Security offices	Control **n = 38**	problems) (mixed employment)	Therapy follow up Tertiary prevention	psychologists	HIGH Dose = 24-32 hours	sessions (group format)	treatment opportunities	12 months follow up.	in mental health for those off sick with psychological problems who attended > 50% sessions compared to CAU over 12 months follow up.
Rebergen et al. 2009 Netherlands OH clinic	Intervention **n = 125** Control **n = 115**	Employees off sick (mental health problems) (police officers)	Indicated guideline based care (GBC) i.e. stress inoculation training plus graded activity Tertiary prevention	LOW Delivered by non-psychologists: OHPs who had received a 3 day training course	Not reported	Not reported	CAU: delivered by OHP	No difference in return-to-work rates over 1 year follow up.	Statistically significant higher health care costs in CAU compared to GBC mainly due to higher utilisation of psychological therapy paid for by employer. **ADVERSE EFFECTS** Statistically significant reduction in treatment satisfaction

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
									scores in both GBC and CAU over 1 year follow up.
Schoenbaum et al. 2002 Switzerland Primary care clinic	Intervention **n = 424** a) Control **n = 443** b) Comparison **n = 489**	Employees at risk of future sickness absence (clinician-rated depression)	Indicated Quality Improvement clinic: QI Therapy (CBT) Tertiary prevention	LOW a) QI Meds delivered by practice staff HIGH b) QI Therapy delivered by psychologists trained and supervised in CBT Of the 81% of participants referred for treatment in the QI Therapy group, only 30% of attended sessions***. Only 40% of participants who attended sessions in the QI Therapy group	MEDIUM-TERM Over 6 months MEDIUM a) Dose = 8-12 hours Over 3 months MEDIUM b) Dose = 12-18 hours	HIGH a) Brief infrequent face-to-face or phone contact (1:1 format) HIGH b) weekly 12 x 1 hour 1:1 sessions or weekly 12 x 1 ½ hour group sessions (using published and freely available treatment manual: Munoz, 2000)	a) CAU: GP consultation plus written information about depression b) QI Meds: patient assessment, education, plus medication follow up and outreach by 'phone	Statistically significant more days at work compared to CAU over 24 months follow up (reported in Schoenbaum et al. 2001).	Statistically significant better role functioning and emotional wellbeing compared to CAU over 24 months follow up, and better role functioning than QI Meds at 6 & 12 months. Statistically significant lower severity of depression than QI Meds but similar to CAU over 24 months follow up.

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
				received CBT**					
Stenlund et al. 2009 Sweden Stress clinic	Intervention **n = 67** Comparison **n = 69**	Employees off sick long-term (stress-related disease and burnout) (mixed employment)	Indicated CBT-informed rehabilitation programme plus qigong Tertiary prevention	HIGH Delivered by non-psychologists: Multi-disciplinary team OHPs, OH nurse, wellness consultant, psychologist, ergonomist and / or a physio-therapist.	LONG-TERM Over 12 months VERY HIGH Dose = approx. 100 hours	HIGH 20 x 3 hour sessions which included Qigong (a form of relaxation exercise similar to yoga) in the first 6 months, and 10 x 3 hour sessions in the following 6 months, with partners or spouses invited to three group meetings, and booster sessions at 3, 6 and 12 months (group format)	Qigong only	Statistically significant improvement in rates of sick leave in both groups with no difference in return-to-work rates over 12 months follow up.	Statistically significant improvement in depressive, anxiety, obsessive compulsive symptoms, burnout, fatigue, and self-rated stress behaviour with no difference between groups over 12 months follow up.
van der Klink 2003	Intervention **n = 109**	Employees off sick	Indicated stress	LOW Delivered by	SHORT-TERM	HIGH Between 4-5	CAU: delivered by	Statistically significant	Statistically significant

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
Netherlands OH clinic	Control **n = 83**	(adjustment disorder) (mixed employment)	inoculation training Tertiary prevention	non-psychologists: OHPs who had received a 3 day training course	Up to 6 weeks VERY LOW Dose = approx. 1 ½ hours	OHP consultations (total time not less than 90 minutes) (1:1 format)	OHP	shorter time to partial return to work and shorter duration of sickness leave compared to CAU over 3 months follow up, but all participants had resumed work over 12 months follow up.	improvement in depressive and anxiety symptoms with no difference between groups over 12 months follow up.
Van Oostrom et al. 2010 Netherlands OH clinic	Intervention **n = 73** Control **n = 72**	Employees off sick (distress) (two universities & steel company)	Indicated guideline based care plus participatory workplace problem-solving intervention delivered by return-to-work coordinator Tertiary prevention	LOW Delivered by non-psychologists: social (support) worker or a labour expert trained in approach	Not reported	LOW CAU plus three x 3-way facilitated meetings between the employee and their line manager (1:1 format)	CAU: guideline based care	No effect on return-to-work rates. Statistically significant reduction in time until "lasting RTW" for those who at baseline intended to return-to-work despite symptoms compared to CAU over 12 months follow	Statistically significant improvement in distress, depressive, anxiety and somatisation symptoms with no difference between groups over 12 months follow up.

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
								up.	
Vlasveld et al. 2012 Netherlands OH clinic	Intervention **n = 65** Control **n = 61**	Employees off sick (with over the cut off score PHQ ≥ 10 for at least moderate depression) (mixed employment)	Indicated collaborative care based on problem solving therapy (PST) Tertiary prevention	LOW Delivered by non-psychologists: OHPs who had received a 2 day training course	Not reported MEDIUM Dose = 8-16 hours	LOW 6-12 sessions of PST plus workplace assessment and adjustments (1:1 format)	CAU: guideline based care	No differences on length of sick leave over 12 months follow up (reported in Vlasveld et al. 2013).	Statistically significant treatment response i.e. reduction of symptoms ≥ 50% but no different from CAU except for participants who scored PHQ-9 ≥ 15 i.e. moderate-severe depression over 3 months follow up. No difference in remission of depressive symptoms over 3 months follow up.
Wang et al. 2007 USA A large managed behavioural health care company	Intervention **n = 304** Control **n = 300**	Employees at risk of future sickness absence (manufacturing, airline, banking, insurance,	Indicated multi-disciplinary team intervention involved enhanced depression	LOW Independent case management with CBT-informed guided self-help with	LONG-TERM Up to 12 months with booster sessions every 4-8 weeks MEDIUM	LOW Eight x 30–40 minutes weekly sessions with weekly (more severe depression) to	CAU: multi-disciplinary team intervention involved enhanced depression care (i.e. anti-	Statistically significant higher job retention and increased working hours compared to CAU over 12	Statistically significant reduction in depressive symptoms compared to CAU over 12 months follow

Study details: Author/date/setting	Sample size	Client group	Level of intervention Type of prevention	Intensity	Duration / Dose	Volume / Frequency Format	Comparison/s	Improvement in work outcomes	Improvement in clinical outcomes
		state government, public utility)	care (i.e. anti-depressant medication plus targeted psychotherapy) plus independent case management with phone outreach and phone CBT for patients who declined in-person psychotherapy Tertiary prevention	workbook delivered by paraprofessionals	Dose = approx. 14 hours	bi-monthly (less severe depression) outreach contact by 'phone (1:1 format)	depressant medication plus targeted psychotherapy)	months follow up.	up.

APPENDIX 19: COMPONENT ANALYSIS

19.1 ANALYSIS OF INTERVENTION COMPONENTS

In order to design the new intervention, it is necessary to understand exactly *what* interventions do and *how* they do it, i.e. the operational logic (Astbury and Leeuw 2010). Due to the limited number of studies in the effectiveness review, this section comprises a comprehensive review and descriptive analysis of the design of relevant and potentially relevant psychotherapeutic interventions used in the RCTs identified by the search. The details of these studies are summarised and tabulated along with brief findings in terms of the impact the intervention had on work and clinical outcomes in Appendix **.

19.2 DATA EXTRACTION

As described above, 24 studies fully or partially met the inclusion criteria, and reported both work and clinical outcomes. The features of each intervention's design are described and critiqued using the Intervention Component Analysis Methodology (Sutcliffe et al. 2015).

This approach employs qualitative data analysis techniques as well as inductive reasoning to ascertain critical features of effective interventions. Sutcliffe's methodology recognises that interventions found to be ineffective can provide information relevant to re-design. Where published, process evaluation is considered in determining what the intervention 'looks like'. Meticulous scrutiny of each article and supplementary material leads to a better understanding of the nature of the intervention in terms of barriers and facilitators of change.

Programme (or intervention) designers may have provided a rationale for their choice of *core practice components*, but where this is not presented, retroductive reasoning is needed to unearth the designers' implicit assumptions about *why* it is supposed to work. In many cases, creative speculation and conjecture (Astbury and Leeuw 2010) has been used to identify plausible explanations for *what* was done and *how* it was done. Explicit reasons for *why* interventions are supposed to work i.e. conceptual logic (Astbury and Leeuw 2010) will be addressed in the Section three of this chapter which interrogates the *core theoretical concepts* and explanatory frameworks informing each intervention's design.

Various taxonomies and graphics are used to elicit patterns which will hopefully aid in the critical realist processes of analysis, synthesis and hypothesis with regard to what might work to enhance job retention in employees with moderate-severe recurrent depression.

19.3 STRATEGIC COMPONENTS

The 24 studies included 29 active psychotherapies and psychotherapeutic interventions which were categorised using the Occupational Health framework, into what model it was based on, the level of prevention, (i.e. primary, secondary, or tertiary), and the level of intervention (i.e. individual, interface, or organisational), and (Table 31).

19.3.1 Models of Practice

Most studies gave a clear indication of the model for psychotherapeutic practice that was used in the design of the intervention, and whilst some interventions were multi-modal and pan theoretical it is possible to classify them broadly into six categories, as shown in Table 31 below. Staff Support refers to interventions designed to impact on the employee's workplace such as environmental improvements, job re-design and career preparedness.

Table 31 – Models of practice

MODEL	TERTIARY	SECONDARY	PRIMARY
Cognitive Behavioural Therapy (CBT)	Blonk et al. 2006b Schoenbaum et al. 2002 Schoenbaum et al. 2002 Stenlund et al. 2009 Blonk et al. 2006a Wang et al. 2007	Lexis et al. 2011	
Psychodynamic Psychotherapy (PP)	Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002		
Problem-Solving Therapy (PST)	Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2012		Tsutsumi et al. 2009
Solution Focused Brief Therapy/ Coaching (SFBT)	Knekt et al. 2008c Nystuen & Hagen 2003, 2006 Bonde et al. 2005	Duijts et al. 2007	
Stress Management or Stress Inoculation Training (SMT/SIT)	De Vente et al. 2008a De Vente et al. 2008b Rebergen, 2009 Van der Klink et al. 2003	Van Rhenen et al. 2007 Willert et al. 2009, 2011	Limm et al. 2011 Eriksen et al. 2002a SMT
Staff Support (SS)			Takao et al. 2006 Eriksen et al. 2002b IHP Vuori et al. 2012

There are no tertiary preventative programmes based on SS. There are no primary preventative programmes based on CBT, PP or SFBT. There are no secondary preventative programmes based on SS or PST. One plausible explanation for choice of model of practice and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose a model based on their professional experience such as PST is popular with

doctors as it aligns with their usual way of working. Another explanation is that they choose an evidence-based psychotherapeutic intervention which aligns with their beliefs about empirical research such as CBT is recommended as a first line treatment for depression. There is no reason why SS for example might not achieve positive work and clinical outcomes for symptomatic individuals.

19.3.2 Level of Prevention

For the purposes of this thesis, *level of prevention* is defined as the main aim of the preventative programme based on the OH framework. Close scrutiny of each intervention allowed for categorisation of:

- **Tertiary preventative programmes**. Designed as reactive indicated interventions for individuals who are high risk and symptomatic.
- **Secondary preventative programmes**. Designed as ameliorative targeted interventions for individuals who are at risk or showing early signs.
- **Primary preventative programmes**. Designed as proactive universal interventions for individuals who are healthy or asymptomatic.

Unsurprisingly, this review found more tertiary (n = 20) and fewer secondary (n = 4) and primary (n = 6) preventative programmes because it was focused on employees with diagnosed or symptomatic with moderate-severe recurrent depression.

One plausible explanation for the choice of level of prevention and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to direct resources at those most in need such that symptomatic individuals are offered high intensity psychotherapy as in the stepped care model. Another explanation is that designers believe that clinical status should not exclude someone who needs indicated treatment from accessing universal and targeted psychotherapeutic interventions. There is no reason why symptomatic individuals could not benefit for earlier intervention such as universal health, wellbeing and lifestyle programmes.

19.3.3 Level of Intervention

For the purposes of this thesis, level of intervention is defined as where change needs to happen such that preventative programmes are implemented successfully. Complex interventions often require multi-level political, structural, strategic and operational support.

Close scrutiny of each intervention allowed for categorisation of:

- **Individual or micro level.** When health is impacted by interventions designed to bring about changes the worker's behaviour or attitudes for example.

- **Organisational or meso level.** When health is impacted by interventions designed to bring about changes in the workplace system such as environmental improvements or the healthcare system such as funding for psychotherapy.
- **Societal or macro level.** When health is impacted by interventions designed to bring about changes in cultural mores for example.
- **Interface level.** Interventions that cross-over from one level to another such as when a General Practitioner works in collaboration with an employee's Occupational Health or Human Resources departments to resolve issues blocking return-to-work, or when an employer applies for government funds to set up wellbeing services for their employees.

None of the included tertiary preventative programmes are delivered at the organisational level of intervention i.e. designed to promote change in the workplace system. However, approximately one third of tertiary preventative programmes are designed to promote change in the healthcare system. The majority of primary and secondary preventative programmes (80%) are delivered at the individual or interface level of intervention i.e. designed to promote change in the employee. Two primary preventative programmes (33%) are delivered at the organisational level of intervention i.e. designed to promote change in the workplace system.

One plausible explanation for the choice of level of intervention and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to concentrate on what they have been commissioned to do such as deliver a policy on vocational rehabilitation for symptomatic individuals who are in receipt of disability welfare benefits. Another explanation is that designers base their choice on their own speciality such as offering occupational health care in liaison with the workplace. There is no reason why psychologically-informed organisational level interventions for example might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4 OPERATIONAL COMPONENTS

19.4.1 Focus

For the purposes of this thesis, *focus* is defined as what issues the intervention mainly concentrates on. Scrutiny of each intervention allowed for categorisation of:

- Person-focused
- Work-focused

Interventions delivered at the individual or interface levels of intervention can still be work-focused if they are designed to help employees cope with redeployment for example.

Approximately half of all interventions are work-focused. Twelve tertiary preventative programmes are work-focused 63%; three secondary preventative programmes are work-focused 75%; and four primary preventative programmes are work-focused 67%.

One plausible explanation for the choice of focus and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose a focus based on their primary objectives such as the psychotherapeutic intervention aims to treat depression and that work outcomes are secondary. Another explanation is that they choose an evidence-based occupational health model such as an activating work-focused PST approach which is recommended as a return-to-work intervention for employees with mental health problems. There is no reason why psychotherapy which focuses on both the person and their job for example might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.2 Base for intervention delivery

For the purposes of this thesis, *base* is defined as where the intervention is actually delivered. Scrutiny of each intervention allowed for categorisation of:

- Clinic
- Worksite
- Social Security offices
- Client's home
- Alternative community venues such as church halls, libraries, colleges or leisure centres

The majority of tertiary preventative programmes are based in clinical settings. There are three secondary preventative programmes (75%) based in clinical settings, with only one based in the worksite (25%). All of the primary preventative programmes are based in the worksite. None of the primary and secondary preventative programmes are based in the client's home, social security offices or alternative community venues.

One plausible explanation for the choice of base and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose a venue that they believe provides more privacy such as an outpatient clinic. Another explanation is that they choose a venue that they believe is more accessible and less-stigmatising such as the worksite. There is no reason why psychotherapeutic interventions based in alternative community venues might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.3 Intensity

For the purposes of this thesis, *intensity* is defined as the amount of skill and experience required to treat mental health disorders ranging from mild-moderate to moderate-severe, and from

single-diagnosis to complex comorbidity. Close scrutiny of each intervention allowed for categorisation of:

- High intensity interventions are delivered by qualified and experienced psychologists or psychotherapists
- Low intensity interventions are delivered by generic practitioners other than qualified and experienced psychologists or psychotherapists or non-clinical workers such as Human Resources personnel or peer support volunteers

There are equal numbers of low- and high-intensity tertiary preventative programmes in all models except PST which is only delivered as a low-intensity intervention. There are three high-intensity secondary preventative programmes (75%), and only one high-intensity primary preventative programme (17%).

One plausible explanation for the choice of intensity and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to offer high intensity psychotherapy because they believe that symptomatic individuals need more specialist treatment such as PP for example. Another explanation is that they need to reduce expenditure on healthcare so choose to train low cost practitioners to deliver psychotherapeutic interventions. There is no reason why psychotherapeutic interventions involving both high- and low-intensity components might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.4 Format

For the purposes of this thesis, *format* is defined as the method used to deliver psychotherapeutic interventions. Face-to-face interventions are usually delivered to individuals, couples, families, teams, or groups of people. Close scrutiny of each intervention allowed for categorisation of:

- 1:1 format
- Group format

There are four times as many tertiary preventative programmes delivered in a 1:1 format as there are in a group format i.e. 80% versus 20%. Three quarters of secondary preventative programmes are delivered in a 1:1 format. All of the primary preventative programmes are delivered in a group format.

One plausible explanation for the choice of format and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to offer a group training course for a number of employees because they believe that if symptomatic individuals listen to different perspectives it may help them to change unhelpful thinking

patterns for example. Another explanation is that they choose to offer 1:1 psychotherapy because they believe symptomatic individuals will only open up to the therapist if they are treated on their own. There is no reason why psychotherapeutic interventions involving both 1:1 and group components might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.5 Duration

For the purposes of this thesis, *duration* is defined as the length of time between treatment initiation and treatment completion. Long-term interventions do not necessarily equate to a high dose of treatment when interventions are provided on an ad hoc basis, or through brief but regular contact. Likewise, short-term interventions may provide a high dose if contact is for several hours on a daily basis for a week or so. Close scrutiny of each intervention allowed for categorisation of:

- Short-term < 12 weeks
- Medium-term >12 weeks < 9 months
- Long-term > 9 months

The majority of tertiary preventative programmes are short-term. The only medium- and long-term interventions are high-intensity psychotherapies. All of the secondary preventative programmes are short-term, and one half of the primary preventative programmes are short-term. The only medium- and long-term interventions are delivered at the interface and organisational levels of intervention.

One plausible explanation for the choice of duration and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to offer long-term interventions because they believe that symptomatic individuals need more time to address the deep-seated root causes of their depression for example. Another explanation is that they choose to offer short-term interventions based on the belief that long-term intervention risk inducing dependence, or based on the principle of parsimony and evidence of diminishing returns in psychotherapy research for example. There is no reason why long-term psychotherapeutic interventions such as psychologically-informed organisational development programmes might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.6 Dose

For the purposes of this thesis, *dose* is defined as how many hours of treatment clients actually receive. Interventions provided in a group format may provide the same dose of therapy for each group member regardless of how many clients are in the group. Close scrutiny of each intervention allowed for categorisation of:

- Very low dose < 3 hours
- Low dose >3 hours < 8 hours
- Medium dose > 8 hours < 24 hours
- High dose > 24 hours < 32 hours
- Very high dose > 32 hours

More than half (56%) of tertiary preventative programmes are medium dose. More than half (55%) of primary and secondary preventative programmes are medium dose.

One plausible explanation for the choice of dose and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to offer a low dose because they believe symptomatic individuals can make transformational changes with brief psychologically-informed motivational interventions for example. Another explanation is that they choose a moderate dose in preference to a high dose because of cost restraints for example. There is no reason why high dose psychotherapeutic interventions such as peer-led SS might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.7 Volume

For the purposes of this thesis, *volume* is defined as how many clients can be treated by one practitioner per hour. Interventions delivered in a group format may be high (or very high) volume depending on the number of practitioners required to deliver the intervention.

Interventions delivered in a 1:1 format may be low volume if only one client is seen per hour as is usual in psychotherapy practice. However, some 1:1 interventions may be high volume due to being delivered in brief OHP or GP consultations sessions, or when interventions are provided through short phone calls or emails. Close scrutiny of each intervention allowed for categorisation of:

- Low volume interventions are when one practitioner provides the equivalent of one hour of treatment for one client
- Medium volume interventions are when one practitioner provides the equivalent of one hour of treatment for between two to four clients
- High volume interventions are when one practitioner provides the equivalent of one hour of treatment for between five to twelve clients
- Very high-volume interventions are when one practitioner provides the equivalent of one hour of treatment for more than twelve clients

Twice as many tertiary preventative programmes are low volume as high volume. There are four times as many high-volume primary and secondary preventative programmes as there is low-volume.

One plausible explanation for the choice of volume and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to treat symptomatic individuals using one-hour 1:1 sessions because this aligns with historical custom and practice in psychotherapy for example. Another explanation is that new media such as email and text messaging support brevity of contact which increases the volume of individuals treated by one practitioner per hour for example. There is no reason why high volume group format psychotherapeutic interventions might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.8 Frequency

For the purposes of this thesis, *frequency* is defined as how often practitioners have contact with clients for the purposes of treatment. Close scrutiny of each intervention allowed for categorisation of:

- One-off session
- Daily
- 2-3 times per week
- Once per week
- Every 2-3 weeks
- Monthly/bimonthly

Just under half of tertiary preventative programmes (48%) are delivered as weekly sessions, with a half of these interventions tailing off in frequency as the intervention comes to an end. Only three tertiary preventative programmes (16%) are delivered as 2-3 times per week. The majority of primary and secondary preventative programmes are delivered as weekly, or as 2-3 times per week (71%).

One plausible explanation for the choice of frequency and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that designers choose to offer more frequent sessions because they believe that symptomatic individuals need sessions 2-3 times per week to induce a regression which will allow PP to reach highly-defended unconscious material for example. Another explanation is that sessions may be spaced out to reduce the risk of dependence and especially at the end of therapy to help clients cope with termination. There is no reason why psychotherapeutic interventions based on a workshop model i.e. delivered daily over one week for example might not achieve positive work and clinical outcomes for symptomatic individuals.

19.4.9 Content components

For the purposes of this thesis, a *content component* is defined as the subject matter of therapeutic sessions in terms of *what* was talked about by the therapist and *what* was provided in terms of written information.

Close scrutiny of each intervention and immersion in the data allowed for the detection of seven main content components as follows:

1. Psycho-education
2. Behavioural skills
3. Emotions, affect regulation
4. Cognitive restructuring
5. Coping strategies
6. Focus on intra-personal
7. Focus on inter-personal

The categorisation of each of these main content components was derived from identification of several sub-categories shown in Appendix **.

It must be noted that some researchers did not publish enough information to ascertain how many (if any) content components were incorporated, and that therefore this review may not reveal the reality of *what* was done and *how* it was done.

Analysis of content components is based on a comparison of how many are incorporated into different models of practice. A low number of content components in one model of practice does not indicate that it is inferior to another model of practice with a high number of content components. It may indicate that this model of practice relies exclusively on one content component such as insight in PP, or that process components are thought to be more important as the mechanism of change such as the therapeutic relationship in PP.

19.4.10 Process components

For the purposes of this thesis, a *process component* is defined as *how* the therapist interacts and communicates with the client or *how* clients interact and communicate with each other e.g. purposeful and planned activities that occur during therapeutic sessions, or *how* the therapy was applied e.g. using homework assignments, keeping a thought diary, eliciting insight.

Close scrutiny of each intervention and immersion in the data allowed for the detection of eight main process components as follows:

1. Style of teaching-learning
2. Facilitation of peer-to-peer dialogue
3. In vivo activities & skills practice
4. Relationship with therapist
5. Relationship with group members / significant others
6. Between-session activities
7. Sharing emotional experiences
8. Provision of resources

The process of categorisation of each of these main process components was derived from identification of several sub-categories shown in Appendix **.

It must be noted that some researchers did not publish enough information to ascertain how many (if any) process components were incorporated, and that therefore this review may not reveal the reality of *what* was done and *how* it was done.

19.5 JOB RETENTION STRATEGIES

For the purposes of this thesis, a *job retention strategy* is defined as any content or process specifically offered or undertaken by the therapist in order to enhance the client's ability to maintain their employment.

Close scrutiny of each intervention and immersion in the data allowed for the detection of seven main job retention strategies as follows:

1. Provision of information
2. Focus on the workplace
3. Support for line managers / supervisors
4. Liaison with other stakeholders
5. Help getting back to work
6. Supporting employment
7. Promoting employee's career management

The categorisation of each of these main process components was derived from identification of several sub-categories shown in Appendix **.

It must be noted that some researchers did not publish enough information to ascertain how many (if any) job retention strategies were incorporated, and that therefore this review may not reveal the reality of *what* was done and *how* it was done.

Summary

Firstly, unpacking programme designers' reasoning is difficult because in many cases interventions are under-specified, and no justification or rationale is given for their choices in terms *what* they did and *how* they did it. Each intervention's operational logic is often a taken-for-granted embodiment of its conceptual logic. So for instance if a therapist believes that a lack of insight is *why* individuals experience a phenomenon called depression, then the development of insight is an essential mechanism of change. It is important to know how this theoretical concept is activated in practice by *what* the therapist does and *how* they do it. To develop insight, the therapist might use techniques such as confrontation, clarification and interpretation which aim to bring about greater self-awareness and emotional understanding i.e. insight.

Secondly, although a range of plausible explanations are proposed, it is possible that programme designers made choices on the basis of pragmatic practicality such as delivering interventions in clinical settings because that is where practitioners usually work and where they feel most comfortable, or on the basis of therapeutic orthodoxy such as delivering one model of practice such as SFBT because that is what practitioners have been trained in and what they believe will work.

Thirdly, a comprehensive list of components was identified and classified which shows that programme designers have a wide choice in which components (and how many) they select, and in what ways they combine them. Figure * shows a schematic representation of how components might dynamically interact with each other (see appendix).

Finally, drawing conclusions about which components to incorporate in the design of a new intervention will depend on which explanatory framework makes most sense. In any case, the new intervention should include some components from each category: strategic and operational components, content components, process components and job retention strategies.

The new work-focused treatment programme for moderate-severe recurrent depression needs to incorporate most of the content and process components, and job retention strategies which were identified when relevant and potentially relevant psychotherapeutic interventions were de-constructed and reviewed.

APPENDIX 20: COMPONENT ANALYSIS TABLES

20.1 ALL INTERVENTIONS

Table 32 – Level of prevention

MODEL	TERTIARY N = 19	SECONDARY N = 4	PRIMARY N = 6
CBT	Blonk et al. 2006b Schoenbaum et al. 2002 (1:1 & group) Stenlund et al. 2009 Blonk et al. 2006a Wang et al. 2007	Lexis et al. 2011	
PP	Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002		
PST	Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2011		Tsutsumi et al. 2009
SFBT	Knekt et al. 2008c Nystuen & Hagen 2003, 2006 Bonde et al. 2005	Duijts et al. 2008	
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b Rebergen, 2009 Van der Klink et al. 2003	Van Rhenen et al. 2007 Willert et al. 2009, 2011	Limm et al. 2010 Eriksen et al. 2002a SMT
SS			Takao et al. 2006 Eriksen et al. 2002b IHP Vuori et al. 2012

Table 33- Focus of intervention

MODEL	WORK-FOCUSED N = 19	PERSON-FOCUSED N = 10
CBT	Blonk et al. 2006a Stenlund et al. 2009	Blonk et al. 2006b Lexis et al. 2011 Schoenbaum et al. 2002 Wang et al. 2007
PP		Burnand et al. 2002 Knekt et al. 2008a Knekt et al. 2008b
PST	Bakker et al. 2007 Brouwers et al. 2006 *Tsutsumi et al. 2009* Van Oostrom et al. 2010 Vlasveld et al. 2011	
SFBT	Bonde et al. 2005 Duijts et al. 2008 Nystuen & Hagen 2003, 2006	Knekt et al. 2008c
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b Rebergen, 2009 Van der Klink et al. 2003 Van Rhenen et al. 2007 Willert et al. 2009, 2011	*Limm et al. 2010* *Eriksen et al. 2002a SMT*
SS	*Takao et al. 2006* *Vuori et al. 2012* *Eriksen et al. 2002b IHP*	

20.2 TERTIARY PREVENTATIVE PROGRAMMES

Table 34 - Model of practice

MODEL	TERTIARY N = 19
CBT	Blonk et al. 2006b Schoenbaum et al. 2002 Stenlund et al. 2009 Blonk et al. 2006a Wang et al. 2007
PP	Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002
PST	Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2011
SFBT	Knekt et al. 2008c Nystuen & Hagen 2003, 2006 Bonde et al. 2005
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b Rebergen, 2009 Van der Klink et al. 2003
SS	

Table 35 - Level of intervention

MODEL	INDIVIDUAL N = 12	INTERFACE N = 7	ORGANISATIONAL workplace system N = 0	ORGANISATIONAL healthcare system N = 6
CBT	Blonk et al. 2006b Schoenbaum et al. 2002 Stenlund et al. 2009 Wang et al. 2007	Blonk et al. 2006a		Schoenbaum et al. 2002 Wang et al. 2007
PP	Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002			
PST	Brouwers et al. 2006	Bakker et al. 2007 Van Oostrom et al. 2010 Vlasveld et al. 2011, 2013		Bakker et al. 2007 Vlasveld et al. 2011
SFBT	Knekt et al. 2008c Nystuen & Hagen, 2003, 2006	Bonde et al. 2005		
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b	Rebergen 2009 Van der Klink et al. 2003		Rebergen, 2009 Van der Klink et al. 2003
SS				

Table 36 - Base

MODEL	WORKSITE N = 1	CLINIC N = 17	SOCIAL SECURITY N= 1	CLIENT'S HOME N = 1	ALTERNATIVE N = 0
CBT	Blonk et al. 2006a	Stenlund et al. 2009 Wang et al. 2007 Schoenbaum et al. 2002 Blonk et al. 2006b		Blonk et al. 2006a	
PP		Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002			
PST		Vlasveld et al. 2011 Brouwers et al. 2006 Bakker et al. 2007 Van Oostrom et al. 2010			
SFBT		Bonde et al. 2005 Knekt et al. 2008c	Nystuen & Hagen 2003, 2006		
SMT/SIT		Rebergen, 2009 Van der Klink et al. 2003 De Vente et al. 2008a De Vente et al. 2008b			
SS					

Table 37 - Intensity

MODEL	HIGH INTENSITY N = 9	LOW INTENSITY N = 10
CBT	Blonk et al. 2006b Schoenbaum et al. 2002 Stenlund et al. 2009	Blonk et al. 2006a Wang et al. 2007
PP	Knekt et al. 2008a Knekt et al. 2008b	Burnand et al. 2002
PST		Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2011
SFBT	Knekt et al. 2008c Nystuen & Hagen 2003, 2006	Bonde et al. 2005
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b	Rebergen, 2009 Van der Klink et al. 2003
SS		

Table 38 - Format

MODEL	1:1 N = 16	GROUP N = 4
CBT	Blonk et al. 2006b Schoenbaum et al. 2002 (1:1) Blonk et al. 2006a Wang et al. 2007	Schoenbaum et al. 2002 (group) Stenlund et al. 2009
PP	Knekt et al. 2008a Knekt et al. 2008b Burnand et al. 2002	
PST	Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2011	
SFBT	Knekt et al. 2008c Bonde et al. 2005	Nystuen & Hagen 2003, 2006
SMT/SIT	De Vente et al. 2008a Rebergen, 2009 Van der Klink et al. 2003	De Vente et al. 2008b
SS		

Table 39 - Duration

MODEL	SHORT-TERM N = 12	MEDIUM-TERM N = 4	LONG-TERM N = 3
CBT	Blonk et al. 2006a	Blonk et al. 2006b Schoenbaum et al. 2002	Stenlund et al. 2009 Wang et al. 2007
PP	Burnand et al. 2002	Knekt et al. 2008b	Knekt et al. 2008a
PST	Bakker et al. 2007 Brouwers et al. 2006 Van Oostrom et al. 2010 Vlasveld et al. 2011		
SFBT	Bonde et al. 2005 Nystuen & Hagen 2003, 2006	Knekt et al. 2008c	
SMT/SIT	De Vente et al. 2008a De Vente et al. 2008b Rebergen, 2009 Van der Klink et al. 2003		
SS			

Table 40 - Dose

MODEL	VERY LOW N = 2	LOW N = 2	MEDIUM N= 9	HIGH N = 1	VERY HIGH N = 2
CBT		Blonk et al. 2006a	Wang et al. 2007 Schoenbaum et al. 2002 Blonk et al. 2006b		Stenlund et al. 2009
PP			Knekt et al. 2008b		Knekt et al. 2008a
PST	Bakker et al. 2007	Brouwers et al. 2006	Vlasveld et al. 2011		
SFBT			Bonde et al. 2005 Knekt et al. 2008c	Nystuen & Hagen 2003, 2006	
SMT/SIT	Van der Klink et al. 2003		De Vente et al. 2008a De Vente et al. 2008b		
SS					

Table 41 - Volume

MODEL	LOW N = 12	HIGH N = 6
CBT	Blonk et al. 2006a Blonk et al. 2006b Schoenbaum et al. 2002 (1:1) Wang et al. 2007	Stenlund et al. 2009 Schoenbaum et al. 2002 (group)
PP	Knekt et al. 2008a Knekt et al. 2008b	
PST	Vlasveld et al. 2011 Van Oostrom et al. 2010 Brouwers et al. 2006	Bakker et al. 2007
SFBT	Bonde et al. 2005 Knekt et al. 2008c	Nystuen & Hagen 2003, 2006
SMT/SIT	De Vente et al. 2008a	Van der Klink et al. 2003 De Vente et al. 2008b
SS		

Table 42 - Frequency

MODEL	One-off session N = 0	2-3 times per wk / daily N = 3	Once per wk. N= 10	Every 2-3 wks. N = 6	Monthly /bimonthly N = 2
CBT		Blonk et al. 2006a Blonk et al. 2006b	Wang et al. 2007 Stenlund et al. 2009 Schoenbaum et al. 2002	Wang et al. 2007 Stenlund et al. 2009	Wang et al. 2007
PP		Knekt et al. 2008a	Knekt et al. 2008b		
PST			Vlasveld et al. 2011	Vlasveld et al. 2011 Brouwers et al. 2006	
SFBT			Bonde et al. 2005 Nystuen & Hagen 2003, 2006	Knekt et al. 2008c	Bonde et al. 2005
SMT/SIT			Van der Klink et al. 2003 De Vente et al. 2008a De Vente et al. 2008b	Van der Klink et al. 2003	
SS					

20.3 SECONDARY AND PRIMARY PREVENTATIVE PROGRAMMES

Table 43 - Model of practice

MODEL	SECONDARY N = 4	PRIMARY N = 6
CBT	Lexis et al. 2011	
PP		
PST		*Tsutsumi et al. 2009*
SFBT	Duijts et al. 2008	
SMT/SIT	Van Rhenen et al. 2007 Willert et al. 2009, 2011	*Limm et al. 2010* *Eriksen et al. 2002a SMT*
SS		*Takao et al. 2006* *Eriksen et al. 2002b IHP* *Vuori et al. 2012*

Table 44 - Level of intervention

MODEL	INDIVIDUAL N = 7	INTERFACE N = 1	ORGANISATIONAL workplace system N = 2
CBT	Lexis et al. 2011		
PP			
PST			*Tsutsumi et al. 2009*
SFBT	Duijts et al. 2008		
SMT/SIT	Van Rhenen et al. 2007 *Limm et al. 2010* Willert et al. 2009, 2011 *Eriksen et al. 2002a*		
SS	*Eriksen et al. 2002b*	*Vuori et al. 2012*	*Takao et al. 2006*

Table 45 - Base

MODEL	WORKSITE N = 9	CLINIC N = 1	SOCIAL SECURITY N= 0	CLIENT'S HOME N = 0	ALTERNATIVE N = 0
CBT	Lexis et al. 2011				
PP					
PST	*Tsutsumi et al. 2009*				
SFBT	Duijts et al. 2008				
SMT/SIT	Van Rhenen et al. 2007 *Limm et al. 2010* *Eriksen et al. 2002a*	Willert et al. 2009, 2011			
SS	*Takao et al. 2006* *Vuori et al. 2012* *Eriksen et al. 2002b*				

Table 46 - Intensity

MODEL	HIGH INTENSITY N = 4	LOW INTENSITY N = 6
CBT	Lexis et al. 2011	
PP		
PST		*Tsutsumi et al. 2009*
SFBT		Duijts et al. 2008
SMT/SIT	Van Rhenen et al. 2007 Willert et al. 2009, 2011 *Limm et al. 2010*	*Eriksen et al. 2002a SMT*
SS		*Takao et al. 2006* *Eriksen et al. 2002b IHP* *Vuori et al. 2012*

Table 47 - Format

MODEL	1:1	GROUP
CBT	Lexis et al. 2011	
PP		
PST		*Tsutsumi et al. 2009*
SFBT	Duijts et al. 2008	
SMT/SIT	Van Rhenen et al. 2007	Willert et al. 2009, 2011 *Limm et al. 2010* *Eriksen et al. 2002a SMT*
SS		*Eriksen et al. 2002b IHP* *Takao et al. 2006* *Vuori et al. 2012*

Table 48 - Duration

MODEL	Short-term N = 4	Medium-term N = 1	Long-term N = 2
CBT	Lexis et al. 2011		
PP			
PST			*Tsutsumi et al. 2009*
SFBT	Duijts et al. 2008		
SMT/SIT	Van Rhenen et al. 2007 *Limm et al. 2010* Willert et al. 2009, 2011 *Eriksen et al. 2002a*		
SS	*Eriksen et al. 2002b*	*Vuori et al. 2012*	*Takao et al. 2006*

Table 49 - Dose

MODEL	VERY LOW N = 0	LOW N = 3	MEDIUM N= 6	HIGH N = 2	VERY HIGH N = 0
CBT		Lexis et al. 2011 (7 sess)	Lexis et al. 2011 (14 sess)		
PP					
PST			*Tsutsumi et al. 2009*		
SFBT			Duijts et al. 2008		
SMT/SIT		Van Rhenen et al. 2007	Willert et al. 2009, 2011 *Limm et al. 2010*	*Eriksen et al. 2002a*	
SS		*Takao et al. 2006*	*Eriksen et al. 2002b*	*Vuori et al. 2012*	

Table 50 - Volume

MODEL	LOW N = 2	HIGH N = 8
CBT	Lexis et al. 2011	
PP		
PST		*Tsutsumi et al. 2009*
SFBT	Duijts et al. 2008	
SMT/SIT		Willert et al. 2009, 2011 Van Rhenen et al. 2007 *Limm et al. 2010* *Eriksen et al. 2002a*
SS		*Takao et al. 2006* *Vuori et al. 2012* *Eriksen et al. 2002b*

Table 51 - Frequency

MODEL	One-off session N = 1	2-3 times per wk / daily N = 2	Once per wk. N= 3	Every 2-3 wks. N = 2	Monthly /bimonthly N = 1
CBT					
PP					
PST					
SFBT					
SMT/SIT		*Limm et al. 2010*	Willert et al. 2009, 2011 *Eriksen et al. 2002a*	Willert et al. 2009, 2011 Van Rhenen et al. 2007	*Limm et al. 2010*
SS	*Takao et al. 2006*	*Vuori et al. 2012*	*Eriksen et al. 2002b*		

Definitions for measuring quantity of components:

Overall low:	0-3	Low = 1
Overall moderate:	4-7	Moderate = 2
Overall high:	8-10	High = > 3
Overall very high:	> 11	

CONTENT COMPONENTS PRIMARY		Tsutsumi et al. 2009 PST	Takao et al. 2006 SS	Vuori et al. 2012 SS	Eriksen et al. 2002b IHP SS	Eriksen et al. 2002a SMT/SIT	Limm et al. 2010 SMT/SIT
Psycho-education	Fight-flight response, physiological symptoms				✓	✓	
	Rationale for behavioural activation, exposure						
	Info about how thoughts, feelings, and behaviour interact					✓	
	Information about coping in general				✓	✓	
	Info about stress, symptoms, causes of mental health problems	✓	✓	✓			
	Information about healthy lifestyle, self-care		✓		✓	✓	
Behavioural skills	Relaxation, mindfulness					✓	
	Behavioural activation, activity scheduling						
	Graded exposure, de-sensitisation						
	Crisis planning, relapse prevention						
Emotions, affect regulation	Acceptance of distressing thoughts & feelings						
	Expressing feelings appropriately					✓	✓
	Eliciting client's feelings in relation to self / others / therapist						
Cognitive restructuring	Recognising faulty thinking, behavioural experiments					✓	
	Disputation						
	Reappraisal, reattribution					✓	
	Positive reframing						
	Highlighting solutions / imagining a future without the problem						
Coping strategies	Active problem-solving (individual or team-based)	✓				✓	
	Coping with internal stressors e.g. negative inner dialogue						
	Coping with external stressors e.g. high workload		✓	✓			
	Goal-setting, decision-making						
Focus on intra-personal	Insight, self-awareness						✓
	Improving self-esteem						
	Personal empowerment through assertiveness					✓	
Focus on inter-personal	Outsight, inter-personal-awareness						✓
	Coping with people						✓
	Social diversion, social support, social connectedness						✓
	Managing conflict			✓			✓
	Improving ways of communicating and interacting					✓	
		2	**3**	**3**	**3**	**11**	**6**

CONTENT COMPONENTS SECONDARY		Lexis et al. 2011 CBT	Willert et al. 2009, 2011 SMT/SIT	Van Rhenen et al. 2007 SMT/SIT	Duijts et al. 2008 SFBT
Psycho-education	Fight-flight response, physiological symptoms		✓		
	Rationale for behavioural activation, exposure				
	Info about how thoughts, feelings, and behaviour interact		✓	✓	
	Information about coping in general			✓	
	Info about stress, symptoms, causes of mental health problems			✓	
	Information about healthy lifestyle, self-care				
Behavioural skills	Relaxation, mindfulness				
	Behavioural activation, activity scheduling	✓	✓		
	Graded exposure, de-sensitisation				
	Crisis planning, relapse prevention			✓	
Emotions, affect regulation	Acceptance of distressing thoughts & feelings				
	Expressing feelings appropriately				
	Eliciting client's feelings in relation to self / others / therapist				
Cognitive restructuring	Recognising faulty thinking, behavioural experiments	✓	✓	✓	
	Disputation				
	Reappraisal, reattribution	✓	✓		
	Positive reframing	✓	✓		
	Highlighting solutions / imagining a future without the problem				
Coping strategies	Active problem-solving (individual or team-based)	✓		✓	✓
	Coping with internal stressors e.g. negative inner dialogue				
	Coping with external stressors e.g. high workload				
	Goal-setting, decision-making				
Focus on intra-personal	Insight, self-awareness				
	Improving self-esteem				
	Personal empowerment through assertiveness				
Focus on inter-personal	Outsight, inter-personal-awareness				
	Coping with people	✓			
	Social diversion, social support, social connectedness				
	Managing conflict				
	Improving ways of communicating and interacting	✓	✓		
		7	**7**	**6**	**1**

CONTENT COMPONENTS	CONTENT COMPONENTS TERTIARY CBT	Blonk et al. 2006a low-intensity	Blonk et al. 2006b high-intensity	Stenlund et al. 2009	Schoenbaum et al. 2002	Wang et al. 2007
Psycho-education	Fight-flight response, physiological symptoms					
	Rationale for behavioural activation, exposure				✓	
	Info about how thoughts, feelings, and behaviour interact				✓	
	Information about coping in general					
	Info about stress, symptoms, causes of mental health problems	✓	✓	✓	✓	✓
	Information about healthy lifestyle, self-care			✓		✓
Behavioural skills	Relaxation, mindfulness	✓	✓	✓		
	Behavioural activation, activity scheduling	✓	✓	✓	✓	✓
	Graded exposure, de-sensitisation					
	Crisis planning, relapse prevention					
Emotions, affect regulation	Acceptance of distressing thoughts & feelings			✓		
	Expressing feelings appropriately			✓		
	Eliciting client's feelings in relation to self / others / therapist					
Cognitive restructuring	Recognising faulty thinking, behavioural experiments	✓	✓	✓	✓	✓
	Disputation				✓	
	Reappraisal, reattribution	✓	✓	✓		✓
	Positive reframing	✓	✓	✓		✓
	Highlighting solutions / imagining a future without the problem					
Coping strategies	Active problem-solving (individual or team-based)					
	Coping with internal stressors e.g. negative inner dialogue			✓		
	Coping with external stressors e.g. high workload			✓		
	Goal-setting, decision-making				✓	
Focus on intra-personal	Insight, self-awareness			✓		
	Improving self-esteem			✓		✓
	Personal empowerment through assertiveness					
Focus on inter-personal	Outsight, inter-personal-awareness				✓	
	Coping with people				✓	
	Social diversion, social support, social connectedness				✓	
	Managing conflict				✓	
	Improving ways of communicating and interacting				✓	
		6	**6**	**13**	**12**	**7**

CONTENT COMPONENTS TERTIARY PP		Knekt et al. 2008a LPP	Knekt et al. 2008b MPP	Burnand et al. 2002
Psycho-education	Fight-flight response, physiological symptoms			
	Rationale for behavioural activation, exposure			
	Info about how thoughts, feelings, and behaviour interact			
	Information about coping in general			
	Info about stress, symptoms, causes of mental health problems			
	Information about healthy lifestyle, self-care			
Behavioural skills	Relaxation, mindfulness			
	Behavioural activation, activity scheduling			
	Graded exposure, de-sensitisation			
	Crisis planning, relapse prevention			
Emotions, affect regulation	Acceptance of distressing thoughts & feelings			
	Expressing feelings appropriately			
	Eliciting client's feelings in relation to self / others / therapist	✓	✓	✓
Cognitive restructuring	Recognising faulty thinking, behavioural experiments			
	Disputation			
	Reappraisal, reattribution			
	Positive reframing			
	Highlighting solutions / imagining a future without the problem			
Coping strategies	Active problem-solving (individual or team-based)			
	Coping with internal stressors e.g. negative inner dialogue			
	Coping with external stressors e.g. high workload			
	Goal-setting, decision-making			
Focus on intra-personal	Insight, self-awareness	✓	✓	✓
	Improving self-esteem			
	Personal empowerment through assertiveness			
Focus on inter-personal	Outsight, inter-personal-awareness	✓	✓	✓
	Coping with people			
	Social diversion, social support, social connectedness			
	Managing conflict			
	Improving ways of communicating and interacting			
		3	**3**	**3**

CONTENT COMPONENTS TERTIARY PST		Vlasveld et al. 2011, 2013	Bakker et al. 2007	Brouwers et al. 2006	Van Oostrom et al. 2010
Psycho-education	Fight-flight response, physiological symptoms				
	Rationale for behavioural activation, exposure				
	Info about how thoughts, feelings, and behaviour interact				
	Information about coping in general				
	Info about stress, symptoms, causes of mental health problems		✓		
	Information about healthy lifestyle, self-care	✓		✓	
Behavioural skills	Relaxation, mindfulness				
	Behavioural activation, activity scheduling		✓	✓	
	Graded exposure, de-sensitisation			✓	
	Crisis planning, relapse prevention				
Emotions, affect regulation	Acceptance of distressing thoughts & feelings				
	Expressing feelings appropriately				
	Eliciting client's feelings in relation to self / others / therapist				
Cognitive restructuring	Recognising faulty thinking, behavioural experiments	✓			
	Disputation				
	Reappraisal, reattribution				
	Positive reframing				
	Highlighting solutions / imagining a future without the problem				
Coping strategies	Active problem-solving (individual or team-based)	✓	✓	✓	✓
	Coping with internal stressors e.g. negative inner dialogue				
	Coping with external stressors e.g. high workload		✓	✓	
	Goal-setting, decision-making				
Focus on intra-personal	Insight, self-awareness				
	Improving self-esteem				
	Personal empowerment through assertiveness				
Focus on inter-personal	Outsight, inter-personal-awareness				
	Coping with people				
	Social diversion, social support, social connectedness				
	Managing conflict				
	Improving ways of communicating and interacting				
		3	**4**	**5**	**1**

CONTENT COMPONENTS TERTIARY SMT / SIT		De Vente et al. 2008a 1:1	De Vente et al. 2008b group	Rebergen 2009	Van der Klink et al. 2003
Psycho-education	Fight-flight response, physiological symptoms				
	Rationale for behavioural activation, exposure				
	Info about how thoughts, feelings, and behaviour interact			✓	
	Information about coping in general				
	Info about stress, symptoms, causes of mental health problems	✓	✓		
	Information about healthy lifestyle, self-care				
Behavioural skills	Relaxation, mindfulness	✓	✓		
	Behavioural activation, activity scheduling			✓	✓
	Graded exposure, de-sensitisation			✓	✓
	Crisis planning, relapse prevention	✓	✓		✓
Emotions, affect regulation	Acceptance of distressing thoughts & feelings				
	Expressing feelings appropriately				
	Eliciting client's feelings in relation to self / others / therapist				
Cognitive restructuring	Recognising faulty thinking, behavioural experiments	✓	✓		
	Disputation				
	Reappraisal, reattribution				
	Positive reframing				
	Highlighting solutions / imagining a future without the problem				
Coping strategies	Active problem-solving (individual or team-based)			✓	✓
	Coping with internal stressors e.g. negative inner dialogue				
	Coping with external stressors e.g. high workload			✓	✓
	Goal-setting, decision-making	✓	✓		
Focus on intra-personal	Insight, self-awareness				
	Improving self-esteem				
	Personal empowerment through assertiveness	✓	✓		
Focus on inter-personal	Outsight, inter-personal-awareness				
	Coping with people				
	Social diversion, social support, social connectedness				
	Managing conflict	✓	✓		
	Improving ways of communicating and interacting				
		7	**7**	**5**	**5**

CONTENT COMPONENTS TERTIARY SFBT		Knekt et al. 2008c SFBT	Nystuen & Hagen 2003, 2006	Bonde et al. 2005
Psycho-education	Fight-flight response, physiological symptoms			
	Rationale for behavioural activation, exposure			
	Info about how thoughts, feelings, and behaviour interact			
	Information about coping in general		✓	
	Info about stress, symptoms, causes of mental health problems			
	Information about healthy lifestyle, self-care		✓	
Behavioural skills	Relaxation, mindfulness			
	Behavioural activation, activity scheduling			
	Graded exposure, de-sensitisation			
	Crisis planning, relapse prevention			
Emotions, affect regulation	Acceptance of distressing thoughts & feelings			
	Expressing feelings appropriately			
	Eliciting client's feelings in relation to self / others / therapist			
Cognitive restructuring	Recognising faulty thinking, behavioural experiments			
	Disputation			
	Reappraisal, reattribution			
	Positive reframing			
	Highlighting solutions / imagining a future without the problem	✓	✓	
Coping strategies	Active problem-solving (individual or team-based)			
	Coping with internal stressors e.g. negative inner dialogue			
	Coping with external stressors e.g. high workload		✓	
	Goal-setting, decision-making		✓	
Focus on intra-personal	Insight, self-awareness			
	Improving self-esteem		✓	
	Personal empowerment through assertiveness			
Focus on inter-personal	Outsight, inter-personal-awareness			
	Coping with people			
	Social diversion, social support, social connectedness			
	Managing conflict		✓	
	Improving ways of communicating and interacting		✓	
		1	**8**	**0**

PROCESS COMPONENTS PRIMARY		Tsutsumi et al. 2009 PST	Takao et al. 2006 SS	Vuori et al. 2012 SS	Eriksen et al. 2002b IHP SS	Eriksen et al. 2002a SMT/SIT	Limm et al. 2010 SMT/SIT
Style of teaching-learning	Didactic lectures / PowerPoint presentations	✓	✓		✓	✓	
	Experiential exercises / active learning techniques			✓	✓	✓	
	Case studies		✓				
	Guided self-help						
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A	✓				✓	
	Working in pairs or triads						✓
	Conversations in small groups						✓
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness		✓			✓	
	Progressive muscular relaxation / mindfulness					✓	
	Video feedback / inter-personal process recall (IPR)					✓	
	Goal-setting, problem-solving						
	Physical exercise				✓		
Relationship with therapist	Directive therapeutic relationship (conscious material)						
	Non-directive therapeutic relationship (unconscious material)						
	Repairing ruptures, limited re-parenting, corrective emotional experience						
	Advice-giving, offering support						
	Motivational enhancement, “circular / miracle questions”						
	Probing for exceptions, asking scaling questions						
	Facilitating emotional expression, empathetic attunement						
Relationship with group members / significant others	Participatory teamwork	✓					
	Perspective-taking, “reality management”						
	Sharing problems together, exchanging experiences						✓
	Generating solutions and reviewing goals together						✓
	Social support / helping others / validating others’ emotions			✓			
	Inter-personal learning through peer feedback			✓			
	“Disconfirmation of the uniqueness of one’s problems”			✓			
	Social contact before, during, after and between sessions						✓
	Inviting spouse or partner to specific group sessions						
Between-session activities	Homework assignments / challenges					✓	
	Keeping a journal / diary / self-monitoring / self-reflection						
	Booster sessions following completion of programme						
	Text reminders / email counselling / outreach by ‘phone						
Sharing emotional experiences	Listening to each other						✓
	Working with transference, resistance, ambivalence, defences						
	Confrontation, clarification and interpretation						
	Expressing empathy towards each other						✓
Provision of resources	Audio-recordings of relaxation / mindfulness training					✓	
	Written material, book chapter, handouts, participant wkbook						
		3	3	4	3	8	7

PROCESS COMPONENTS SECONDARY		Lexis et al. 2011 CBT	Willert et al. 2009, 2011 SMT/SIT	Van Rhenen et al. 2007 SMT/SIT	Duijts et al. 2008 SFBT
Style of teaching-learning	Didactic lectures / PowerPoint presentations		✓	✓	
	Experiential exercises / active learning techniques				
	Case studies				
	Guided self-help				
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A				
	Working in pairs or triads				
	Conversations in small groups				
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness				
	Progressive muscular relaxation / mindfulness			✓	
	Video feedback / inter-personal process recall (IPR)				
	Goal-setting, problem-solving		✓	✓	
	Physical exercise				
Relationship with therapist	Directive therapeutic relationship (conscious material)	✓		✓	✓
	Non-directive therapeutic relationship (unconscious material)				
	Repairing ruptures, limited re-parenting, corrective emotional experience				
	Advice-giving, offering support	✓		✓	✓
	Motivational enhancement, "circular / miracle questions"				
	Probing for exceptions, asking scaling questions				
	Facilitating emotional expression, empathetic attunement				
Relationship with group members / significant others	Participatory teamwork				
	Perspective-taking, "reality management"				
	Sharing problems together, exchanging experiences				
	Generating solutions and reviewing goals together				
	Social support / helping others / validating others' emotions				
	Inter-personal learning through peer feedback				
	"Disconfirmation of the uniqueness of one's problems"				
	Social contact before, during, after and between sessions				
	Inviting spouse or partner to specific group sessions				
Between-session activities	Homework assignments / challenges	✓	✓	✓	
	Keeping a journal / diary / self-monitoring / self-reflection		✓	✓	
	Booster sessions following completion of programme				
	Text reminders / email counselling / outreach by 'phone				
Sharing emotional experiences	Listening to each other				
	Working with transference, resistance, ambivalence, defences				
	Confrontation, clarification and interpretation				
	Expressing empathy towards each other				
Provision of resources	Audio-recordings of relaxation / mindfulness training				
	Written material, book chapter, handouts, participant wkbook	✓		✓	
		4	**4**	**8**	**2**

PROCESS COMPONENTS TERTIARY CBT		Blonk et al. 2006a low-intensity	Blonk et al. 2006b high-intensity	Stenlund et al. 2009	Schoenbaum et al. 2002	Wang et al. 2007
Style of teaching-learning	Didactic lectures / PowerPoint presentations					
	Experiential exercises / active learning techniques					
	Case studies					
	Guided self-help					✓
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A					
	Working in pairs or triads					
	Conversations in small groups					
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness					
	Progressive muscular relaxation / mindfulness			✓		
	Video feedback / inter-personal process recall (IPR)					
	Goal-setting, problem-solving					
	Physical exercise					
Relationship with therapist	Directive therapeutic relationship (conscious material)	✓	✓		✓	
	Non-directive therapeutic relationship (unconscious material)					
	Repairing ruptures, limited re-parenting, corrective emotional experience					
	Advice-giving, offering support	✓	✓		✓	
	Motivational enhancement, "circular / miracle questions"					✓
	Probing for exceptions, asking scaling questions					✓
	Facilitating emotional expression, empathetic attunement					
Relationship with group members / significant others	Participatory teamwork					
	Perspective-taking, "reality management"				✓	
	Sharing problems together, exchanging experiences					
	Generating solutions and reviewing goals together					
	Social support / helping others / validating others' emotions					
	Inter-personal learning through peer feedback					
	"Disconfirmation of the uniqueness of one's problems"					
	Social contact before, during, after and between sessions					
	Inviting spouse or partner to specific group sessions			✓		
Between-session activities	Homework assignments / challenges	✓	✓		✓	
	Keeping a journal / diary / self-monitoring / self-reflection			✓	✓	
	Booster sessions following completion of programme			✓		
	Text reminders / email counselling / outreach by 'phone					✓
Sharing emotional experiences	Listening to each other					
	Working with transference, resistance, ambivalence, defences					
	Confrontation, clarification and interpretation					
	Expressing empathy towards each other					
Provision of resources	Audio-recordings of relaxation / mindfulness training					
	Written material, book chapter, handouts, participant wkbook	✓	✓		✓	✓
		4	**4**	**4**	**6**	**5**

PROCESS COMPONENTS TERTIARY PP		Knekt et al. 2008a LPP	Knekt et al. 2008b MPP	Burnand et al. 2002
Style of teaching-learning	Didactic lectures / PowerPoint presentations			
	Experiential exercises / active learning techniques			
	Case studies			
	Guided self-help			
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A			
	Working in pairs or triads			
	Conversations in small groups			
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness			
	Progressive muscular relaxation / mindfulness			
	Video feedback / inter-personal process recall (IPR)			
	Goal-setting, problem-solving			
	Physical exercise			
Relationship with therapist	Directive therapeutic relationship (conscious material)			
	Non-directive therapeutic relationship (unconscious material)	✓	✓	✓
	Repairing ruptures, limited re-parenting, corrective emotional experience	✓		
	Advice-giving, offering support			
	Motivational enhancement, "circular / miracle questions"			
	Probing for exceptions, asking scaling questions			
	Facilitating emotional expression, empathetic attunement	✓	✓	✓
Relationship with group members / significant others	Participatory teamwork			
	Perspective-taking, "reality management"			
	Sharing problems together, exchanging experiences			
	Generating solutions and reviewing goals together			
	Social support / helping others / validating others' emotions			
	Inter-personal learning through peer feedback			
	"Disconfirmation of the uniqueness of one's problems"			
	Social contact before, during, after and between sessions			
	Inviting spouse or partner to specific group sessions			
Between-session activities	Homework assignments / challenges			
	Keeping a journal / diary / self-monitoring / self-reflection			
	Booster sessions following completion of programme			
	Text reminders / email counselling / outreach by 'phone			
Sharing emotional experiences	Listening to each other			
	Working with transference, resistance, ambivalence, defences			
	Confrontation, clarification and interpretation			
	Expressing empathy towards each other			
Provision of resources	Audio-recordings of relaxation / mindfulness training			
	Written material, book chapter, handouts, participant wkbook			
		3	**3**	**3**

PROCESS COMPONENTS TERTIARY PST		Vlasveld et al. 2011, 2013	Bakker et al. 2007	Brouwers et al. 2006	Van Oostrom et al. 2010
Style of teaching-learning	Didactic lectures / PowerPoint presentations				
	Experiential exercises / active learning techniques				
	Case studies				
	Guided self-help				
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A				
	Working in pairs or triads				
	Conversations in small groups				
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness				
	Progressive muscular relaxation / mindfulness				
	Video feedback / inter-personal process recall (IPR)				
	Goal-setting, problem-solving				
	Physical exercise				
Relationship with therapist	Directive therapeutic relationship (conscious material)	✓	✓	✓	✓
	Non-directive therapeutic relationship (unconscious material)				
	Repairing ruptures, limited re-parenting, corrective emotional experience				
	Advice-giving, offering support	✓	✓	✓	✓
	Motivational enhancement, "circular / miracle questions"				
	Probing for exceptions, asking scaling questions				
	Facilitating emotional expression, empathetic attunement				
Relationship with group members / significant others	Participatory teamwork				
	Perspective-taking, "reality management"				
	Sharing problems together, exchanging experiences				
	Generating solutions and reviewing goals together				
	Social support / helping others / validating others' emotions				
	Inter-personal learning through peer feedback				
	"Disconfirmation of the uniqueness of one's problems"				
	Social contact before, during, after and between sessions				
	Inviting spouse or partner to specific group sessions				
Between-session activities	Homework assignments / challenges			✓	
	Keeping a journal / diary / self-monitoring / self-reflection				
	Booster sessions following completion of programme				
	Text reminders / email counselling / outreach by 'phone				
Sharing emotional experiences	Listening to each other				
	Working with transference, resistance, ambivalence, defences				
	Confrontation, clarification and interpretation				
	Expressing empathy towards each other				
Provision of resources	Audio-recordings of relaxation / mindfulness training				
	Written material, book chapter, handouts, participant wkbook	✓			
		3	**2**	**3**	**2**

PROCESS COMPONENTS TERTIARY SMT / SIT		De Vente et al. 2008a 1:1	De Vente et al. 2008b group	Rebergen 2009	Van der Klink et al. 2003
Style of teaching-learning	Didactic lectures / PowerPoint presentations			✓	
	Experiential exercises / active learning techniques				
	Case studies				
	Guided self-help				
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A				
	Working in pairs or triads				
	Conversations in small groups				
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness				
	Progressive muscular relaxation / mindfulness				
	Video feedback / inter-personal process recall (IPR)				
	Goal-setting, problem-solving				
	Physical exercise				
Relationship with therapist	Directive therapeutic relationship (conscious material)	✓		✓	✓
	Non-directive therapeutic relationship (unconscious material)				
	Repairing ruptures, limited re-parenting, corrective emotional experience				
	Advice-giving, offering support	✓		✓	✓
	Motivational enhancement, "circular / miracle questions"				
	Probing for exceptions, asking scaling questions				
	Facilitating emotional expression, empathetic attunement				
Relationship with group members / significant others	Participatory teamwork				
	Perspective-taking, "reality management"		✓		
	Sharing problems together, exchanging experiences		✓		
	Generating solutions and reviewing goals together		✓		
	Social support / helping others / validating others' emotions		✓		
	Inter-personal learning through peer feedback		✓		
	"Disconfirmation of the uniqueness of one's problems"		✓		
	Social contact before, during, after and between sessions				
	Inviting spouse or partner to specific group sessions				
Between-session activities	Homework assignments / challenges	✓	✓		
	Keeping a journal / diary / self-monitoring / self-reflection				
	Booster sessions following completion of programme				
	Text reminders / email counselling / outreach by 'phone				
Sharing emotional experiences	Listening to each other				
	Working with transference, resistance, ambivalence, defences				
	Confrontation, clarification and interpretation				
	Expressing empathy towards each other				
Provision of resources	Audio-recordings of relaxation / mindfulness training	✓	✓		
	Written material, book chapter, handouts, participant wkbook				
		4	**8**	**3**	**2**

PROCESS COMPONENTS TERTIARY SFBT		Knekt et al. 2008c SFBT	Nystuen & Hagen 2003, 2006	Bonde et al. 2005
Style of teaching-learning	Didactic lectures / PowerPoint presentations			
	Experiential exercises / active learning techniques			
	Case studies			
	Guided self-help			
Facilitation of peer-to-peer dialogue	Group discussion, large group plenary, Q & A		✓	
	Working in pairs or triads			
	Conversations in small groups			
In vivo activities & skills practice	Behavioural rehearsal / role play / assertiveness			
	Progressive muscular relaxation / mindfulness			
	Video feedback / inter-personal process recall (IPR)			
	Goal-setting, problem-solving			
	Physical exercise			
Relationship with therapist	Directive therapeutic relationship (conscious material)		✓	✓
	Non-directive therapeutic relationship (unconscious material)			
	Repairing ruptures, limited re-parenting, corrective emotional experience			
	Advice-giving, offering support			✓
	Motivational enhancement, "circular / miracle questions"	✓	✓	✓
	Probing for exceptions, asking scaling questions	✓	✓	
	Facilitating emotional expression			
Relationship with group members / significant others	Participatory teamwork			
	Perspective-taking, "reality management"			
	Sharing problems together, exchanging experiences			
	Generating solutions and reviewing goals together		✓	
	Social support / helping others / validating others' emotions		✓	
	Inter-personal learning through peer feedback			
	"Disconfirmation of the uniqueness of one's problems"			
	Social contact before, during, after and between sessions			
	Inviting spouse or partner to specific group sessions			
Between-session activities	Homework assignments / challenges			
	Keeping a journal / diary / self-monitoring / self-reflection			
	Booster sessions following completion of programme			
	Text reminders / email counselling / outreach by 'phone			
Sharing emotional experiences	Listening to each other			
	Working with transference, resistance, ambivalence, defences			
	Confrontation, clarification and interpretation			
	Expressing empathy towards each other			
Provision of resources	Audio-recordings of relaxation / mindfulness training			
	Written material, book chapter, handouts, participant wkbook			
		2	**6**	**3**

JOB RETENTION STRATEGIES PRIMARY		Tsutsumi et al. 2009 PST	Takao et al. 2006 SS	Vuori et al. 2012 SS	Eriksen et al. 2002b IHP SS	Eriksen et al. 2002a SMT/SIT	Limm et al. 2010 SMT/SIT
Information	Information about occupational hazards	✓			✓		
	Information about coping at work		✓		✓		
	Information about organisational supports e.g. EAP counselling	✓	✓				
Focus on the workplace	Stress surveillance / use of screening tools / job profiling	✓					
	Workplace assessment				✓		
	Environmental improvement action plans	✓			✓		
	Regular monitoring of action plans	✓					
	Individualised supervision / appraisal, focus on stress / work		✓				
	Implementation of new solutions / coping strategies at work						
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace	✓	✓				
	Info about how to deal with sources of occupational stress	✓	✓				
	Training for managers in counselling skills		✓				
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables						
	Provision of up-dates to & collaboration between stakeholders						
Help getting back to work	Negotiation of workplace adjustments				✓		
	Agreed return-to-work / rehabilitation plan						
	Conflict resolution / mediation						
	Gradual exposure to work situation						
	Phased work resumption / part-time hours						
Supporting employment	Place-then-train approach						
	Further on-the-job training / retraining						
	Transfer to another job, redeployment						
	Time- and task-management skills						
	Endorsing work as a resource for wellbeing & self-esteem			✓			
Promoting employee's career management	Taking responsibility for one's own professional development			✓			
	Emphasising lifelong learning			✓			
	Being adaptable & flexible in a changing organisational context			✓			
		7	**4**	**4**	**5**	**0**	**0**

JOB RETENTION STRATEGIES SECONDARY		Lexis et al. 2011 CBT	Willert et al. 2009, 2011 SMT/SIT	Van Rhenen et al. 2007 SMT/SIT	Duijts et al. 2008 SFBT
Information	Information about occupational hazards		✓	✓	
	Information about coping at work		✓	✓	
	Information about organisational supports e.g. EAP counselling				
Focus on the workplace	Stress surveillance / use of screening tools / job profiling				
	Workplace assessment				
	Environmental improvement action plans				
	Regular monitoring of action plans				
	Individualised supervision / appraisal, focus on stress / work				
	Implementation of new solutions / coping strategies at work		✓		
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace				
	Info about how to deal with sources of occupational stress				
	Training for managers in counselling skills				
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables				✓
	Provision of up-dates to & collaboration between stakeholders				
Help getting back to work	Negotiation of workplace adjustments				
	Agreed return-to-work / rehabilitation plan				
	Conflict resolution / mediation				
	Gradual exposure to work situation				
	Phased work resumption / part-time hours				
Supporting employment	Place-then-train approach				
	Further on-the-job training / retraining				
	Transfer to another job, redeployment				
	Time- and task-management skills				
	Endorsing work as a resource for wellbeing & self-esteem				
Promoting employee's career management	Taking responsibility for one's own professional development				
	Emphasising lifelong learning				
	Being adaptable & flexible in a changing organisational context				
		0	**3**	**2**	**1**

JOB RETENTION STRATEGIES TERTIARY CBT		Blonk et al. 2006a low-intensity	Blonk et al. 2006b high-intensity	Stenlund et al. 2009	Schoenbaum et al. 2002	Wang et al. 2007
Information	Information about occupational hazards	✓		✓		
	Information about coping at work					
	Information about organisational supports e.g. EAP counselling					
Focus on the workplace	Stress surveillance / use of screening tools / job profiling	✓				
	Workplace assessment					
	Environmental improvement action plans					
	Regular monitoring of action plans					
	Individualised supervision / appraisal, focus on stress / work					
	Implementation of new solutions / coping strategies at work					
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace					
	Info about how to deal with sources of occupational stress					
	Training for managers in counselling skills					
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables	✓				
	Provision of up-dates to & collaboration between stakeholders					
Help getting back to work	Negotiation of workplace adjustments	✓				
	Agreed return-to-work / rehabilitation plan	✓		✓		
	Conflict resolution / mediation	✓				
	Gradual exposure to work situation					
	Phased work resumption / part-time hours	✓				
Supporting employment	Place-then-train approach					
	Further on-the-job training / retraining					
	Transfer to another job, redeployment					
	Time- and task-management skills	✓				
	Endorsing work as a resource for wellbeing & self-esteem					
Promoting employee's career management	Taking responsibility for one's own professional development					
	Emphasising lifelong learning					
	Being adaptable & flexible in a changing organisational context					
		8	**0**	**2**	**0**	**0**

JOB RETENTION STRATEGIES TERTIARY PP		Knekt et al. 2008a LPP	Knekt et al. 2008b MPP	Burnand et al. 2002
Information	Information about occupational hazards			
	Information about coping at work			
	Information about organisational supports e.g. EAP counselling			
Focus on the workplace	Stress surveillance / use of screening tools / job profiling			
	Workplace assessment			
	Environmental improvement action plans			
	Regular monitoring of action plans			
	Individualised supervision / appraisal, focus on stress / work			
	Implementation of new solutions / coping strategies at work			
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace			
	Info about how to deal with sources of occupational stress			
	Training for managers in counselling skills			
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables			
	Provision of up-dates to & collaboration between stakeholders			
Help getting back to work	Negotiation of workplace adjustments			
	Agreed return-to-work / rehabilitation plan			
	Conflict resolution / mediation			
	Gradual exposure to work situation			
	Phased work resumption / part-time hours			
Supporting employment	Place-then-train approach			
	Further on-the-job training / retraining			
	Transfer to another job, redeployment			
	Time- and task-management skills			
	Endorsing work as a resource for wellbeing & self-esteem			
Promoting employee's career management	Taking responsibility for one's own professional development			
	Emphasising lifelong learning			
	Being adaptable & flexible in a changing organisational context			
		0	**0**	**0**

JOB RETENTION STRATEGIES TERTIARY PST		Vlasveld et al. 2011, 2013	Bakker et al. 2007	Brouwers et al. 2006	Van Oostrom et al. 2010
Information	Information about occupational hazards				
	Information about coping at work				
	Information about organisational supports e.g. EAP counselling				
Focus on the workplace	Stress surveillance / use of screening tools / job profiling				
	Workplace assessment	✓			
	Environmental improvement action plans				✓
	Regular monitoring of action plans				
	Individualised supervision / appraisal, focus on stress / work				
	Implementation of new solutions / coping strategies at work	✓		✓	✓
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace				
	Info about how to deal with sources of occupational stress				
	Training for managers in counselling skills				
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables		✓		✓
	Provision of up-dates to & collaboration between stakeholders				
Help getting back to work	Negotiation of workplace adjustments	✓			✓
	Agreed return-to-work / rehabilitation plan	✓	✓	✓	✓
	Conflict resolution / mediation	✓			
	Gradual exposure to work situation			✓	
	Phased work resumption / part-time hours				
Supporting employment	Place-then-train approach				
	Further on-the-job training / retraining				
	Transfer to another job, redeployment				
	Time- and task-management skills				
	Endorsing work as a resource for wellbeing & self-esteem				
Promoting employee's career management	Taking responsibility for one's own professional development				
	Emphasising lifelong learning				
	Being adaptable & flexible in a changing organisational context				
		5	**2**	**3**	**5**

JOB RETENTION STRATEGIES TERTIARY SMT / SIT		De Vente et al. 2008a 1:1	De Vente et al. 2008b group	Rebergen 2009	Van der Klink et al. 2003
Information	Information about occupational hazards			✓	
	Information about coping at work			✓	
	Information about organisational supports e.g. EAP counselling				
Focus on the workplace	Stress surveillance / use of screening tools / job profiling				
	Workplace assessment				
	Environmental improvement action plans				
	Regular monitoring of action plans				
	Individualised supervision / appraisal, focus on stress / work				
	Implementation of new solutions / coping strategies at work				
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace				
	Info about how to deal with sources of occupational stress				
	Training for managers in counselling skills				
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables				✓
	Provision of up-dates to & collaboration between stakeholders				
Help getting back to work	Negotiation of workplace adjustments				
	Agreed return-to-work / rehabilitation plan			✓	✓
	Conflict resolution / mediation				
	Gradual exposure to work situation			✓	✓
	Phased work resumption / part-time hours				
Supporting employment	Place-then-train approach				
	Further on-the-job training / retraining				
	Transfer to another job, redeployment				
	Time- and task-management skills				
	Endorsing work as a resource for wellbeing & self-esteem	✓	✓		
Promoting employee's career management	Taking responsibility for one's own professional development				
	Emphasising lifelong learning				
	Being adaptable & flexible in a changing organisational context				
		1	**1**	**4**	**3**

JOB RETENTION STRATEGIES TERTIARY SFBT		Knekt et al. 2008c SFBT	Nystuen & Hagen 2003, 2006	Bonde et al. 2005
Information	Information about occupational hazards			
	Information about coping at work		✓	
	Information about organisational supports e.g. EAP counselling			
Focus on the workplace	Stress surveillance / use of screening tools / job profiling			
	Workplace assessment			✓
	Environmental improvement action plans			
	Regular monitoring of action plans			
	Individualised supervision / appraisal, focus on stress / work			
	Implementation of new solutions / coping strategies at work			
Support for line managers / supervisors	Advice on reducing psychosocial hazards in the workplace			
	Info about how to deal with sources of occupational stress			
	Training for managers in counselling skills			
Liaison with stakeholders	Facilitated dialogue with line manager, roundtables			✓
	Provision of up-dates to & collaboration between stakeholders			✓
Help getting back to work	Negotiation of workplace adjustments			
	Agreed return-to-work / rehabilitation plan			✓
	Conflict resolution / mediation			
	Gradual exposure to work situation			
	Phased work resumption / part-time hours			
Supporting employment	Place-then-train approach			
	Further on-the-job training / retraining			✓
	Transfer to another job, redeployment			✓
	Time- and task-management skills			✓
	Endorsing work as a resource for wellbeing & self-esteem			
Promoting employee's career management	Taking responsibility for one's own professional development			
	Emphasising lifelong learning			
	Being adaptable & flexible in a changing organisational context			
		0	**1**	**7**

APPENDIX 21: COMPONENT ANALYSIS PIE CHARTS

21.1 CONTENT COMPONENTS

21.1.1 Psycho-education

This component includes providing information about the fight-flight response and physiological symptoms; about how thoughts, feelings, and behaviour interact; about coping in general; about stress, symptoms, and the causes of mental health problems; about healthy lifestyle and self-care; and a rationale for behavioural activation or exposure.

Table 52 – Psycho-education

PSYCHO-EDUCATION	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT (n = 5)	0	2	2	1
PP (n = 3)	3	0	0	0
PST (n = 4)	1	3	0	0
SMT (n = 4)	1	3	0	0
SFBT (n = 3)	2	0	1	0
Secondary Preventative Programmes (n = 4)	2	0	1	1
Primary Preventative Programmes (n = 6)	1	2	1	2
TOTAL	10	10	5	4
	20 = 69%		9 = 31%	

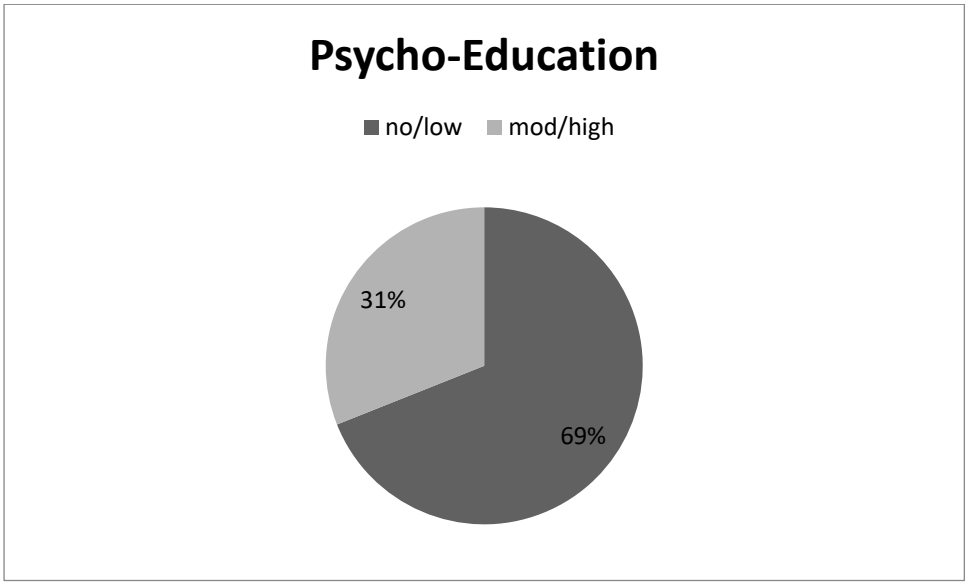


Figure 1- Psycho-education

It can be seen that only 31% of programmes have moderate or high psycho-educational content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need knowledge about depression in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need knowledge about

what the intervention involves, and how it aims to improve their mental health. On the other hand 69% of programmes have no or low content dedicated to psycho-education. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.2 Behavioural skills

This component includes a focus on relaxation or mindfulness; behavioural activation or activity scheduling; graded exposure or de-sensitisation; and crisis planning and relapse prevention.

Table 53 – Behavioural skills

BEHAVIOURAL SKILLS	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	0	2	3	0
PP	3	0	0	0
PST	2	1	1	0
SMT	0	0	3	1
SFBT	3	0	0	0
Secondary Preventative Programmes	1	3	0	0
Primary Preventative Programmes	5	1	0	0
TOTAL	14	7	7	1
	21 = 72%		8 = 28%	

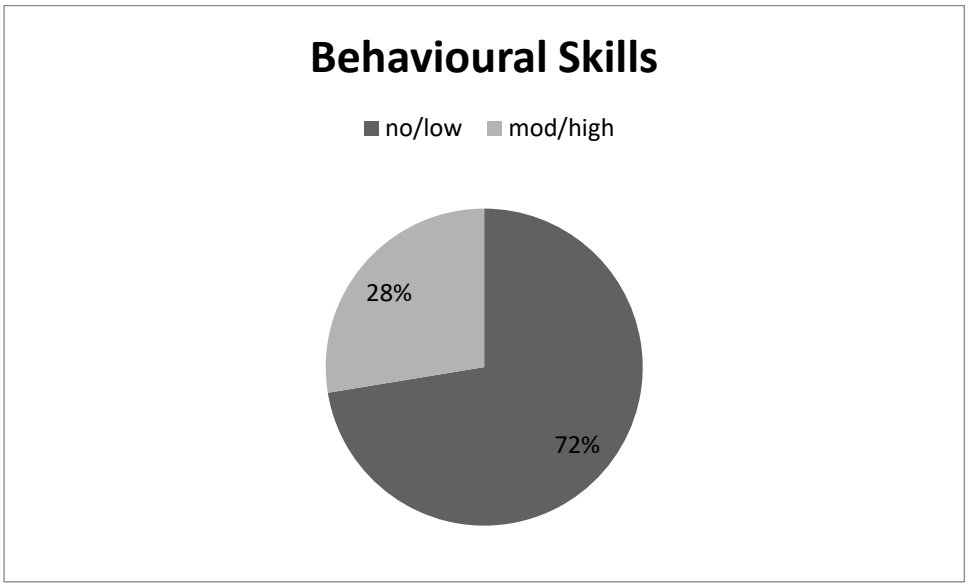


Figure 2 – Behavioural skills

It can be seen that only 28% of programmes have moderate or high behavioural skills content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals have never had, or have lost, behavioural skills that have been shown to protect against depression such as making friends to prevent loneliness, and therefore they need help to acquire these skills. Another explanation is that symptomatic individuals need to learn and

practice specific skills such as relapse prevention in order to achieve positive clinical and work outcomes. On the other hand 72% of programmes have no or low content dedicated to behavioural skills. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.3 Emotions, affect regulation

This component includes a focus on acceptance of distressing thoughts and feelings; expressing feelings appropriately; and eliciting client's feelings in relation to self, others, or the therapist.

Table 54 – Emotions, affect regulation

EMOTIONS, AFFECT REGULATION	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	0	1	0
PP	0	3	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	4	2	0	0
TOTAL	23	5	1	0
	28 = 97%		1 = 3%	

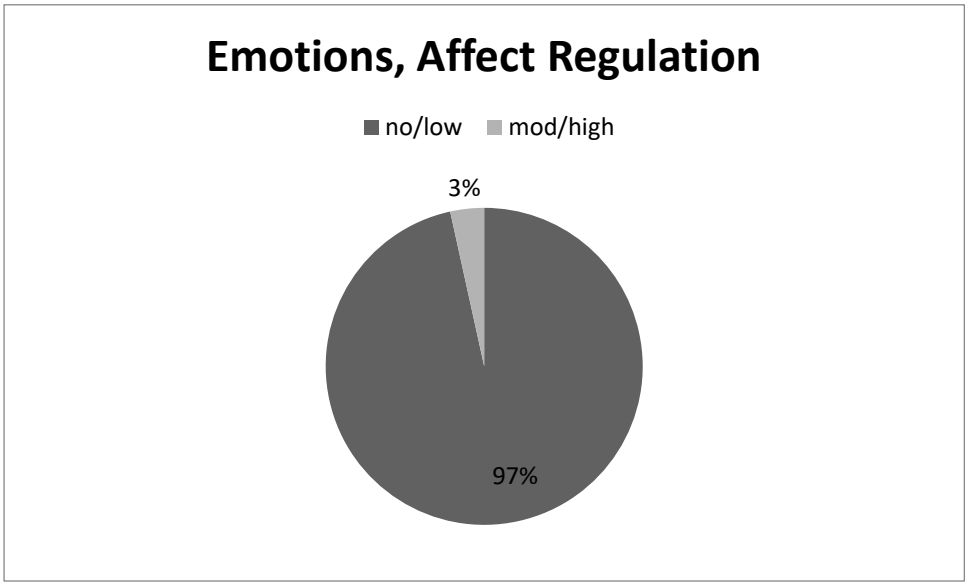


Figure 3 – Emotions, affect regulation

It can be seen that only 3% of programmes have moderate or high emotions and affect regulation content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals find it difficult to put their feelings in to words, and therefore they need help to do so in order to achieve positive clinical and work outcomes. Another explanation is that

symptomatic individuals are experiencing dysregulation of the autonomic nervous system, and therefore they need help to learn how to soothe their emotions. On the other hand 97% of programmes have no or low content dedicated to emotions and affect regulation. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.4 Cognitive restructuring

This component includes a focus on recognising faulty thinking or behavioural experiments; disputation; reappraisal or reattribution; positive reframing; and highlighting solutions or imagining a future without the problem.

Table 55 – Cognitive restructuring

COGNITIVE RESTRUCTURING	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	0	0	1	4
PP	3	0	0	0
PST	3	1	0	0
SMT	0	2	2	0
SFBT	1	2	0	0
Secondary Preventative Programmes	1	1	0	2
Primary Preventative Programmes	5	0	1	0
TOTAL	13	6	4	6
	19 = 66%		10 = 34%	

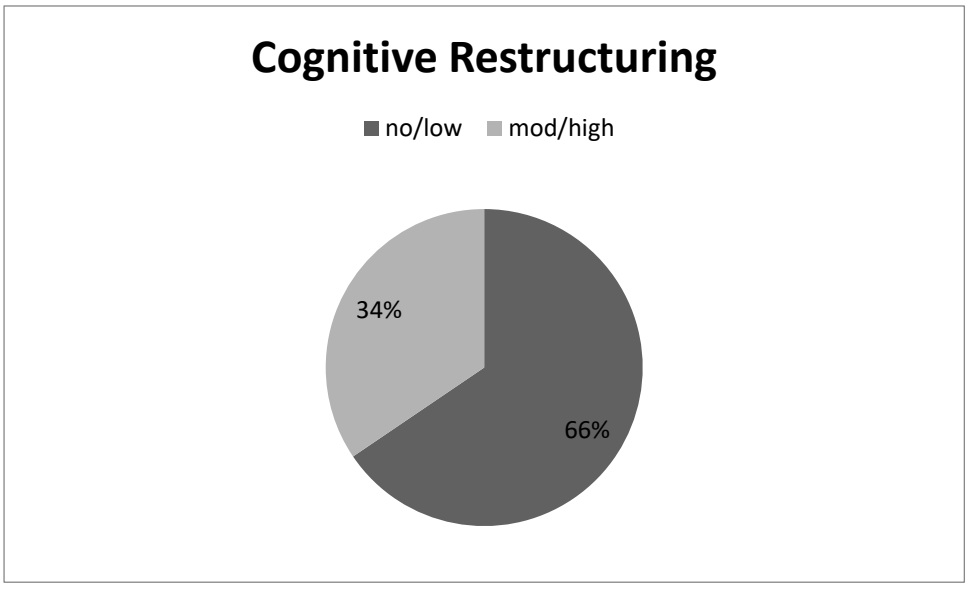


Figure 4 – Cognitive restructuring

It can be seen that only 34% of programmes have moderate or high cognitive restructuring content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals tend to have a negative memory, attention and interpretative biases

which perpetuate depression, and therefore they need help to change their unhelpful belief systems and attitudes in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals use emotional reasoning / reactions by which what they say and do is governed by their mood state rather than their true values, and therefore they need help to make intentional choices about what they say and do. On the other hand 66% of programmes have no or low content dedicated to cognitive restructuring. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.5 Coping strategies

This component includes a focus on active problem-solving (individual or team-based); coping with internal stressors e.g. negative inner dialogue; coping with external stressors e.g. high workload; and goal-setting or decision-making.

Table 56 – Coping strategies

COPING STRATEGIES	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	3	1	1	0
PP	3	0	0	0
PST	0	2	2	0
SMT	0	2	2	0
SFBT	2	0	1	0
Secondary Preventative Programmes	1	3	0	0
Primary Preventative Programmes	2	4	0	0
TOTAL	11	12	6	0
	23 = 79%		6 = 21%	

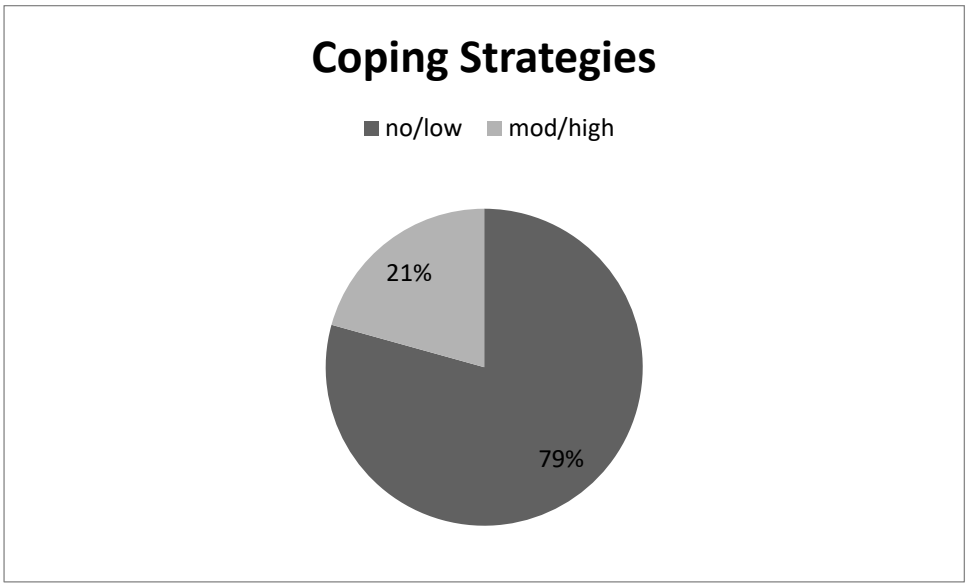


Figure 5 – Coping strategies

It can be seen that only 21% of programmes have moderate or high coping strategies content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals tend to use avoidant coping strategies which results in high levels of negative reinforcement and low levels of positive reinforcement, and therefore they need help to change these conditioned behavioural responses to internal and external threats in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals have developed maladaptive coping strategies such as interpersonal aggression as a result of trauma in early life, and therefore they need help to develop more adaptive coping strategies. On the other hand 79% of programmes have no or low content dedicated to coping strategies. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.6 Focus on intra-personal

This component includes a focus on insight or self-awareness; improving self-esteem; and personal empowerment through assertiveness.

Table 57 – Focus on intra-personal

FOCUS ON INTRA-PERSONAL	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	3	1	1	0
PP	0	3	0	0
PST	4	0	0	0
SMT	2	2	0	0
SFBT	2	1	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	4	2	0	0
TOTAL	19	9	1	0
	28 = 97%		1 = 3%	

It can be seen that only 3% of programmes have moderate or high intra-personal content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals may lack self-awareness, and therefore they need help to explore their inner world of thoughts and feelings in order to achieve positive clinical and work outcomes.

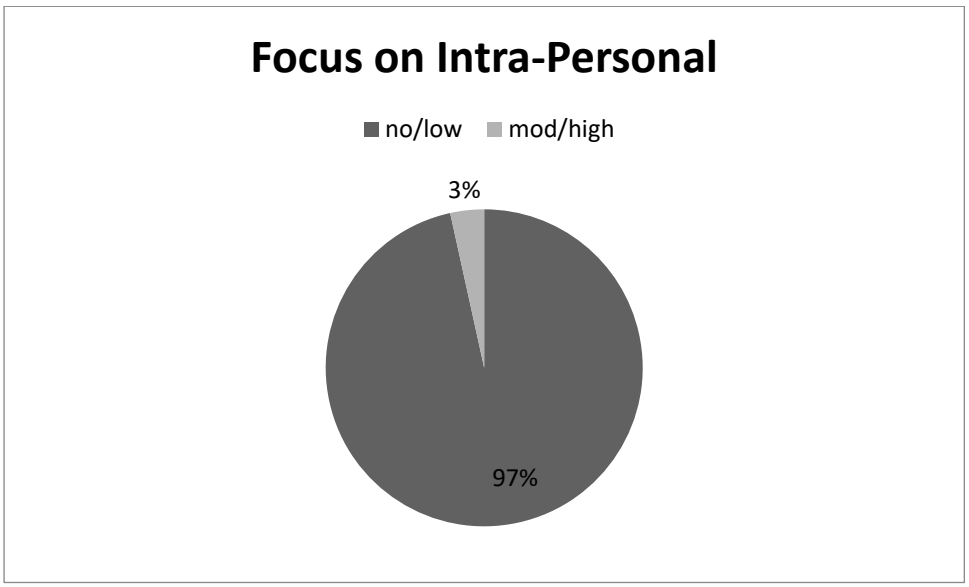


Figure 6 – Focus of the intra-personal

Another explanation is that symptomatic individuals tend to blame themselves which results in excessive shame and guilt, and therefore they need help to be more compassionate towards themselves. On the other hand 97% of programmes have no or low content dedicated to addressing intra-personal issues. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.1.7 Focus on inter-personal

This component includes a focus on outsight or inter-personal-awareness; coping with people; social diversion, social support, or social connectedness; managing conflict; and improving ways of communicating and interacting.

Table 58 – Focus on inter-personal

FOCUS ON INTER-PERSONAL	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	0	0	1
PP	0	3	0	0
PST	4	0	0	0
SMT	2	2	0	0
SFBT	2	0	1	0
Secondary Preventative Programmes	2	1	1	0
Primary Preventative Programmes	3	2	0	1
TOTAL	17	8	1	2
	25 = 86%		4 = 14%	

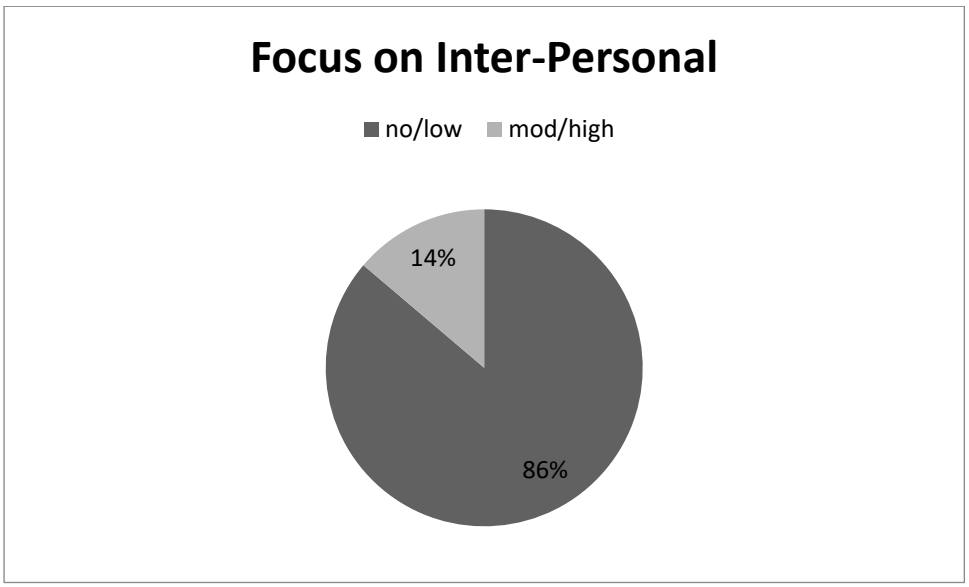


Figure 7 – Focus on the inter-personal

It can be seen that only 14% of programmes have moderate or high inter-personal content. One plausible explanation for how much to focus on this component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals tend to be preoccupied and self-centred which results in a lack awareness of their impact on other, and therefore they need corrective feedback to improve how they communicate and interact in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals have withdrawn from social contact due to fear of rejection, and therefore they need help to re-engage with the social world. On the other hand 86% of programmes have no or low content dedicated to addressing inter-personal issues. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2 PROCESS COMPONENTS

21.2.1 Style of teaching-learning

This component includes making use of didactic lectures or PowerPoint presentations; experiential exercises or active learning techniques; case studies; and guided self-help.

Table 59 – Style of teaching-learning

STYLE OF TEACHING - LEARNING	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	1	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	3	1	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	2	2	0	0
Primary Preventative Programmes	1	2	3	0
TOTAL	20	6	3	0
	26 = 90%		3 = 10%	

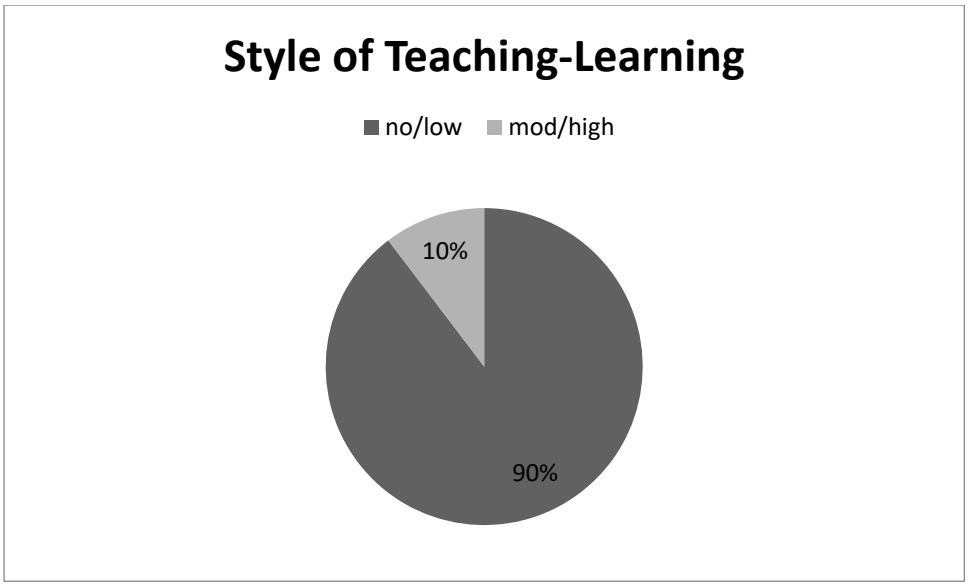


Figure 8 – Style of teaching-learning

It can be seen that only 10% of programmes make moderate or high use of a specific style of teaching-learning. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals are working age adults, and therefore need to learn new knowledge, skills and attitudes through active learning techniques or experiential exercises in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals have low motivation and poor concentration as a result of depression and their engagement in therapy, needs to be enhanced with high quality presentations. On the other hand 90% of programmes have no or low content dedicated to the use of use of a specific style of teaching-learning. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.2 Facilitation of peer-to-peer dialogue

This component includes making use of group discussion, large group plenary, or Q & A sessions; working in pairs or triads; and conversations in small groups.

Table 60 – Facilitation of peer-peer dialogue

FACILITATION OF PEER-PEER DIALOGUE	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	5	0	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	2	1	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	3	2	1	0
TOTAL	25	3	1	0
	28 = 97%		1 = 3%	

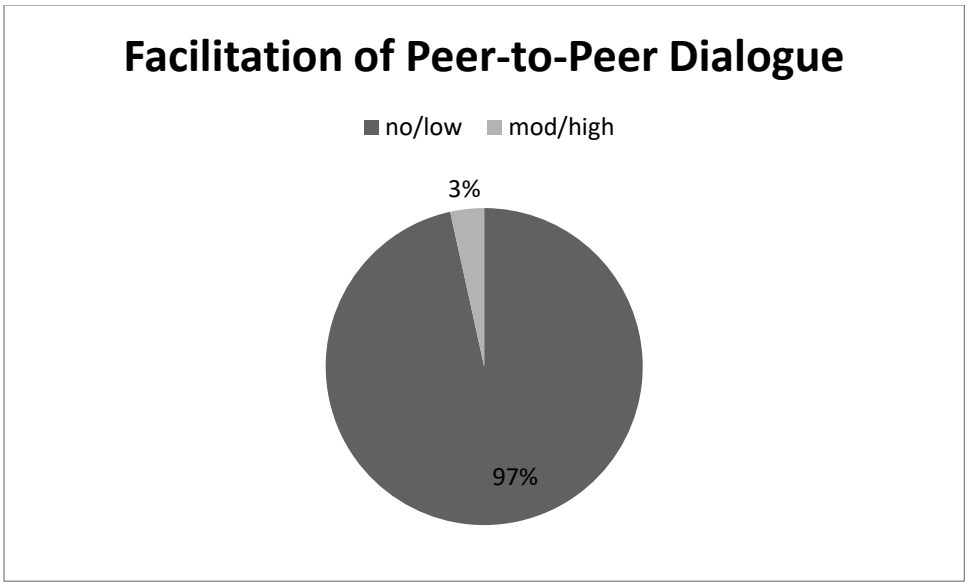


Figure 9 – Facilitation of peer-to-peer dialogue

It can be seen that only 3% of programmes make moderate or high use of the facilitation of peer-to-peer dialogue. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals can be inspired to change by listening to other group members' stories of recovery, and therefore they need opportunities to talk with fellow sufferers in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals find it easier to confide in a peer who has had similar experiences, and therefore they need opportunities to speak privately without intrusion from a therapist. On the other hand 97% of programmes make no or low use of the facilitation of peer-to-peer dialogue. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.3 In vivo activities and skills practice

This component includes making use of behavioural rehearsal, role play or assertiveness; progressive muscular relaxation or mindfulness; video feedback or inter-personal process recall (IPR); goal-setting or problem-solving; and physical exercise.

Table 61 – In-vivo activities and skills practice

IN VIVO ACTIVITIES & SKILLS PRACTICE	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	1	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	2	1	1	0
Primary Preventative Programmes	3	2	0	1
TOTAL	23	4	1	1
	27 = 93%		2 = 7%	

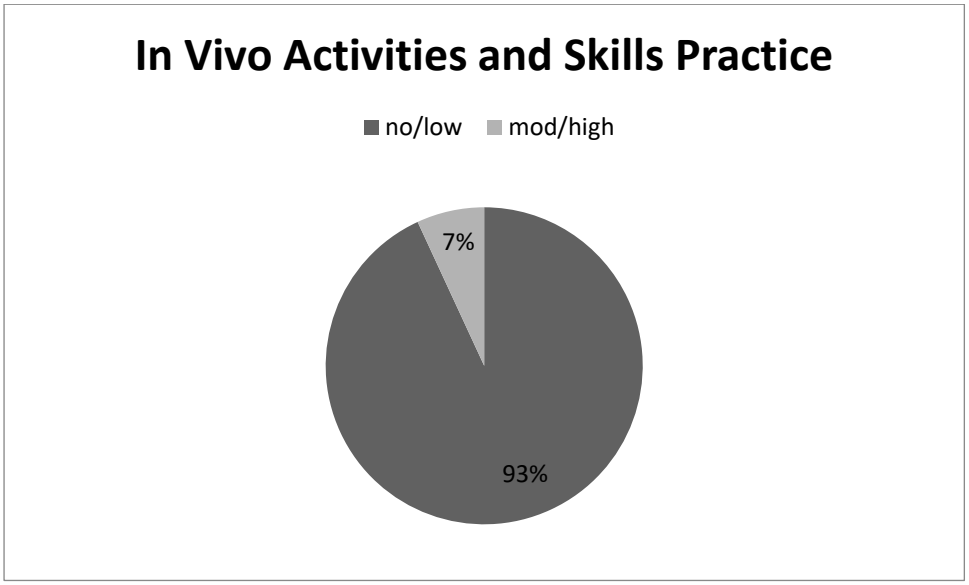


Figure 10 – In-vivo activities and skills practice

It can be seen that only 7% of programmes make moderate or high use of specific in vivo activities and skills practice. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals require considerable support to acquire and consolidate skills, and therefore they need opportunities for frequent and regular repetition in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals are easily discouraged due to depression, and therefore they need corrective feedback in a safe setting for new skills to be learned. On the other hand 93% of programmes make no or low use of specific in vivo activities and skills practice. This suggests that the majority of

programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.4 Relationship with therapist

This component includes making use of (mainly in 1:1 formats) a directive therapeutic relationship focused on conscious material); a non-directive therapeutic relationship focused on unconscious material; repairing ruptures, limited re-parenting, or a corrective emotional experience; advice-giving or offering support; motivational enhancement or 'circular / miracle questions'; probing for exceptions or asking scaling questions; and facilitating emotional expression or empathetic attunement.

Table 62 – Relationship with therapist

RELATIONSHIP WITH THERAPIST	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	1	0	4	0
PP	0	0	2	1
PST	0	0	4	0
SMT	1	0	3	0
SFBT	0	0	1	2
Secondary Preventative Programmes	1	0	3	0
Primary Preventative Programmes	6	0	0	0
TOTAL	9	0	17	3
	9 = 69%		20 = 31%	

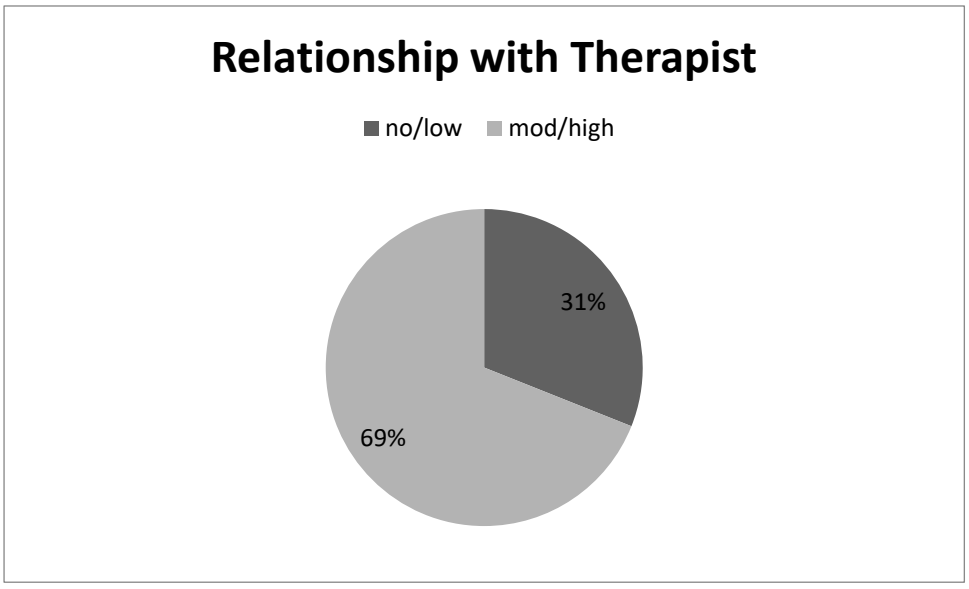


Figure 11 – Relationship with the therapist

It can be seen that 69% of programmes make moderate or high use of the relationship with the therapist. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals will only be able to open up if they feel as if they are not going to be

judged, and therefore they need a therapist who is competent at establishing a therapeutic alliance in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals might find it difficult to trust people due to past inter-personal trauma, and therefore they need a therapist who is competent at repairing ruptures in the therapeutic relationship. On the other hand 31% of programmes make no or low use of the relationship with the therapist. This suggests that a minority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.5 Relationship with group members / significant others

This component includes making use of (mainly in group formats) participatory teamwork; perspective-taking or 'reality management'; sharing problems together or exchanging experiences; generating solutions and reviewing goals together; social support, helping others, or validating others' emotions; inter-personal learning through peer feedback; 'disconfirmation of the uniqueness of one's problems'; social contact before, during, after and between sessions; and inviting spouse or partner to specific group sessions.

Table 63 – Relationship with others

RELATIONSHIP WITH OTHERS	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	3	2	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	3	0	0	1
SFBT	2	0	1	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	3	1	0	2
TOTAL	22	3	1	3
	25 = 86%		4 = 14%	

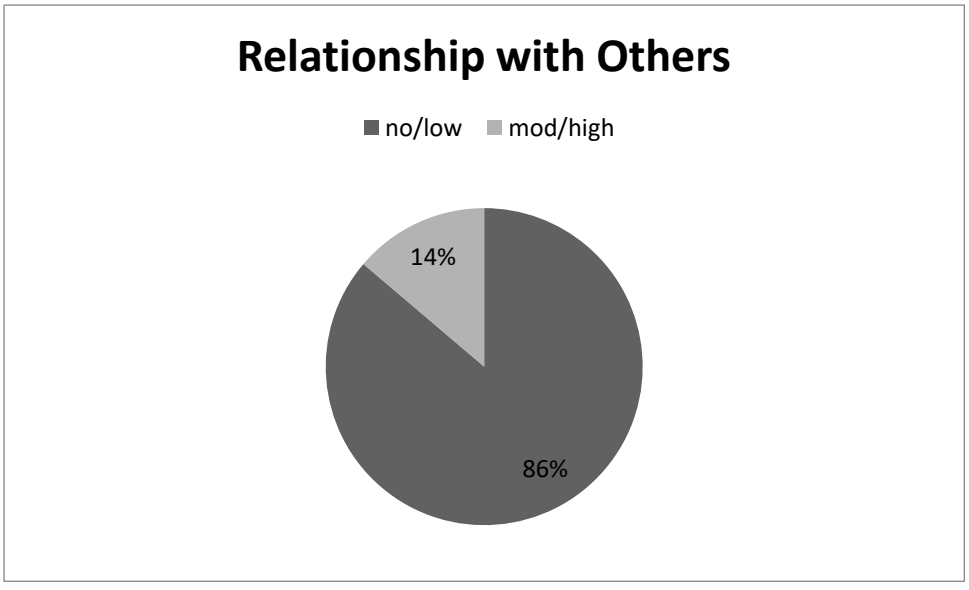


Figure 12 – Relationship with others

It can be seen that only 14% of programmes make moderate or high use of the relationship with group members or significant others. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals might be able to relate positively to people in authority but might struggle to relate positively with colleagues, and therefore they need opportunities to learn how to work more effectively with peers in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals might need to 'become their own therapist, and therefore they need opportunities to apply CBT techniques by helping other group members. On the other hand 86% of programmes make no or low use of the relationship with group members or significant others. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.6 Between session activities

This component includes making use of homework assignments or challenges; keeping a journal; thought diary, self-monitoring or self-reflection; booster sessions following completion of programme; and text reminders, email counselling or outreach by 'phone.

It can be seen that only 14% of programmes make moderate or high use of specific between-session activities.

Table 64 – Between session activities

BETWEEN SESSION ACTIVITIES	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	0	3	2	0
PP	3	0	0	0
PST	3	1	0	0
SMT	2	2	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	1	1	2	0
Primary Preventative Programmes	5	1	0	0
TOTAL	17	8	4	0
	25 = 86%		4 = 14%	

One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals will forget to practice and that the skills will not generalise to other contexts, and therefore they need encouragement to undertake homework assignments in order to achieve positive clinical and work outcomes.

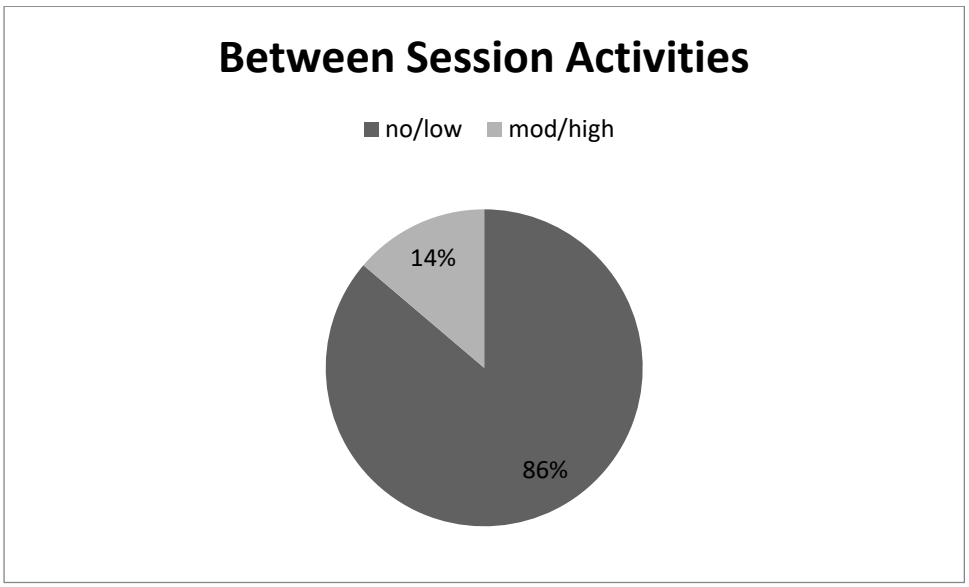


Figure 13 – Between session activities

Another explanation is that symptomatic individuals might feel unsupported between sessions if they are spaced out weekly or monthly, and therefore they need contact by text for example to prevent them from dropping out of therapy. On the other hand 86% of programmes make no or low use of specific between-session activities. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.7 Sharing emotional experiences

This component includes making use of listening to each other; working with transference, resistance, ambivalence, or defences; confrontation, clarification and interpretation; and expressing empathy towards each other.

Table 65 – Sharing emotional experiences

SHARING EMOTIONAL EXPERIENCES	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	5	0	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	5	0	1	0
TOTAL	28	0	1	0
	28 = 97%		1 = 3%	

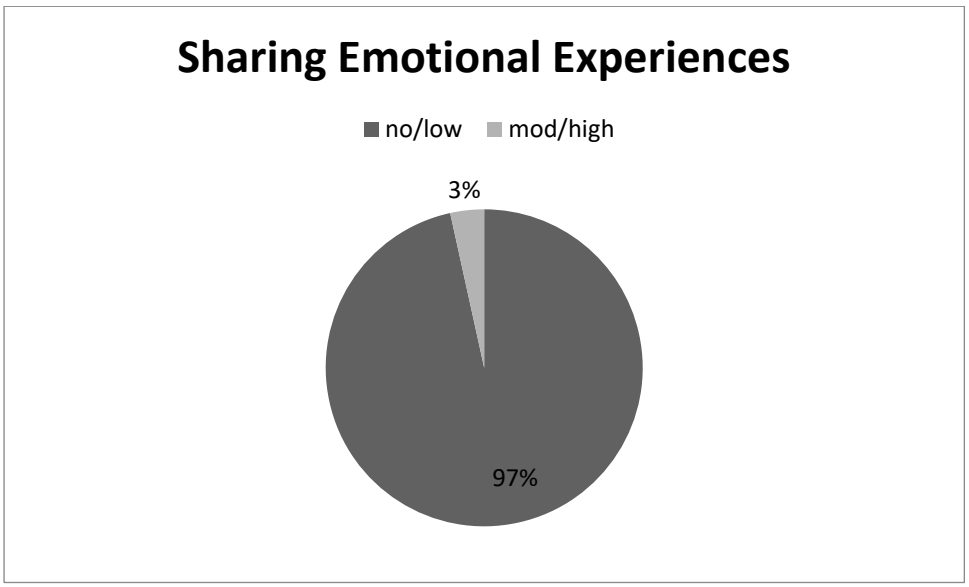


Figure 14 – Sharing emotional experiences

It can be seen that only 3% of programmes make moderate or high use of the sharing emotional experiences. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals often act out when they feel emotionally overwhelmed, and therefore they need opportunities to off load in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals might mask their emotions especially at work leading to managers and colleagues having unrealistic expectations, and therefore they need to learn how to express how they are feeling so that others might be more understanding and tolerant. On the other hand 97% of programmes make no or low use of the sharing emotional experiences. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.2.8 Provision of resources

This component includes giving clients to take home audio-recordings of relaxation or mindfulness training; and written material, book chapters, handouts, or participant workbooks.

Table 66 – Provision of resources

PROVISION OF RESOURCES	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	1	0	4	0
PP	3	0	0	0
PST	3	0	1	0
SMT	2	0	2	0
SFBT	3	0	0	0
Secondary Preventative Programmes	2	0	2	0
Primary Preventative Programmes	5	0	1	0
TOTAL	19	0	10	0
	19 = 66%		10 = 34%	

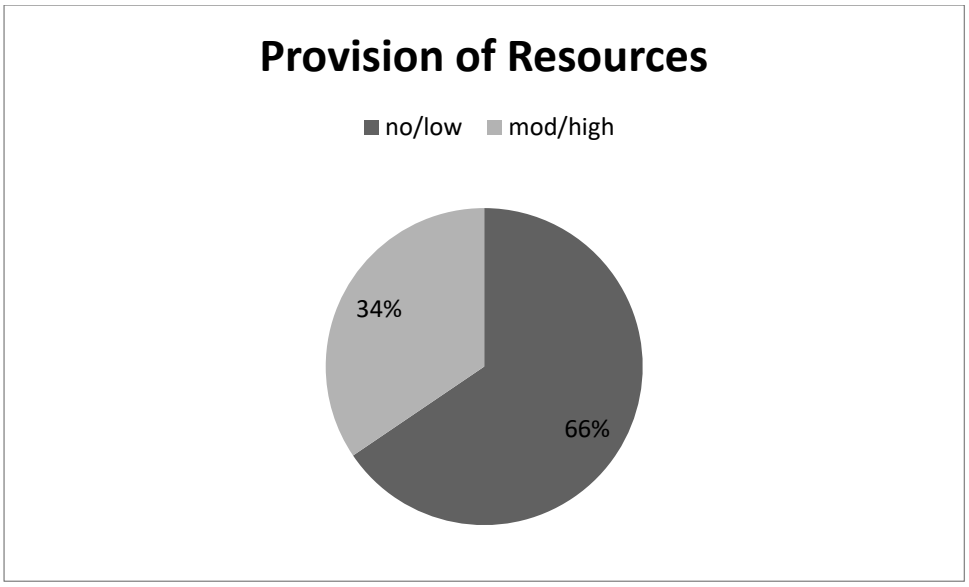


Figure 15 – Provision of resources

It can be seen that only 34% of programmes make moderate or high use of the provision of resources. One plausible explanation for how much to use this process component and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need concrete resources to remind themselves to learn and practice new knowledge, skills and attitudes between-sessions and after therapy has ended, and therefore they need handouts or audio-recordings for example to take home to read or listen to in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals might need a participant workbook to show to others in order to gain their support during therapy. On the other hand 66% of programmes make no or low use of the provision of resources. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3 JOB RETENTION STRATEGIES

21.3.1 Information

This strategy includes providing employees with information about occupational hazards; about coping at work; and about organisational supports e.g. EAP counselling.

Table 67 - Information

INFORMATION	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	3	2	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	3	0	1	0
SFBT	2	1	0	0
Secondary Preventative Programmes	2	0	2	0
Primary Preventative Programmes	3	0	3	0
TOTAL	20	3	6	0
	23 = 79%		6 = 21%	

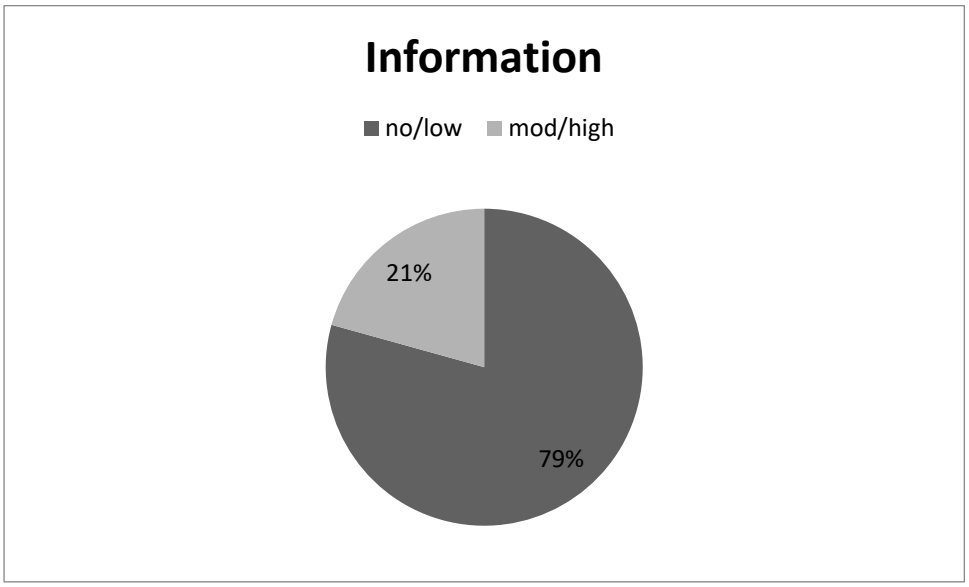


Figure 16 – Information

It can be seen that only 21% of programmes make moderate or high use of work-related and occupational health-related information. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need knowledge about psycho-social hazards in the workplace for example in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need knowledge about how the organisation they work for contributes to employees' positive and negative mental health. On the other hand 79% of programmes make no or low use of work-related and occupational health-related information. This suggests that the majority of programme designers believe this might be an

unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.2 Focus on the workplace

This strategy includes making use of stress surveillance, use of screening tools or job profiling; workplace assessment; environmental improvement action plans; regular monitoring of action plans; individualised supervision or appraisal with a focus on stress at work; and implementation of new solutions or coping strategies at work.

Table 68 – Focus on the workplace

FOCUS ON THE WORKPLACE	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	1	0	0
PP	3	0	0	0
PST	1	1	2	0
SMT	4	0	0	0
SFBT	2	1	0	0
Secondary Preventative Programmes	3	1	0	0
Primary Preventative Programmes	3	1	1	1
TOTAL	20	5	3	1
	25 = 86%		4 = 14%	

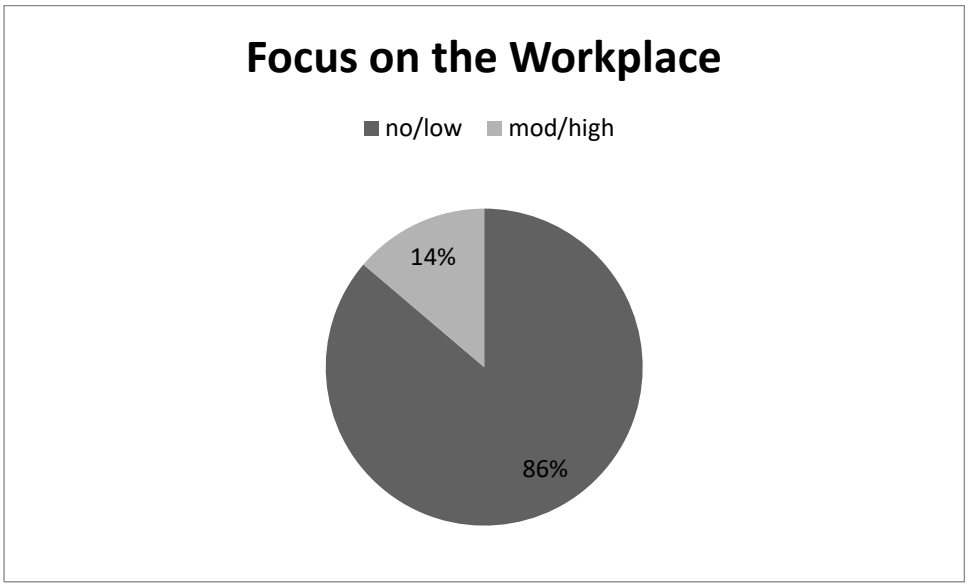


Figure 17 – Focus on the workplace

It can be seen that only 14% of programmes make moderate or high use of a focus on the workplace. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need interventions to identify and tackle workplace issues in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need to transfer their learning in terms of new knowledge, skills and attitudes to the workplace.

On the other hand 86% of programmes make no or low use of a focus on the workplace. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.3 Support for line managers / supervisors

This strategy includes providing line managers or supervisors with advice on reducing psychosocial hazards in the workplace; information about how to deal with sources of occupational stress; and training them in counselling skills.

Table 69 – Support for line managers / supervisors

SUPPORT FOR LINE MANAGERS / SUPERVISORS	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	5	0	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	4	0	1	1
TOTAL	27	0	1	1
	27 = 93%		2 = 7%	

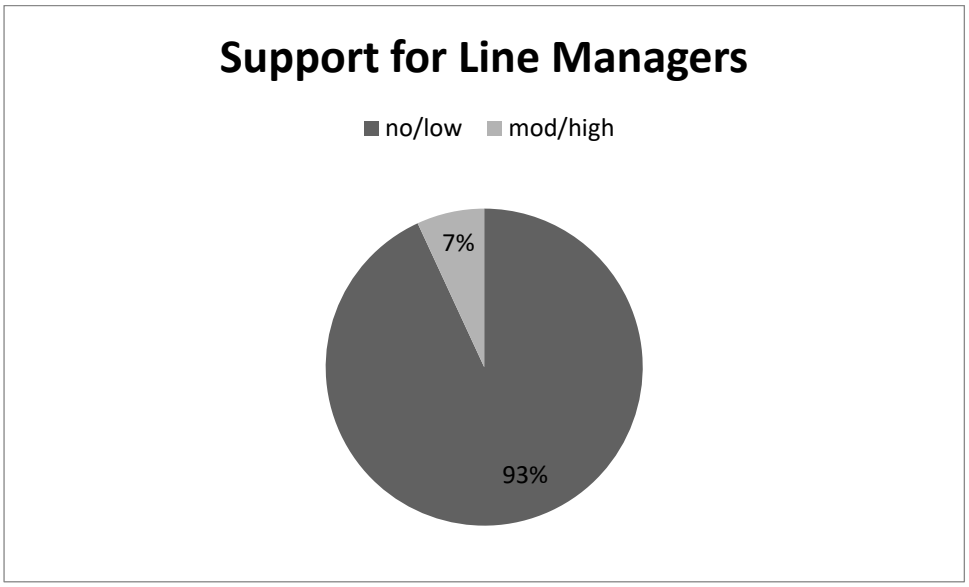


Figure 18 – Support for line managers

It can be seen that only 7% of programmes make moderate or high use of support for line managers or supervisors. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need their line managers to be knowledgeable and capable in supporting employees with mental health problems in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals

need their line managers to identify and tackle sources of occupational stress in the workplace. On the other hand 93% of programmes make no or low use of support for line managers or supervisors. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.4 Liaison with stakeholders

This strategy includes setting up a facilitated dialogue with an employee's line manager or roundtables; and the provision of up-dates to and collaboration between stakeholders.

Table 70 – Liaison with stakeholders

LIAISON WITH STAKEHOLDERS	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	1	0	0
PP	3	0	0	0
PST	2	2	0	0
SMT	3	1	0	0
SFBT	2	0	1	0
Secondary Preventative Programmes	3	1	0	0
Primary Preventative Programmes	6	0	0	0
TOTAL	23	5	1	0
	28 = 97%		1 = 3%	

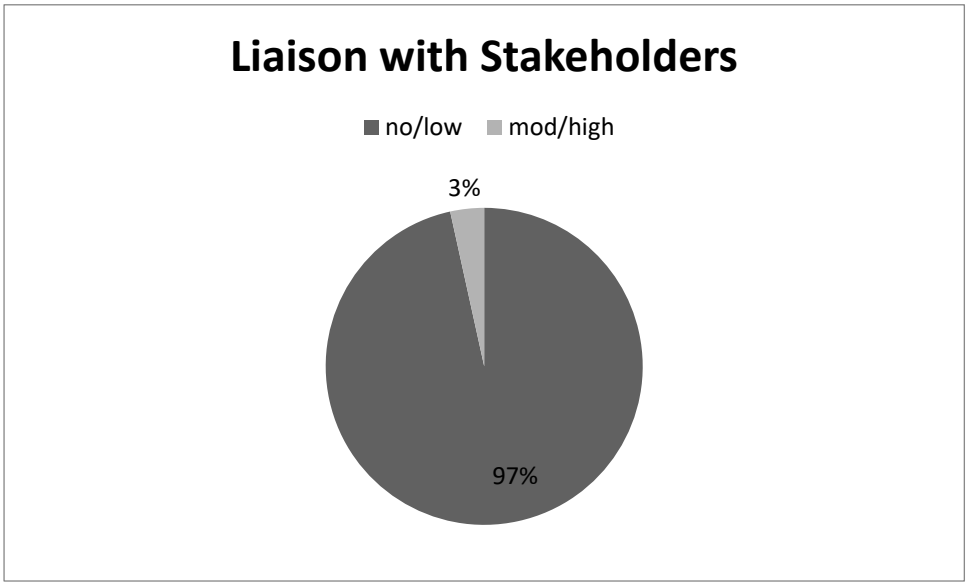


Figure 19 – Liaison with stakeholders

It can be seen that only 3% of programmes make moderate or high use of liaison with stakeholders. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need psychotherapeutic interventions that coordinate with the workplace in order to achieve positive clinical and work outcomes. Another explanation is that

symptomatic individuals need interventions to support them in communicating effectively with the workplace. On the other hand 97% of programmes make no or low use of liaison with stakeholders. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.5 Help getting back to work

This strategy includes negotiating workplace adjustments; an agreed return-to-work or rehabilitation plan; conflict resolution or mediation; gradual exposure to work situation; and phased work resumption or part-time hours.

Table 71 – Help getting back to work

HELP GETTING BACK TO WORK	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	3	1	0	1
PP	3	0	0	0
PST	0	1	2	1
SMT	2	0	2	0
SFBT	2	1	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	5	1	0	0
TOTAL	19	4	4	2
	79 = 90%		6 = 21%	

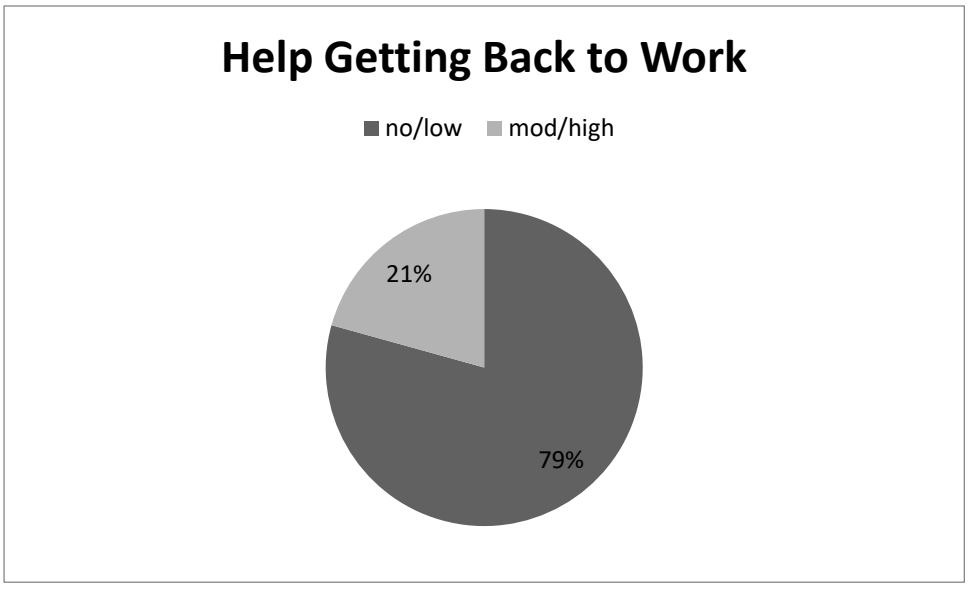


Figure 20 – Help getting back to work

It can be seen that only 21% of programmes make moderate or high use of a focus on help getting back to work. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need mediation to resolve inter-personal conflict that is acting as a

barrier to work resumption in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need interventions to support them in negotiating reasonable adjustments. On the other hand 79% of programmes make no or low use of a focus on help getting back to work. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.6 Supporting employment

This strategy includes making use of a place-then-train approach; setting up further on-the-job training or retraining; transfer to another job or redeployment; time- and task-management skills; and endorsing work as a resource for wellbeing and self-esteem.

Table 72 – Supporting employment

SUPPORTING EMPLOYMENT	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	4	1	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	2	2	0	0
SFBT	2	1	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	5	1	0	0
TOTAL	24	5	0	0
	29 = 100%		0 = 0%	

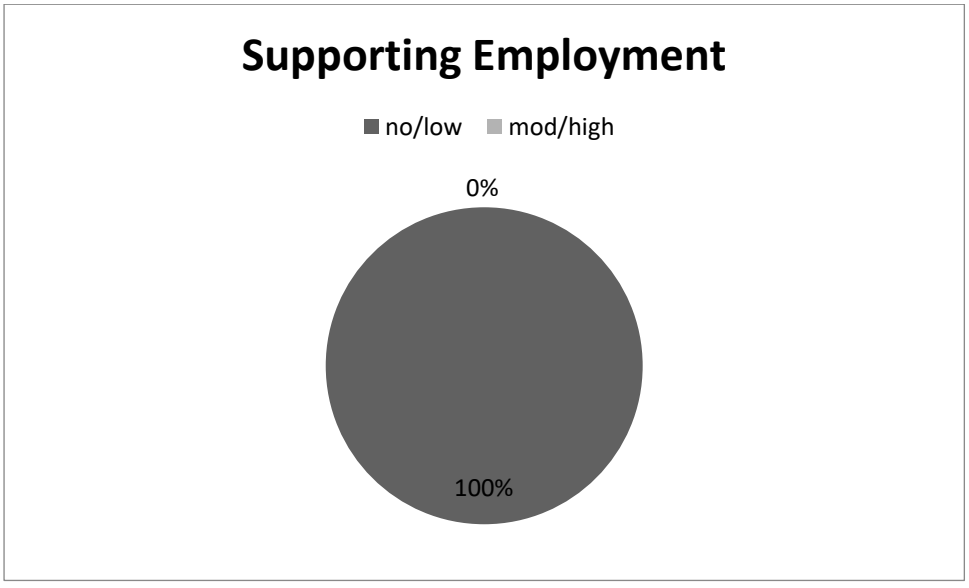


Figure 21 – Supporting employment

It can be seen that none of the programmes make moderate or high use of a focus on supporting employment. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is

that symptomatic individuals need help to move to a more suitable job when their existing role is a source of excessive stress in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need help to modify counter-productive work behaviours and / or negative attitudes towards work that are a source of conflict in the workplace or disciplinary action for example. On the other hand 100% of programmes make no or low use of a focus on supporting employment. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.

21.3.7 Promoting employee's career management

This strategy includes training employees to take responsibility for their own professional development; emphasising lifelong learning; and being adaptable and flexible in a changing organisational context.

Table 73 – Promoting employee's career management

EMPLOYEE'S CAREER MANAGEMENT	NO	LOW	MODERATE	HIGH
Tertiary Preventative Programmes				
CBT	5	0	0	0
PP	3	0	0	0
PST	4	0	0	0
SMT	4	0	0	0
SFBT	3	0	0	0
Secondary Preventative Programmes	4	0	0	0
Primary Preventative Programmes	5	0	0	1
TOTAL	28	0	0	1
	28 = 97%		1 = 3%	

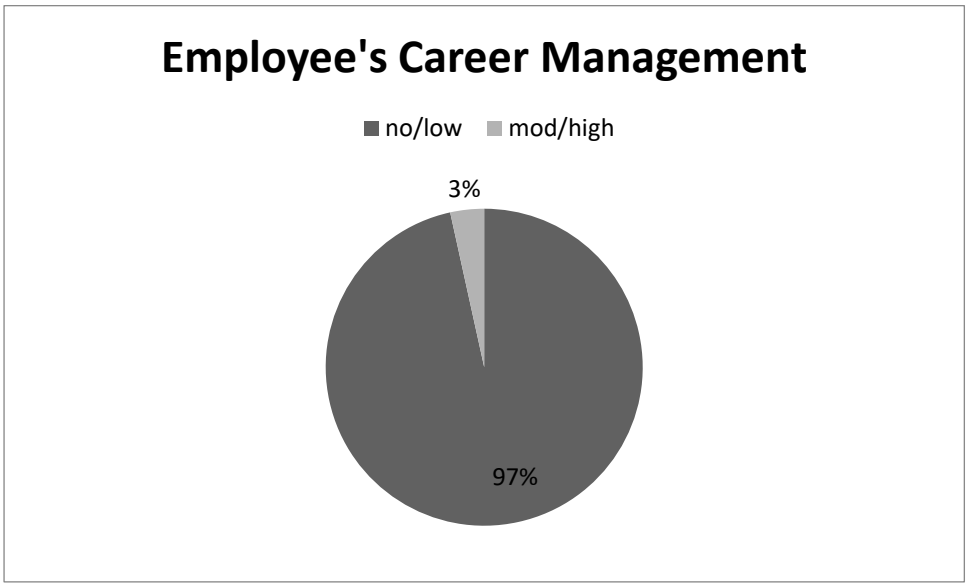
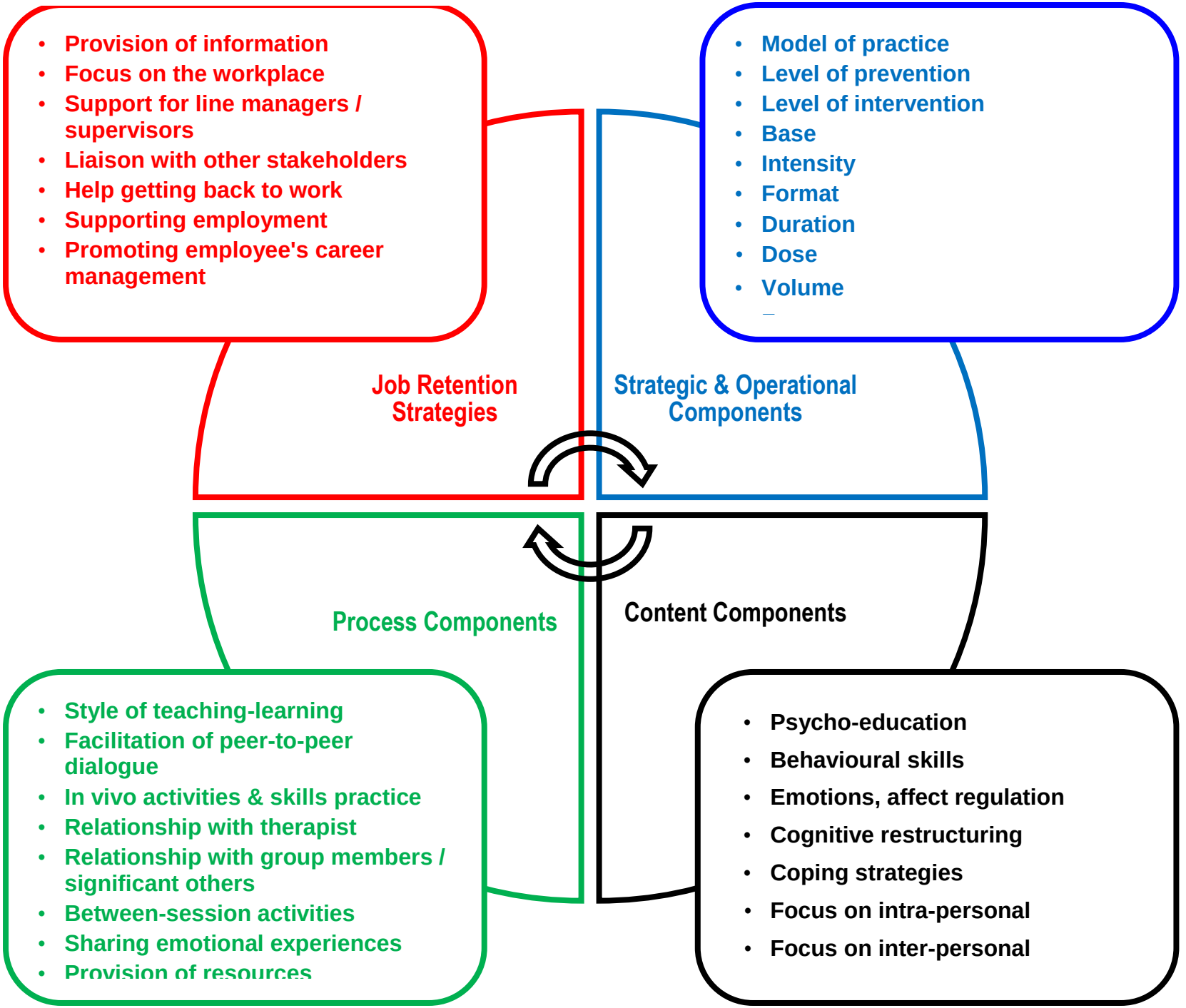


Figure 22 – Employee's career management

It can be seen that only 3% of the programmes make moderate or high use of a specific focus on promoting employees' career management. One plausible explanation for how much to use this job retention strategy and how it might act to enhance job retention for employees with moderate-severe recurrent depression is that symptomatic individuals need help to adjust to organisational change in order to achieve positive clinical and work outcomes. Another explanation is that symptomatic individuals need help to improve their willingness to learn new knowledge, skills and attitudes as they get older. On the other hand 97% of programmes make no or low use of a specific focus on promoting employees' career management. This suggests that the majority of programme designers believe this might be an unnecessary or an unhelpful component, or that they are ignorant of its potential as a mechanism of change.



APPENDIX 22: COMPONENTS OF THE NEW INTERVENTION

APPENDIX 23: THEORETICAL INTEGRATION

23.1 OCCUPATIONAL STRESS THEORIES

23.1.1 Effort-Reward Imbalance model

The "effort-reward imbalance" model (Siegrist 1996) is based on evidence that jobs requiring high effort with low rewards predict strong negative emotions, and if sustained, also predict increased neuroendocrine and autonomic arousal which is linked with poor long-term physical and mental health. When the effort required at work, in relation to factors such as number of hours, shift patterns, unsocial hours, workload, or time pressures, is perceived as more than the reward, in relation to factors such as pay and perks, job security, job satisfaction, or career advancement, employees may become distressed.

One intervention (Limm et al. 2011) was underpinned by the Effort-Reward Imbalance model. The intervention provided training in a group format to help employees recognise factors such as high effort with low rewards in their jobs and how "to deal with them in a constructive manner" (p127), and thus appeared to focus on the empowerment of employees and enhancement of social networks between them, thereby giving them the confidence and wherewithal to negotiate as a collective, to influence their environments, to improve their working conditions, and ultimately to achieve an effort-reward rebalance. Interestingly, this intervention is one of the few primary preventative programmes also underpinned by psychodynamic theory (see below).

23.1.2 Person-Environment Fit model

The "person-environment (P-E) fit" model (Caplan 1983) is based on evidence that jobs not suiting individual employees' skills, abilities, experience, ambitions or needs are more likely to be associated with occupational stress. There are two types of misfit: when the perceived demands of the job exceed the employee's abilities, and / or the employee's needs exceed the perceived environment's supplies.

One intervention (Vuori et al. 2012) was underpinned by the Person-Environment Fit model. The intervention provided elements of career guidance to help clients rethink their vocational choices in unpredictable work environments, and thus appeared to focus on changing workers' subjective evaluation of their job and changing their attitudes towards their work. This might lead to changing their objective evaluation of P-E fit through redeployment or retraining (as opposed to retirement through ill health) resulting in better "correspondence".

23.1.3 High Demands-Low Control-Low Support model

The "job demand-control-support" (JDCS) model (Johnson, J.V. and Hall 1988) is based on evidence that several factors in the workplace can cause stress and predict emotional problems in employees (Health and Safety Executive 2012; OECD 2012). These factors include high demands such as heavy workload, responsibility for others as a supervisor or manager, or jobs with a lot of pressure or intensification; low control such as little decision latitude, a lack of autonomy or personal discretion, and low support such as a lack of resources required to do the job, low levels of social support from supervisors and co-workers or working in isolation.

23.1.4 Demand-Support-Constraint model

The "demand-support-constraint model (Payne, R. and Fletcher 1983) is similar to the JDCS model but emphasises how high constraints (which is the opposite of high support) can cause stress. This is associated with a line manager or supervisor is perceived as a hindrance rather than a help, and limits what the worker can do via micromanagement leading to low demands and under-utilisation of an employee's skills. Other sources of stress include role ambiguity or role conflict that tends to occur in the context of poor management.

23.1.5 Job strain model

The "job strain" model (Karasek Jr 1979) is based on evidence that certain objective characteristics of the job such as monotonous work requiring few technical or interpersonal skills, unpredictable work with tight deadlines requiring more technical or interpersonal skills, low task significance, or a lack of feedback on performance cause stress especially if there are not sufficient job satisfaction or sense of belonging to off-set these demands. This model proposes that certain "passive" jobs reduce the employee's ability to make judgements, solve problems and tackle challenges, in contrast to "active" jobs which develop and reinforce these skills leading to improved resilience, self-efficacy and enhanced mental health.

23.1.6 Over-Commitment model

The Over-Commitment model (Siegrist 2004) is based on evidence that employees with predisposing cognitive-motivational traits, and maladaptive coping styles characterised by a need for approval, an inability to withdraw from obligations, and an excessive striving to achieve may have distorted perceptions and over-high expectations with regard to their own resources, and the cost-benefit value of work. These individual factors eventually cause distress even in the absence of the organisational factors outlined above.

One intervention (van Oostrom et al. 2010) was underpinned by *core theoretical concepts* derived from several of these models. The intervention used a participatory approach to activate sick-listed employees' problem-solving skills, and thus expedite their return-to-work. In addition,

feedback was given to employees about the stressors present in the workplace, and they then identified goals and agreed action plans to tackle these stressors. A return-to-work coordinator facilitated a meeting between employees and their line managers to agree negotiated adjustments to the work environment. In this way employees contributed to individual and organisational change such as uptake of supports, team functioning, and job re-design.

23.1.7 The Burnout model

The causal model of burnout (Maslach 1978) is based on evidence that chronic interpersonal difficulties in the workplace predict a range of psychological effects such as feeling emotionally exhausted, feeling cynical about work with a sense of demotivation, detachment and disengagement, and feeling ineffective in one's occupational role.

One intervention (Stenlund et al. 2009) was underpinned by occupational stress theories in general, but focused on employees who were on LTSA due to burnout. The intervention used principles of intensive rehabilitation to encourage employees to return-to-work. Interestingly, although this multi-modal intervention was focused on burnout, it did not seem to have an explicit theory of change related to that model in terms of improving relationships with line managers and / or colleagues. It is one of several tertiary preventative programmes also underpinned by cognitive behavioural theory (see below).

23.1.8 Organisation Injustice models

The "procedural or relational injustice" model (Vermunt, R., and Steensma 2001) and "equity theory" (Adams 1965) are based on evidence that jobs affected by perceived management unfairness i.e. employees being treated differently and inconsistently, or employees being treated disrespectfully or inconsiderately, predict adverse health outcomes (Elovainio et al. 2006; Kivimäki et al. 2007). Employees who believe that they are not being paid enough or that other employees are being treated more favourably for example, may respond by reducing their productivity and / or the quality of their work by going off sick, arriving late, leaving early, and wasting time for example.

One intervention (Tsutsumi et al. 2009b) was underpinned by occupational stress theories in general but with a specific focus on organisational injustice. The main causal mechanisms in terms of *why* this intervention was supposed to work were elicited by reading between the lines. The intervention used a participatory approach to involve and empower employees to contribute to organisational change such as environmental improvements as a way of breaking the cycle of apathy and alienation. The intervention also trained supervisors in the sources of occupational stress and poor mental health as a way of promoting greater democracy, equality and impartiality in organisations via supervisors' more positive behaviour and attitudes.

23.2 PSYCHOLOGICAL THEORIES

23.2.1 Cognitive and Behavioural

Several interventions (Eriksen et al. 2002; Lexis et al. 2011; Schoenbaum et al. 2002; Wang et al. 2007; Bonde et al. 2005; de Vente et al. 2008a; Willert et al. 2009; Blonk et al. 2006a; Stenlund et al. 2009) had a central cognitive component based on Cognitive Theory (Beck 1976), Coping Process Theory (Chan 1993), Rational Emotive Behavior Therapy (Ellis 2004), or the Transactional Model of Stress and Coping (Lazarus 1966). These interventions used established therapeutic techniques to promote knowledge about stress, mental health and / or depression, attitude change, cognitive re-appraisal, cognitive re-structuring especially in terms of illness beliefs and the "sick role", problem-solving, and goal-setting. Most emphasised coping skills which have been shown to play "a mediational role between the impact of environmental stressors and cognitive, emotional, physiological and behavioural outcomes" (Jones and Johnston 2000).

Several other interventions (Van Der Klink et al. 2003; Bakker et al. 2007; Rebergen et al. 2009; Blonk et al. 2006a) had a central behavioural component based on Learning Theory (Skinner 1965), or Functional Contextualism (Gifford, E. V., & Hayes 1999), whereby a reduction in work-related stress depends on behavioural activation, activity scheduling, reduction in avoidance behaviours and negative reinforcement, increase in approach behaviours and positive reinforcement, exposure and systematic desensitisation of feared stimulus i.e. the work situation.

Across these studies, the main causal mechanisms in terms of *why* these interventions are supposed to work appear to have been taken for granted. Broadly they aim for more adaptive patterns of thinking and behaviour although few studies investigated what variables mediated the relationship between better cognitive and behavioural functioning and improved clinical and work outcomes. It has been shown that evidence-based psychotherapy (CBT) and pharmacotherapy are both associated with a reduction in depressive symptoms mediated by interpersonal factors such as an increase in perceived social support (Dour et al. 2014) or involvement in decision-making (Clever et al. 2006). Therefore the actual mechanisms of change are unclear.

23.2.2 Affect Regulation

Two interventions were underpinned by Affect Regulation Theory (Takao et al. 2006; Limm et al. 2011) which proposes that distress is due to an intolerance of, or an inability to manage, one's emotions either alone or in relationship with others (i.e. co-regulation). One intervention (Takao et al. 2006) involved training line managers to recognise signs of work-related stress and training them in counselling skills. The other intervention (Limm et al. 2011) used a group format to provide opportunities for employees to talk together about their distressing experiences, to ventilate their emotions, and to empathise with each other. In the former, improvements in

supervisors' relational capacity, and in the latter, sharing one's feelings and being listened to non-judgementally, are thought to help to reduce employees' distress, leading to enhanced commitment, performance and motivation.

23.2.3 Psychodynamic

Four interventions (Knekt et al. 2008; Burnand et al. 2002; Limm et al. 2011) were underpinned by Psychodynamic Theory (Freud 1923, 1937), by which presenting symptoms of depression are seen as expressions of latent unconscious intra-psychic conflicts, perhaps manifesting as interpersonal problems in the workplace.

One short-term intervention Burnand et al. 2002) used an exploratory approach based on the principles of psychodynamic psychotherapy (Luborsky 1984) and relational psychotherapy to help clients understand and make links between their attachment experiences in childhood and how they perceive and make sense of current interpersonal encounters at work and at home, as well as in idealising or denigrating transference responses towards, and phantasies about, the therapist. (Safran, J.D. and Muran 2000)

Another short-term intervention (Limm et al. 2011) used CBT techniques integrated with Psychodynamic Theory to understand how unacknowledged interpersonal conflicts in the workplace may result in repressed or suppressed emotion. This creates internal stress which is then projected onto colleagues and managers.

One medium-term intervention (Knekt et al. 2008) used an exploratory approach based on the principles of brief focal therapy (Malan 1979) in a similar way to the processes outlined above but with more emphasis on the confrontation of unconscious defences, clarification, interpretation, and management of resistances, ruptures and impasses in the therapeutic relationship.

One long-term intervention (Knekt et al. 2008) used a exploratory approach based on the principles of long-term psychodynamic psychotherapy (Gabbard 2004) whereby therapist abstinence induces a regression to early and pre-verbal experiences. This provides an opportunity for limited re-parenting or a "corrective emotional experience" (Gabbard 1999). Similarly, firm and consistent boundaries elicit repressed feelings in relation to self / others / the therapist, which are "worked through" (i.e. made conscious) to bring about structural change of the mind i.e. more integration between id, ego and superego.

Across these studies, the main causal mechanisms in terms of *why* these interventions are supposed to work appear to have been taken for granted. Broadly they aim for insight and an emotional experience termed "mourning" whereby the client grieves for the past and faces the future with greater tolerance, understanding and self acceptance.

23.2.4 Positive Psychology

Four interventions (Duijts2007; Nystuen & Hagen 2006; Knekt et al. 2008; Vuori et al. 2012) were underpinned by Positive Psychology Theory (Seligman et al. 2005) which proposes that human beings are motivated by the need for positive emotions, good relationships, creativity, challenge, a sense of purpose and accomplishments for example. Positive Psychology emphasises quality of life and happiness as in the recovery model of wellbeing, in contrast to the emphasis on "cure" in the medical model of illness. The Individual Placement and Support (IPS) approach is broadly based on principles of Positive Psychology.

One intervention (Duijts 2007) used a coaching approach with employees who had been identified as at risk for future sickness absence due to stress. This intervention involved joint meetings between the employee and supervisor facilitated by the coach to discuss objectives for the employee and the organisation. Subsequent 1:1 sessions were about setting and monitoring progress towards these goals.

Two interventions (Nystuen & Hagen 2006; Knekt et al. 2008) used Solution Focused Brief Therapy which incorporates similar constructs to Positive Psychology in designing treatment programmes. These interventions aimed to respect the individual's strengths, capabilities and wisdom by using an impartial and enabling approach in contrast to interventions which focus on pathology and tend to use a potentially stigmatising and disabling approach. Positive emotions "broaden and build" (Fredrickson, B.L. 1998), and act as catalysts for self-esteem, personal growth and connectedness with others.

Another intervention (Vuori et al. 2012) used a construct derived from Positive Psychology called "resilience", defined as the ability to cope with adversity. Some employees do not sustain their careers into late middle age, and frequently retire early or leave work permanently on long-term sickness absence due to burnout or mental health problems. In many cases employees' work-related decisions are influenced by automatic stress reactions evoked by organisational change such as down-sizing, re-structuring, and the need to adapt to new tasks, roles and responsibilities. The intervention encouraged employees to adopt a growth mindset such that they reframe stressful events and problems as challenges to be overcome, and reframe "failure" is a necessary step towards "success", especially in relation to work. The intervention promoted coping, optimism, life-long learning and self-efficacy. Path analysis showed that career preparedness, which is the confidence to achieve what you want in your working life even when things go wrong, mediated the effect of the intervention on depression and burnout.

Across these studies, the main causal mechanisms in terms of *why* these interventions are supposed to work were elicited by reading between the lines. By redefining an individual as

resilient, resourceful and responsible rather than focusing on their problems, deficits and symptoms, provides a new personal narrative and a new identity.

23.3 SOCIAL / INTERPERSONAL THEORIES

23.3.1 Social Cognitive Theory

Social Cognitive Theory (Bandura 1986) proposes that people can learn and adapt when they have a sense of personal agency. A process of mutual influence or reciprocal determinism means the employee is viewed as both the product and the producer of his or her environment. However opportunity, aspiration and motivation are also vital in how proactive and how engaged employees are in "making things happen" in the workplace, and in their own personal and professional development. These ideas were applied in defining "career management preparedness" (Vuori et al. 2012).

Another intervention (Van Oostrom et al. 2010) also cites the construct of self-efficacy in formulating difficulties in work resumption. Negative social pressure or a perceived loss of control in the return-to-work process may influence employees' expectations about work resumption. These expectations shape their intentions and motivation, and thus their behaviour.

Across these studies, the main causal mechanisms in terms of *why* these interventions are supposed to work were elicited by reading between the lines. Employees are likely to be more engaged if they believe they are in charge of their (working) lives and that they can make their own minds up about what to do.

23.3.2 Interpersonal Theory of Depression

The Interpersonal Theory of Depression (Coyne, 1976; Joiner & Metalsky, 1995) is based on evidence that behavioural patterns commonly seen in depressed people, for instance excessive reassurance-seeking (ERS) and negative feedback-seeking (NFS), elicit behavioural patterns in their significant others such as expressing impatience, withdrawing, criticising, or become controlling. These relationship dynamics serve to perpetuate and exacerbate depression resulting in relapse and recurrence.

One intervention (Schoenbaum et al. 2002) had a section on improving interpersonal awareness and social skills such as assertiveness thereby generating reciprocally positive and supportive responses from others. Increasing employee's confidence and ability to relate positively allows them greater access to sources of emotional support.

23.3.3 Social Problem-Solving

Three interventions (Vlasveld et al. 2012; Brouwers et al. 2006; Lexis et al. 2011) were informed by the Social Problem-Solving model (D'Zurilla et al. 2004) from which Problem-Solving Therapy arose. Problems are defined as:

> *Anything "that might affect a person's functioning, including impersonal problems (e.g., insufficient finances, stolen property), personal or intrapersonal problems (emotional, behavioral, cognitive, or health problems), interpersonal problems (e.g., marital conflicts, family disputes), as well as broader community and societal problems (e.g., crime, racial discrimination)" p.11.*

The theory proposes that problems are the result of dysfunctional responses to internal or external demands which in turn leads to maladaptive functioning manifested as symptoms of anxiety and depression for example. These interventions instructed clients in the problem-solving method which helps them to discover different ways that they might either change the problematic situation, change how they respond to the problem, or change how they cope with the situation, then to choose and implement the best solution/s. This might involve removing obstacles and barriers that have prevented them from dealing with the situation effectively. Routine application of the problem-solving method reduces emotional distress that the problem typically produces.

Across these studies, the main causal mechanisms in terms of *why* these interventions are supposed to work were articulated in a hypothesis. Depression is more likely to be resolved by dealing directly with the issues that have caused work-related or home-related stress rather than avoiding them.

23.4 BIO-MEDICAL THEORIES

23.4.1 Physiology of Stress

The "physiology of stress" theory (Selye 1950) is based on evidence that strain or burnout is due to difficulties in regulating the autonomic nervous system when stress triggers the hardwired threat system. Several interventions (Blonk et al. 2006; Eriksen et al. 2002; de Vente et al. 2008; Stenlund et al. 2009) incorporated relaxation therapy, autogenic training, meditation, healthy nutrition and exercise as major components in order to teach employees how to reduce and control psycho-physiological arousal. It may be that the synergistic effect of these physical interventions helps employees feel physically calm and psychologically safe.

APPENDIX 24: EXPLANATORY FRAMEWORKS

What are the *core theoretical concepts* of different psychotherapeutic interventions that explain *why* they might work to enhance job retention in employees with moderate-severe recurrent depression?

24.1 MECHANISMS OF CHANGE

Evaluations that focus on outcomes alone do not provide sufficient information for policy makers, commissioners or clinicians about the future potential of implementing any intervention in the real world. Programme designers should provide detailed information to aid decision-makers about strategic components such as model of practice, level of prevention and level of intervention, and operational components such as intensity, duration, dose, volume, frequency, format, or content and process components. Doing so also improves knowledge translation in healthcare sciences. It is especially important to identify mechanisms of change because these may have unintended or 'surprising side effects', and to identify key ingredients without which the intervention would be unlikely to achieve its specified outcomes (Sutcliffe et al. 2015).

This review has been undertaken in an attempt to find out 'what works for whom in what circumstances and in what respects, and how?' (Pawson, R. and Tilley, 2004 p.2). The realist evaluation approach is based on specifying an intervention's 'mechanism, context and outcome pattern configurations', in other words, what is in the 'black box'. This process is intended to improve replication and implementation in practice, and should improve the experience of participating in interventions for both practitioners and clients.

The term 'mechanism' refers to a change-inducing measure by which the intervention has a particular outcome in a particular context.

The term 'context' refers to the particular conditions, at the individual, organisational, and societal levels for example, necessary for the intervention (or one of its components) to activate the particular mechanism in order to produce particular outcomes patterns.

The term 'outcomes patterns' refers to the actual effects generated by causal mechanisms in particular contexts (Tilley, 1998 p.145). Pawson & Tilley (2004 p.2) explain:

> *Programmes are thus shaped by a vision of change and they succeed or fail according to the veracity of that vision. Evaluation, by these lights, has the task of testing out the underlying programme theories. When one evaluates realistically one always returns to the core theories about how a programme is supposed to*

work and then interrogates it - is that basic plan sound, plausible, durable, practical and, above all, valid?

It can be seen that when a study has a clear hypothesis based on a theory underpinning the intervention's proposed mechanism of change, it is possible, when the hypothesis is not upheld or when there are adverse outcomes, to decide whether there has been a programme theory failure or a programme implementation failure. However, even when explicit explanations are spelled out, it is often necessary to 'mine' the document by looking 'below the surface' to elucidate the designers' implicit assumptions about human behaviour which informed *why* they did *what* they did and *how* they did it. Reconstructing programme theory (Leeuw 2003) often requires careful reading between the lines when only documentary data is available. It is also necessary to look for confirmatory as well as contradictory data before proposing how existing *core theoretical concepts* could be merged and refined.

The 24 included studies were reviewed using RS methodology to establish whether an explanatory framework has been used in the design of the intervention. The process began with immersion in the data by reading, re-reading, annotating, collating and mapping descriptions of interventions provided in each article as well as in any foundational texts cited which explained *why* the intervention was supposed to work (Pawson 2006). Data extraction forms (Appendix 25) which were partially populated in Section two were used to help the researcher locate, integrate, compare and contrast empirical evidence relating to the theoretical concepts underpinning the design of the intervention/s being evaluated (Pawson et al. 2004).

24.2 THEORETICAL UNDERPINNINGS

This review provides a brief overview of theories underpinning different interventions. Each theory, and how it was applied in practice, was mined to find out what programme designers believed might influence employees' choices about whether to stay-at-work or return-to-work, particularly in terms of reasoning, reactions and resources.

Four broad theories were identified: occupational stress, psychological, social / inter-personal, and bio-medical, and these comprised several mid-range theories which are described in appendix.

24.3 ELICITATION CYCLES

Candidate mechanisms were elicited by looking for plausible explanations in conceptually 'rich' and conceptually 'thick' accounts (Ritzer 1991) of the full range of interventions. These were then subject to an iterative process of discussion, dialogue and debate with experts in psychotherapy and vocational rehabilitation, which culminated in probable mechanisms

framework #3 which will be integrated with frameworks #1 and #2. Further elaboration and refinement of both the intervention design and the programme theory will take place in the stakeholder consultation stage of this research.

Mechanisms are decision-making processes which are not directly visible or knowable, and may be unarticulated or unconscious. Therefore, creative speculation and conjecture is used to identify any plausible 'candidate explanations'. How these mechanisms were codified and mapped is presented in Appendix 48.

APPENDIX 25: DATA EXTRACTION FORMS REALIST SYNTHESIS

Table 74 – Work-focused mechanisms

Full reference			
THEORY AREA 1: **Work-focused mechanisms**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

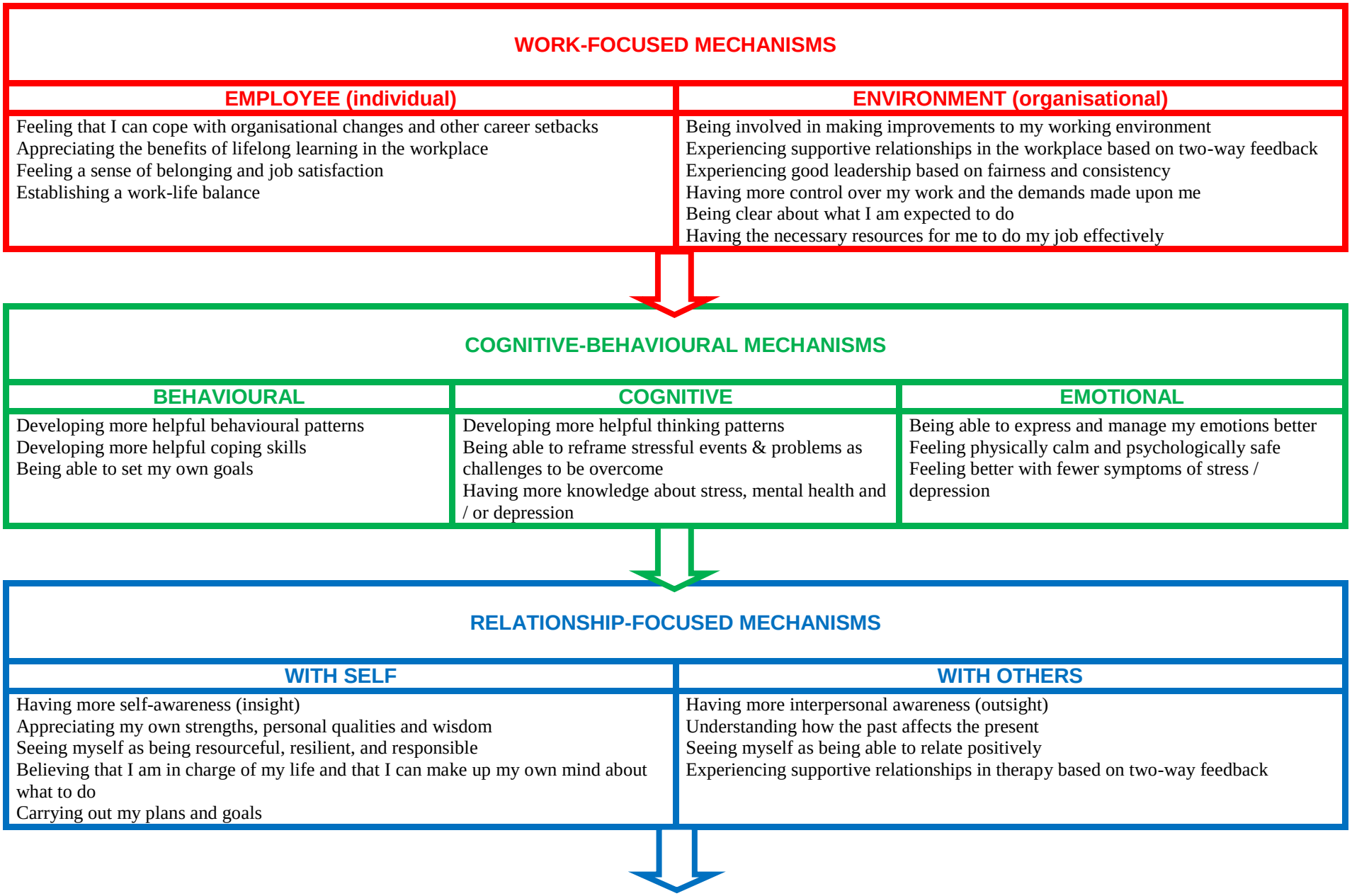
Table 75 – Cognitive behavioural mechanisms

Full reference			
THEORY AREA 2: **Cognitive-behavioural mechanisms**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

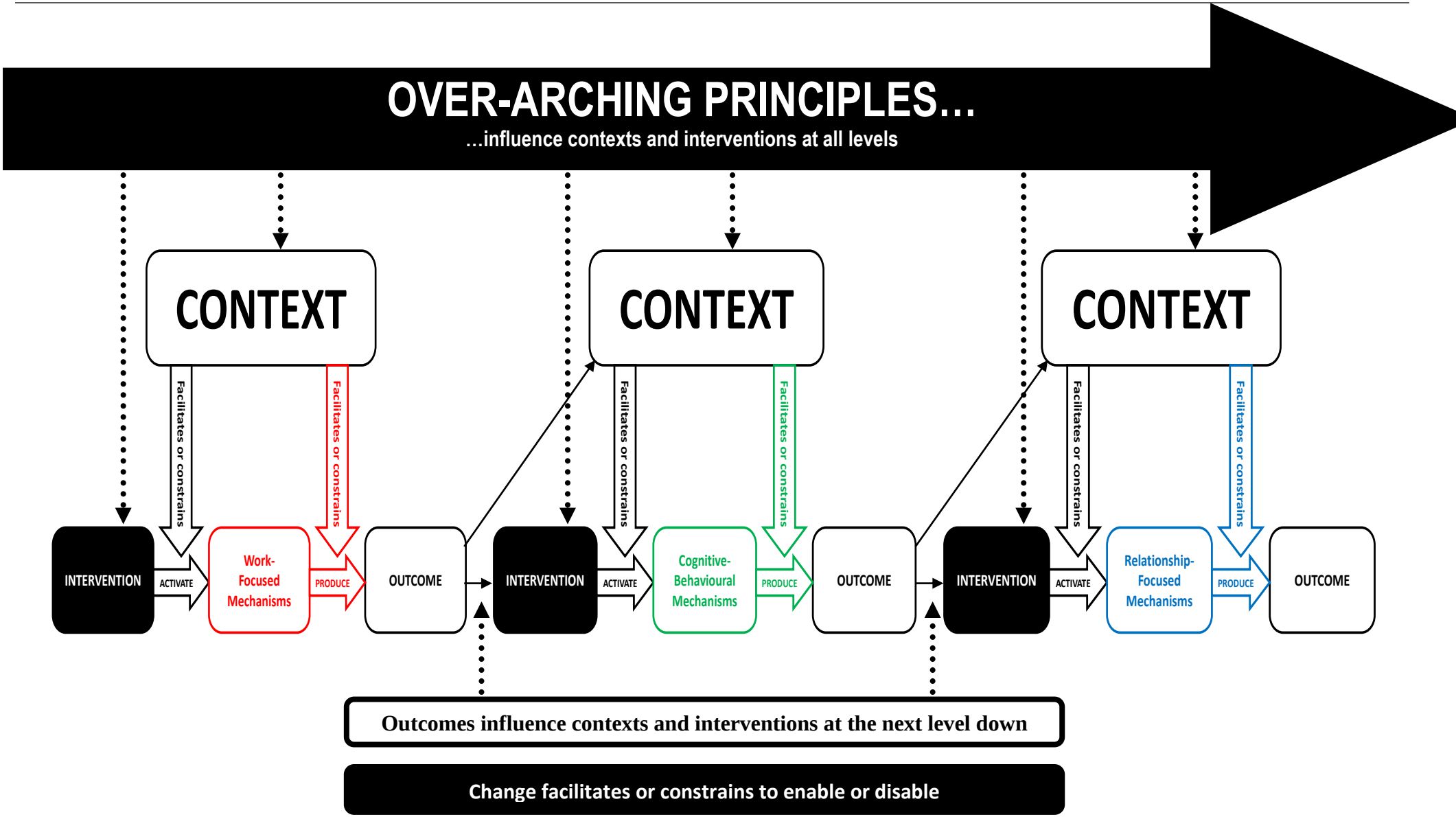
Table 76 – Relationship-focused mechanisms

Full reference			
THEORY AREA 3: **Relationship-focused mechanisms**			
Context	**Intervention**	**(Probable) Mechanism**	**Outcome**
Who? Whom? Where? When? Which circumstances?	What? How?	Why?	Work status? Clinical status?
Is this meaningful?			

Figure 23 – Plausible mechanisms



APPENDIX 26: POSSIBLE CONTEXT-INTERVENTION-MECHANISM-OUTCOME (CIMO) CONFIGURATIONS



APPENDIX 27: THEORY OF CHANGE DIAGRAM

Hypothesis or theory of change: The Interpersonal Theory of Depression:

Maladaptive personal and interpersonal coping styles commonly observed in people with depression cause stress in relationships with significant others. This often leads to the perpetuation of a stress-inducing dynamic in terms of communication and interaction between them, which results in relapse or recurrence in people with depression, and possible sickness absence and job loss.

IF

THEN

INPUTS critical to supply	ACTIVITIES critical to quality	OUTPUTS critical to delivery	OUTCOME / IMPACTS critical to success
Initially a CBT group psychotherapist and Occupational Therapist trained to deliver training programme. Ultimately voluntary Peer Facilitators will be trained to deliver training programme using a 'training the trainer' approach.	Monthly four session trauma-informed educational / experiential workshop sessions. Monthly / bi-monthly structured peer-led staff support groups. Quality assurance processes in place.	Appropriate administrative systems for new staff induction, accepting self-referrals, monitoring outcomes, as well as adequate accommodation, and other necessary resources for offering a training programme. More relational leadership and management via collaborative relationships in the organisation.	Employees with moderate-severe recurrent depression will be able to stay at work and cope more adaptively with their symptoms. Employees in stressful occupations will be able to stay at work and cope more adaptively with their symptoms.

ASSUMPTIONS
critical to viability

If employees with moderate-severe recurrent depression improve their interaction and communication patterns via peer-learning, peer-feedback and peer-support in a group format, then they will strengthen their relationships and social support networks at home and at work. These changes will act as a preventive factor against relapse and recurrence, a protective factor against inter-personal distress, and a promotive factor in improving quality of life and self-efficacy. Relationship problems are addressed through the facilitation of high quality peer interaction and the art of 'good conversation' which has the purpose not just of social bonding or group cohesion, but of cognitive restructuring, problem-solving, behavioural activation, and emotional co-regulation.

Appendix 27 - The Theory of Change for the new Training (and staff support) Programme (ref: www.midlandsandlancashirecsu.nhs.uk, 2016)

APPENDIX 28: CASE VIGNETTES

Table 77 – Clients in summary

CLIENT	Physical health	Medication	Skilled unskilled etc.	Baseline	Married single etc.	Housing	Children or not	Work stress	Positive clinical	Follow up data	Positive work	Accessed OT
Mandy	GRED Chronic pain	NONE	Unskilled Unemployed	LTSA Depression	LT lesbian cohabiting	Private landlord	Childless	red-red	SEV- MILD	REL	Still unemployed	NO
Jill	Morbid obese	NONE	Skilled Full-time	LTSA Depression	LT hetero married	Owner- occupier	1 young daughter	red-blue	SEV- MILD	REM	Return-to- work	YES
Christine	Severe asthma Chronic pain	ADM	Semi-skilled Part-time	LTSA Depression	LT hetero married	Owner- occupier	2 young sons	red-red	SEV- MILD	REM	Became self- employed	YES
Harriet	Freq infections	NONE	Unskilled Part-time	STSA Physical	LT hetero married	Owner- occupier	Childless	green-green	SEV- MILD	NO	Still at work	YES
Paula	Significantly underweight	ADM	Unskilled Full-time	At work	Single hetero	Private landlord	Childless	red-yellow	SEV- SEV	SEV	Became LTSA	NO
Annabel	Morbid obese Chronic pain	ADM	Skilled Voluntary work	Looking for work	LT hetero married	Owner- occupier	Childless	red-green	MILD- REM	REM	Found employment	YES
Betty	Undiagnosed Chronic pain	ADM	Unskilled Full-time	At work	LT hetero cohabiting	Owner- occupier	2 adult sons	red-red	SEV- MOD	NO	Still at work	YES
Naomi	Freq skin rashes	ADM	Skilled Part-time	STSA Physical	LT hetero married	Owner- occupier	3 young sons	red-red	SEV- REM	NO	Return-to- work	NO

A brief clinical vignette is presented here for each participant to give context and depth to the quantitative data.

28.1 BIOGRAPHICAL INFORMATION: MANDY

28.1.1. PAST HISTORY

Mandy's emotional needs were unmet throughout her early life. Her childhood experience included harsh discipline, chaotic and neglectful parenting. She described being treated like a slave.

Mandy's younger brother died in a road traffic accident when she was 11 years old. Her grief was never recognised or validated.

Mandy was sexually abused by her step-father between ages 13-16 years old.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Mandy relates to herself and to people from whom she needs affection and approval.

28.1.2 CURRENT STRESSORS

Triggers include conflict in relationship and fear of abandonment (especially with her partner, Rebecca). A recent traumatic incident when Rebecca took an overdose activated feelings of intense insecurity.

Mandy tends to respond to interpersonal threats by making catastrophic misinterpretations which escalate her feelings of anxiety and anger ultimately leading to panic and dissociation. In the past she misused alcohol to block awareness of distress but has now been abstinent for over 5 years. Triggers may be out-of-awareness such as the smell of alcohol which may be associated with childhood sexual abuse.

28.1.3 HOME

Mandy has lived with Rebecca for 3 years. They have a volatile relationship and Mandy thinks Rebecca drinks too much. However Rebecca denies this saying that she thinks Mandy just resents her going out after work for a drink.

28.1.4 WORK

Mandy was dismissed from her job as an unskilled caterer while off sick and on the waiting list for psychological therapies. She is taking part in The Work Programme to find a job.

28.1.5 LEISURE/SOCIAL

Mandy has few leisure interests and does not go out much due to anxiety in public places. Mandy has become dependent on Rebecca for company as she has few friends.

28.1.6 PHYSICAL HEALTH

Mandy has been diagnosed with gastro-oesophageal reflux disease which causes symptoms of heartburn and reflux.

Table 78 - Mandy 031

DEMOGRAPHIC INFORMATION					
Gender	FEMALE				
Age	40				
Number of children at home	None				
Ethnic group	White-British				
Marital status	Co-habiting (long-term female partner)				
Accommodation	Private landlord				
Employment	Unemployed (previously **unqualified unskilled** pub cook)				
Welfare benefits	Employment Support Allowance (on the Work Programme)				
Psychotropic medication at baseline	None				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	77 (MOD)	77	47	34	70
BDI-II:	36 (SEV)		30	16 (MILD) 55.5%	32 (SEV)
CSES:		29 unhealthy		115 unhealthy	74
EQ-5D:		11212		11212	
EQ VAS:		33		60	
IIP-32:		68 (caseness)		65 (caseness)	
W&SAS:		15.5		16.5	
HSE:		80 2.29 (red)		81 2.31 (red)	
HAM-D:		24 (VSEV)			

28.2 BIOGRAPHICAL INFORMATION: JILL

28.2.1 PAST HISTORY

Jill believes that as the youngest child in the family her feelings and opinions were often ignored. She remembers getting the blame unjustly whereas her sister escaped punishment and there is an ongoing sense of being wronged.

Jill's mother withdrew if Jill expressed any negative emotions. Even now her mother tends to sulk if Jill expresses any feelings. On-going invalidation and fear of upsetting her mother has led Jill to hide her distress and put on a brave face.

Jill felt she had to do what she was told and never really questioned her mother's 'emotional blackmail'. Jill believed that she was not allowed to have 'a mind of my own'. Unmet needs in childhood may have been externalised in shyness, fussy eating, bingeing, nail biting.

Jill's first husband was controlling and she felt she had to defer to him and conform to his wishes.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Jill relates to herself and to people from whom she needs affection and approval.

28.2.2 CURRENT STRESSORS

Triggers include perceived criticism at home and at work, especially when Jill's mother makes judgmental comments. Jill tends to respond to interpersonal threats by trying harder to be perfect which manifests as over-commitment in work roles.

28.2.3 HOME

Jill has a young daughter whose demands for attention can be irritating sometimes. Jill tries to suppress her feelings but when she snaps at her daughter she feels very guilty as Jill does not want to be like her mother.

Jill tends to isolate herself if she is feeling 'moody' but this makes her Graham (husband) feel pushed away.

28.2.4 WORK

Jill has been made redundant many times throughout her career and although working she is paid 50% less than she was and have lost the role that she had worked hard for and found rewarding. Jill's current job requires her to commute to Manchester which adds hours to her working day.

28.2.5 LEISURE/SOCIAL

Jill and Graham met through a shared love of motorcycles but Jill has noticed a reduced interest in previously pleasurable activities. Jill has become dependent on Graham for company as she has few friends.

28.2.6 PHYSICAL HEALTH

Jill is morbidly obese and admits during the course that she has a 'sugar addiction'.

Table 79 – Jill 032

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	45				
Number of children at home	1 daughter (aged 8)				
Ethnic group	White-British				
Marital status	Married				
Accommodation	Owner-occupier				
Employment	Off sick from full-time **professionally qualified skilled** Human Resources Business Partner				
Welfare benefits	None				
Psychotropic medication at baseline	None				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	74 (MOD)	78	91	19	5
BDI-II:	36 (SEV)		40	16 (MILD)	2 (REM)
CSES:		118 unhealthy		184 healthy	223
EQ-5D:		12313		11221	
EQ VAS:		20		25	
IIP-32:		49 (non-caseness)		50 (non-caseness)	
W&SAS:		25		16	
HSE:		109 3.11(red)		126 3.6 (blue)	
HAM-D:		33 (VSEV)	20 (SEV)	19 (SEV)	

28.3 BIOGRAPHICAL INFORMATION: CHRISTINE

28.3.1 PAST HISTORY

Christine's early childhood was characterised by parental conflict, which led to talk of divorce when mother found out that father had been having an affair, but ultimately they stayed unhappily together. Christine describes her mother as 'cold' and 'not maternal'. Christine was verbally abused and disciplined harshly by mother, and Christine felt she was expected to be seen and not heard. She was sent to her room as punishment spending many hours on her own.

Christine's emotional needs were mostly unmet in childhood. She had no siblings but was not allowed to go out to play after school or have friends at home. She was not invited to many parties and this has perhaps resulted in a sense of loneliness and estrangement from people around her.

Christine was sexually abused over a period of months in her teenage years by her father who she describes as 'emotionally unavailable' and 'sleazy'.

However Christine had a loving relationship with her paternal grandparents which gave her a vital source of self-esteem. When her grandparents died 10 years and 6 years ago she did not get to say, 'Goodbye' and Christine regrets this and blames herself.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Christine relates to herself and to people with power over her.

28.3.2 CURRENT STRESSORS

Triggers include perceived criticism at home and at work. Christine's parents are still very judgemental of her and this causes anxiety and low mood. Christine also finds her mother-in-law who she describes mother-in-law as intrusive, highly critical and domineering, and finds her an 'extremely difficult character' to get on with.

Christine and James (husband) are under financial pressure at the moment due to James losing his well-paid job 4 years ago. They may have to sell their home if they cannot increase their income. James has found a job but now spends more time commuting. Both of them are working long hours and Christine carries out most of the domestic and childcare responsibilities.

Christine tends to respond to interpersonal threats by isolating herself and regularly misuses alcohol and sometimes takes over-doses to block awareness of her distress.

28.3.3 HOME

Christine's relationship with her eldest son is 'challenging' as he reaches adolescence and she feels he is 'constantly pushing me'.

28.3.4 WORK

Christine works part-time as a doctor's receptionist but has been off sick for several weeks due to stress. She also works self-employed in her own shop but this is not very profitable. James asked his mother to help out in the shop but this is actually more stressful for Christine as they do not get on.

28.3.5 LEISURE/SOCIAL

Christine has become dependent on James for company as she has few friends.

28.3.6 PHYSICAL HEALTH

Christine has severe asthma. Also since a riding accident 19 years ago she experiences chronic pain which is often difficult to cope with.

Table 80 – Christine 033

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	41				
Number of children at home	2 sons (aged 10 and 13)				
Ethnic group	White-British				
Marital status	Married				
Accommodation	Owner-occupier				
Employment	Off sick from part-time **semi-skilled** NHS GP receptionist Self-employed gift shop owner				
Welfare benefits	None				
Psychotropic medication at baseline	Citalopram 40mgs daily, Zopiclone 75mgs daily				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	88 (SEV)	67	71	61	32
BDI-II:	34 (SEV)		23	16 (MILD)	12 (REM)
CSES:		78 unhealthy		115 unhealthy	143
EQ-5D:		11222		11222	
EQ VAS:		35		60	
IIP-32:		81 (caseness)		50 (non-caseness)	
W&SAS:		16		26	
HSE:		108 3.09 (red)		107 3.06 (red)	
HAM-D:		31 (VSEV)		26 (VSEV)	

28.4 BIOGRAPHICAL INFORMATION: HARRIET

28.4.1 PAST HISTORY

Harriet's family moved to Hong Kong when she was 5 years old. She remembers her mother initially as warm and loving but following the move mother started to suffer from schizophrenia and changed to being cold and distant. Mother's mental health was poor from this time throughout Harriet's childhood and adolescence.

There is evidence of neglect as Harriet remembers herself and Angela (older sister) being told to go by themselves to swim in the sea without adult supervision from a very young age.

Harriet's father drank heavily and physically abused mother and Angela who both 'got the brunt' of his aggression whilst he 'worshipped' Harriet and never hurt her. However Harriet believes that Angela took the punishment to protect her. Exposure to serious and prolonged domestic violence affected Harriet's education as she was too frightened to sleep at night and could not concentrate at school.

Harriet was seriously attacked by her first boyfriend who could have killed her. She made up an excuse at the hospital to account for her injuries. Harriet chose not to report this incident to the police to protect her father's reputation (he had a high profile job in the government) and her boyfriend from arrest.

Harriet's step-grandmother Edna was an important support to her in childhood and early adulthood. Edna confronted Harriet's father about his abusive behaviour towards Harriet. Although Edna lived in the UK they spoke regularly on the 'phone. Her death 12 years ago has not been grieved as Harriet still cannot visit her grave.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Harriet relates to herself and to people from whom she needs approval.

28.4.2 CURRENT STRESSORS

Triggers include perceived criticism at home and at work. Harriet tends to respond to interpersonal threats by dramatic displays of emotion, by becoming over-active or trying too hard perhaps showing off to be liked. Harriet also misuses alcohol to block awareness of distress. She often feels very lonely.

28.4.3 HOME

Harriet married Steve 2 years ago. He is a farmer and spends many hours working.

28.4.4 WORK

Harriet works part-time as a support worker for people with profound learning disabilities. She takes on extra responsibilities which she is not trained for, and often complains to the management when she thinks the residents are not being looked after properly.

28.4.5 LEISURE/SOCIAL

Harriet wants to join in with village social events but feels like an 'outsider' as she grew up in Hong Kong. She tends to get drunk to cope with her anxiety which makes Steve feel embarrassed by her behaviour. Otherwise Harriet has become dependent on Steve for company as she has few friends.

28.4.6 PHYSICAL HEALTH

Harriet gets frequent chest and throat infections perhaps due to a compromised immune system.

Table 81 – Harriet 034

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	41				
Number of children at home	None				
Ethnic group	White-British				
Marital status	Married				
Accommodation	Owner-occupier				
Employment	Part-time **unqualified unskilled** Healthcare Support Worker				
Welfare benefits	None				
Psychotropic medication at baseline	None				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	87 (SEV)	92	52	55	
BDI-II:	40 (SEV)		30	15 (MILD) 62.5%	
CSES:		29 unhealthy		67 unhealthy	
EQ-5D:		22323		11322	
EQ VAS:		25		28	
IIP-32:		84 (caseness)		56 (caseness)	
W&SAS:		29		23	
HSE:		161 4.6 (green)		144 4.11(green)	
HAM-D:		22 (SEV)			

28.5 BIOGRAPHICAL INFORMATION: PAULA

28.5.1 PAST HISTORY

Paula's childhood was characterised by emotional deprivation due to both parents misusing alcohol and neglecting to attend to her needs. Paula was never shown any warmth or affection which has resulted in life-long low self-esteem. There was on-going domestic violence between her parents throughout Paula's early life; she often got between them to protect her mother but Paula also resented her mother's weakness.

Paula grew up too quickly and did not have a carefree childhood. She was very shy and quiet, spending a lot of time on her own out of the way in her bedroom.

During Paula's adolescence and early adulthood, she took care of both parent's physical needs when her father had cancer of the bowel requiring a colostomy and her mother suffered from emphysema.

A critical event was when Paula lost her secure accommodation (Council flat), which has been destabilising and traumatic.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Paula relates to herself and to people from whom she needs approval.

28.5.2 CURRENT STRESSORS

Triggers include feeling lonely or bored. Paula also feels stressed when she has to look after other people out of duty, especially when her own resources are exhausted.

Paula tends to respond to threat by withdrawing into herself or shutting down (freezing). Paula manages her despair by self-harming by cutting her arms and legs. She also has a stash of prescription medication which she plans to take if she decides to end her life. Paula was encouraged to give this to me for safe disposal which she did on session 9.

28.5.3 HOME

Paula left her Council flat when a noisy neighbour moved in next door. Her boss offered her a bedsit next to the business and now expects Paula to be 'on-call' for emergencies. Paula regrets moving there now but has no idea how to find alternative accommodation.

28.5.4 WORK

Paula works full-time as a cleaner but gets asked to do general household tasks as well such as looking after the pets when her boss goes on holiday or babysitting for her boss's granddaughter.

28.5.5 LEISURE/SOCIAL

Paula has no friends and does not go out socially at all.

28.5.6 PHYSICAL HEALTH

Paula is significantly underweight, she smokes heavily.

Table 82 – Paula 035

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	49				
Number of children at home	None				
Ethnic group	White-British				
Marital status	Single				
Accommodation	Private landlord				
Employment	Full-time **unqualified unskilled** cleaner				
Welfare benefits	None				
Psychotropic medication at baseline	Mirtazapine 15mgs daily to be increased to 60mgs				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	87 (SEV)	83	105	92	105
BDI-II:	32 (SEV)		53	44 (SEV)	50 (SEV)
CSES:		10 unhealthy		26 unhealthy	5
EQ-5D:		11212		11212	
EQ VAS:		30		30	
IIP-32:		68 (caseness)		66 (caseness)	
W&SAS:		30		26	
HSE:		115 3.29 (red)		120 3.43 (yellow)	
HAM-D:		24 (VSEV)		29 (VSEV)	

28.6 BIOGRAPHICAL INFORMATION: ANNABEL

28.6.1 PAST HISTORY

Annabel's parents had their own business and she was aware of their financial worries from an early age. Her needs for attention were relatively neglected as the family business took priority over child care. These needs were met at school and by unrelated 'aunts' and 'uncles'. Annabel was treated as a grown-up before she had properly matured. Her parents moved the family to Filey to look after Annabel's paternal grandparents and she remembers a lot of tension, with a specific memory of her mother threatening to leave her father and take Annabel and Fiona (younger sister) back to There which father refused to let mother do. Annabel experienced long-term sexual abuse perpetrated by an employee of father's business. She has never been able to disclose this to her parents. Annabel kept the abuse secret because she believed the adults around her at the time would have not coped well with any disclosure. She told Fiona but only to protect her from the abuse.

Annabel struggled with reading, spelling and maths due to dyslexia. However she masked the problem and coped with it by being determined to 'prove to myself I'm not a failure' even if that meant pushing herself above and beyond her limitations. In childhood Annabel bit her nails and comfort-ate possibly displacement activity caused by anxiety.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Annabel relates to herself and to people with perceived power over her.

28.6.2 CURRENT STRESSORS

Triggers include feeling inadequate and memories of losing her job. There have also been several negative life events over the years that have caused stress such as excessive work load, back injury and surgery resulting in chronic pain and significant disability, and her parents retiring and moving to Scotland without warning.

Annabel tends to respond to interpersonal threats by trying harder to be perfect which manifests as over-commitment in work roles. When faced by problems she cannot admit to, Annabel tries to ignore them if possible, then wants to run away and when this seems impossible, reacts with tears or anger which she finds shameful.

28.6.3 HOME

Annabel lives with Peter. They have no children by choice. He works long hours. Annabel says she cannot talk to him as he 'doesn't do feelings'.

28.6.4 WORK

Annabel lost her temper at work and threw an object at her boss. She went off sick and then decided to resign. She claimed and won financial compensation due to the unacceptable workload which had caused her 'emotional meltdown'. However when taking up a new job, Annabel quickly felt overwhelmed by the demands, did not negotiate a reduction in duties and could not talk to anyone about her fears so she left abruptly. Annabel works as a volunteer gardener.

28.6.5 LEISURE/SOCIAL

Annabel has become dependent on Fiona and her family for company as she has few friends.

28.6.6 PHYSICAL HEALTH

Annabel is morbidly obese and has a 'bad back' and other joint problems causing chronic pain.

Table 83 – Annabel 036

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	47				
Number of children at home	None				
Ethnic group	White-British				
Marital status	Married				
Accommodation	Owner-occupier				
Employment	Part-time voluntary work (former **qualified skilled** administrative worker)				
Welfare benefits	None				
Psychotropic medication at baseline	Venlafaxine 150mgs daily				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	23 (MOD)	17	21	14	12
BDI-II:	16 (MILD)		7	1 (REM)	3 (REM)
CSES:		140 near healthy		198 healthy	181
EQ-5D:		21222		21221	
EQ VAS:		65		75	
IIP-32:		38 (non-caseness)		22 (healthy)	
W&SAS:		11		8	
HSE:		102 2.91 (red)		133 3.8 (green)	
HAM-D:		13 (MILD)		8	

28.7 BIOGRAPHICAL INFORMATION: BETTY

28.7.1 PAST HISTORY

Betty was the third youngest in a large family of twelve siblings which may have resulted in significant emotional deprivation. When she was 2 years old, her younger sister Diane was born and she was seriously ill. Betty's mother spent a lot of time at the hospital; as a result Betty often felt unloved by her mother and that Diane was mother's favourite. Betty was father's favourite but this caused jealousy in the family. Betty's mother was very domineering telling her to 'Do what you're told' without any questions; Betty found it hard to take orders and rebelled against authority by always answering back and being argumentative. There was little warmth or affection in Betty's relationship with her mother, she was treated harshly and punished physically by her mother; any need for comfort was dismissed and invalidated when her mother told Betty, 'It's not life threatening!' There was not much freedom in Betty's early life and she got frustrated when she 'couldn't get my own way' or make her own decisions. All through Betty's childhood she was sent to bed early at 6pm when other kids were still allowed to play out leaving her feeling very alone and neglected. Betty was expected (and perhaps exploited) to baby sit for younger sisters and neighbours. She described a pattern of sleep walking which may be displacement activity caused by anxiety and unhappiness.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Betty relates to herself and to people from whom she needs approval.

28.7.2 CURRENT STRESSORS

Triggers include feeling neglected and unloved by Eric (partner). Other stressors have included Betty's parents' deaths; conflict at work; and her kids growing up. Betty tends to respond to interpersonal threats by moaning and excessive reassurance-seeking. When this causes people to back off, she reacts by retaliating and fighting back even when this is not proportionate or necessary.

Betty uses her hair straighteners to burn her arm when she feels emotionally over-whelmed. She also isolates herself by hiding in a play tent in the garden. Her attempts to elicit support are mainly responded to by her youngest son. Betty has a close relationship to her granddaughter and is upset by the way this child is harshly disciplined at home. Betty identifies with the child but does not know how to confront her daughter-in-law about the maltreatment.

28.7.3 HOME

Betty lives with Eric and 2 of their grown up sons. Betty has always wanted to get married but Eric does not feel the same need. Betty nags him but he is 'stubborn'.

28.7.4 WORK

Betty works full-time as a cleaner. She enjoys her work but the boss's sister has mental health problems and is abusive towards Betty which she finds difficult to deal with.

28.7.5 LEISURE/SOCIAL

Betty tends to socialise with her large extended family. However her brothers and sisters still see her as the 'black sheep' and tease her when she talk about how their mother didn't love her.

28.7.6 PHYSICAL HEALTH

Betty has been experiencing symptoms of abdominal pain for some months. She undergoes investigations during the group-CBT programme.

Table 84 – Betty 037

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	49				
Number of children at home	2 sons (aged 26 and 27)				
Ethnic group	White-British				
Marital status	Co-habiting (long-term male partner)				
Accommodation	Owner-occupier				
Employment	Full-time **unqualified unskilled** cleaner				
Welfare benefits	None				
Psychotropic medication at baseline	Mitazapine 15-30mgs daily; Sertraline 50mgs				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	93 (SEV)	87		82	
BDI-II:	47 (SEV)			24 (MOD) 48.9%	
CSES:		39 unhealthy		140 near healthy	
EQ-5D:		11223		11222	
EQ VAS:		40			
IIP-32:		101 (caseness)		76 (caseness)	
W&SAS:		29		28	
HSE:		96 2.74(red)		106 3.03 (red)	
HAM-D:		37 (VSEV)	29 (VSEV)	36	

28.8 BIOGRAPHICAL INFORMATION: NAOMI

28.8.1 PAST HISTORY

Naomi was born in Africa and brought up mainly by her mother because her father worked away. Naomi remembers many incidents of domestic violence when he was at home. Naomi became her mother's confidante and as the eldest daughter she was expected to assume a lot of responsibility for her younger brothers meaning she did not have a carefree childhood. Naomi's mother was strict and controlling especially when Naomi reached adolescence and wanted a boyfriend. Naomi took an overdose as a 'cry for help' when she was 16 years old. After this her mother seemed more prepared to listen to Naomi's views. Both parents were very loving at times, but violent at other times, perhaps giving Naomi mixed feelings about relationships. At 19 years old, Naomi became pregnant and had to keep herself 'in check' (inhibiting her behaviour to appear passive and obedient) so her parents did not throw her out. In Naomi's early 20s she was working as a teacher in a rural area of Africa. She was outspoken against the political system. As a result Naomi was kidnapped by armed men. Her captors used her as a slave and raped her repeatedly over a period of several months. Any defiance would have been punished by violence so Naomi had to be passive and compliant in order to stay alive. Eventually she was rescued.

The cumulative effects of these events resulted in complex trauma which has had long-term effects especially in how Naomi relates to herself and to people with perceived power over her.

Naomi has also experienced several bereavements of close family members and friends.

28.8.2 CURRENT STRESSORS

Triggers include feeling unappreciated at home and at work, as well as family problems.

Naomi tends to respond to threat by tackling problems head-on whilst taking out her resentments and frustration on Peter who is then subject to verbal aggression and rejection.

28.8.3 HOME

Naomi had an unplanned pregnancy 3 years ago. Peter (husband) wanted her to have a termination due to financial worries, whereas Naomi wanted another child (hoping for a daughter). Naomi could not understand why Peter did not want another child especially when he had been happy when she had got pregnant with their first child and they later got married. Naomi interprets his behaviour now as evidence that he cannot really love her. Naomi's family make frequent demands on her for support. She tends to prioritise her family and this makes Peter feel 'second best'. He tends to assert himself by controlling the family finances which Naomi resents.

28.8.4 WORK

Naomi returned to work part-time as a social worker in Child Protection within 2 weeks of the start of the treatment programme. The works is very stressful and at times upsetting.

28.8.5 LEISURE/SOCIAL

Naomi tends to socialise with her large extended family. Peter does not tend to get involved as he does not feel welcome.

28.8.6 PHYSICAL HEALTH

Naomi is generally well but had a severe rash on her face which prevented her from starting the group-CBT programme on time.

Table 85 - Naomi 038

DEMOGRAPHIC INFORMATION					
Gender	Female				
Age	36				
Number of children at home	3 sons (aged 3, 10 and 17)				
Ethnic group	African migrant with British nationality				
Marital status	Married				
Accommodation	Owner-occupier				
Employment	Off sick part-time **professionally qualified skilled** Social Worker				
Welfare benefits	None				
Psychotropic medication at baseline	Mirtazapine 45mgs daily				
OUTCOME SCORES					
	T0 baseline screening	T1 first group session	T2 mid point	T3 last group session	T4 12 week follow up
CORE:	107 (SEV)	98	76	25	
BDI-II:	40 (SEV)		41	8 (REM)	
CSES:		34 unhealthy		157 near healthy	
EQ-5D:		11222		11222	
EQ VAS:		30		60	
IIP-32:		95 (caseness)		29 (healthy)	
W&SAS:		30		14	
HSE:		70 2 (red)		114 3.26 (red)	
HAM-D:		23 (VSEV)	22 (SEV)		

APPENDIX 29: DATA INTEGRATION PROCESS

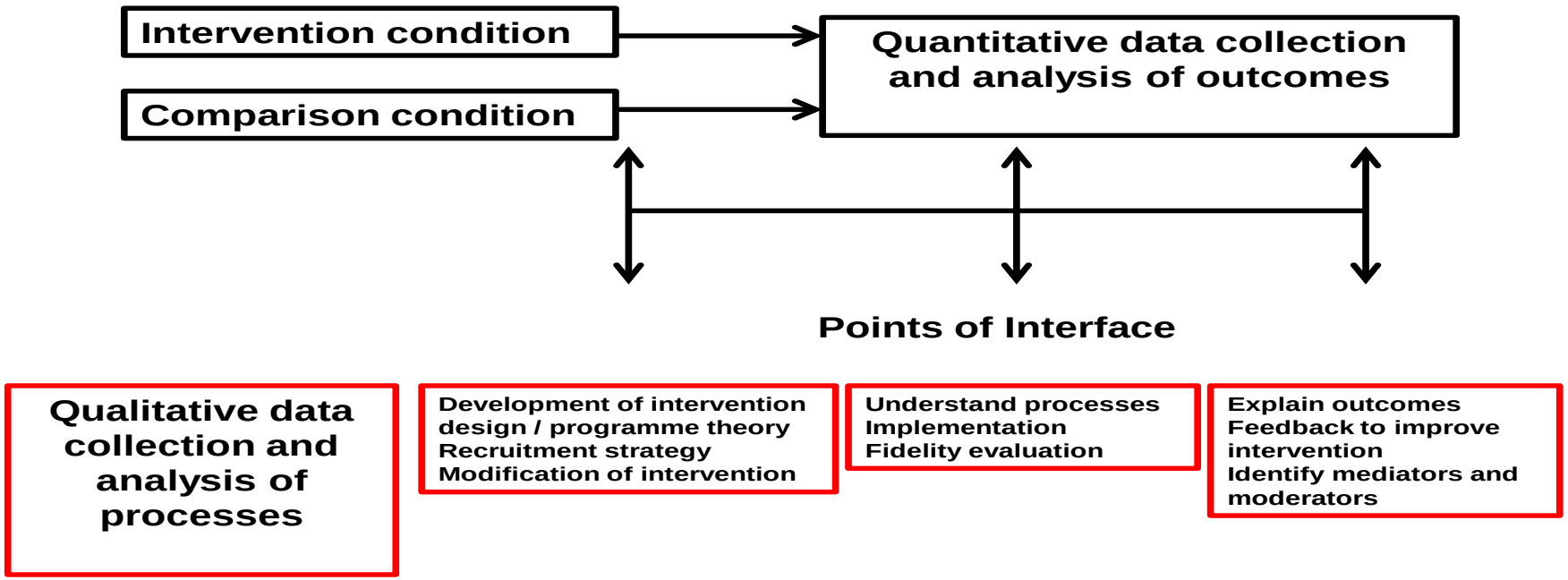


Figure 24 - Data integration process Adapted from Gallo, J.J. & Lee 2015 p.202

APPENDIX 30: SAMPLE DATA OF THE FOCUS GROUPS

Recruitment of the participants of the focus groups was achieved by contacting former service-users by post and frontline practitioners and managers by email and word-of-mouth (see appendix **).

All participants had either experience of receiving or providing relational group-CBT in secondary mental health care, or experience of receiving or providing job retention interventions.

30.1 OBTAINING INFORMED CONSENT FROM PARTICIPANTS

Information about the study was given in written form and explained face-to-face or by 'phone before consent was obtained. In addition, everybody was given the opportunity to ask questions about the study and signposted to a DVD with the author explaining what the research was all about on a dedicated website (www.group-cbt.com). Participants were asked to sign a consent form at the first focus group they attended.

Letters were written to former service-users' GP to inform them that their patient had consented to take part in a research study.

Table 1 shows the characteristics of attendees.

Dates and times for eight focus groups were circulated. Initially four pre-intervention planning focus groups for frontline practitioners and managers, and four pre-intervention planning focus groups for former service-users were planned. However it was decided to change the last service-user focus group to an evening because some people could only attend after work, and two practitioners joined this group.

Overall composition of the focus groups provided the necessary heterogeneity and demographic diversity of participants.

Table 86 - Register of the focus groups

Study Number	Attribution	Focus groups	Number of groups attended
001	Male, Psychotherapist/Manager, LYPFT	FGB1; FGB3	2
002	Male, CBT/Manager, LYPFT	FGB1, FGB2, FGB3, FGB4, FGC1	5
003	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT	FGB1, FGB2	2
004	Male, Psychotherapist, LYPFT	FGB1	1
005	Female, Psychotherapist/Manager, LYPFT	FGB2	1
006	Female, Psychologist, LYPFT	FGB2, FGB4, FGC2	3
007	Male, Psychologist/Manager, LYPFT, Union Rep	FGB7, FGC1	2
008	Female, OT, Job Ret Specialist, Voc Rehab Service	FGB2	1
009	Female, OT/Manager, LYPFT	FGB3, FGB4	2
010	Female, RMN, OH	FGB3	1
011	Female, RMN, OH	FGB3, FGB4	2
012	Male, Former SU, IT Manager	FGA1, FGA2, FGA3, FGA4, FGC2	5
013	Female, Former SU, Civil Servant	FGA1, FGA2	2
014	Male, Former SU, Engineer	FGA1, FGA2, FGA3, FGA4	4
015	Female, Former SU, Staff Nurse	FGA3	1
016	Female, Former SU, Financial Assistant	FGA1, FGA2, FGC1	3
017	Female, Former SU, Retail Worker	FGA1, FGA3	2
018	Unallocated number		
019	Female, Former SU, Retired HE Lecturer	FGA1, FGA2, FGA3, FGA4	4
020	Female, OT, LYPFT	FGB4	1
021	Female, CBT/OT, LYPFT	FGB3	1
022	Unallocated number		
023	Female, Former SU, unemployed	FGA2, FGA3	2
024	Female, Former SU, Bank Worker	FGA3, FGA4	2
025	Male, Service-user representative, LYPFT	FGA4	1
026	Female, OT, LYPFT	FGA4	1
027	Male, Former SU, Traffic Manager LA	FGA4, FGC2	2
028	Male, Former SU, Financial Manager LA, Union Rep	FGA4, FGC2	2
029	Female, Former SU, Retired Bank Manager	FGA4	1
030	Male, Former SU, unemployed	FGA4, FGC1	2
TOTAL	28 participants: 15 frontline practitioners/managers (5 male, 10 female) and 13 former service-users (5 male, 8 female)		

Table 2 shows the number of former service-users who contributed to the planning focus groups.

Table 87 – Focus Group A attendance registers

Type	FGA1	FGA2	FGA3	FGA4
Date	5th Oct	12th Oct	19th Oct	7th Nov
PARTICIPANT NUMBER	012	012	012	012
	013	013	014	029
	014	014	015	014
	016	016	017	030
	017	019	019	019
	019	023	023	024
			024	025
				026
				027
				028
No of Participants	6	6	7	10

Table 3 shows the number of frontline practitioners and managers who contributed to the planning focus groups.

Table 88 - Focus Group B attendance registers

Type	FGB1	FGB2	FGB3	FGB4
Date	21st Sept	27th Sept	5th Oct	12th Oct
PARTICIPANT NUMBER	001	005	001	020
	002	006	002	002
	003	007	009	009
	004	008	010	011
		002	011	006
		003	021	
No of Participants	4	6	6	5

A similar process took place to invite those who had participated in the planning focus groups to the post-intervention reviewing focus groups. The groups were mixed for convenience.

Table 4 shows the number of former service-users, frontline practitioners and managers who contributed to the reviewing focus groups.

Table 89 - Focus Group C registers

Type	FGC1	FGC2
Date	12th June	12th June
PARTICIPANT NUMBER	007	006
	002	012
	016	027
	030	028
No of Participants	4	4

APPENDIX 31A: CONSENT FORM (PHASE 1)

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM Phase 1

Title of Project: Pilot Group CBT work retention programme

Name of Researcher: **Nicola Walker**

Please initial all boxes

1	I confirm that I have read and understand the information sheet dated 12.07.2012 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3	I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Here & There Partnership Foundation Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4	I agree to video recording to be made of the focus groups, and for these recordings to be watched by an independent expert to verify research quality/content of the intervention.	
5	I understand that quotes from the focus group may be used in research reports but that my personal details will be removed so that it is not possible to identify me and that all material about me will be kept strictly confidential.	
6	I agree to my GP being informed of my participation in the study.	
7	I agree to take part in the above study.	

Name of Participant	Date	Signature
Name of Person	Date	Signature of person taking consent

APPENDIX 31B: CONSENT FORM (PHASE 2)

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM Phase 2

Title of Project: Pilot Group CBT work retention programme

Name of Researcher: **Nicola Walker**

Please initial all boxes

1	I confirm that I have read and understand the information sheet dated 12.07.2012 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3	I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Here & There Partnership Foundation Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4	I understand that the researcher may approach me regarding making contact with my employer and occupational health department by 'phone or post if appropriate.	
5	I understand that quotes from the group may be used in research reports but that my personal details will be removed so that it is not possible to identify me and that all material about me will be kept strictly confidential.	
6	I agree to my GP being informed of my participation in the study.	
7	I agree to take part in the above study.	

Name of Participant	Date	Signature
Name of Person	Date	Signature of person taking consent

APPENDIX 32: FOCUS GROUP INTRODUCTORY SCRIPT

Focus groups are about bouncing ideas off each other, it is not a test of knowledge so there is no right or wrong answers

Informal, relaxed discussion – there is no pressure on you to agree but I would like everyone to feel free to contribute their personal views, half-formed thoughts, especially off-the-wall, out-of-the-box ideas etc

I have pre-determined questions which I want to ask but no-one is under any obligation to come up with definitive answers – it is more important to generate lots of ideas and opinions which I will later analyse and check back with you whether my conclusions represent a good enough synthesis of the topic or issues under discussion

Your discussion may veer off at a tangent and that's OK if it's relevant – however I may interrupt the flow and ask you to re-focus if I feel it's irrelevant

I have invited a cross section of people who represent to me a "panel of experts" – from within PTS, the Trust and 3rd sector organisations so that we can come up with whole system thinking

Start by introducing yourself and sharing your preliminary views about the need for this sort of group.

APPENDIX 33: FOCUS GROUP A DISCUSSION GUIDE

1. What format would be best for the pilot group? For example:
   a) shorter term (12 sessions or less)
   b) longer-term (12 sessions or more)
   c) once-weekly or less
   d) twice-weekly or more
   e) 1 ½ - 3 hour sessions (over 6-12 weeks)
   f) ½ - full day sessions (over 4-6 weeks)

2. When would be the best time to run the pilot group? For example:
   a) during the day
   b) in the evening
   c) at weekend

3. Where would be the best place to run the pilot group? For example:
   a) out-patient clinic
   b) hospital site
   c) community mental health team
   d) church hall
   e) library

4. How could the sessions be structured? For example:
   a) pair work
   b) small group work (trauma-focussed or schema-focussed etc)
   c) skills practice (coping-strategies or problem-solving etc)
   d) experiential learning (in vivo self-awareness exercises)
   e) goal-setting
   f) presentation of psycho-educational material
   g) reflective journal
   h) mindfulness
   i) negotiating self-help out-of-session plans and reviewing progress
   j) role play
   k) ice breakers

5. What form of evaluation could be used? Examples will be available to examine:
   a) CORE
   b) ARM-5
   c) CSES
   d) HSE
   e) IIP 32
   f) GAF
   g) HAM-D
   h) Weekly free text

6) What format would be best for assessment/preparation for the pilot group? For example:
   a) one x 1:1 session to complete screening assessment
   b) more than one x 1:1 session to complete full holistic assessment
   c) use of assessment forms, worksheets and diaries
   d) telephone screening
   e) group information-giving session
   f) use of group assessment, preparation and motivational enhancement groups

7) In terms of ground rules and group guidelines, what issues are non-negotiable? For example:

a) confidentiality
b) no offensive or insulting language
c) no physical or verbal aggression
d) no misuse of alcohol or illegal drugs before or during a session
e) no outside contact with other members of the group during the course of therapy
f) development of a crisis/relapse prevention plan
g) willingness to undertake out-of-session assignments
h) development of behavioural change goals from personal problem-target list
i) reliable attendance
j) peer support (expectation that group members will actively help each other in the session by listening, asking questions, giving feedback and constructive criticism etc)

8) If there is a conflict between members of the group or between member/s and the therapists, how should this be resolved? For example:
a) through group discussion
b) through separate meetings between those involved
c) contact with professionals and/or peer support workers not directly involved
d) use of complaints policy and/or PALS

9) What role could a peer support worker fulfil? For example:
a) screening ("telling my story" re work etc)
b) information-giving
c) helping with crisis/relapse-prevention planning
d) conflict resolution
e) sign-posting to community/online resources
f) sharing his/her own story of recovery
g) practical tasks (preparing handouts, setting up room, providing refreshments etc)
h) liaison with carers if appropriate

10) What would be the pros and cons of low-key liaison (i.e. by post or 'phone) with the service-user's employer and/or occupational health staff?

11) What would be the pros and cons of involving a carer?

12) How might the self-help manual be employed in the group? For example:
a) group members read specific chapters in-between sessions
b) group members bring self-selected sections of the book to discuss in the group
c) group members only use sections of the book that are relevant to their needs
d) group facilitators use the book to present specific therapeutic concepts
e) group facilitators split the group into 2 sub-groups to discuss different sections of the book

13) What strategies could be used to reduce drop outs?

14) How might rates of follow up be improved?

APPENDIX 34: FOCUS GROUP B DISCUSSION GUIDE

- In what ways would the current pathway enable the identification of potential recruits or not?
- At what point following referral could PTS staff identify service-users where workplace stress may be negatively affecting depression and/or depression may be negatively affecting workplace performance?
- How might PTS staff work with referrers to persuade them to provide information about employment problems or work-related stress?
- How might the researcher persuade PTS staff to refer service-users who match the research criteria on initial assessment for screening re the pilot study?
- How might the researcher work with professionals to provide baseline data (i.e. GAF & HAM-D scores)?
- What are the potential pros and cons of PTS staff conducting baseline and end-of-treatment assessments for the pilot group?
- How might PTS staff work with service-users to elicit information about employment problems or work-related stress?
- How might PTS staff prioritise clinical needs where employment problems or work-related stress is only part of the initial presentation?
- What are the pros and cons of all PTS staff being expected to offer therapy to participants in the "treatment-as-usual" group?
- What are the potential pros and cons of prioritising occupational health over other issues?
- What are the potential pros and cons of liaison with the service-user's employer either verbally (face-to-face, by 'phone) or in writing?
- What are the potential pros and cons of liaison with the service-user's carer either verbally (face-to-face, by 'phone) or in writing?
- What are the potential pros and cons of signposting the service-user to different organisations such as Job Centre Plus (e.g. disability employment advisors, Access to Work), trade unions, professional bodies, advocacy services, welfare rights providers, employment law specialists etc?
- What ethical dilemmas might arise for PTS staff when focussing on the service-user's employment problems or work-related stress?
- How might the pilot group be delivered to meet the needs of service-users in secondary care (moderate-severe mental health problems) compared to service-users in primary care (mild-moderate mental health problems)?

APPENDIX 35: FOCUS GROUP C DISCUSSION GUIDE

- To what extent do the ideas presented in the manual make sense?
- To what extent are they helpful in terms of learning how to cope with depression?
- To what extent where the additional resources helpful?

APPENDIX 36: SCHEDULE OF WORK

	W/E	W/E	W/E	W/E	W/E
APRIL 2011	**08** Continue work on draft proposal; Continue with literature review: first sift; Send draft to academic supervisor: 'phone discussion on 13/04; Set up next supervision 22/04; Set up meeting with service-user reference group (SURG); Set up meeting with author; Obtain 12+ copies of manual; Discuss project with line manager: set up monthly meetings.	**15** Check use of outcome measures on PARIS; Send draft with workplace mentor – set up monthly 'phone consultations; Continue with NREC application; Send draft to R&D: discuss by email; Identify independent experts who would be willing to spot-check review video and audio recordings; Send draft to chair of PTS Clinical Governance group and line manager; Set up meetings with local IAPT employment services: e.g. MIND; disability employment advisor at local Job Centre; Trust diversity worker re employment training in collaboration with Here College.	**22** Complete and proof read draft proposal for submission; Ask library for journal email alerts; Start to design website; Final selection of studies to include in literature review; Book slot to present literature review at CBT journal club in May or June; Meetings with employment experts as arranged; Meet with administrative staff to discuss requirements; 'Phone consultation with academic supervisor.	**29** Submit proposal to university and REC & NREC; Send copy to mentor, author and clinical governance; Complete design of website; Meet with author: discuss clinical supervision with author for pilot study: set up monthly meetings.	

MAY	**06** Begin work on new critical literature review; Learn how to use Endnote; Meet with SURG to discuss proposal; Update website; Discuss with line manager.	**13** Continue with literature review; Book rooms for focus groups; Obtain video equipment from IT; 'Phone consultation with workplace mentor.	**20** Write up draft literature review; 'Phone consultation with academic supervisor.	**27** Present literature review at CBT journal club; Ask University to check literature review prior to submission for publication; Meet with author.	
JUNE	**03** Begin recruitment for focus groups A&B: identify potential recruits, send out letters or emails; Update website; Discuss project with line manager.	**10** Deal with enquiries; Check potential recruits meet inclusion criteria; 'Phone consultation with workplace mentor. Derby University – progress report.	**17** Meet with independent experts to discuss project. Finalise names for focus groups; Send out information re dates, times, venues and lend manuals; 'Phone consultation with academic supervisor.	**24** Meet with author; Check video equipment; Finalise practical arrangements for focus groups A&B.	
JULY	**01** Focus group A: number 1 Summarise themes and send written report to participants; Update website; Discuss project with line manager.	**08** Focus group A: number 2 Summarise themes and send written report to participants; 'Phone consultation with workplace mentor.	**15** Focus group A: number 3 Summarise themes and send written report to participants; Phone consultation with academic supervisor.	**22** Focus group A: number 4 Collect written feedback from participants; Summarise themes and send written report to participants; Meet with author.	**29** Meet with author - discuss potential pathway based on focus group A; Begin to collate and analyse information; Begin to write design of pathway based on analysis. Identify potential co-facilitators of pilot group; Independent experts to

					review video recordings to check for good practice.
AUG	**05** Focus group B: number 1 Summarise themes and send written report to participants; Update website; Discuss project with line manager.	**12** Focus group B: number 2 Summarise themes and send written report to participants; 'Phone consultation with workplace mentor.	**19** Focus group B: number 3 Summarise themes and send written report to participants; 'Phone consultation with academic supervisor.	**26** Focus group B: number 4 Collect written feedback from participants; Summarise themes and send written report to participants; Meet with author - discuss potential pilot programme based on focus group B.	
SEPT	**02** Independent experts to review video recordings to check for good practice; Begin to collate and analyse information; Begin to write design of pilot group based on analysis; Peer-supporters to apply for CRB etc via Trust volunteer service; Update website; Discuss project with line manager.	**09** Agree training dates with co-facilitators; Agree dates for pilot group; Book rooms for training sessions and pilot group sessions; Begin to design training materials; Set up individual and peer clinical supervision dates, times, venues; 'Phone consultation with workplace mentor.	**16** Begin preparing student conference presentation; Independent experts to review whether pathway and pilot programme accurately reflect focus group discussions; 'Phone consultation with academic supervisor.	**23** Meet with author - discuss training materials; 1st monthly report.	**30** Check volunteer recruitment is complete; Prepare for training sessions.

OCT	**07** Training session; Student conference; Update website; Discuss project with line manager.	**14** Training session; 'Phone consultation with workplace mentor.	**21** Training session; 'Phone consultation with academic supervisor.	**28** Meet with author – discuss last minute details; 2nd monthly report.	
NOV	**04** Pilot group to begin; Recruitment and screening (enrolment and allocation); T=0 outcomes (independent assessor).	**11** Recruitment and screening (enrolment and allocation); T=0 outcomes (independent assessor); 'Phone consultation with workplace mentor.	**18** Recruitment and screening (enrolment and allocation); T=0 outcomes (independent assessor); 'Phone consultation with academic supervisor.	**25** Recruitment and screening (enrolment and allocation); T=0 outcomes (independent assessor); Clinical supervision; Meet with author; 3rd monthly report.	
DEC	**02** Intervention group and control group: treatment and data collection phase; Clinical supervision.	**09** Intervention group and control group: treatment and data collection phase; Clinical supervision; 'Phone consultation with workplace mentor.	**16** Intervention group and control group: treatment and data collection phase; Clinical supervision; 'Phone consultation with academic supervisor.	**23** Intervention group and control group: treatment and data collection phase; Clinical supervision; Meet with author; 4th monthly report.	**30** **XMAS BREAK**
JAN 2013	**06** **NEW YEAR BREAK**	**13** Intervention group and control group: treatment and data collection phase; Clinical supervision; 'Phone consultation with workplace mentor.	**20** Intervention group and control group: treatment and data collection phase; T= 1 outcomes; Clinical supervision; 'Phone consultation with academic supervisor.	**27** Intervention group and control group: treatment and data collection phase; Clinical supervision; Meet with author; 5th monthly report.	

MAR	**03** Intervention group and control group: treatment and data collection phase; Clinical supervision.	**10** Intervention group and control group: treatment and data collection phase; Clinical supervision; 'Phone consultation with workplace mentor.	**17** Intervention group and control group: treatment and data collection phase; Clinical supervision; 'Phone consultation with academic supervisor.	**24** Intervention group and control group: treatment and data collection phase; Clinical supervision; Meet with author; 6th monthly report.	
APR	**07** Intervention group and control group: treatment and data collection phase; T=2 outcomes GCBT group (independent assessor).	**14** **EASTER BREAK**	**21** **EASTER BREAK**	**28** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing; Meet with author; 7th monthly report.	
MAY	**05** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing.	**12** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing; 'Phone consultation with workplace mentor.	**19** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing; 'Phone consultation with academic supervisor.	**26** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing; Meet with author; 8th monthly report.	
JUNE	**02** 1:1 follow up for participants of GCBT; Phase 4 focus groups; Control group treatment continuing.	**09** Preliminary data analysis; Phase 4 focus groups; Control group treatment continuing; 'Phone consultation with workplace mentor.	**16** Preliminary data analysis; Phase 4 focus groups; Control group treatment continuing; 'Phone consultation with academic supervisor.	**23** Preliminary data analysis; Phase 4 focus groups; Control group treatment continuing; Meet with author; 9th monthly report.	**30** Preliminary data analysis; Phase 4 focus groups; Control group treatment continuing.
JULY	**07** First draft of	**14** First draft of	**21** First draft of	**28** First draft of	

	dissertation; Control group treatment continuing.	dissertation; Control group treatment continuing; 'Phone consultation with workplace mentor.	dissertation; T=2 outcomes control group (independent assessor); 'Phone consultation with academic supervisor.	dissertation; Meet with author; 10th monthly report.	
AUG	**04** **SUMMER BREAK**	**11** **SUMMER BREAK**	**18** Follow up of GCBT group T= 3; data analysis; 'Phone consultation with academic supervisor.	**25** Follow up of GCBT group T= 3; data analysis; Meet with author; 11th monthly report.	
SEPT	**01** Write up dissertation and prepare for publication; Agree dissemination strategy.	**08** Write up dissertation and prepare for publication; Agree dissemination strategy; 'Phone consultation with workplace mentor.	**15** Write up dissertation and prepare for publication; Agree dissemination strategy; 'Phone consultation with academic supervisor.	**22** Write up dissertation and prepare for publication; Agree dissemination strategy; Meet with author; 12th (& final monthly report)	**29** Write up dissertation and prepare for publication; Agree dissemination strategy.

APPENDIX 37: GROUND RULES: CBT GROUP PSYCHOTHERAPY

- The group sessions are confidential within NHS guidelines. All members have an ethical responsibility not to talk about what other members have disclosed or to reveal other members' identities outside of sessions.

- Members should be aware that all professionals have an ethical duty to consider the needs of children and vulnerable adults which means confidentiality is limited in the NHS. Also if you have concerns about a safeguarding issue, please raise them as appropriate with staff.

- The Trust has a zero tolerance policy regarding discrimination based on race, class, gender, age, sexuality for example. This also applies to group members. Your therapy will be terminated if you are physically abusive or intimidating to any member of the group or staff.

- To ensure safe boundaries for psychotherapy you are advised not to disclose your full name, address or 'phone number to other members while you are still in therapy. You are advised not to contact each other via social media or to take photographs of each other. You are advised not to lend or borrow money, buy or sell items with other group members.

- CBT is based on self-help principles and there is an expectation that members will help each other (within appropriate limits) as a way to learn how to apply the therapy tools.

- Members are asked to commit to attending group for the full course of therapy i.e. 12 sessions.

- Since it is difficult to begin a session without all group members present, please be prompt.

- If you are going to miss a session, please let one of the group facilitators know. If booked holidays conflict with group times please negotiate a period of absence with the group and the facilitators will provide up-dates and handouts when you return if appropriate.

- You will find it difficult to catch up if you have missed more than 2 consecutive sessions. If there is repeated absence and lateness an attendance contract may be agreed. In exceptional circumstances you may be asked to withdraw from the group.

- If you have decided at some point that you have gained as much as possible from the group, or that the group isn't right for you, we ask that you come one last time and say goodbye. We welcome positive and negative feedback about your experience. If you are unhappy about any aspect of your therapy, please ask for details of the Trust's complaints policy.

- Mutual respect is essential to maintaining the safety of the group. It is important that members perceive the group as a safe place to share their experiences, thoughts and feelings without threat of exposure, ridicule or personal attack. It is okay to disagree with others, but it is not okay to treat members disrespectfully.

- You may wish to share your formulation or other assessment information. You do not have to disclose anything you do not want to. It is the responsibility of each person to talk about his/her reasons for being in the group.

- Most of the time, members are expected to stay in the group room when the sessions are running. However if you cannot manage to do this, you may ask for a 'timeout' in a private room. The group facilitators also reserve the right to call for a 'timeout' if someone needs a period of quiet reflection to contain themselves. This means that the group member, with staff support if appropriate, can leave the group room for 5-10 minutes to recover. They will be welcome to rejoin the group if appropriate.

- Brief between-session self-help assignments will be planned each session. There is an expectation that members will try to complete their assignments unless otherwise negotiated.

- If a member has a relapse during their treatment in the group, the staff will discuss with them if they wish to start the treatment again when recovered. This may be appropriate and can be arranged.

- We ask that everyone participates as fully as possible, even when this makes them feel slightly uncomfortable, to get maximum benefit from the therapy.

I agree to abide by these guidelines:

NAME..... SIGN.....

APPENDIX 38A: INVITATION LETTER (PHASE 1)

Psychological Therapy Service
[redacted]
Here
[redacted]

Contact Person: Nicola Walker
Contact No: [redacted]
Our Ref:
Date:

Dear

My name is Nicola Walker. I am a Cognitive Behavioural Group Psychotherapist for Here and There Partnership Foundation Trust.

I am conducting a research study as part of the requirements of a doctorate in CBT. I would like to invite you to participate in my project. This study is sponsored by Derby University.

Phase 1 of the project involves focus group discussions to design a pilot group CBT programme for service-users of secondary mental health care with moderate-severe depression who are employed.

The programme will be based on the book "Overcoming your workplace stress: a CBT-based Self-help guide" by Martin Bamber published in 2011.

The focus groups will be facilitated by me and will take place in August 2012. It is intended to pilot and evaluate the group programme in 2012/13 as Phase 2.

I have enclosed an information sheet giving more details about the project. Please contact me by 'phone on [redacted] or email nicoladrurywalker@nhs.net if you have any study related questions or problems. You are also advised to discuss this information with anyone who could help you decide whether to take part e.g. family members, friends, your doctor or other health professional.

If I do not hear from you within 2 weeks, I will send a reminder letter. If I have still not heard back from you I assume you do not wish to participate in the focus groups.

Yours sincerely,

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 38B: INVITATION LETTER (PHASE 2)

Psychological Therapy Service
[redacted]
Here
[redacted]

Contact Person: Nicola Walker
Contact No: [redacted]
Our Ref:
Date:

Dear

My name is Nicola Walker. I am a Cognitive Behavioural Group Psychotherapist for Here and There Partnership Foundation Trust.

You have been referred to the Psychological Therapies Service with symptoms of depression.

I am conducting a research study as part of the requirements of a doctorate in CBT. I would like to invite you to participate in my project. This study is sponsored by Derby University.

Phase 2 of the project involves the evaluation of a pilot group CBT programme for service-users of secondary mental health care with moderate-severe depression who are employed.

The pilot programme has been designed on the basis of Phase 1 focus group discussions with service-users and professionals. It is based on the book "Overcoming your workplace stress: a CBT-based Self-help guide" by Martin Bamber published in 2011.

I have enclosed an information sheet giving more details about the project. Please contact me by 'phone on [redacted] or email nicoladrurywalker@nhs.net if you have any study related questions or problems. You are also advised to discuss this information with anyone who could help you decide whether to take part e.g. family members, friends, your doctor or other health professional.

If I do not hear from you within 2 weeks, I will send a reminder letter. If I have still not heard back from you I will assume you do not wish to be considered for the research project. You will stay on the waiting list until another therapist is available to meet with you for assessment.

Yours sincerely,

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 38C: LETTER TO CLIENT'S GP

Psychological Therapy Service
[redacted]
Here
[redacted]

Contact Person: Nicola Walker
Contact No: [redacted]
Our Ref:
Date:

Dear General Practitioner,
Re: Patient's name; date of birth, NHS number, address

I am writing to tell you that your patient has consented to participate in my research project. I will be conducting the research as part of the requirements of a doctorate in CBT.

The title of my study is:
A multi-phase mixed-methods pilot study to investigate whether a Group Cognitive Behavioural Therapy (GCBT) programme adapted from "Overcoming Your Workplace Stress: a CBT-based Self-help Guide" (Bamber, M: 2011) plus low-key liaison (by post or 'phone) with the service-user's employer and/or occupational health is effective in improving the functioning of employed service-users with moderate-severe depression compared to a treatment-as-usual control group.

It is a preliminary study which aims to adapt and operationalise a self-help manual in order to develop a standardised intervention which hopefully will be subject to further investigation with a larger sample.

More information about the research including the full proposal is available on my website: www.group-cbt.com

The intervention has been approved by Trust senior management, research, clinical governance and service-user reference groups. Assessment and discharge summaries will be sent to you as usual before and after the intervention.

I have enclosed the service-user information sheets giving more details about the project. Please contact me by 'phone on [redacted] or email nicoladrurywalker@nhs.net if you have any questions about the project's aims, ethics or methodology.

Yours sincerely,

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here [redacted]
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 39A: RESEARCH INFORMATION SHEET FOR SERVICE-USERS (PHASE 1)

You are being invited to take part in a research study. Before you decide whether you want to take part or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can contact me to ask if there is anything that is not clear or if you would like more information. Further information and a video of me talking about the research are available at www.group-cbt.com.

1. What is the purpose of this study?

Research is has been called for into evidence-based approaches to help people with moderate-severe mental health problems maintain employment.

Phase 1 of the project involves focus group discussions to design a group CBT programme for employed service-users of secondary mental health care with depression. The programme will be based on the book "Overcoming your workplace stress: a CBT-based Self-help guide" by Martin Bamber published in 2011. You will be lent a copy of the book 2 weeks before the first focus group so that you can become familiar with the materials.

2. Why have I been asked to take part in this study?

You have completed a group CBT programme within Here and There Partnership Foundation Trust either as a service-user, a co-facilitator or a manager with strategic and operational responsibilities. Your experience will be extremely valuable in helping to design this new intervention.

3. Do I have to take part?

Participation is entirely voluntary and no-one is obliged to take part.

4. What will I have to do if I take part?

There will be a focus group every week for 4 weeks. Each will last for 2 hours which will include a refreshment break. There will be separate focus groups for service-users and professionals. There will be between 6-10 participants in each group.

It is hoped that participants will be able to attend for all 4 groups plus 1 follow up focus group (after the pilot study has been completed) to contribute to the evaluation of the findings.
If you wish, written reports will be sent to you at monthly intervals to keep you up-to-date with how the research is progressing.

The focus groups will be video-recorded so that the discussion can be more easily written up. Some of these recordings may be watched by an independent expert to verify research quality/content of the intervention. Your identity will be protected and the video will never be used for commercial purposes. It will be destroyed after the research has finished.

5. What will happen if I don't want to take part or if I don't want to carry on with it?

Taking part in this study is your decision. You do not have to be involved if you do not want to. You may also quit at any time. Participation, non-participation or withdrawal will have no effect

on any potential referral to, or your work within the Psychological Therapies Service now or in the future.

6. What will happen when the research comes to an end?

At the end of Phase 1, a protocol will be developed based on the focus group discussions. This will be delivered as a pilot group CBT programme in Phase 2 which will be evaluated in comparison with a matched "treatment-as-usual" sample. Any members of the focus groups who wish to help co-facilitate the pilot group CBT programme as peer-supporters will be eligible for selection and training in the protocol (please ask me for details).

7. What will happen to the results of the study?

The results will be written up as a thesis and submitted to the University of Derby as part of my doctorate in Health and Social Care Practice (CBT). Anonymised reports will also be sent to the Trust's Research and Development department and other relevant committees.
Findings may also be written up for publication, professional meetings and conference presentations. Your identity will always be protected.

8. Will my taking part in this project be kept confidential?

You are advised not to disclose your full name, address or 'phone number to other focus group members while you are still involved in the study. Other members of the group will hear what you say, and it is possible that they could tell someone else. Therefore I cannot guarantee that what you say will remain absolutely confidential. However all participants will be asked to agree to ground rules which outline the expectation to respect others' privacy.

Only staff from the Psychological Therapies Service and your General Practitioner will know that you are taking place in the study.

You will be asked to use a participant number and not to write your name on any study materials. All information collected about you during the course of the research will have your name and personal details removed so that you cannot be recognised and will be kept strictly confidential (except where there are serious safeguarding concerns). All information about you (including video-recordings) will be stored and transported securely.

The Lead Researcher has an obligation to break confidentiality should you disclose that they or others are at risk of harm. This will almost always be done with your knowledge unless to do so involves increased risk.

9. What are the possible benefits of taking part?

Some people find that being involved in research an enjoyable and rewarding experience. Focus group members will be contributing to an innovative service development which may benefit service-users in the future.

10. What are the possible side effects/risks/disadvantages of taking part?

Some people find taking part in a focus group difficult and distressing. There is the potential to be disturbed by hearing about other members' experiences, or to become involved in disagreements or conflict. I will be facilitating the focus groups and I am aware of the need to support members to manage their discussions in a constructive manner. There will be the opportunity for brief 1:1 support before or after each group if required.

11. What if there is a problem or something goes wrong?

If you have any concerns about any aspect of the research, I will do my best to resolve them with you informally**.** If you are not satisfied, or wish to make a formal complaint, you can do so by contacting my manager: Lesley Geary at Southfield House on 0113 295 5430.

12. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect participants' interests. This study has received a favourable opinion by the LREC and by Here and There Research and Development. The University of Derby Research Ethics Committee has also given the go ahead.

13. Who is organising and funding the research?

I am organising the research within my role as CBT Group Psychotherapist for Here and There Partnership Foundation Trust.

14. Why are you conducting this research?

I am conducting this research as part of my doctoral studies in Health and Social Care Practice (CBT). As part of my work providing specialist psychological therapy for LYPFT I have become aware of the problems encountered by service-users in trying to maintain employment when they suffer from depressive disorders. It is important to me to develop a clinically-effective and cost-effective group programme which will help service-users who may be at risk of losing their jobs.

15. Travel expenses:

You may be eligible for travel expenses depending on which welfare benefits you receive. If you are entitled we will reimburse fares for public transport costs or pay you per mile if you use a car. We cannot cover car parking expenses.

How do I contact you?

If you would like to take part in the study or if you have any questions, problems or wish to get more information at any point, please contact me:

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 39B: RESEARCH INFORMATION SHEET FOR PRACTITIONERS & MANAGERS (PHASE 1)

You are being invited to take part in a research study. Before you decide whether you want to take part or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can contact me to ask if there is anything that is not clear or if you would like more information. Further information and a video of me talking about the research are available at www.group-cbt.com.

1. What is the purpose of this study?

Research is has been called for into evidence-based approaches to help people with moderate-severe mental health problems maintain employment.

Phase 1 of the project involves focus group discussions to design a group CBT programme for employed service-users of secondary mental health care with depression. The programme will be based on the book "Overcoming your workplace stress: a CBT-based Self-help guide" by Martin Bamber published in 2011. You will be lent a copy of the book 2 weeks before the first focus group so that you can become familiar with the materials.

2. Why have I been asked to take part in this study?

You have completed a group CBT programme within Here and There Partnership Foundation Trust either as a service-user, a co-facilitator or a manager with strategic and operational responsibilities. Your experience will be extremely valuable in helping to design this new intervention.

3. Do I have to take part?

Participation is entirely voluntary and no-one is obliged to take part.

4. What will I have to do if I take part?

There will be a focus group every week for 4 weeks. Each will last for 1 hour which will include a refreshment break. There will be separate focus groups for service-users and professionals. There will be between 6-10 participants in each group.

It is hoped that participants will be able to attend for all 4 groups plus 1 follow up focus group (after the pilot study has been completed) to contribute to the evaluation of the findings.

If you wish, written reports will be sent to you at monthly intervals to keep you up-to-date with how the research is progressing.

The focus groups will be video-recorded so that the discussion can be more easily written up. Some of these recordings may be watched by an independent expert to verify research quality/content of the intervention. Your identity will be protected and the video will never be used for commercial purposes. It will be destroyed after the research has finished.

5. What will happen if I don't want to take part or if I don't want to carry on with it?

Taking part in this study is your decision. You do not have to be involved if you do not want to. You may also quit at any time. Participation, non-participation or withdrawal will have no effect

on any potential referral to, or your work within the Psychological Therapies Service now or in the future.

6. What will happen when the research comes to an end?

At the end of Phase 1, a protocol will be developed based on the focus group discussions. This will be delivered as a pilot group CBT programme in Phase 2 which will be evaluated in comparison with a matched "treatment-as-usual" sample. Any members of the focus groups who wish to help co-facilitate the pilot group CBT programme as peer-supporters will be eligible for selection and training in the protocol (please ask me for details).

7. What will happen to the results of the study?

The results will be written up as a thesis and submitted to the University of Derby as part of my doctorate in Health and Social Care Practice (CBT). Anonymised reports will also be sent to the Trust's Research and Development department and other relevant committees.

Findings may also be written up for publication, professional meetings and conference presentations. Your identity will always be protected.

8. Will my taking part in this project be kept confidential?

You are advised not to disclose your full name, address or 'phone number to other focus group members while you are still involved in the study. Other members of the group will hear what you say, and it is possible that they could tell someone else. Therefore I cannot guarantee that what you say will remain absolutely confidential. However all participants will be asked to agree to ground rules which outline the expectation to respect others' privacy.

Only staff from the Psychological Therapies Service will know that you are taking place in the study.

You will be asked to use a participant number and not to write your name on any study materials. All information collected about you during the course of the research will have your name and personal details removed so that you cannot be recognised and will be kept strictly confidential (except where there are serious safeguarding concerns). All information about you (including video-recordings) will be stored and transported securely.

The Lead Researcher has an obligation to break confidentiality should you disclose that they or others are at risk of harm. This will almost always be done with your knowledge unless to do so involves increased risk.

9. What are the possible benefits of taking part?

Some people find that being involved in research an enjoyable and rewarding experience. Focus group members will be contributing to an innovative service development which may benefit service-users in the future.

10. What are the possible side effects/risks/disadvantages of taking part?

Some people find taking part in a focus group difficult and distressing. There is the potential to be disturbed by hearing about other members' experiences, or to become involved in disagreements or conflict. I will be facilitating the focus groups and I am aware of the need to support members to manage their discussions in a constructive manner. There will be the opportunity for brief 1:1 support before or after each group if required.

11. What if there is a problem or something goes wrong?

If you have any concerns about any aspect of the research, I will do my best to resolve them with you informally**.** If you are not satisfied, or wish to make a formal complaint, you can do so by contacting my manager: Lesley Geary at Southfield House on 0113 295 5430.

12. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect participants' interests. This study has received a favourable opinion by the LREC and by Here and There Research and Development. The University of Derby Research Ethics Committee has also given the go ahead.

13. Who is organising and funding the research?

I am organising the research within my role as CBT Group Psychotherapist for Here and There Partnership Foundation Trust.

14. Why are you conducting this research?

I am conducting this research as part of my doctoral studies in Health and Social Care Practice (CBT). As part of my work providing specialist psychological therapy for LYPFT I have become aware of the problems encountered by service-users in trying to maintain employment when they suffer from depressive disorders. It is important to me to develop a clinically-effective and cost-effective group programme which will help service-users who may be at risk of losing their jobs.

15. How do I contact you?

If you would like to take part in the study or if you have any questions, problems or wish to get more information at any point, please contact me:

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here [redacted]
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 39C: RESEARCH INFORMATION SHEET FOR SERVICE-USERS (PHASE 2)

You are being invited to take part in a research study. Before you decide whether you want to take part or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can contact me to ask if there is anything that is not clear or if you would like more information. Further information and a video of me talking about the research are available at www.group-cbt.com.

1. What is the purpose of this study?

Research is has been called for into evidence-based approaches to help people with moderate-severe depression maintain employment. Many people with mental health problems encounter discrimination and ignorance in the workplace. They are twice as likely to lose their job as a result of ill health compared to someone with a physical disability.

The research is aimed at employed service-users of secondary mental health care with depression.

Phase 2 of the project involves service-users being either allocated to "treatment-as-usual" which is up to 26 sessions of 1:1 psychological therapy or allocated to the pilot group CBT programme.

The group CBT programme has been designed on the basis of Phase 1 focus group discussions with service-users and professionals. It is adapted from the book "Overcoming your workplace stress: a CBT-based Self-help guide" by Martin Bamber published in 2011. If you decide to participate and are allocated to the group CBT programme, you will be lent a copy of the book 2 weeks before the first session and for the duration of the course.

2. Why have I been asked to take part in this study?

You have been referred for assessment by the LYPFT Psychological Therapies Service. On your referral documents symptoms of depression were identified. We also noticed that you are in employment so this study may be of potential interest to you.

3. Do I have to take part?

Participation is entirely voluntary and no-one is obliged to take part.

4. What will I have to do if I take part?

If you wish to find out more you will first meet with a therapist 1:1 for an initial assessment. At this point, if your depression is diagnosed as moderate-severe you will be invited to meet with the Lead Researcher for a further screening assessment to find out if there are any obstacles to your participation. You can also ask questions about the study face-to-face. If you agree to be included in the research you will be allocated at random to either the pilot group CBT programme or "treatment-as-usual" (see ***** below) so that we can compare the effectiveness of both interventions.

There will be two 1:1 preparation sessions before the group CBT programme and two 1:1 follow up sessions after completion of the course. Participants in the group CBT programme will be

asked for consent to allow low-key liaison (i.e. by post or 'phone) with their employer and/or occupational health staff if appropriate.

It is anticipated that the group CBT programme will run for 12 sessions lasting 6 hours over in total up to 24 weeks. There will be between 6-8 members of the group. ***Treatment-as-usual** refers to up to 26 once-weekly individual assessment and therapy sessions with another Clinical Psychologist, Cognitive Behavioural Therapist or Adult Psychotherapist depending on need.

Following completion of your therapy either in the pilot group CBT programme or "treatment as usual", you will be asked to complete evaluation questionnaires and provide written feedback about your experience in therapy. If you do not complete the group CBT programme, we would still be very interested in your progress and you will be asked to fill in the same questionnaires. There will also be a 12 week follow-up in Phase 4 of the project which will involve a 'phone consultation and evaluation questionnaires being sent to you by post to be returned in the stamped-addressed envelope provided.

5. Will my employer and/or occupational health department be contacted?

If appropriate the Lead Researcher will contact your employer and/or occupational health department with your knowledge to enable you to remain in employment. This requirement is an essential element of the project because employers are often unaware of or non-compliant with their legal obligations and government guidance to support people with disabilities to carry on working. Participants must be willing to inform their employer of their mental health problems because lack of knowledge and understanding on the part of the employer may be exacerbating stress at work. The researcher will support the participant's claim for reasonable adjustments to be made to the working environment if necessary.

6. What will happen if I don't want to take part or if I don't want to carry on with it?

Taking part in this study is your decision. You do not have to be involved if you do not want to. You may also quit at any time. Participation, non-participation or withdrawal will have no effect on any potential referral to or your work within the Psychological Therapies Service now or in the future.

7. What will happen when the research comes to an end?

At the end of Phase 2, the findings will be discussed at two follow up focus groups (one for service-users and one for professionals). I will then analyse the data from questionnaires and feedback forms to determine whether participation in the group CBT programme reduced your symptoms of depression and helped you to function better at work and whether there were any other significant effects in comparison with "treatment-as-usual".

8. What will happen to the results of the study?

The results will be written up as a thesis and submitted to the University of Derby as part of a doctorate in Health and Social Care Practice (CBT). Anonymised reports will also be sent to the Trust's Research and Development department and other relevant committees.
Findings may also be written up for publication, professional meetings and conference presentations. Your identity will always be protected.

9. Will my taking part in this project be kept confidential?

You are advised not to disclose your full name, address or 'phone number to other group members while you are still involved in the study. Other members of the group will hear what

you say, and it is possible that they could tell someone else. Therefore I cannot guarantee that what you say will remain absolutely confidential. However all participants will be asked to agree to ground rules which outline the expectation to respect others' privacy.

I will use your unique Trust number (e.g. 123-456) which cannot identify you name to anyone outside the Trust. Only me, co-facilitators, managers and administrative staff employed by the Trust will have access to your personal information on a "need-to-know" basis as is normal practice in the Psychological Therapies Service. Your number will be used on all paperwork which will be stored and transported securely.

Only staff from the Psychological Therapies Service (PTS), your General Practitioner and other professionals involved in their care (if appropriate) will know that you are taking place in the study. The outcome measures you have provided will contribute to an assessment report and discharge summary which will be sent to you copied to your General Practitioner and/or referrer. These measures will also contribute to the evaluation of the pilot as a whole.

You will be asked to use your Trust number and not to write your name on any study materials. All information collected about you during the course of the research will have your name and personal details removed so that you cannot be recognised and will be kept strictly confidential (except where there are serious safeguarding concerns). In addition to PTS staff who have access to participants' personal data during the study, all NHS care records may be monitored, audited and reviewed by regulatory bodies such as the Care Quality Commission.

In unusual cases the Lead Researcher may be required (for up to 5 years after the participant's last contact with the service) to release identifiable information related to a participant's treatment if ordered to do so by a court of law.

The Lead Researcher has an obligation to break confidentiality should you disclose that they or others are at risk of harm. This will almost always be done with your knowledge unless to do so involves increased risk.

10. What are the possible benefits of taking part?

The pilot group programme has been designed to help you remain in employment by applying CBT self-help skills to overcome your workplace stress/mental health problems. The majority of participants of previous GCBT programmes run in LYFPT have provided feedback that the experience was positive and helpful. It is possible that your symptoms will have reduced and that your coping skills will have improved.

11. What are the possible side effects/risks/disadvantages of taking part?

Some people find taking part in group therapy difficult and distressing. There is the potential to be disturbed by hearing about other members' experiences, or to become involved in disagreements or conflict. I will be co-facilitating the pilot group CBT programme alongside another psychological therapist and/or a volunteer peer-support worker. We are aware of the need to support members to manage their discussions in a constructive manner. There will be the opportunity for brief 1:1 support before or after each group if required. I have over 10 years experience in running psychotherapy groups and am qualified as a Cognitive Behavioural Psychotherapist and a Group Analyst. I am bound by the Institute of Group Analysis Code of Practice and Code of Ethics.

All group members will have developed a crisis plan before commencing the pilot group to use in case of sudden deterioration in their mental health. This will include personalised relapse prevention strategies and emergency contact details for sources of support and relevant services.

12. What if there is a problem or something goes wrong?

If you have any concerns about any aspect of the research, I will do my best to resolve them with you informally**.** If you are not satisfied, or wish to make a formal complaint, you can do so by contacting my manager: Lesley Geary at Southfield House on 0113 295 5430.

13. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect participants' interests. This study has received a favourable opinion by the NREC ***(if applicable)*** and by Here and There Research and Development ***(if applicable)***. The University of Derby Research Ethics Committee has also given the go ahead ***(if applicable)***.

14. Who is organising and funding the research?

I am organising the research within my role as CBT Group Psychotherapist for Here and There Partnership Foundation Trust.

15. Why are you conducting this research?

I am conducting this research as part of my doctoral studies in Health and Social Care Practice (CBT) at the University of Derby. As part of my work providing specialist psychological therapy for LYPFT I have become aware of the problems encountered by service-users in trying to maintain employment when they suffer from depressive disorders. It is important to me to develop a clinically-effective and cost-effective group programme which will help service-users who are at risk of losing their jobs.

16. Travel expenses:

You may be eligible for travel expenses depending on which welfare benefits you receive. If you are entitled we will reimburse fares for public transport costs or pay you per mile if you use a car. We cannot cover car parking expenses.

17. How do I contact you?

If you would like to take part in the study or if you have any questions, problems or wish to get more information at any point, please contact me:

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 40: SAMPLE DATA OF THE FEASIBILITY STUDY

Potential participants were identified by a variety of methods. Posters were displayed in clinical areas aimed at service-users, frontline staff and managers. If service-users self-referred, the Researcher liaised with any professionals currently involved in their care to elicit a formal referral if appropriate. Marketing strategies were used to contact Clinical Leads, Consultant Psychiatrists, local IAPT providers, Occupational Health services, Workplace Here, Remploy and There MIND. The Trust electronic data system was used to identify service-users who are employed with depression. Their key worker was approached to discuss whether a referral to the project was appropriate. In this way it was envisaged that potential recruits would be referred by staff members who had previously triaged, assessed or treated them.

Potential participants were identified at the Single Point of Access (SPA), triage of Psychological Therapy Service (PTS) waiting list referrals, formulation meetings, referred by any member of staff, or in response to study posters and other marketing strategies.

40.1 OBTAINING INFORMED CONSENT FROM PARTICIPANTS

Potential participants were checked for eligibility using inclusion criteria with telephone screening by the Researcher. Demographic data was also confirmed. If the service-user wished to find out more, the Patient Information Sheet (Appendix 39c) was sent with an appointment for a face-to-face meeting during which the Researcher answered any questions about the study. An assessment was made to check that the service-user meets PTS severity criteria using the Beck Depression Inventory II (BDI-II). If this questionnaire revealed:

- High scores (> 2) on item 9 (indicating suicidal ideation), further risk assessment aimed to identify whether the suicide risk was manageable without input from community services. If not, the service-user was referred to their GP and/or community services for risk management and crisis intervention if appropriate.
- Overall high score (> 29), further assessment was undertaken to find out whether the service-user had been prescribed appropriate dose of anti-depressant medication. If not, the service-user was referred to their GP and/or community services for care co-ordination and medication review if appropriate.

Neither of these options necessarily resulted in exclusion if the service-user still wanted to participate in the research.

Information about how work affects depression and how depression affects work was also collected on the referral form (Appendix 38d).

If the service-user agreed to proceed, written informed consent was obtained (Appendix 31b).

40.2 BASELINE PROCEDURES

Participants were asked to complete a battery of baseline measures. If service-users required help to complete the forms, a 1:1 meeting was arranged with a Research Assistant. Otherwise they were given the assessment questionnaires with a stamped addressed envelope to return by a specified date.

Details were agreed about when a Research Assistant could contact them to conduct the HAM-D over the 'phone at T = 1. Information was given about the necessity for concealment of allocation so as not to influence the assessment process.

A trial ID was assigned once the baseline assessments have been carried out. After all information had been received, it was intended to randomise participants into either one of the control groups i.e. CMHT or 1:1 psychotherapy. In the event not sufficient numbers of participants were recruited. So they were all allocated to the intervention group i.e. a work-focused relational group-CBT treatment programme.

Results were recorded on the Case Record Form (Appendix 41) using the service-user's participant ID number.

40.3 BASELINE INTER-PERSONAL PROBLEMS

Inter-personal problems were measured using the IIP-32 (Barkham et al, 1996). Table 8 shows the norms that have been established for the general population and for an outpatient population (Barkham et al, 1996). The total scores of this sample show that with one exception all participants exceeded the cut-off criteria for an outpatient population. In addition, all of the participants had identified at least one inter-personal problem which matched the top 5-10% of an outpatient sample (Leach et al. 2004). This finding suggests that they had serious difficulties in relationships in at least one domain on the IIP-32. (See case vignettes for more details).

All participants were in long-term relationships with the exception of one person who had never had a romantic partner.

Table 9 shows how many people who were assessed brought a significant other to one of the assessment sessions. Interestingly, four participants scored very high on 'hard to be sociable'. Seven married or cohabiting participants reported relationship dissatisfaction or distress with their significant other.

Table 90 - Significant others

Participant ID	Carer
031	Female partner
032	Husband
033	Husband
034	Husband
035	Support Worker
036	Sister
037	Male partner
038	Husband

Interestingly, four participants scored very high on 'hard to be sociable'. Seven married or cohabiting participants reported relationship dissatisfaction or distress with their significant other. Three married women scored high on 'hard to be involved', one of whom had marital problems caused by her avoidant attachment style, and the other two had marital problems which they attributed to their husbands who they described as being avoidant of intimacy and unempathic. One single participant reported extreme loneliness and social isolation. Participants also reported high levels of relationship distress and dissatisfaction.

Table 91 - Relationships

Participant	Significant other or Carer	
031	Female partner	Client described relationship as volatile with unresolved conflict over partner's drinking
032	Husband	Client described herself as isolating / avoidant and husband as supportive
033	Husband	Client described herself as isolating / avoidant and husband as emotionally unavailable
034	Husband	Client described relationship as volatile with unresolved conflict over her drinking
035	Single	Client described herself as mistrustful of others / lonely / isolating
036	Male partner	Client described herself as needing to be needed and partner as emotionally unavailable
037	Male partner	Client described herself as needy and partner as unloving / neglectful
038	Husband	Client described herself as needy and husband as unloving / neglectful

It can be seen that all participants had difficulties in gaining and maintaining mutually satisfying personal relationships. In addition, the HSE data showed problematic relationships at work, with a lack of managerial and peer support at work caused participants the most stress, with high demands and unclear role being stressful for two participants.

Table 92 – Inter-personal problems in clinical populations

	PROBLEMS RELATING TO COMPETITION		PROBLEMS RELATED TO SOCIALISING		PROBLEMS RELATED TO NURTURANCE		PROBLEMS RELATED TO INDEPENDENCE	
	HARD TO BE ASSERTIVE	**TOO AGGRESSIVE**	**HARD TO BE SOCIABLE**	**TOO OPEN**	**HARD TO BE SUPPORTIVE**	**TOO CARING**	**HARD TO BE INVOLVED**	**TOO DEPENDENT**
5% of clinical population	3.75	3.75	4.00	3.25	3.00	3.50	3.75	3.25
10% of clinical population	3.25	3.25	3.50	2.75	2.75	3.00	3.25	3.00
25% of clinical population	2.75	2.50	2.75	2.00	1.75	2.50	2.25	2.25

Table 93 - Inter-personal problems in pilot study clients

	Participant ID	Total score T = 1	Total score T = 3	**HARD TO BE ASSERTIVE**	**TOO AGGRESSIVE**	**HARD TO BE SOCIABLE**	**TOO OPEN**	**HARD TO BE SUPPORTIVE**	**TOO CARING**	**HARD TO BE INVOLVED**	**TOO DEPENDENT**
Mandy	031	2.13	2.03	3.75		3.50					
Jill	032	1.53	1.56	3.25					3.25		
Christine	033	2.53	1.56			3.00	3.00			3.25	
Harriet	034	2.63	1.75			4.00			4.00		
Paula	035	2.13	2.06			3.75				2.75	
Annabel	036	1.19	0.69		2.00				3.00		
Betty	037	3.16	2.38		4.00				3.75		
Naomi	038	2.97	0.91						3.75	3.75	
	MEAN	2.28	1.62								
	SD	(0.64)	(0.54)								

Table 94 – IIP-32 cut-offs

General population			Out patient population		
Male	Female	Combined	Male	Female	Combined
1.02 (0.54)	0.95 (0.52)	0.98 (0.52)	1.59 (0.74)	1.47 (0.65)	1.51 (0.68)

40.4 BASELINE RISKS

The group as a whole showed a range for ongoing risks which suggest that participants felt overwhelmed with emotion at times. One person took a parasuicidal overdose during the treatment programme, experienced ongoing suicidal thoughts, with ongoing deliberate self-harm by cutting herself, taking unnecessary risks by driving dangerously and misusing alcohol. One person experienced ongoing deliberate self-harm by burning and cutting herself and neglected her physical health. The other participants showed one or two main risks such as a previous suicide attempt, current suicidal thoughts, ongoing deliberate self-harm by burning, neglect of physical health, current alcohol misuse and previous or ongoing explosive anger outbursts towards others. (See case vignettes for more details).

Table 95 - Baseline risks

Participant ID	Suicide attempt	Suicidal thoughts	Deliberate self-harm	Neglect of physical health	Dangerous driving	Alcohol misuse	Explosive anger outbursts
031		Ongoing					
032				Ongoing			Past x 1
033	Present x 1	Ongoing	Ongoing		Ongoing	Ongoing	
034						Ongoing	Past x 1
035			Ongoing	Ongoing			
036							Past x 1
037			Ongoing				Ongoing
038	Past x 1						

It can be seen that all participants were experiencing in the present, or had experienced in the past, a high level of emotional distress, and several participants responded to their distress by maladaptive coping such as DSH, alcohol misuse, or aggressive acting out for example. In many cases, carers expressed concern and / or frustration at their partner's behaviour.

40.5 BASELINE PHYSICAL HEALTH PROBLEMS

At baseline all except one of the clients reported physical health problems. Three clients had long-standing conditions such as asthma, morbid obesity, or Gastro-oesophageal Reflux Disease. One client was significantly underweight (with no evidence of an eating disorder). Three clients complained of chronic pain. (See case vignettes for more details).

During the course of the study, several clients took time off work for physical illnesses and investigations such as endoscopies, blood tests and a routine smear. All of them, with the exception of one client, made high use of Primary Care services for minor illnesses and symptomatic complaints such as chest and urine infections, thrush, upset stomach, abdominal

pain, and a severe rash. One client was admitted to the acute hospital for a routine operation to treat long-standing Gastro-oesophageal Reflux Disease (GERD).

As described above, mental health temporarily worsened in two clients which required additional healthcare resources. One client took an overdose (without suicidal intent) which required assessment and treatment in hospital. She also had a planned consultation with an Occupational Health Physician as part of her return-to-work procedures, and was recalled several times by her General Practitioner to monitor her mental state and medication compliance. One client made use of the 24/7 crisis helpline between sessions.

APPENDIX 41: CASE RECORD FORM

Name:.....

	T = 0 Baseline	T = 1 Pre-group assessment	Week 1	Week 2	Week 3	Week 4	Week 5	T = 2 Week 6	T = 3 Week 12	T = 4 Week 24
The Global Assessment of Functioning scale (9-item: clinician rated)										
The Hamilton Rating Scale for Depression (21-item: clinician rated)										
Clinical Outcomes in Routine Evaluation (34-item: self rated)										
The Inventory of Interpersonal Problems (32-item: self rated)										
The Health and Safety Executive Management Standards Indicator Tool (35-item: self rated)										
The Beck Depression Inventory BDI-II (21-item: self rated)										

The Coping Self-Efficacy Scale (26-item: self rated)										
The Work and Social Adjustment scale (5-item: self rated)										
Medication use (confirmed with GP practice)										
Clinical Outcomes in Routine Evaluation (10-item: self rated)										
Agnew Relationship Measure-5 (5-item: self rated)										
Weekly Questionnaire re work and health service use (self-rated)										
Weekly session review sheet										
Final feedback form										

APPENDIX 42: DE-BRIEF CHECKLIST / FACILITATOR SELF-ASSESSMENT TOOL

1) Fidelity to the manual

0	Therapist did not refer to material presented in the manual
2	Therapist made infrequent/unclear references to material presented in the manual
4	Therapist made frequent/clear references to material presented in the manual
6	As above plus therapist expanded on/developed material presented in the manual in response to service-user need

2) Agenda-setting

0	Therapist did not set an agenda
2	Set an agenda that was vague or did not involve group members
4	Worked with group members to set a mutually satisfactory agenda
6	Set an agenda that was suitable for the available time. Established priorities and tracked agenda

3) Session planning

0	Therapist was poorly organised; there was no clear plan for the session
2	There was a clear plan for the session, but therapist did not carry it out or inform group members about aims and objectives.
4	There was a clear plan for the session, and therapist carried it out but rather rigidly.
6	There was a clear plan for the session, and therapist carried it out adapting it flexibly if appropriate.

4) Review of previous session's self-help plan/between-session assignment

0	Therapist did not review previous session's self-help plan/between-session assignment
2	Therapist made vague reference to previous session's assignment
4	Difficulties and obstacles to success with previous session's assignment were explored
6	Success with previous session's assignment was acknowledged and reinforced; difficulties and obstacles were effectively problem-solved

5) Relevance

0	Therapist did not ensure content was relevant to every group member at some point in the session
2	Ensured content was relevant to most group members most of the time
4	Ensured content was relevant to all group members most of the time
6	Ensured content was relevant to all group members throughout the session

6) Adaptation

0	Therapist did not check out group members' understanding of information that was being presented or skill that was being taught
2	Did some checking out of group members' understanding but failed to successfully adapt material or teaching techniques for those who had difficulty
4	Checked out understanding of all group members and was able to adapt material or teaching technique for most of those with difficulties
6	Tailored presentation of information and teaching of skills to the level of understanding of each group member

7) Inclusion

0	Therapist allowed the most talkative members to dominate the group
2	Made attempts to include less vocal group members but was not able to give them enough time to express their thoughts and feelings
4	Ensured all group members had sufficient time to express themselves but did not facilitate expression of less vocal group members' thoughts and feelings
6	Enabled all group members to express their thoughts and feelings, including commentary on the group process/interaction

8) Additional concerns

0	Therapist either did not acknowledge a group member's expression of concern with a disorder or problem that was not the prime focus of the group, or spent such time on these difficulties that other group members were losing interest
2	Acknowledged a group member's additional concern but without signposting a direction from which appropriate help might be found e.g. specialist debt advice, or tried unsuccessfully to address the additional concern but showed a lack of competence
4	Managed group member's expressions of additional concerns and was mostly able to offer succinct advice and reassurance about how these difficulties could be addressed
6	Managed to address all group member's expressions of additional concerns and suggested appropriate options for their resolution without losing focus on the session's main presentation of information and teaching of skills

9) Enhancing support and constructive criticism

0	Therapist did not provide opportunities for group members to support and/or challenge each other
2	Did not reinforce spontaneous expressions of emotional support or challenge from group members to each other
4	Provided opportunities for group members to offer emotional support to each other; reframed unhelpful criticism but didn't encourage constructive criticism
6	Encouraged honest feedback about each others' strengths and weaknesses; provided opportunities for group members to challenge each other by giving constructive criticism linked to behaviour/attitude change goals

10) Resolving conflict

0	Either therapist either did not allow expression of contrary opinions, or let the discussion turn into an unhelpful argument between individuals and sub-groups
2	Gave group members opportunities to disagree with each other but without full exploration of the underlying conflict; did not let discussion turn into an unhelpful argument
4	Gave group members opportunities to disagree with each other and explored the underlying conflict
6	Resolved conflict by encouraging group members to identify differences within sub-groups and similarities between sub-groups

11) Utilising group members as role models

0	Therapist focused entirely on him/herself as the only role model
2	Made fleeting references to the positive behaviour/attitude of different group members but without making it explicit to whom it might be particularly relevant
4	Used pair-work and provided opportunities for peer-support so that group members could share their learning and expertise with each other
6	Created space for group members to assume leadership roles in the group by remaining quiet at times so that group members could find their own solutions to problems together

12) Therapist presentation skills

0	Therapist gave a didactic presentation with no written summary of material covered
2	Provided written summaries of material covered but it consisted largely of printed words as a reading/comprehension level above some of the group
4	Provided written summaries and diagrams at a level accessible to all. Used experiential methods to enhance in vivo learning
6	As above plus highlighted other resources, books, websites, DVDs etc

13) Addressing group dynamics & critical incidents

0	Therapist did not identify or address any group dynamics or critical incidents
2	Identified and addressed some issues such as a disruptive member or a psychological emergency, but in a defensive or dismissive manner
4	Identified and addressed most of the issues and responded effectively, but without involving all group members in reflecting on group dynamics
6	Identified and addressed all of the issues and responded effectively in a collaborative way involving all group members and engaging them in an active problem-solving process

14) **Psychotherapeutic interventions**

0	Therapist was focused on practical tasks and did not spend time attending to group members' emotional needs or eliciting personal information
2	Attended to some aspects of group members' emotional needs by reassurance rather than eliciting information and integrating this into individual formulation
4	Attended to most aspects of group members' emotional needs by acknowledging, clarifying, summarising, confronting, understanding and responding empathically to their behaviour, thoughts and feelings but without eliciting information and integrating this into individual formulation
6	As above plus eliciting information and integrating this into individual formulation

15) Co-facilitation

0	Tasks were not equally shared there was no synchrony between them, they did not reinforce what each other said or help each other out when challenged they shared the presentation but there was little communication between them
2	Tasks were equally shared they worked well together with humour and sensitivity
4	Tasks were equally shared allowing for each others' strengths and weaknesses
6	They worked well together demonstrating the ability to disagree, negotiate and compromise

16) Core CBT Skills

0	Therapist did not use skills such as Socratic questioning to guide discovery; therapist did not refer to problem-target list
2	Used skills such as Socratic questioning and used information elicited to develop hypotheses about the maintenance cycle of current problems; used information to set targets; used some coping strategies e.g. problem-solving, activity scheduling, emotional regulation
4	Used skills such as Socratic questioning plus functional analysis to develop hypotheses about maintenance cycle to inform interventions; used some behavioural methods e.g. ERP, BA, MET
6	Used skills as above plus using imagery, metaphor and downward arrow to develop formulation of group member's compensatory behaviours, core beliefs and schemas; used some cognitive methods e.g. set up behavioural experiments, empty chair, re-scripting

Adapted from "Simply Effective Group Cognitive Behaviour Therapy (2012) Michael J. Scott [Routledge]

APPENDIX 43: SESSION REVIEW SHEET

NAME..... DATE.....

Please reflect on the following questions and answer as many or as few as you wish. Your feedback will form part of your clinical record and you will get a copy at the next session with feedback from the therapists. Use overleaf if you need more room

1. What interpersonal skills were you practising today? With what results?
2. What did you find helpful/relevant today?
3. What did you find unhelpful/irrelevant today?
4. What did you learn in terms of effective coping skills?
5. Was there anything you were reluctant to say in the group?
6. Did you experience any disturbing/unsettling thoughts & feelings today?
7. Is there anything you need to deal with before and/or in the next session?

APPENDIX 44A FINAL FEEDBACK FORM (COMPLETING SERVICE-USER)

NAME..... DATE.....

Use overleaf if you need more room

Name one positive thing that stands out in your mind about the programme:

Name one negative thing that stands out in your mind about the programme:

Is there anything that you think should be included in the programme?

Is there anything that you think should be removed from the programme?

Please give any other feedback which could contribute to a re-design of the programme:

APPENDIX 44B: FINAL FEEDBACK FORM (NON-COMPLETING SERVICE-USER)

NAME..... DATE.....

Use overleaf if you need more room

Please detail why you did not complete the programme:

Please give any other feedback which could contribute to a re-design of the programme:

APPENDIX 45: FOLLOW UP LETTER (PHASE 2)

Psychological Therapy Service
[redacted]
Here
[redacted]

Contact Person: Nicola Walker
Contact No: [redacted]
Our Ref:
Date:

Dear……

I hope you are keeping well. I would be very grateful if you would complete the enclosed questionnaires and return them to me in the stamped addressed envelope as soon as possible. These questionnaires will give me your 3 month follow up data. I would also be interested in any information you wish to provide about how you are getting on if you have time to write a short summary of your progress in general.

With thanks and best wishes,

Nicola Walker
CBT Group Psychotherapist
[redacted]
Here
Tel: [redacted]
Email: nicoladrurywalker@nhs.net
Website: www.group-cbt.com

APPENDIX 46: SERVICE-USER INVOLVEMENT

Involving service-users in this study was a decision based on a critical approach that aims to reduce the alienation of this group, and to question some of the social and economic structures that contribute to their oppression and exclusion, which may be a causative factor in recurrent depression. Whilst the National Institute of Health Research (Bagley et al. 2016), the Mental Health Research Network (National Institute for Mental Health (NIHR) 2013; Staley, 2012) and the National Institute for Health & Care Excellence (Barham, 2011) calls for public and patient involvement in research and review, it is vital to guard against 'pseudo participation' (Goeke, S. and Kubanski 2012) or tokenism (Beresford, P., Lowes, L. and Hulat 2005). The Service-user Research Group for England (SURGE) outlines three different levels of involvement (Morgan 2006): consultation (service-users' views are sought but they do not have a role in decision-making), collaboration (genuine sharing of power and cooperative working) and control (service-user led research).

The function of the focus groups in this study is mainly consultation, with some elements of collaboration (Shippee et al. 2015), but they were not 'maximally empowered to make decisions at every stage of the mixed research process' as (Onwuegbuzie and Frels 2015) describe in a 'critical dialectical pluralist focus group discussion', although this should be considered in further research. The Mental Health Research Network has developed a menu of service-user involvement which provides a framework to identify the knowledge, skills, experience and training needed at different degrees and stages of the research process (NIHR 2013).

Morgan (2006) proposes three key principles which researchers should uphold when involving service-users:

- **Clarity and transparency**: The involvement of service-users as co-researchers should be founded on open and honest discussions which outline the expectations and obligations of all concerned.
- **Accessibility:** All service-users regardless of their disabilities and needs should be able to contribute to research. Resources in terms of appropriate accommodation, expenses, jargon-free materials and support should be available to ensure as wide participation as possible.
- **Diversity**: Recruitment should reflect the demographic range of the study population. It should aim to engage members of under-represented groups taking into account age, ethnicity, gender, sexuality, social class and diagnosis for example.

Servicer-users may require emotional and practical support as well as adequate training in order for their involvement to be meaningful.

Mental health care practice has been criticised as oppressive and often leads to the perpetuation of stigma and social exclusion (Porter 2002). Survivors of mental health problems are a marginalised group and collaborative research is one way for service-users to have a voice. It is vital that 'above all multi-perspectivity and multivocality must be preserved in representation of the results' (Bergold, J. and Thomas, 2012 p.13) in participatory research.

However participatory research could be misused as a way to gain access to service-users and to influence their choices (Hagey 1997). There is also an increased risk of boundary transgression due to role confusion between researcher-participant, leaving both parties vulnerable to abuse. Strier (2007 p.3) warns that 'any intervention or research project, regardless of the benevolent and progressive nature of its goals and intentions, may replicate the structural conditions' that perpetuate oppression.

The true role of the researcher in participatory research is 'an ally, an advisor, an enabler, and maybe a partner' (Evans, C. and Jones, 2004 p.9). The author hoped to be able to really listen to service-users' perspectives so that the research is based on a better understanding of their lived experience. As well as being the moderator of the focus group, the author is also a member. In order to enter the world of an employee with mental health problems, some degree of self-disclosure is appropriate. Under supervision the author will acknowledge her own difficulties encountered at work when suffering from depression.

APPENDIX 47: MIND MAP PRE-INTERVENTION PLANNING FOCUS GROUPS 'A'

Each focus group had a different discussion guide to cover the issues the author wanted to consult upon. The former service-user group (A) were asked to consider questions related to possible components of the intervention as well as practical issues about running the intervention (Appendix 33).

Immediately following each focus group, the Mind Mapping Method was used to identify and summarise participants' concerns and advice that emerged from the discussion. This was later circulated to participants by email to verify the main themes and responses. Illustrative quotes are provided here, attributed to the person who said it; their place of work; gender; participant code; with focus group number and time point.

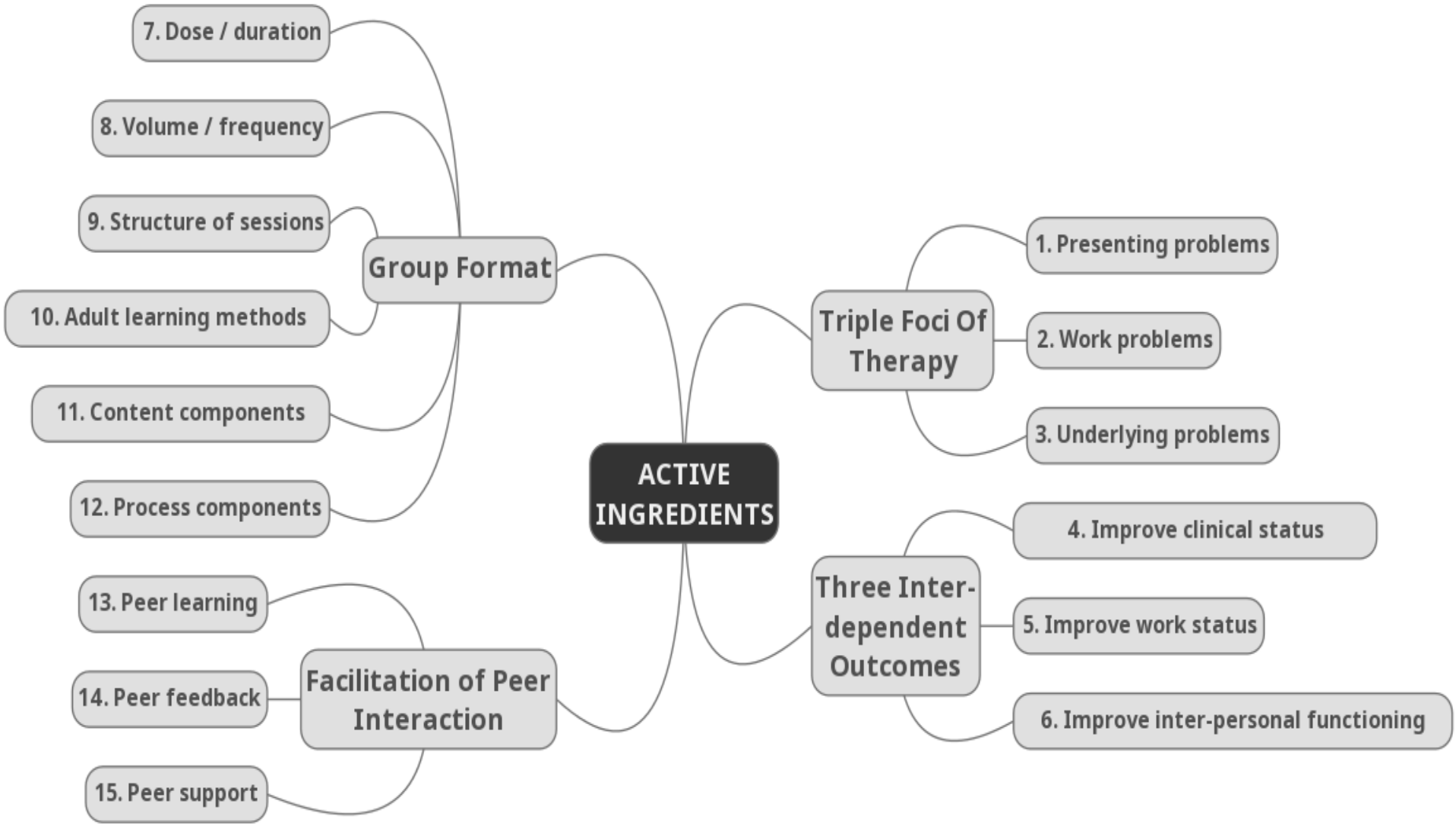


Figure 25 – Mind Map Active Ingredients

Table 96 – Active Ingredients Sample Quotes

	Intervention	Sub theme	Attribution	*Concerns raised / advice offered by participants of focus group A*
ACTIVE INGREDIENTS	Triple Foci	1. Focusing on presenting problems	Female, Former SU, Civil Servant: **013:FGA1:46**	*It is going to be a valuable research area, how prevalent it's become, it's just so many people going off work with depression more and more these days and there is an area where there's a lack of research and any piece of work is going to be valuable isn't it.*
			Male, Former SU, Engineer: **014:FGA2:586**	*For me I was depressed so I would put it as to alleviate your depression somehow or try to help you to manage it.*
			Female, Former SU, Bank Worker: **024:FGA3:1077**	*That's the bit I find hard, the getting on with it because I'm really depressed, or whatever.*
			Female, Former SU, Bank Worker: **024:FGA3:1087**	*I'm in between, I'm up and down. It can be on an hourly basis, on a minute, you know, every half hour I'm in a different mood and it's whether I do some work or I don't or I suddenly get into the mode of wow I can do several cases now, blah blah blah and then, you know…*
			Male, Former SU, IT Manager: **012:FGA2:742**	*It could be either and you could have been depressed and that's made your work totally stressful or the work could have been so stressful that it's sent you into depression or anywhere in between basically.*
		2. Focusing on work problems	Male, Former SU, Engineer: **014:FGA1: 82**	*When there's external things to work that caused your depression and that carries through into work, it may be caused by work because mine had been latent. I was pushed over the edge by a combination of over work, too much travelling overseas and just complete utter fuckwit management, they were useless.*
			Female, Former SU, Parent: **023:FGA2:684**	*How can you work when you're that physically depressed, sometimes you can't get out of bed?*
			Female, Former SU, Staff Nurse: **015:FGA3:851**	*Some of it is partly to do with how you are with work and your personal life, you know, because I know for me, I'm like my work side of things you know with my depression and things like that, my work side of things was always smooth, no problem, assertive, I can deal with all sorts, deal with anything but the minute something little at home would have happened it would have been all like trauma and everything would have gone to pot, but you know and I think that's, I don't know whether that's the type of job that you do in that, you know, sometimes in the job when you dealing with people, you can't let those, you can't let what is bothering you show, you have to deal, you know with things like that. So sometimes depending on the type of job you do, people are more able to do that easier than others I think.*
			Female, Former SU, Staff Nurse: **015:FGA3:1095**	*I mean some people that are workaholics, they work because it gets them away from whatever the main issue is you know so therefore that's why they are always at work because they don't want to deal with whatever is behind, if you make them stop work then they sort of realise because they are just avoiding everything, then they are causing themselves more stress because they are always at work which then compounds the problem and it's obviously they would have to get a better balance in their life to try and deal with whatever issues that they have got.*
			Male, Former SU, IT Manager: **012:FGA3:1097**	*Or they are a workaholic because they are trying to prove something, they think the harder they work the more they will get recognised, it's just recognising that that isn't actually the case.*

		3.Focusing on underlying problems	Male, Former SU, Engineer: **014:FGA1:238**	*That's something that you want to try and identify fairly early in your group therapy programme, what is causing it for the individuals, whether it is something they are taking to work, or it's work that is causing it, it's two different things.*
			Male, Former SU, Engineer: **014:FGA1:318**	*Yeah and possibly identifying the underlying problems as well.*
			Male, Former SU, Engineer: **014:FGA1:326**	*Yeah, there's an awful lot of factors that can affect the situation, personal relationships, outside factors, how is the management structure the company structure of the organisation, lots of different things.*
			Male, Former SU, Engineer: **014:FGA3:915**	*How do people react in similar but different situations, whether you can have an argument at home for example…. or an argument at work with your boss who is an authority figure, similar things happening and transferring it to the other, you react with your Boss in the same way as it's happening there….is it your personality traits?*
			Female, Former SU, Staff Nurse: **015:FGA3:917**	*Yeah or is it to do with just in general going back to like the core beliefs really.*
			Female, Former SU, Civil Servant: **013:FGA2:404**	*And that would give you insight into what you think is where the bigger problems are.*
	Group Format	**4. Dose / duration**	Male, Former SU, IT Manager: **012:FGA1:116**	*That's a difficult one to answer until you have actually got into what you are going to actually put into it I suppose but I think it's the sort of thing where you could do longer sessions. I think longer sessions because there's probably going to be a lot of material to actually work through.*
			Female, Former SU, Civil Servant: **013:FGA1:122**	*Different kind of people are in work or not, because I never took time off work to come to my sessions for just one day a week but if you are saying every day for 2 weeks that's a serious decision to make for someone, if you're not already on the sick.*
			Male, Former SU, Engineer: **014:FGA2:304**	*If you are going to do all day you might as well make more use of the day at least till 10 – 4, I would have thought.*
		5. Volume / frequency	Female, Former SU, Parent: **023:FGA2:434**	*People need to feel comfortable. They won't open up if there's more than 8 people will they? We need to trust each other…*
			Male, Former SU, IT Manager: **012:FGA2:308**	*We did full days twice a week which was really intensive but helpful.*
			Male, Former SU, Engineer: **014:FGA2:312**	*Once a week is more feasible for working people I would've thought.*
		6. Structure of sessions	Male, Former SU, Engineer: **014:FGA2:350**	*It could be a situation, given it's work related, a situation at work, maybe you could work through that in role play, some people will have personal issues, some people will have structural issues and…*

			Male, Former SU, IT Manager: **012:FGA2:358**	*You have got your different sort of things you can do, a sort of full group sort of getting information across or in small groups or role play or quizzes and sort of out of each of the, when you start to look at the information out of each of the sessions then you can sort of look at how what's most appropriate to get that information across.*
			Female, Former SU, Civil Servant: **013:FGA2:362**	*You can have a loose structure, like you said, you know you have got small group morning, large group afternoon,. If you are wanting to have a say structured loose...*
			Female, Former SU, Civil Servant: **013:FGA2:366**	*…that's your loose structure but then you have got little variations.*
			Female, Former SU, Civil Servant: **013:FGA2:396**	*The point I was making was if you want the same loose structure every day.*
			Female, Former SU, Civil Servant: **013:FGA2:1184**	*But that's why time limits are good, five minutes for you, five minutes for me.*
		7. Adult learning methods	Male, Former SU, IT Manager: **012:FGA1:220**	*See that's like another level, this is all about informing the person giving them things they might not have thought about and how to deal with the situation themselves then you are moving on to how do you interact with the work, how can you from an organisation interact with the workplace is almost like, don't know.*
			Female, Former SU, Civil Servant: **013:FGA2:1154**	*I think the pair thing was good for because when you were teaching us to do a Therapist's role I think that's just a great skill because you can apply it again and I think it would be beyond therapy, it is something you can apply to yourself, so learning it as a skill I just think would be really valuable for each individual anyway so to practice it in the sessions I thought it was really…*
			Female, Former SU, Retired HE Lecturer: **019:FGA2:408**	*I mean for me the most important thing is to have variety and activities and it's really important for me personally to have you know larger group activities but also small group activities which I find perhaps a little less threatening and variety also just to keep me on my toes really and keep me focused on – because my tendency is to start looking inwards rather than, you know and sometimes I really liked the way you structured the activities in the group that we had because we were doing different things all the time and sometimes we were doing individual things and sometimes small group, sometimes large group and that's what I would do as a teacher as well, to keep everybody on their toes and to give people a chance to feel more confident in certain situations, so somebody might feel very unconfident in a large group but if they were in a small group, they wouldn't, or if they had to stand up on their own they might find that very suitable for them. So it's variety for me is the most important thing.*
			Male, Former SU, IT Manager: **012:FGA3:102**	*You can share the solutions to your problems so if your first solutions don't work then you are going to know that's why you are here, you can't solve your problems but by the end of it you should be able to get some ideas from the group how to deal with that and that would mean that's going to go…*
			Female, Former SU, Staff Nurse: **015:FGA3:1039**	*How to sort of learn to actually you know go in and like do their job and not let management get, you know and let them be able to you know like shrug it off in way, do you know what I mean?*
			Female, Former SU, Bank Worker: **024:FGA3:1041**	*You have got to stand up for yourself. Be confident.*

			Female, Former SU, Staff Nurse: **015:FGA3:100**	*Well this talks about like sort of problems and problem solving you know sort of solutions to your problems and things like that so you have got something specific that's causing you stress and you know obviously you can work with that, the problems in that sort of way, it's not just talking about general depression.*
		8. Process e.g. pairs, triads, small group, large group discussion	Female, Former SU, Retired HE Lecturer: **019:FGA1:290**	*I think role play is a really useful way of at least sort of trying to practice ways of being assertive, you are more likely to succeed if you practiced beforehand but my feeling is that, you know overall, it sounds very challenging to say it's the managers that need to change their behaviour, not…*
			Female, Former SU, Parent: **023:FGA2:1096**	*A small group of 2 people and then bring it back to the group together.*
			Male, Former SU, Engineer: **014:FGA2:1118**	*You break that individual thing down into the small groups so that anyone can do that and talk about it in the small group but you have already done what you were going to say.*
			Female, Former SU, Financial Assistant: **016:FGA2:332**	*Taking on board what you have actually done in the morning you can do some role play against that. One of the things I found about the book is the best thing about it is the quizzes and the questionnaires so you could do a lot around that and think about the groups that have been to the information sheets per week all the jargon could go, obviously condensed to that because that is, oh, but you know into the booklet then questions put in there as well as to how they felt and things like that to be discussed the week after.*
			Male, Former SU, Engineer: **014:FGA2:416**	*Yeah, it might be an idea to try and get the attendees to share their history in the session, so that people know what problems other people have got and the more you know the more you can target and focus the work and activities you are going to do.*
			Female, Former SU, Retired HE Lecturer: **019:FGA2:1140**	*I think role play and sort of having, well I really like the Gestalt idea where you have for example your boss in another chair and you talk, and that sort of technique was for me very useful but it still didn't solve the problem of my incredible emotionality within these stressful situations and that was my big sort of Diazepam, the only thing that made it possible for me to be in therapy, you know and it's…*
			Male, Former SU, Engineer: **014:FGA4:212**	*Certainly I think the relationships with colleagues because we touched on that before when we were talking about maybe role play and things like that. Various people have talked about being bullied and how do you respond when somebody is trying to bully you?*
			Female, Former SU, Civil Servant: **013:FGA2:400**	*One of the activities could be either by drawing or using the stone things that we did to map out the things that are causing you stress so you could have a big stone for work and you might choose a little stone for something else but you could map it some way.*
		9. Content e.g. CBT-based, intra- and inter-personal coping	Male, Former SU, Engineer: **014:FGA3:1149**	*Going back to what you were saying a couple of minutes ago that to me is more along the lines of managing and coping and developing strategies for living with depression… it doesn't seem to look very much at the underlying causes and I think if you are going to have a group such as this, you have to move away from the book…*
			Male, Former SU, Engineer: **014:FGA4:56**	*You might want to cover that in the assessment somewhere and then once you have identified the hazards you could then possibly in the group look at individual strategies for mitigating because some of those will be common across different people.*
			Male, Former SU, IT Manager: **012:FGA1:102**	*There's loads, I mean there is so much good stuff in that book, I mean a lot of the stuff I already knew from CBT but a lot of people wouldn't know that either and then even a lot of the work stuff is just a lot of sensible things that a lot of people don't sort of pick up on.*

			Male, Former SU, Traffic Manager LA: **027:FGA4:436**	*Basically what it's doing it's again helping the people to understand what the actual problem is that's going on.*
	Three Inter-dependent Outcomes	**10. Improvement in clinical status**	Female, Former SU, Parent: **023:FGA3:370**	*I think that's quite good is that one. You can look back on it can't you and think last week was a bit crap but this week I've improved.*
			Male, Former SU, IT Manager: **012:FGA2:630**	*I mean they're both your aims, one feeds into the other. So if your aim was to stay in work, it's implicit in that, that you're going to, that you have to manage the condition but…*
			Male, Former SU, 014:Engineer: **FGA2:640**	*For some people it might be the other way round, if you improve what's going on at work, your condition improves.*
		11. Improvement in work status	Male, Former SU, IT Manager: **012:FGA3:454**	*I suppose yeah you could say how many hours were you due to work one day and how many hours did you work.*
			Female, Former SU, Staff Nurse: **015:FGA3:464**	*It gives you sort of, it makes you sort of think about your last week as well and pinpoint problems, the difficulties that you had, do you know what I mean but it also at the same time gives you a snapshot of what's actually happening for that person so quickly we can see how they are working or if they are not, if they are going to the Doctor regularly or not. So it would be quite beneficial in that way.*
			Male, Former SU, IT Manager: **012:FGA2:630**	*I mean they're both your aims, one feeds into the other. So if your aim was to stay in work, it's implicit in that, that you're going to, that you have to manage the condition but…*
			Male, Former SU, Engineer: **014:FGA2:640**	*For some people it might be the other way round, if you improve what's going on at work, your condition improves.*
		12. Improvement in inter-personal functioning	Female, Former SU, Staff Nurse: **015:FGA3:825**	*Yeah, but do you think that some part of that comes a natural progression in the group, when they start looking at the problems and the issues as to what the problems are at work and when they start breaking down the problems and the issues, it may then go back to why did they react in that way because other people in the group as well may say well yeah but that's a reasonable request from your Boss or your colleague or whatever, that's a reasonable thing for them and other people might say that so it might just be a natural progression in the group, that eventually it would come back to them having to work out why they reacted the way they did to then bring it into whatever other relationship that they have got.*
			Male, Former SU, IT Manager: **012:FGA3:913**	*It might be a case where people should have better, so if they had a better social understanding of their colleagues then they might not take things as personally. So I think it's a really difficult one to judge I would say.*
	Skilful Facilitation of Peer Interaction	**13. Peer learning**	Female, Former SU, Financial Assistant: **016:FGA2:1068**	*If you did that as you know like talking to the group and put it on like a thing, different kind of groups that I've done the more input that you get from everybody as a group, or you can split them off into smaller sections, give them all a piece of paper and say what are your kind of, well, you know, what is your panic button, you find that people will come up with the same answer or somebody will say something and somebody else will say oh yeah, yeah that's one of mine as well and it opens*

				people's minds into thinking actually I do that, do you know what I mean because a lot of mine was I didn't know what I was doing and I thought I had everything under control but if other people – if I had been in a group and other people had been saying what they did I'd be able to recognise it in myself.
			Male, Former SU, IT Manager: **012:FGA2:1094**	*It's not, everyone is learning something from everyone else so even if you are just doing one, it gives you there is that opportunity for other people just to give you feedback from other people who learn from that.*
		14. Peer feedback	Female, Former SU, Parent: **023:FGA2:26**	*Yeah like we did the little group circles and then you have got to do some feedback and they say well what do you think and in a few groups we had, if you said something and this other person's got really, really a bit bolshie and I felt awful for the other people that would feel a bit intimidated by it as well.*
			Female, Former SU, Bank Worker: **024:FGA4:1015**	*That's not always the best thing is it? You need people to see things [different] from your perspective otherwise you way as well just sit in a room with people that agree and then you are never going to learn anything, are you? What are you going to learn?*
			Female, Former SU, Financial Assistant: **016:FGA2:1122**	*It also gives you, you know like if you bring something up, you know like you say you have already discussed it, it would be nice to have feedback to say I actually tried what we discussed and it didn't work or I tried this instead, you know, open it up even more for more information to be given to people. So both things but…*
			Female, Former SU, Financial Assistant: **016:FGA2:1098**	*I don't think you have understood what I was saying, what I was saying was on the initial panic room thing, open it up as discussion amongst the group to come up with scenarios that have happened to them but not, you know, my boss looking this way drives me mad…*
		15. Peer support	Female, Former SU, Financial Assistant: **016:FGA2:448**	*No, just you know you have got five minutes to chat to each other and what you can pick up from that conversation you just relay that to the group and it could just be a name and what they do for a living and do you know what I mean, it doesn't have to necessarily be the full history or anything like that. It's just you know I'm here because I'm struggling at work, something general so that it's not…*
			Female, Former SU, Staff Nurse: **015:FGA3:564**	*I was going to say they could you know just be there just to, you know and maybe some people might open up to them a bit more than they may do someone else, you know because if they are sharing, if you have been through something and you are sharing your experiences and a lot of people can relate, some people that maybe, maybe they are very reserved and they are very quiet and they don't say an awful lot but maybe they relate to something that you say that might help them to come forward a bit more.*
			Male, Former SU, Financial Manager LA, Union Rep: **028:FGA4:186**	*It can help, you can feel better as well, you can put a hand out and help a fellow sufferer. I feel better for it as well.*
			Female, Former SU, Parent: **023:FGA2:1148**	*I enjoyed doing the small groups, we used to go downstairs and like 3 or 4 people something like that and we would really open up.*
			Female, Former SU, Parent: **023:FGA2:1170**	*It was nice because we built up the trust with each other anyway because we did those small groups downstairs didn't we and we all be, basically we would re-enact what had happened to us and stuff, so you had the trust with people so you didn't mind doing it.*

APPENDIX 48: MECHANISMS OF CHANGE

The stakeholder consultations were undertaken both pre- and post-intervention. Secondary analysis of the data using the critical realist method provided a rich source of plausible mechanisms of change which might be activated in an enabling workplace context to produce the desired outcomes i.e. improved clinical status, improved work status and improved inter-personal functioning. Twenty four sub-themes and twelve themes emerged from the data, which were collapsed into six meta-mechanisms.

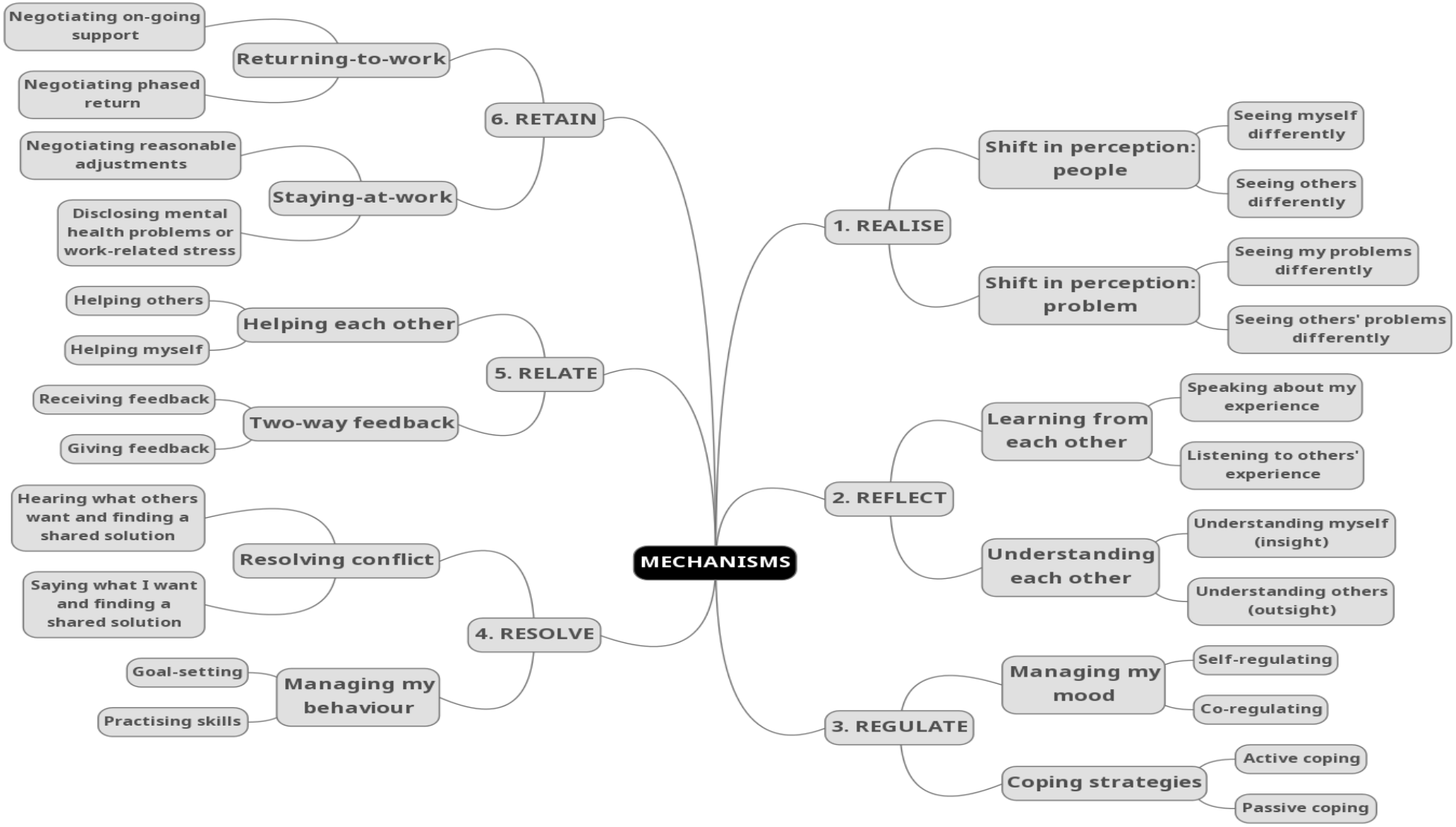


Figure 26 – Mechanisms of change

48.1 REALISE

48.1.1 Shift in perception: people

This mechanism refers to ***seeing myself differently*** and ***seeing others differently***. Participants used phrases such as 'you start doubting yourself', 'it's difficult to be objective', and 'I just didn't realise' to describe a low level of self-awareness before starting psychotherapy. Over time, through the assessment process and the treatment process, there was a shift in perception. Participants used phrases such as 'now I can see', 'I'd be able to recognise it in myself', 'creating awareness', 'I can relate to some of that', and 'you see it in the light' to describe a dawning moment in time where how they see who they are and what they are like differently. This process also applied to how they see other people as well.

Participants provided evidence that this mechanism might be activated in group-CBT.

> *You find that people will come up with the same answer or somebody will say something and somebody else will say "Oh yeah, yeah that's one of mine as well", and it opens people's minds into thinking "Actually I do that".*
>
> **16:FGA2:1068 / Female, Former SU, Financial Assistant**
>
> *Sometimes a lot of people are talking then it triggers something in somebody else.*
>
> **23:FGA2:1084 / Female, Former SU, Parent**

48.1.2 Shift in perception: problem

This mechanism refers to ***seeing my problems differently*** and ***seeing others' problems differently***. Participants used phrases such as 'it became clear to me', 'you can actually acknowledge that you have got problems', 'that person came to the conclusion', 'now I get it' and 'they sort of realise' to describe this process of intra- and inter-personal awareness.

Participants provided evidence that this mechanism might be activated in group-CBT.

> *It's where it is, you have got everybody in the room and everyone else thinks that's a reasonable request for your boss to ask you but you think they are bullying you so you have interpreted it as bullying… [in some cases] where it is actually the person is contributing to it.*
>
> **12:FGA3:995, 1023 / Male, Former SU, IT Manager**

Because a lot of mine was I didn't know what I was doing and I thought I had everything under control but…if I had been in a group and other people had been saying what they did I'd be able to recognise it in myself.

16:FGA2:1068 / Female, Former SU, Financial Assistant

48.2 REFLECT

48.2.1 Learning from each other

This mechanism refers to ***speaking about my experience*** and ***listening to others' experience***. Participants used phrases such as 'talking to likeminded people', 'really open up, 'everyone is learning something from everyone else', and 'to see somebody who has gone through it' to describe the process of identifying with others and being inspired by them to change.

Participants provided evidence that this mechanism might be activated in group-CBT.

Sharing and realising that you are not alone…other people have the same problems. That's the greatest benefit I think of group therapy.

19:FGA2:1112, FGA1:50 / Female, Former SU, Retired HE Lecturer

I think I agree, I think it helps massively…it's alright you [therapist] saying you can get rid of them but I'd say I was like that and now I just don't have them anymore [panic attacks] and they are like, alright, so there is a light at the end of the tunnel… say well my experience of being through all this and this is, just for them to see there is a way to get out of the other side, you have got a walking example of someone who has got out the other side.

12:FGA3:514, 552 / Male, Former SU, IT Manager

48.2.2 Understanding each other

This mechanism refers to ***understanding myself*** and ***understanding others***. Participants used phrases such as 'putting a name to the problem', 'it must be me', 'understand what the actual problem is', 'what about the underlying causes…you have got to have the why and the what' and 'determine what the big issues are' to describe the process of working out how much of the problem is work-related and how much the individual is contributing to the problem by the way they are coping with a variety of stressors which could be personal or occupational.

They also used phrases such as ‘work is also a social environment’, ‘if they had a better social understanding of their colleagues’ and ‘explore…interpersonal dynamics’ to describe the process of finding out how others’ think and feel.

Participants provided evidence that this mechanism might be activated in group-CBT.

> *One of the activities could be either by drawing or using the stone things that we did to map out the things that are causing you stress…and that would give you insight into what you think is where the bigger problems are.*
>
> **13:FGA2:400, 404 / Female, Former SU, Civil Servant**
>
> *If you take a certain situation we can understand too, as something that has happened to somebody, reconstruct it in those terms and then deconstruct it and you find out what’s going on.*
>
> **14:FGA2:1088 / Male, Former SU, Engineer**

48.3 REGULATE

48.3.1 Managing my mood

This mechanism refers to emotional regulation in terms of ***self-regulating*** and ***co-regulating*** by which people stabilise their mood either by themselves or with the help of another person. Participants used phrases such as ‘I’m up and down…on an hourly basis’, ‘it's the speed of the behavioural reaction and the physical reaction’, and ‘you’ve got to feel the emotion’ to describe their experience of feeling unstable and overwhelmed by their moods.

One participant realised that by not seeking support from his partner meant ‘I felt I had no one really to turn to’, and another realised that if she had not tried to hide how she was feeling ‘you could have shared what you were going through’. The process by which others tried to help was summed up by phrases such as ‘it's just saying I know what you are feeling’. Participants recognised the value of peer support because sometimes it was easier ‘to take that on board from someone who has been through it’.

Participants provided evidence that this mechanism might be activated in group-CBT.

> *I think a group where you have got people that have got these things in common validate each other’s experiences in a way that sometimes clinicians, doctors, nurses, all respected….but that they might not you know they sort of see symptoms and the negative*

stuff where your peers can recognise and validate your experiences and that is a very important thing.

25: FGA4:180 / Male, Service-user representative, LYPFT

I think you feel a bit more comfortable with each other if you know you are all suffering with something similar.

23:FGA2:422 / Female, Former SU, Parent

48.3.2 Coping better

This mechanism refers to emotional regulation in terms of ***active coping*** and ***passive coping*** by which people stabilise their mood either by dealing directly with a problematic situation or by putting up with it. Participants used phrases such as 'start breaking down the problems', 'if you can get one under control I suppose you can actually focus on the other one', 'managing and coping and developing strategies for living with depression' and 'here is some practical tips' to describe the process of addressing issues in a proactive and a potentially constructive way rather than a reactive and potentially destructive way.

Participants used phrases such as 'being able to accept the situation as it is', 'I can rise above it', 'shrug it off in way' and 'get a thick skin'. One participant thought passive coping was not helpful:

Yeah but if [you just] sit there and think oh I'll just cope with it, I'll learn to just cope with the way they are then it's never going to change and you are just hiding really, aren't you, just thinking, you are just giving up.

24: FGA3:1015 / Female, Former SU, Bank Worker

Participants provided evidence that this mechanism might be activated in group-CBT.

You can share the solutions to your problems so if your first solutions don't work then you are going to know that's why you are here, you can't solve your problems but by the end of it you should be able to get some ideas from the group how to deal with that.

12:FGA3:102 / Male, Former SU, IT Manager

People could give examples of how they dealt with it, good or bad… because it gives you alternatives that you mull over in your mind, what if I had done that or is that an approach I could use now, would that work for me, so it gives you options to think about.

13:FGA2:1136 / Female, Former SU, Civil Servant

48.4 RESOLVE

48.4.1 Managing my behaviour

This mechanism refers to behavioural regulation in terms of ***practising skills*** and ***goal-setting*** by which people learn (or re-learn) and consolidate which will reduce the probability of relapse of depression. Participants used phrases such as 'role play is a really useful way of at least sort of trying to practice ways of being assertive', 'you need to learn to [change] the ways you respond to people…so the way they respond to you as this different person it's going to change' and 'many of these skills are transferable…to sort of transfer these skills across to other aspects of the person's life' to describe the process of generalising the skills that people have acquired during psychotherapy. Participants used phrases such as 'it's not all about what's the world done to me, I need to change', 'what can I do differently?" and 'let's move forward' to describe the process of identifying a behavioural target and making a commitment to change. Goal-setting might involve developing a healthy work-life balance.

Participants provided evidence that this mechanism might be activated in group-CBT.

> *I think the pair thing was good for [me] because when you were teaching us to do a therapist's role I think that's just a great skill because... it is something you can apply to yourself... you go into two's and one person would be, you know the therapist…but they would be the listener and they would challenge things maybe that they heard, you would have a specific time to do this in, you took it in turns.*
>
> **13:FGA2:1154, 1158 / Female, Former SU, Civil Servant**
>
> *I'm not certain about the CBT techniques but do you things akin to role play or that kind of live experience that other people could then perhaps to give some sort of feedback on you know, I don't know, a situation was there was one being victimised by a manager but actually…they may be quite aggressive themselves.*
>
> **05:FGB2:256 / Female, Psychotherapist/Manager, LYPFT**

48.4.2 Dealing with conflict

This mechanism refers to ***saying what I want and finding a shared solution*** and ***hearing what others want and finding a shared solution***. Participants used phrases such as 'it just ends up in a battle of wills', 'we were at loggerheads', 'confrontational side of things' and 'taking up arms against your employer' to describe some of the ways people respond to disputes in the workplace. Most participants accepted that 'lots of people didn't say anything' and 'nobody really dares to tackle it head on'. Therefore learning that 'you have got to say right I can't actually do all of this'

and ‘you have got to stand up for yourself’ is a proactive way of dealing with conflict. Participants also recognised that conflict in the workplace is a two-way process and that finding shared solutions requires a ‘win-win’ approach.

Three participants showed awareness of the other sides’ point of view:

> *At the end of the day we are in a contract with them anyway and we are sort of meant to be in the workplace. They want us there, they want us well but they can only go so far with that.* **27:FGA4:306 / Male, Former SU, Traffic Manager LA**

> *So I understand both sides really because at the end of the day it's a business.*

> **24:FGA4:440 / Female, Former SU, Bank Worker**

> *I think it's difficult to say that it's either an outside source or an inside source, you know, it's whether you or your manager. I think it's just an accumulation of both of you are you are not getting to be able to speak to each other and do it calmly. He’s got his job to do and you have got your job to do.*

> **16:FGA1:250 / Female, Former SU, Financial Assistant**

Conflict resolution may involve learning social skills such as saying sorry and making amends.

> *You see I don’t mind if people apologise afterwards, you know if they say “I’m sorry I flew off the handle I shouldn’t have shouted”, that’s fine, you know, that’s an apology, but it's when it doesn’t happen.*

> **19:FGA3:835 / Female, Former SU, Retired HE Lecturer**

Participants provided evidence that this mechanism might be activated in group-CBT.

> *I mean I’ve worked with people…when I get to the nitty gritty of it, actually it’s half a dozen of one and it's half a dozen of the other and I suppose that’s where…you get them to be open and start discussing some other things.*

> **08:FGB2:258 / Female, OT, Job Ret Specialist, Voc Rehab Service**

48.5 RELATE

48.5.1 Two-way feedback

This mechanism refers to ***giving feedback*** and ***receiving feedback***. Participants used phrases such as and 'it's there to be challenged basically' and 'you have got to do some feedback and they say, well what do you think?' to describe telling others how you see them and their problems, and providing a new perspective on things.

Giving feedback sometimes caused distress which potentially made it hard for people to receive feedback:

> *You are thinking about what you are doing to annoy people, or how you are, and it can actually work the opposite way and really annoy you…you might just completely lose the plot and start thinking too much and over ruminating stuff like that but that's what you could do.* **24:FGA4:238, 234 / Female, Former SU, Bank Worker**

> *I've gone home and said something to my friends but it's because I was distressed by a certain person in our group, I was hurt by that person but I didn't go into detail of what had happened, I just said she really distressed me, it had an effect on me because obviously [my friends said] "Oh are you alright?"*

> **23:FGA2:136 / Female, Former SU, Parent**

> *In a few groups we had, if you said something and this other person's got really, really a bit bolshie. You give your views and then they get up on their high horse.*

> **23:FGA2:26 / Female, Former SU, Parent**

However one participant who had experienced a negative response to being given feedback reflected on the benefit of it:

> *The more input that you get from everybody as a group…I think it has to be done to show how you are.*

> **16:FGA2:1068 / Female, Former SU, Financial Assistant**

Receiving feedback was mostly welcome and participants used phrases such as 'it would be nice to have feedback' and '[the] opportunity for other people just to give you feedback' to describe the process of listening to others saying how you see you and your problems.

Feedback might come in the form of a goal review or care plan.

We did it with the chart in the room didn't we and I found the progress, do you remember? So 10%, 20%, 30%. we used to have to refer back to our progress… I think that's quite good is that one. You can look back on it can't you and think last week was a bit crap but this week I've improved.

23:FGA2:1240, 1244, 1248, FGA3:370 / Female, Former SU, Parent

Participants provided evidence that this mechanism might be activated in group-CBT.

You need people to see things [different] from your perspective otherwise you way as well just sit in a room with people that agree and then you are never going to learn anything, are you? What are you going to learn?

24:FGA3:1015 / Female, Former SU, Bank Worker

48.5.2 Helping each other

This mechanism refers to ***helping myself*** and ***helping others***. Participants used phrases such as 'working out how they can help themselves as well', 'how we take control and responsibility' and 'you won't help yourself get anywhere like that' to describe the process of active engagement in the psychotherapeutic change.

Helping others involved 'informing the person, giving them things they might not have thought about and how to deal with the situation'. One participant acknowledged that 'you learn to trust in people' by being helped by them. Participants used phrases such as 'a peer [mentor] that would be able to help you and sit alongside you and say what you are doing there isn't helping you' to describe the benefits of helping others.

Participants provided evidence that this mechanism might be activated in group-CBT.

Other people give you suggestions how you could have coped with it, it just makes you think differently, you know, so instead of just being stuck on yourself all the time you took it on.

23:FGA2:1166 / Female, Former SU, Parent

It can help, you can feel better as well, you can put a hand out and help a fellow sufferer. I feel better for it as well.

28:FGA4:186 / Male, Former SU, Financial Manager LA, Union Rep

48.6 RETAIN

48.6.1 Staying at work

This mechanism refers to ***disclosing mental health problems or work-related stress*** and ***negotiating reasonable adjustments***. Participants used phrases such as 'you know I could see people struggling to come forward to say I'm struggling at work', 'I don't want to say I can't cope, I don't want to look like I'm rubbish', 'not everybody wants to come out with their mental health challenges…people want to keep it [quiet]' and 'people might shy away from is if it's seen as therapy in the conventional sense which indicates some sort of a deficit, some sort of a peculiarity, some sort of fundamental deficit with you' to describe the reluctance to disclose mental health problems in the workplace, as well as the reluctance to be given a 'diagnosis' or to accept a referral for 'therapy'.

Participants provided evidence that this mechanism might be activated in a work-related psychotherapeutic intervention through empowering people to negotiate reasonable adjustments.

> *Because you also need to feel confident in asking them, we can make adaptations as much as possible but it's whether that person feels empowered enough to be able to request what they need, the support that they need, so that's where CBT really comes into it.*
>
> **11:FGB3:488 / Female, RMN, OH**

48.6.2 Returning to work

This mechanism refers to ***negotiating a phased return*** and n***egotiating on-going support***. Both depend on prior disclosure.

If people are willing to disclose mental health problems or work-related stress, participants provided evidence that this mechanism might be activated in a work-related psychotherapeutic intervention through supporting them to take things at their own pace:

> *Well when I had what was nearly a breakdown I did go into work specifically every week just to see them, that's the most I could commit to…I went in and just said look this is where I am and you know just nice to see the office and to see people and just you know to chat with them but on my own terms and then I went off and did my own thing and it was a month before I felt even ready and then it was a phased return, come in when I want, if I needed to go home and if you got too much go out of the office.*
>
> **28:FGA4:516, 520 / Male, Former SU, Financial Manager LA, Union Rep**

If people are unwilling to disclose mental health problems or work-related stress, participants provided evidence that this mechanism might be activated in a work-related psychotherapeutic intervention through encouraging people to maintain a work schedule whilst off sick in preparation for work resumption:

> *Yeah like you say I agree you don't want to alienate people, and I think it's about sort of valuing structure people put into their week even if it's not work, it's structure, it's getting up on time, it's routine, the sort of other activities that we all do that don't include work which are really important in many ways and it's capturing that isn't it?*
>
> **09:FGB3:498 / Female, OT/Manager, LYPFT**

Table 97 - REALISE

	Sub theme	Mechanism	Attribution	Illustrative quote
REALISE	Shift in perception: people	1. Seeing myself differently	**024:FGA4:448** Female, Former SU, Bank Worker	*There's a lot of people, suddenly…you have heard they are going through depression or somebody's just had a panic attack on the floor and you are like, you just seem so normal all the time and you just think, what? And there's been a lot of that in the last few years, especially in this new job that we are all in, I mean there's a lot of pressure and there's a lot of stuff and someone like me who is up and down in my moods anyway sometimes, and then you know, and that's fine and I am kind of doing alright but in a way it's because there is so many people falling around me, it kind of takes pressure off me in a way because I'm not the one constantly, you know and although it is hard, well actually I'm not like that and I'm not like that so it does make you feel a bit more [better].*
			016:FGA2:1068 Female, Former SU, Financial Assistant	*You find that people will come up with the same answer or somebody will say something and somebody else will say oh yeah, yeah that's one of mine as well and it opens people's minds into thinking actually I do that.*
			016:FGA1:160 Female, Former SU, Financial Assistant	*It's like, you have got that thought pattern and you start doubting yourself.*
		2. Seeing others differently	**023:FGA2:478** Female, Former SU, Parent	*That certain person but I could never follow, she would go from one thing to another to another, my head was like that thinking what's she on about, what's she here for, do you know what I mean but now I can see, afterwards now you can see, she was trying to get it out because it's starting to have an effect on her now.*
			024:FGA3:1063, 1067 Female, Former SU, Bank Worker	*Other people, you have to look at yourself first. And when you have done that you realise that actually you are okay yourself so it must be these people and sod them.*
			012:FGA3:995, 1023 Male, Former SU, IT Manager	*It's where it is, you have got everybody in the room and everyone else thinks that's a reasonable request for your boss to ask you but you think they are bullying you so you have interpreted it as bullying… [in some cases] where it is actually the person is contributing to it.*
	Shift in perception: problem	3. Seeing my problems differently	**016:FGA2:1052** Female, Former SU, Financial Assistant	*Because a lot of mine was I didn't know what I was doing and I thought I had everything under control but…if I had been in a group and other people had been saying what they did I'd be able to recognise it in myself.*
			012:FGA4:272 Male, Former SU, IT Manager	*If you can actually acknowledge that you have got problems taking instructions and realising that's part and parcel of being in the hierarchy of position, you have to take instructions and when to take instructions.*
			014:FGA1:306 Male, Former SU, Engineer	*It became clear to me that for my own health, get out of there… there are times when you just need to be able to get the person to work out actually is this the most important things for you.*
		4. Seeing others' problems differently	**27:FGA4:240, 248** Male, Former SU, Traffic Manager LA	*In a group you are going to see one side of the story, you are never necessarily going to get that person coming in and saying my performance is poor …But there has to be some sort of mechanism for that person to actually come to the conclusion that the state that they are in is affecting their performance.*
			15:FGA3:1095 Female, Former SU, Staff Nurse	*I mean some people that are workaholics, they work because it gets them away from whatever the main issue is you know so therefore that's why they are always at work because they don't want to deal with whatever is behind, if you make them stop work then they sort of realise because they are just avoiding everything, then they are causing themselves more stress because they are always at work which then compounds the problem and it's obviously they would have to get a better balance in their life to try and deal with whatever issues that they have got.*

			023:FGA2:1084 Female, Former SU, Parent	*Sometimes a lot of people are talking then it triggers something in somebody else.*

Table 98 - REFLECT

	Sub theme	Mechanism	Attribution	Illustrative quote
REFLECT	**Learning from each other**	**5. Speaking about my experience**	**023:FGA2:422** Female, Former SU, Parent	*I think you feel a bit more comfortable with each other if you know you are all suffering with something similar.*
			028:FGA4:178 Male, Former SU, Financial Manager LA, Union Rep	*You are talking to likeminded people and you can just throw it out and know that most people understand and it's a safe place.*
			23:FGA2:1148, 1152, FGA3:642 Female, Former SU, Parent	*We would really open up…you learn to trust in people then don't you and it feels safer… I could sit and say what had happened to me. I would be able to say it now, where before I wouldn't have been able to say it.*
			019:FGA1:50, FGA2:1112 Female, Former SU, Retired HE Lecturer	*Sharing and realising that you are not alone…other people have the same problems. That's the greatest benefit I think of group therapy.*
		6. Listening to others' experience	**012:FGA2:1094** Male, Former SU, IT Manager	*Everyone is learning something from everyone else.*
			19:FGA3:510 Female, Former SU, Retired HE Lecturer	*It would be very heartening for people in the group to see somebody who has gone through it and come out the other end and has got better because I think when you're in that situation you often think you are never going to get better.*
			012:FGA3:514, 552 Male, Former SU, IT Manager	*I think I agree, I think it helps massively…it's alright you [therapist] saying you can get rid of them but I'd say I was like that and now I just don't have them anymore [panic attacks] and they are like, alright, so there is a light at the end of the tunnel… say well my experience of being through all this and this is, just for them to see there is a way to get out of the other side, you have got a walking example of someone who has got out the other side.*
	Under-standing each other	**7. Under-standing myself: insight**	**024:FGA4:452** Female, Former SU, Bank Worker	*You start panicking or worrying or thinking oh it must be me, it must be me and nobody is going to help me because they don't understand and really there's nothing I can do, they basically want someone who is well.*
			027:FGA4:436 Male, Former SU, Traffic Manager LA	*It's again helping the people to understand what the actual problem is that's going on and like I said earlier about recognising two years later that I was actually bullied, it's recognising that someone else independent in the group saying oh actually that's divide and conquer going on there and then you are right, and that's what I need to address. It's not always other emotions, it's the practical issue.*
			012:FGA2:742 Male, Former SU, IT Manager	*It could be either and you could have been depressed and that's made your work totally stressful or the work could have been so stressful that it's sent you into depression or anywhere in between basically.*

			015:FGA3:851 Female, Former SU, Staff Nurse	*Some of it is partly to do with how you are with work and your personal life, you know, because I know for me, I'm like my work side of things you know with my depression and things like that, my work side of things was always smooth, no problem, assertive, I can deal with all sorts, deal with anything but the minute something little at home would have happened it would have been all like trauma and everything would have gone to pot.*
			001:FGB1:142 Male, Psychotherapist/ Manager, LYPFT	*I guess that you know the personal issues affect work and vice versa, so if someone comes along and says 'I want to talk to you about my work situation' and you know, well not that you know but you can see from what's being brought that there's other aspects that's contributing to the difficulties at work.*
			014:FGA1:326, 318, FGA3:1149, 1153 Male, Former SU, Engineer	*There's an awful lot of factors that can affect the situation, personal relationships, outside factors, how is the management structure the company structure of the organisation, lots of different things…[but it should involve] identifying the underlying problems as well….[what about] the underlying causes…you have got to have the why and the what.*
			013:FGA2:400 Female, Former SU, Civil Servant	*One of the activities could be either by drawing or using the stone things that we did to map out the things that are causing you stress…and that would give you insight into what you think is where the bigger problems are.*
		8. Under-standing others: outsight	**027:FGA4:466** Male, Former SU, Traffic Manager LA	*If you are just going and talking about how it is making you feel, they can't work with that… helping people hone down to see actually this is what's happening…. putting a name to the problem.*
			011:FGB4:46, 54 Female, RMN, OH	*I guess you could use a screen tool and find out what the main things people are highlighting it. Or if there's anything on there that could maybe help sort of determine what the big issues are for each person.*
			005:FGB2:300 Female, Psychotherapist/ Manager, LYPFT	*I just wondered what the possibilities were for people to enter the group with a kind of schema that they would want to explore whilst they are in the group you know, some of the inter-personal dynamics, we assume that there'll be that, then you can explicitly kind of call upon in the therapy so it doesn't get carried away you know, victim, isn't it awful you know and there might be some acknowledgement that it is.*
			014:FGA2:1088 Male, Former SU, Engineer	*If you take a certain situation we can understand too, as something that has happened to somebody, reconstruct it in those terms and then deconstruct it and you find out what's going on.*
			014:FGA3:857, 861 Male, Former SU, Engineer	*Work is also a social environment as well as a professional one and social relationships at work are for a lot of people very, very important. Because you have got two things going on: social interactions as well as the professional ones. When they get out of kilter you can have problems.*
			012:FGA3:913 Male, Former SU, IT Manager	*If they had a better social understanding of their colleagues then they might not take things as personally.*
			014:FGA1:238 Male, Former SU, Engineer	*That's something that you want to try and identify fairly early in your group therapy programme, what is causing it for the individuals, whether it is something they are taking to work, or it's work that is causing it, it's two different things.*

Table 99 - REGULATE

	Sub theme	Mechanism	Attribution	Illustrative quote
REGULATE	Managing my mood	9. Self-regulating	**024:FGA3:1087** Female, Former SU, Bank Worker	*I'm in between, I'm up and down. It can be on an hourly basis, on a minute, you know, every half hour I'm in a different mood and it's whether I do some work or I don't or I suddenly get into the mode of wow I can do several cases now, blah blah blah and then, you know.*
			027:FGA4:146 Male, Former SU, Traffic Manager LA	*It is very difficult to do because you are so up and down through the day. So if you can't do it it's even harder for the employer because they see you in different states, it's very difficult for them to do that.*
			019:FGA2:1028 Female, Former SU, Retired HE Lecturer	*It's all very well to know the theory but when your behaviour…it's the speed of the behavioural reaction and the physical reaction, it's so difficult.*
			023:FGA2:1048, 1060 Female, Former SU, Parent	*You've got to feel the emotion… You're stuck in a rut aren't you because you can't get rid of that feeling.*
		10. Co-regulating	**025:FGA4:188** Male, Service-user representative, LYPFT	*It's non-judgemental as well isn't it? It's not looking down, oh yeah I can see you have got this wrong and that wrong, it's just saying I know what you are feeling.*
			025:FGA4:180 Male, Service-user representative, LYPFT	*I think a group where you have got people that have got these things in common validate each other's experiences in a way that sometimes clinicians, doctors, nurses, all respected….but that they might not you know they sort of see symptoms and missing the negative stuff where your peers can recognise and validate your experiences and that is a very important thing.*
			28:FGA4:178 Male, Former SU, Financial Manager LA, Union Rep	*One of the things I've done in the past is not always revealed these things to my partner because you feel oh I don't want to put the pressure on them and I felt I had no one really to turn to.*
			029:FGA4:158 Female, Former SU, Retired Bank Manager	*I think you could have shared what you were going through, I felt like I had to hide it and I think a lot of people hide your depression and hide what you are going through.*
			026:FGA4:184 Female, OT, LYPFT	*What I've heard from people is that it's easier for them to take that on board from someone who has been through it rather than somebody [practitioner] coming and sitting in your home and saying well why don't you try this and you know it has more meaning doesn't it, if somebody else has tried it and it actually helped.*
	Coping better	11. Active coping	**015:FGA3:835** Female, Former SU, Staff Nurse	*When they start looking at the problems and the issues as to what the problems are at work and when they start breaking down the problems and the issues…it's like developing some coping strategies isn't it to help you sort of deal with it… you have got to try and find the way that you can manage to cope with it and do your job.*
			016:FGA2:510 Female, Former SU, Financial Assistant	*And then if you can get one under control I suppose you can actually focus on the other one sort of thing.*
			014:FGA3:1149 Male, Former SU, Engineer	*Going back to what you were saying a couple of minutes ago that to me is more along the lines of managing and coping and developing strategies for living with depression.*
			028:FGA4:276	*If you have got this particular stress here is some practical tips. So if you did that kind of checklist with yourself thinking right are you*

			Male, Former SU, Financial Manager LA, Union Rep	*finding that you are over-thinking on things, try breaking your task down throughout your day and writing yourself lists and tick them off and things like, it might sound like, you know easy peasy now you say it but a lot of the time the simple ideas and you have just seen it there, thinking yeah that's good, I think maybe I can start doing that and then I'll feel more in control if I'm ticking lists off and I'm feeling it's all running away from me trying to do too much at once because that's something else that I found myself doing, flipping from task to task rather than sticking on the one at hand.*
			013:FGA2:1128, 1136 Female, Former SU, Civil Servant	*People could give examples of how they dealt with it, good or bad… because it gives you alternatives that you mull over in your mind, what if I had done that or is that an approach I could use now, would that work for me, so it gives you options to think about.*
			012:FGA3:102 Male, Former SU, IT Manager	*You can share the solutions to your problems so if your first solutions don't work then you are going to know that's why you are here, you can't solve your problems but by the end of it you should be able to get some ideas from the group how to deal with that.*
		12. Passive coping	**007:FGB2:262** Male, Psychologist/ Manager, LYPFT, Union Rep	*Yeah, yeah, that's what I was thinking, yeah this thing about being able to accept the situation as it is. You know I mean things are tough at the moment aren't they so maybe what we are looking at is ways of staying afloat, you know, just treading water or just basically surviving in the organisation.*
			024:FGA4:460 Female, Former SU, Bank Worker	*At the moment the whole of my work force moans and moans and moans. So if I'm good at the time I can rise above it and whatever.*
			015:FGA3:1039, 1043 Female, Former SU, Staff Nurse	*How to sort of learn to actually you know go in and like do their job and not let management get, you know and let them be able to you know like shrug it off in way, do you know what I mean? If you can't change the management and you know they are going to whatever way and this is going to be the way it is…*
			012:FGA3:843 Male, Former SU, IT Manager	*I think a lot of it is down to how you are and some of this about can you learn that, get a thick skin. I've got quite a thick skin.*
			024:FGA3:1055 Female, Former SU, Bank Worker	*Yeah but if [you just] sit there and think oh I'll just cope with it, I'll learn to just cope with the way they are then it's never going to change and you are just hiding really, aren't you, just thinking, you are just giving up.*

Table 100 - RESOLVE

	Sub theme	Mechanism	Attribution	Illustrative quote
RESOLVE	**Managing my behaviour**	**13. Practising skills**	**019:FGA2:1140** Female, Former SU, Retired HE Lecturer	*I think role play is a really useful way of at least sort of trying to practice ways of being assertive…I really like the Gestalt idea where you have for example your boss in another chair and you talk.*
			009:FGB4:196 Female, OT/ Manager, LYPFT	*With some appreciation and sharing that appreciation that many of these skills are transferable and it's not always helpful to think in silos the whole time but to sort of transfer these skills across to other aspects of the person's life. I mean I understand what you are saying completely about keeping focus, keeping the work focus.*
			024:FGA3:1051 Female, Former SU, Bank	*You need to learn to, if you focus on yourself…your own this, your own that, then the ways you respond to people…the manager's not changed, they are the same but you are going to be different so the way they respond to you as this different person it's going to*

			Worker	*change.*
		14. Goal-setting	**028:FGA4:264** Male, Former SU, Financial Manager LA, Union Rep	*It's not all about what's the world done to me, I need to change.*
			002:FGB2:284 Male, CBT/Manager, LYPFT	*Again it seems very skills based type of thing, acknowledging certain things but not being able to [change them]. That's what we are teasing out isn't it, what is culture, what can influence control, it's again saying to what level can change things, "What can I do differently?"*
			008:FGB2:272 Female, OT, Job Ret Specialist, Voc Rehab Service	*And it is about the positive experience, it's not just about dwelling. It's not about just constantly talking about rubbish. It's about let's look at strategies, let's move forward. This isn't going to be the miracle at the end of the tunnel but it might actually give you a few ideas to cope better with the situation.*
	Dealing with conflict	15. Saying what I want and finding a shared solution	**016:FGA1:276** Female, Former SU, Financial Assistant	*It infuriates me…so my anger would go straight up then obviously that comes across as aggression and then it just ends up in a battle of wills really.*
			012:FGA4:398 Male, Former SU, IT Manager	*We were at loggerheads on what we were expected to do and then people started to see quite strongly that you come up with adding more people in and the effect was positive but if I hadn't said anything and lots of people didn't say anything they just take from that, then that's when everybody's working long hours, so.*
			014:FGA2:772 Male, Former SU, Engineer	*Some people when they are very stressed show ratty argumentative, confrontational, if you can recognise that, you might be able to manage the confrontational side of things, aggressive.*
			012:FGA3:1121 Male, Former SU, IT Manager	*Sometimes you have got to say right I can't actually do all of this so I've got to work out how can I still do it, so it's fit for purpose but without going at it nth detail.*
			024:FGA3:1041 Female, Former SU, Bank Worker	*You have got to stand up for yourself. Be confident.*
			025:FGA4:374 Male, Service-user representative, LYPFT	*When I had depression it hasn't all been about what's going on at work or it might feel it's maybe contributed whether it's to do with relationships or activities or things in life that we have talked about and you can change what you can change, can't you but when you are in that disempowered state, taking up arms against your employer to change things…*
			019:FGA1:282 Female, Former SU, Retired HE Lecturer	*I know a lot of my colleagues go to counselling [service] and all of that but nobody really dares to tackle it head on because they are scared of losing their job and they are scared of the stress that it is going to cause.*
		16. Hearing what others want and finding a shared solution	**028:FGA4:410** Male, Former SU, Financial Manager LA, Union Rep	*It's affecting their customers as well because that's the other thing that you find that the organisations don't always think, is like saying we have got great customer care but if they have got members of staff who are under stress and the strain is showing and it's coming out that they are not showing customer care because they are feeling unwanted, [invisible], feeling stressed and then reacting badly to customers, that's bad for them, they lose – that's bottom line whether it's in a private organisation or a public sector. That's give a wrong perception from day one. So it's getting picked, they see it's got a benefit win-win for them.*
			008:FGB2:258 Female, OT, Job Ret	*I mean I've worked with people…when I get to the nitty gritty of it, actually it's half a dozen of one and it's half a dozen of the other and I suppose that's where…you get them to be open and start discussing some other things.*

			Specialist, Voc Rehab Service	
			024:FGA4:440 Female, Former SU, Bank Worker	*So I understand both sides really because at the end of the day it's a business.*
			014:FGA4:122 Male, Former SU, Engineer	*It's both sides have a duty, the employer has a duty to maintain the health of the employees and equally the employee has a duty to himself, the employer and also the people that they work with.*
			027:FGA4:190 Male, Former SU, Traffic Manager LA	*At the end of the day we are in a contract with them anyway and we are sort of meant to be in the workplace. They want us there, they want us well but they can only go so far with that.*

Table 101 - RELATE

	Sub theme	Mechanism	Attribution	Illustrative quote
RELATE	Two-way feedback	17. Giving feedback	**023:FGA2:23** Female, Former SU, Parent	*Yeah like we did the little group circles and then you have got to do some feedback and they say well what do you think and in a few groups we had, if you said something and this other person's got really, really a bit bolshie.*
			016:FGA2:1068 Female, Former SU, Financial Assistant	*The more input that you get from everybody as a group.*
			012:FGA3:1107 Male, Former SU, IT Manager	*I think if you are in this group and you have got a problem, so even if you don't think that any part of it is a problem that it's there to be challenged basically.*
			024:FGA4:234, 238 Female, Former SU, Bank Worker	*You are thinking about what you are doing to annoy people, or how you are, and it can actually work the opposite way and really annoy you…you might just completely lose the plot and start thinking too much and over ruminating stuff like that but that's what you could do.*
		18. Receiving feedback	**012:FGA2:1094** Male, Former SU, IT Manager	*There is that opportunity for other people just to give you feedback from other people who learn from that.*
			016:FGA2:1122 Female, Former SU, Financial Assistant	*It would be nice to have feedback to say "I actually tried what we discussed and it didn't work or I tried this instead".*
			024:FGA3:1015 Female, Former SU, Bank Worker	*You need people to see things [different] from your perspective otherwise you way as well just sit in a room with people that agree and then you are never going to learn anything, are you? What are you going to learn?*
	Helping each other	19. Helping myself	**012:FGA4:268** Male, Former SU, IT Manager	*I think it's important…to know that they are also contributing to it and working out how they can help themselves as well.*

			027:FGA4:306 Male, Former SU, Traffic Manager LA	*One of the focuses of the group…needs to be on how we take control and responsibility because no one else is going to do it for us and our managers can only go so far.*
			013:FGA2:452, 456 Female, Former SU, Civil Servant	*When you ask people to come, to commit to a group, [do you ask if] they are willing to share things about themselves? Because we did have someone in the group, they never spoke did they…every week…it was I'll just listen to other people…and you won't help yourself get anywhere like that.*
			023:FGA2:1148, 1152 Female, Former SU, Parent	*I enjoyed doing the small groups, we used to go downstairs and like 3 or 4 people something like that and we would really open up…you learn to trust in people then don't you and it feels safer.*
		20. Helping others	**012:FGA1:220** Male, Former SU, IT Manager	*This is all about informing the person giving them things they might not have thought about and how to deal with the situation.*
			023:FGA2:1166 Female, Former SU, Parent	*Other people give you suggestions how you could have coped with it, it just makes you think differently, you know, so instead of just being stuck on yourself all the time you took it on.*
			028:FGA4:186 Male, Former SU, Financial Manager LA, Union Rep	*It can help, you can feel better as well, you can put a hand out and help a fellow sufferer. I feel better for it as well.*
			027:FGA4:190 Male, Former SU, Traffic Manager LA	*I would be very willing to do some of these sort of training sessions to come in as a person that has suffered and explain some of the issues as a sufferer… someone like a peer [mentor] that would be able to help you and sit alongside you and say what you are doing there isn't helping you, slow it down and you know what you are going through is bullying and this sort of thing.*

Table 102 - RETAIN

	Sub theme	Mechanism	Attribution	Illustrative quote
RETAIN	**Staying at work**	**21. Disclosing mental health problems or work-related stress**	**012:FGA1:152, 156** Male, Former SU, IT Manager	*Yeah I mean both of those would be valid and you could still want to not disclose and believe there is still a stigma involved in that in mental health and not be prepared to disclose whilst still wanting to……get some treatment and without it necessarily affecting your ability to receive that treatment. You don't necessarily think you are to blame or anything, I'm not to blame but I don't necessarily want to be disclosing.*
			029:FGA4:158 Female, Former SU, Retired Bank Manager	*I think you could have shared what you were going through, I felt like I had to hide it and I think a lot of people hide your depression and hide what you are going through.*
			003:FGB2:134 Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT	*But my point is that …. people are very reluctant often to disclose their mental health issues to an employer and it's a big piece of work to talk to people about disclosure and to support them to open up but then if the support isn't in place to manage that then it's almost like you have kind of encouraged people to do something that might leave them feeling quite unsafe I think.*
		22. Negotiating	**11:FGB3:488**	*Because you also need to feel confident in asking them, we can make adaptations as much as possible but it's whether that person*

		reasonable adjustments	Female, RMN, OH	*feels empowered enough to be able to request what they need, the support that they need, so that's where CBT really comes into it.*
			014:FGA2:350 Male, Former SU, Engineer	*It could be a situation, given it's work related, a situation at work, maybe you could work through that in role play, some people will have personal issues, some people will have structural issues and…*
			026:FGA4:256 Female, OT, LYPFT	*Well it could be things they find difficult at work, you know, I don't know, writing reports and just having difficulty, just doing half of one, you know things they just find hard.*
			014:FGA4:66 Male, Former SU, Engineer	*Can I come back in? I think that's a really, really important question actually because some of these hazards maybe either cause or are contributing factors to people's depression.*
	Returning to work	23. Negotiating phased return	**028:FGA4:516, 520** Male, Former SU, Financial Manager LA, Union Rep	*Well when I had what was nearly a breakdown I did go into work specifically every week just to see them, that's the most I could commit to…I went in and just said look this is where I am and you know just nice to see the office and to see people and just you know to chat with them but on my own terms and then I went off and did my own thing and it was a month before I felt even ready and then it was a phased return, come in when I want, if I needed to go home and if you got too much go out of the office.*
			009:FGB3:498 Female, OT/ Manager, LYPFT	*Yeah like you say I agree you don't want to alienate people, and I think it's about sort of valuing structure people put into their week even if it's not work, it's structure, it's getting up on time, it's routine, the sort of other activities that we all do that don't include work which are really important in many ways and it's capturing that isn't it?*
			014:FGA4:592 Male, Former SU, Engineer	*The reason I was asking that was because if you wanted people to get back in contact with work if they are off sick, then do you have the opportunity to engage with what the service user does to engage with the company to work out a sort of back to work programme that you could have input into.*
		24. Negotiating on-going support	**027:FGA4:466** Male, Former SU, Traffic Manager LA	*I think there is value in the exercise as far as it helps to name the problem. When you speak to the employer it becomes nebulous, talking about feelings, the employer can't get a handle on that and they start to dismiss you and become aversive. When you go to the employer and say … what you are doing is wrong, they understand that because you are almost talking in Union threat terms and they can work with that. There is a behavioural I think you are talking about, what you are doing wrong that you need to put right because we are not going to work with that. It's unacceptable. If you are just going and talking about how it is making you feel, they can't work with that.*
			003:FGB1:176 Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT	*…it's for people with depression who are struggling to work. the typical example of somebody who has been referred to [us] having had an acute episode of depression using acute services in the Trust and then be supported back into work, having found work very stressful when she was depressed and have mental sort of recovery, now finding work to be an important part of the recovery journey and I think that's quite a sort of typical example…*
			28:FGA4:58 Male, Former SU, Financial Manager LA, Union Rep	*I've been a Unison Steward before I had my latest problems and we regularly would do risk assessments at work along with management but there's no risk assessment for psycho-social hazards done on a regular basis.*

APPENDIX 49: MIND MAP PRE-INTERVENTION PLANNING FOCUS GROUPS 'B'

Each focus group had a different discussion guide to cover the issues the author wanted to consult upon. The frontline practitioner and manager group (B) were asked to consider questions related to practical issues about running the research study (Appendix 34).

Immediately following each focus group, the Mind Mapping Method was used to identify and summarise participants' concerns and advice that emerged from the discussion. This was later circulated to participants by email to verify the main themes and responses. Illustrative quotes are provided here, attributed to the person who said it; their place of work; gender; participant code; with focus group number and time point.

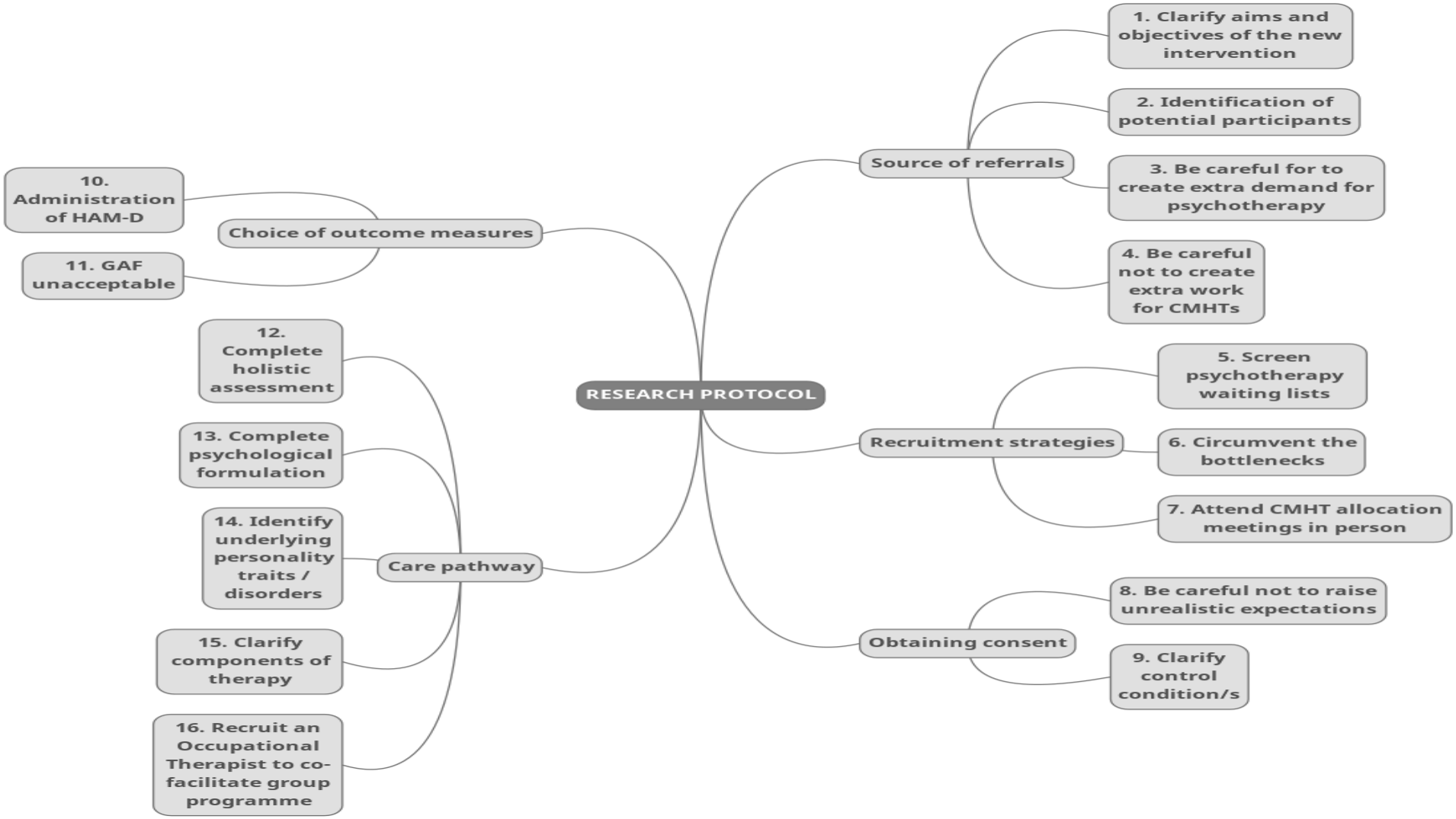


Figure 27 – Mind Map Research Protocol

Table 103 – Research Protocol Sample Quotes

	Study procedures	Sub theme	Attribution	Concerns raised / advice offered by participants of Focus Group B
RESEARCH PROTOCOL	Source of referrals	1. Clarify aims and objectives of the new intervention	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB1:256**	*It's a really interesting question because I think it sort of might fundamentally change the nature of the group. Because for example if it's a group designed for people referred in the way you just described, 004, then the primary kind of impetus for joining the group is definitely workplace stress, whereas if it's a group that's configured to suit people who have had a moderate to severe episode of depression and who are having that at work that's a different focus and I think it would be important really probably not to try to meet the needs of those two groups the people in the same group. I think that would be difficult to do, not that there might be a need for both of those.*
			Female, Psychologist, LYPFT **006:FGB2:108**	*So it is people who are in secondary care services, we are not talking around some kind of proactive, what word am I looking for? Preventative…*
			Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB2:186**	*I would say though from being in ICS and CMHT, that a large proportion of the people especially in ICS are people who are in work and [struggling].*
			Female, OT, Job Ret Specialist, Voc Rehab Service **008:FGB2:52**	*I think just from my experience and the referrals I get there probably is a demand for both because I would say a large section of the clients that I work with work within the NHS so that's quite telling I suppose.*
		2. Identification of potential participants (employed or unemployed, staff or service users)	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB1:176**	*I'm thinking is it quite possible for both of things to co-exist in terms of, for example, that book, but actually it's for people with depression who are struggling to work. the typical example of somebody who has been referred to Workplace Here having had an acute episode of depression using acute services in the Trust and then be supported back into work, having found work very stressful when she was depressed and have mental sort of recovery, now finding work to be an important part of the recovery journey and I think that's quite a sort of typical example of how that might don't know if that makes sense with what you were thinking.*
			Male, Psychotherapist, LYPFT **004:FGB1:214**	*If you take that stance referrals could come from anywhere, a lot of different places, it could be a Supervisor, just struggling with work, or a Manager…*
			Male, Psychotherapist/ Manager, LYPFT: **001:FGB3:306**	*I need to understand something here because if you need to warn PTS to say they are eligible to come into our service what happens then because I suppose how then does this fit in with the notion of a waiting list because we then have created – and I have no major issues with that but we then have created a group of people who will jump the queue.*
		3. Be careful for to create extra demand	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB2:128**	*I think this issue of capacity is a really interesting one in terms of what could be expected from a group setting and I would imagine looking if you could back me up on this point but if you are involved with the job retention process then a large proportion of your time and effort is spent with that liaison, it's a large proportion.*

		for psychotherapy	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB2:134**	*But my point is that if you try to engage with employer or Occupational Health or HR then you might be opening something up which if that work isn't done has actually been unsafe to open up, so for example like you said that people are very reluctant often to disclose their mental health issues to an employer and it's a big piece of work to talk to people about disclosure and to support them to open up but then if the support isn't in place to manage that then it's almost like you have kind of encouraged people to do something that might leave them feeling quite unsafe I think, if there isn't a one to one sort of backup from the group. Does that make sense, I don't know if I explained that very well.*
			Female, Psychotherapist/ Manager, LYPFT **005:FGB2:144**	*So I suppose the offer, if it were accepted the offer of contact with the employer could raise expectations in the service user something that could be quite demanding, bearing in mind from what you have just described and you know the machinations of the system.*
		4. Be careful not to create extra work for CMHTs	Male, Psychotherapist/ Manager, LYPFT: **001:FGB1:448**	*I think what 004 is saying is very important here….. anyway, anymore but I know that when people are under pressure they tend to focus and options become less and less available and I think that is happening across the organisation so my suggest would be that you need to go to them, you need to, I don't know what sort of, meeting there that would facilitate you attending, I would say they need to see you, they need to see who you are and they need to be able to ask questions then hopefully they will turn up to the meeting. There is no guarantee but if you go to a meeting that's already established, yeah, at the source.*
			Female, OT/Manager, LYPFT **009:FGB3:110**	*Yeah I suppose my initial reaction is CMHT staff are so busy at the moment so absolutely overwhelmed with work and there's a real danger that sort of additional pierces of information just get put to one side. I suppose my thinking was around maybe there need to be some sort of champion person, I mean there are only three hubs now, some sort of champion person within CMHT to kind of, I don't know, be the main link person or who might act as an advocate for you within CMHT. I think if this arrived on a Clinician's desk with everything else that's going on at the moment it would probably not get the attention that it deserves.*
	Recruitment strategy	**5. Screen psychotherapy waiting lists for employed people with depression**	Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB1:60**	*I think there would definitely be a need because of working across both Workplace Here and the Trust I kind of have an overview of the sort of referrals that are coming through and there are a lot of referrals coming through for people who are moderately to severely depressed and struggling to say in work. That suggests to me there is a need.*
			Female, OT/Manager, LYPFT **009:FGB3:174**	*I was just thinking about the assessment I know a couple of things, I think we have to collect that minimum data don't we – if someone is employed or not so it's on the minimum data that we have to collect and then there is a section, they have just changed the holistic assessment and it's much larger now.*
		6. Circumvent the	Male, Psychotherapist, LYPFT **004:FGB1:470-474**	*I mean just going slightly aside, [CMHT] aren't aware of it, [they] aren't aware of this. They are not aware of it…of referring outside of the quota because they have got an email but they've forgotten about it.*

		bottlenecks	Male, Psychotherapist, LYPFT **004:FGB1:230**	*Why not? Why could I not if I was struggling, feeling depressed approach my Manager and sort of say look, in management supervision, I need some help. I don't want to go and see CHMT because I feel uncomfortable, I don't want to go via my GP, it feels awkward going to primary health care, you know is this open, could I go please?*
		7. Attend CMHT allocation meetings in person	Male, Psychotherapist/ Manager, LYPFT: **001:FGB1:216**	*They need somebody to go and tell them and just re-emphasise because they will remember a face and a name more so than an email…But just going back to your particular approach you know they will remember your face and name more so than you just sending out a generic email. I may be wrong.*
	Obtaining consent	**8. Be careful not to raise unrealistic expectations**	Male, Psychotherapist/ Manager, LYPFT: **001:FGB1:138**	*I think it would be crucial that you stay within that area that you have identified that's related to work, but we know that that is also an artificial boundary, so I see some really you know skilful stepping here that will be essential because if someone's signed up to deal with aspects associated with the work you know you could inadvertently stray into areas they didn't sign up to.*
			Male, Psychotherapist/ Manager, LYPFT: **001:FGB3:598**	*The research is about you. So for it is how you keep those two areas that potentially could conflict, you know, clear in a person's mind because Ombudsman sitting here thinking well if you keep asking more and more information from me, what am I getting back from you, or from the experience. That's my response.*
			Male, CBT/Manager, LYPFT: **002:FGB3:320**	*Can I check what is involved with the consent because I was thinking they have probably gone through quite a lot before they get to discuss, I'm just wondering what would be involved in there, could that be at an earlier stage or not…*
			Male, CBT/Manager, LYPFT: **002:FGB3:324**	*They have gone through all of that and then you say no there.*
		9. Clarify control condition/s	Female, OT/Manager, LYPFT **009:FGB4:430**	*So the control group wouldn't have to sit in PTS…*
			Male, Psychotherapist/ Manager, LYPFT: **001:FGB3:358**	*Well I would suggest that you get ** involved on this because I know that the Research Assistant is not on this.*
			Male, CBT/Manager, LYPFT: **002:FGB4:378**	*If it was me and it is a work related issue…. Probably would be approached in 1:1…. So again there might be an overlap there that might cover some of the…. Treatment as usual couldn't…*
			Female, Psychologist, LYPFT **006:FGB4:390**	*Yeah I was going to say, or people who are in not in PTS…*

			Female, Psychologist, LYPFT **006:FGB4:394**	*You would have to promise them treatment at the end.*
			Female, Psychologist, LYPFT **006:FGB4:402**	*You could if you created a false waiting list, if you assess enough people for two groups…*
			Female, OT, LYPFT **020:FGB4:406**	*Could you kind of have people in the group and then the other people for 12 weeks of one to one but with a workplace stress, is that what you were going to do?*
			Female, Psychologist, LYPFT **006:FGB4:414**	*Could you not just do pre and post measures then compare it with other norms from other studies?*
	Choice of outcome measures	**10. Administration of HAM-D**	Female, CBT/OT, LYPFT **021:FGB3:290**	*I was just wondering where you have got them in the process with the referral form, I can understand why you have got them there, but just thinking about [009]'s point about the volume of work and CMHT staff, I'm just wondering whether there is anywhere else they could go, whether there is somebody that's independent that could do that as role, I don't know.*
			Female, CBT/OT, LYPFT **021:FGB3:298**	*Could you almost use a side kick there couldn't you, somebody independent? Junior doctor, trainee psychiatrist?*
			Female, RMN, OH **010:FGB3:410**	*If the Psychology Assistant did the scores consistently then that would take that problem out of the equation, wouldn't it.*
		11. GAF unacceptable	Male, Former SU, IT Manager **012:FGA3:1161**	*Well that's actually, that's a ridiculous scale…*
			Female, RMN, OH **010:FGB3:282**	*I suppose in OH one the issues that immediately that I think of is some of my colleagues are general nurses and I don't necessarily see every person who walks through the door because often obviously people present with a physical kind of problem and then through their consultation with the OHA who are general nurse trained, mental health issues are discovered. Now they wouldn't need these.*
	Care pathway	**12. Complete holistic assessment**	Female, RMN, OH **011:FGB3:188**	*The assessment that we do carry out does take into account it's very holistic it does take into account work and personal life, any factors that are impacting on health and well-being.*
		13. Complete psychological formulation	Female, RMN, OH **011:FGB4:46**	*I guess you could use a screen tool and find out what the main things people are highlighting it.*
			Female, RMN, OH **011:FGB4:54**	*Or if there's anything on there that could maybe help sort of determine what the big issues are for each person.*

			Female, OT/Manager, LYPFT **009:FGB4:98**	*It's all very inter related you know, it is very difficult to sort of…to tease out... it is personal, what is work related and you know looking at these, if somebody was depressed… your self esteem's quite low, it's very difficult to be assertive when you are depressed, whether it's a specific work related issue or not.*
			Female, OT, LYPFT **020:FGB4:168**	*Especially because some people like their work self and their other self, a lot of people have different, so if they are all work based then you are coming in with that in mind, that it's about how you are at work and where you want to get to in terms of yourself at work.*
			Male, CBT/Manager, LYPFT **002:FGB4:170**	*But there might be influences at home….so say if they're stressed at work they might be taking it out on people at home.*
			Male, CBT/Manager, LYPFT **002:FGB4:120**	*Formulation…. You have got environmental factors anyway but that could be work related… but if specifically it's about depression… that's the way I would look at these, adapt that one because it's already there isn't it?*
			Male, CBT/Manager, LYPFT **002:FGB4:158**	*I think the work based theme, I would do problems and targets so a problem might be let's say, I'm not assertive I don't know and low self-esteem at work. Sometimes it might be the boss saying do this, do that and taking on everything so it's to learn not necessarily to say no but not to take on too much…*
			Male, CBT/Manager, LYPFT **002:FGB4:162**	*So you need to be more specific than, the taking on that they can't really do… I can't do that but I'm going to have say I can't do X report…. So problems and targets...It's a similar thing.*
		14. Identify underlying personality traits / disorders	Male, Psychotherapist, LYPFT **004:FGB1:148**	*How do you unpick the sort of personal temperament disposition nature of somebody from the workplace stress? How do you make it specifically different? Different people experience work in different ways some people get stressed and depressed about it and some people won't and some of that might be dependent on the job the role and the circumstances but some of it might be dependent on the type of person it is and how do you sort of unpick that in terms of…how do you keep it to work?*
			Female, Psychotherapist/ Manager, LYPFT **005:FGB2:300**	*I just wondered what the possibilities were for people to enter the group with a kind of schema that they would want to explore whilst they are in the group you know, some of the interpersonal dynamics, we assume that there'll be that, then you can explicitly kind of call upon in the therapy so it doesn't get carried away you know, victim, isn't it awful you know and there might be some acknowledgement that it is.*
		15. Clarify components of therapy	Female, RMN, OH **011:FGB4:110**	*When you are looking at the sessions you probably would, I envisage be starting .. in general, sort of exploring resilience so looking at how do you approach everything , like general stress and that kind of thing but then you go into sort of becoming more specialised in terms of the workplace later in the programme.*
			Female, OT/Manager, LYPFT **009:FGB4:196**	*With some appreciation and sharing that appreciation that many of these skills are transferable and it's not always helpful to think in silo's the whole time but to sort of transfer these skills across to other aspects of the person's life. I mean I understand what you are saying completely about keeping focus, keeping the work focus.*

			Female, Psychologist, LYPFT **006:FGB4:320**	*I guess how you get round that is…we make our sessions very, very long half of the session about psychoeducation half of the session for some psychotherapy, it's how we get around it.*
		16. Recruit an Occupational Therapist to co-facilitate group programme, provide 1:1 employment support, and low key liaison	Female, Psychotherapist/ Manager, LYPFT **005:FGB2:64**	*Yeah I was just thinking about the potential then in the intervention to think about the cultural aspects that can get in the way or impede or create anxiety that then in a manageable way sort of organisational consultancy, you could liaise with the employers.*
			Female, OT, Job Ret Specialist, Voc Rehab Service, LYPFT **003:FGB2:246**	*I wonder whether introducing an Occupation Therapy model might help here. When occupational therapists look at this issue they tend to use models that look at the person, the environment and the occupation. So in that sense you have kind of covered the environment if you are talking about discussing the cultures of workplaces, discussing the legislation because the environment isn't just physical, it is institutional, cultural, social and then we are looking at the person and the technique in this book, look at the person, how the person perceives things, how the person experiences things and then the occupation is the job task itself and the modifications that might be made to that.*
			Female, OT, LYPFT **020:FGB4:474-486**	*I guess maybe targeting OTs for the training needs…. For a service to allow a person to come out of work…it's quite a good learning opportunity you could take it back…. Improve work skills generally…. It would be good if you had somebody who knows about workplace issues.*

APPENDIX 50: THE TREATMENT PROGRAMME

The new intervention as a work-focused relational group-CBT Treatment Programme for moderate-severe recurrent dperession is outlined below, and it will include several components which are highlighted in bold italics.

50.1 INDIVIDUAL SESSIONS

Following referral, each client will be seen for up to four 1:1 sessions to complete a holistic assessment in line with the Trust's Care Programme Approach policy. This stipulates that the client's care plan should include ***risk management***, ***crisis contingency***, and ***relapse prevention plans***. The policy also recommends that family members should also be offered support so the intervention will include one joint ***carer's support session*** in the pre-intervention stage and one in the post-intervention stage. As part of crisis contingency plans joint sessions will be available during the treatment programme if needed.

The ***holistic assessment*** will also involve an ideographic ***psychological formulation*** using the predisposing, precipitating, and perpetuating framework to understand the presenting problems in context. A ***personalised care plan*** will be based on each client's particular **problems** which will be operationalised so that behavioural change ***goals*** will be agreed.

A written assessment summary will be sent to the client and copied to any involved practitioners and professionals, with the client's consent. The client might also request that the letter be copied to their line manager, OH or HR departments to improve co-ordination and collaboration.

During the group-CBT programme, clients will also be able to ask for brief 1:1 time (up to 15 minutes) with therapists if they can come early or leave late, mainly to clarify anything that may have confused them during the group sessions or to ask for specific advice about a planned behavioural experiment for example.

50.2 GROUP SESSIONS

The group-CBT programme will involve 12 weekly sessions (with a one-week break in the middle). The sessions will run from 10am-3pm. Clients will be asked to sign an informal contract which lists the ***group guidelines*** as bullet points. These will be re-iterated at the first session to check out whether everyone agreed to abide by them (see appendix *).

Routine outcome measurement using CORE-OM 34 will allow for ***case tracking*** so that drop-out can be prevented if possible. After every session clients will be asked to complete the ARM-5 questionnaire which identifies changes in therapeutic alliance, as well as asking them to give some

brief written feedback about the session including to answer the question, 'Has anything or anyone upset you today?' Clients will be given an opportunity to address difficulties in the plenary session but if they do not the therapist will respond to negative or ambiguous comments by ***outreach***: sending a text, having a phone conversation, or meeting 1:1 and encouraging them to use the inter-personal problem-solving method, with the therapist's help if required, to deal with whatever it was that upset or disturbed them proactively and assertively.

Text messages will also be used to remind clients about upcoming sessions before the first few group sessions, and to positively reinforce their attendance after the first few group sessions. Likewise, clients will be asked to text if they were likely to be late, or if they cannot make it. After any missed sessions, they will be contacted by text and gently encouraged to attend the next session, and offered a 'phone call if needed.

Clients will also be encouraged to seek support from a named individual in their social support network between sessions if they are feeling very low, but if that is not possible they can make use of text messages and emails to the therapist who will respond with brief supportive messages and this may be enough to prevent a crisis or disengagement (see appendix for details of between-session contacts).

Written ***feedback*** based on clinical case notes and their CORE-OM graph will be provided to each client at the beginning of each session about their observed use of inter-personal skills and progress against personalised goals in the previous session.

These strategies serve to attenuate any emotional distress, act as an incentive to regular attendance, ***engage and motivate*** clients in order to maintain them on the care pathway from treatment initiation to treatment completion.

Alternative treatment will be offered if the client shows no or negative response to therapy or in the event of any serious adverse events. In addition, ***commitment strategies*** such as asking clients to confirm in the plenary session if they will be attending the following week as these strategies have been shown to maintain engagement and improve treatment persistence.

The group sessions will incorporate a range of inter-personal processes to optimize the acquisition, consolidation and application of basic CBT concepts and skills.

The twelve building blocks of ***'good conversation'*** (see appendix) will form the framework for effective communication and interaction between facilitators and clients, and between clients with the aim of generating forms of verbal and non-verbal behaviours that are 'stress-reducing' rather than 'stress-inducing'.

Animal metaphors (see appendix) will be used to help clients represent how they think their verbal and non-verbal behaviour is perceived by others with the aim of providing non-confrontation opportunities for honest feedback and mirroring amongst group members. For example, under stress one client may think they come across like a timid mouse whereas their partner actually sees them as a growling dog, or another client may think they come across as a laid back sloth whereas their partner actually sees them as a prickly hedgehog.

The first four sessions will take the form of a psycho-educational workshop with the aim of providing a rationale for group-CBT and socialising the client to the model. Basic concepts underpinning this approach will be conveyed using evidence-based adult learning and teaching methods. The first session will start with an ice breaker / warm up exercise to help clients overcome anticipatory anxiety about meeting new people and learning new things. Different ice breakers will be used for the next three sessions as well.

Loosely scripted PowerPoint presentations will be used to structure the first four sessions and each client will be provided with a folder to keep any handouts. Experiential exercises will be used to explore new ways of looking at oneself, others and the world, such as painting an image of a volcano to represent how one expressed or suppresses different emotions, or making a collage of a mountain to represent progress towards one's goals, and any obstacles encountered on the journey. Clients will form triads to discuss what they have discovered through doing the exercise. Opportunities will be set up for clients to practice core relational skills such as disclosure of personal information, as well as giving and receiving feedback.

Each session will start with goal review in different ***reciprocating pairs*** chosen by the therapists so that everyone works with everyone else over the 12 weeks. Each client will have an allocated amount of time to discuss with their partner what they learned from their goal/s and what they would do differently next time. The partner will ask questions and probe for deeper understanding using the 12 building blocks of good conversation. The pairs will then swap other and repeat the process with the other client. Later each client will feedback to the morning plenary what their partner achieved in undertaking their goal/s. Clients will be given ***the role of 'therapist'*** to consolidate their learning and to build capacity for self-help in future.

Silences will be used deliberately as reflective spaces and quiet times for writing in one's journal and perhaps for slowing down the pace of the group's interaction or for providing extra support for an individual who is struggling with applying the concepts and skills.

At the end of each session clients will be asked to work with the same partner as in the morning and to complete a goal plan which involves committing to taking 'one small step' towards their overall behaviour change goals. Therapists will ***prescribe one or more goals*** with the aim of

challenging the client to try behavioural experiments and new activities. These goals can be modified by the client in negotiation with their partner. In the final plenary each client speaks for themselves and describes what they intend to do between sessions. Doing so encourages client to make a formal commitment to their goal/s.

Different inter-personal skills will be prescribed for each client depending on their individual weaknesses and strengths identified during the assessment process and shaped by clients' post-session written feedback. This process will allow therapists to precisely calibrate and personalise the therapy in real-time. Goals will be written on the therapists' feedback form, and clients will be advised not to tell other group members what skill they are practising in vivo. At the afternoon plenary, other group members will be invited to guess which skill they thought the client might have been practising. Doing so affords multiple opportunities for implicit and explicit feedback. The written feedback that therapists provide at the beginning of each session will include their observations of the client's performance of inter-personal skills during the session as recorded in the client's case notes.

All clients will be asked to keep a ***therapy journal*** to record any triggers and their 'inner me' of thoughts and feelings, and their 'outer me' of verbal and non-verbal behaviours using the 'donut'. Quiet time will be set aside for reflecting on what they would like to explore in more depth. The group will be split into ***two small groups*** comprising up to 4 clients and one therapist which last for 1 hour of facilitated discussion. In the small group clients will have up to 15 minutes to share their reflections, seek new perspectives, and get ideas for adaptive personal and inter-personal coping strategies from other group members.

In the last eight sessions, mornings will be taken up with ***inter-personal problem-solving*** using the 'double donut'. Clients will take turns to describe to their partner what happened i.e. what they thought, what they felt, and what they did / said, and what they believe their significant other thought and what they felt, and what they observed their significant other do / say. The partner will be asked to try and identify with the client's significant other, be that their husband, mother, son, neighbour, manager or colleague depending on the specific situation. In the plenary session each client's partner will report back and give their impression of what was going on and what went wrong in terms of misunderstandings and misattributions. The whole group will ask questions, make suggestions and give feedback about how the relationship problem could be addressed using the 12 building blocks of 'good conversation' for example.

Opportunities for ***socialising*** will be set up during the refreshment breaks. Lunchtime will be an unstructured 'social space' to mimic this element of the workplace environment and to encourage group members to practice different ways of communicating such as 'small talk'. Any difficulties could be reflected upon in group discussion.

During the lunch break, clients will be asked to choose an activity that they would all like to do on the final session to say, 'Goodbye' such as planning a coach trip, going out in the evening for a meal or to the cinema, holding a 'concert party', or sharing a picnic at the venue. After each lunch break, clients will be asked to reflect on their contribution to this task and how it provides for investing in relationships with others. As differences of opinions emerge within the group, with perhaps the formation of sub-groups, clients can practice how to resolve conflict by seeing differences in the apparently similar, and similarities in the apparently different (Agazarian). Any learning can be transferred to the workplace context.

In the afternoon clients will be asked to opt for one of two exercises which will provide them with either an opportunity to reveal more private information about themselves and their lives, or an opportunity to ask for feedback about how they are perceived by others and the impact that they have had on the group. Slots will be booked well in advance for the last eight sessions. The ***Telling my Story*** exercise will involve 45 minutes to talk about one's personal narrative (using whatever medium the client wants). ***The Hot Seat*** exercise will involve 45 minutes to ask other group members for structured feedback (focusing on the client's strengths rather than their weaknesses).

Every month clients will be asked to score their own progress towards clearly specified and operationalised behavioural change goals on the personalised care plan (see appendix for worked example).

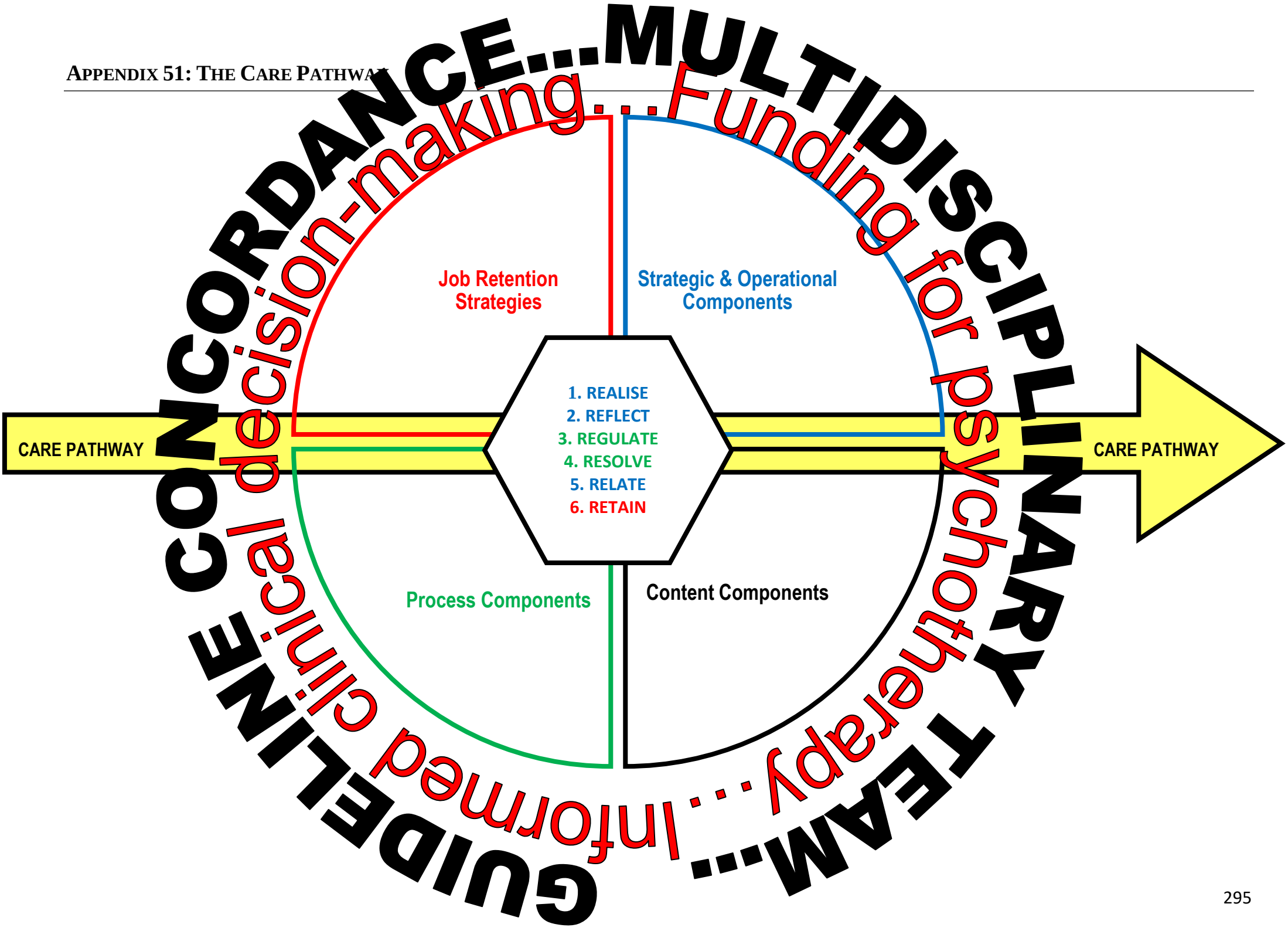
50.3 OCCUPATIONAL THERAPY SESSIONS

The new intervention also provides opportunities for up to four 1:1 sessions focused on ***job retention strategies***. These sessions will be planned to take place before or after the group sessions, or on a different day. They may involve the Occupational Therapist visiting the client's workplace to evaluate the worker, her work, and her workplace i.e. a personal, functional, and / or environmental assessment of the client and their job, or they may involve low key liaison with the client's line manager, OH or HR departments, and general employment support using CBT strategies.

50.4 DISCHARGE-PLANNING SESSION

In the 2 weeks following the end of the group-CBT treatment programme, each client will be offered a ***discharge-planning 1:1 session*** (accompanied by their significant other if possible) to discuss therapy outcome in terms of symptomatic improvements, progress towards behavioural change, and whether any further intervention is indicated (if the client's symptomatic scores meet 'caseness' criteria). A written discharge summary will be sent to the client and copied to any involved practitioners and professionals, with the client's consent. At this point clients will be

reminded to complete and return the follow up questionnaires which will be sent to them by mail 3 months post-intervention.


GUIDELINE CONCORDANCE...MULTIDISCIPLINARY TEAM...
decision-making...Funding for psychotherapy...informed clinical
Job Retention Strategies
Strategic & Operational Components
1. REALISE
2. REFLECT
3. REGULATE
4. RESOLVE
5. RELATE
6. RETAIN
CARE PATHWAY
CARE PATHWAY
Process Components
Content Components

APPENDIX 52: TABLE OF CIMOS

Seeing myself differently	a) Shift in perception: people	1. REALISE
Seeing others differently		
Seeing my problems differently	b) Shift in perception: problem	
Seeing others' problems differently		
Speaking about my experience	a) Learning from each other	2. REFLECT
Listening to others' experience		
Understanding myself (insight)	b) Understanding each other	
Understanding others (outsight)		
Self-regulating	a) Managing my mood	3. REGULATE
Co-regulating		
Active coping	b) Coping strategies	
Passive coping		
Practising skills	a) Managing my behaviour	4. RESOLVE
Goal-setting		
Saying what I want and finding a shared solution	b) Resolving conflict	
Hearing what others want and finding a shared solution		
Giving feedback	a) Two-way feedback	5. RELATE
Receiving feedback		
Helping myself	b) Helping each other	
Helping others		
Disclosing mental health problems or work-related stress	a) Staying-at-work	6. RETAIN
Negotiating reasonable adjustments		
Negotiating phased return	b) Returning-to-work	
Negotiating on-going support		

KEY: GREEN = cognitive-behavioural-emotional mechanisms
BLUE = relationship-focused mechanisms
RED = work-focused mechanisms

APPENDIX 54: GRAPHS CLINICAL OUTCOMES

54.1 DATA / STATISTICAL ANALYSIS OF GROUP SCORES

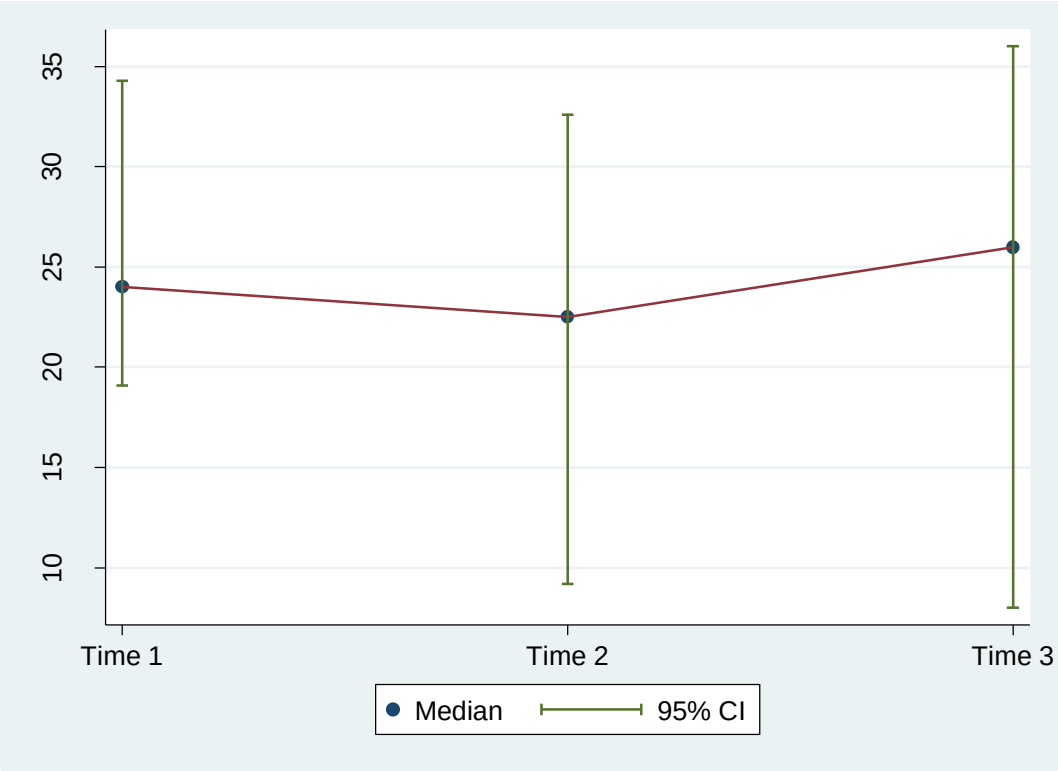


Figure 28- HAM-D

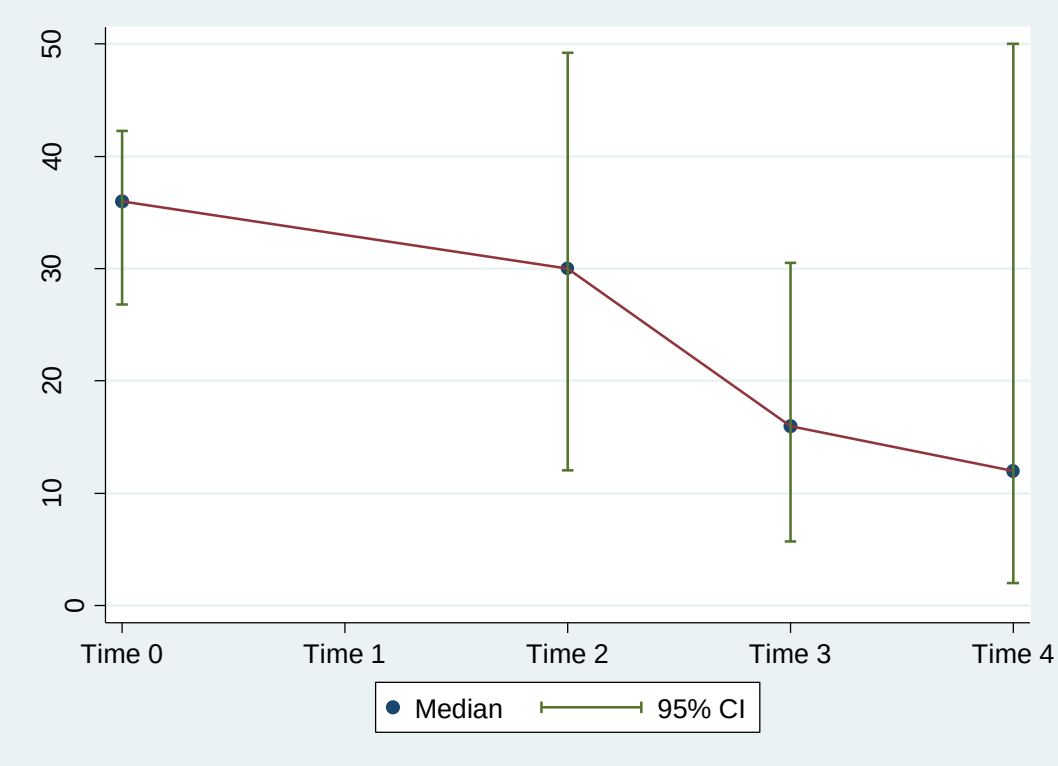


Figure 29 – BDI II

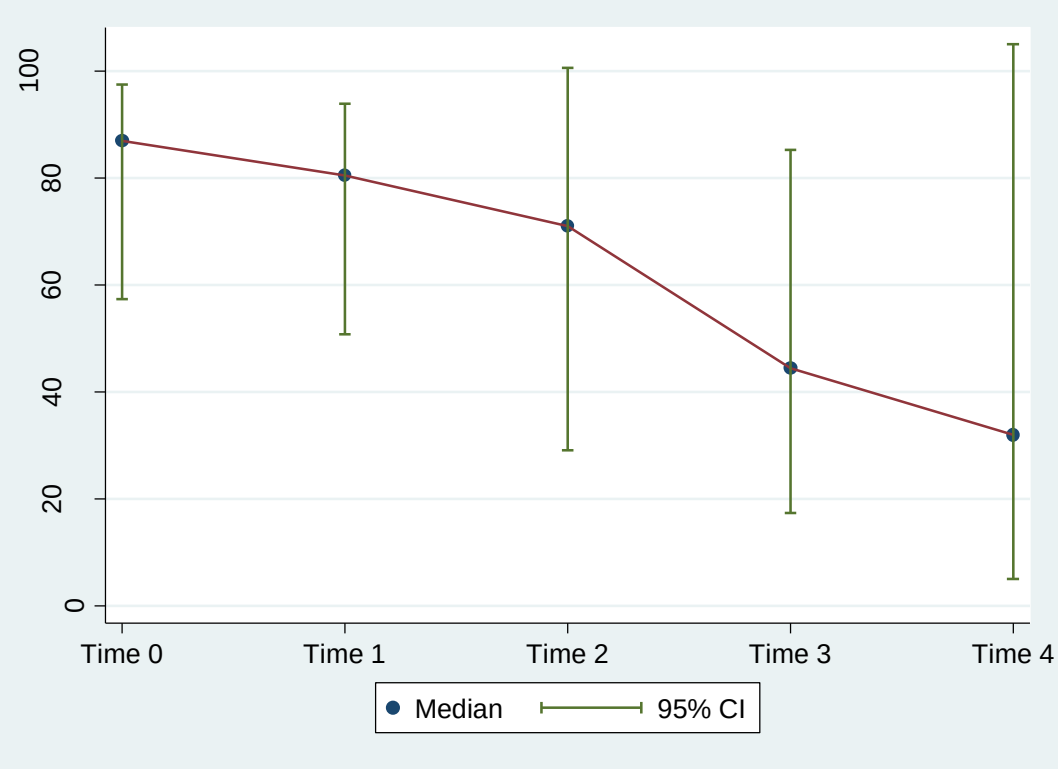


Figure 30 – CORE-OM

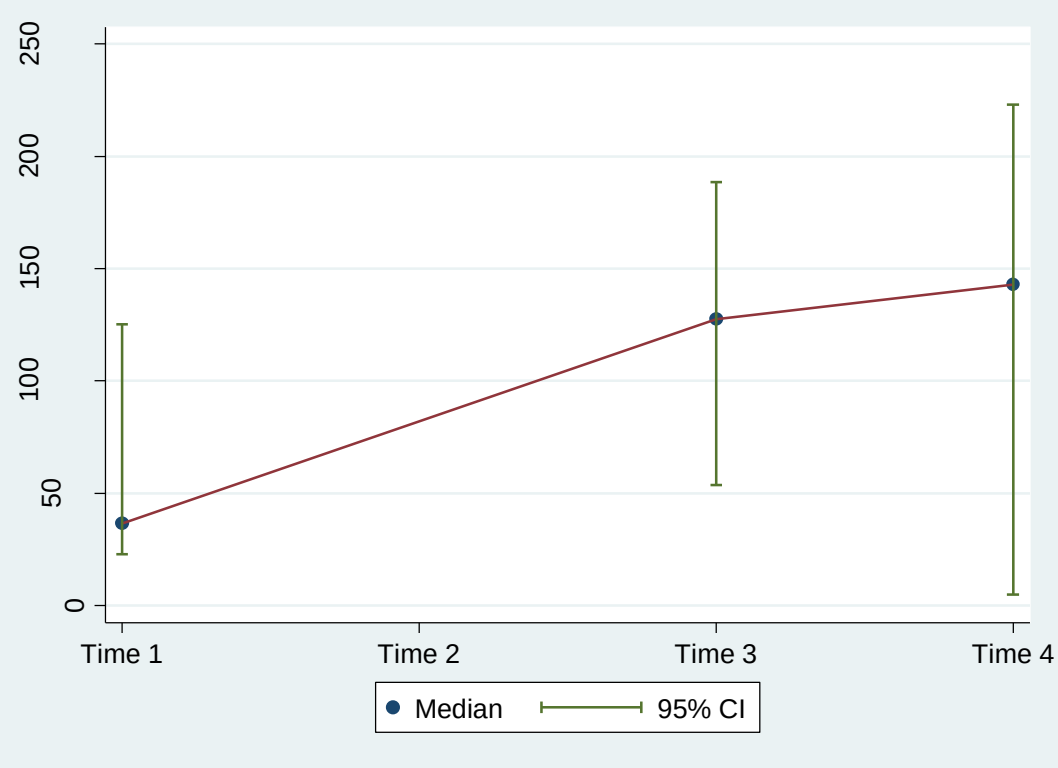


Figure 31 - CSES

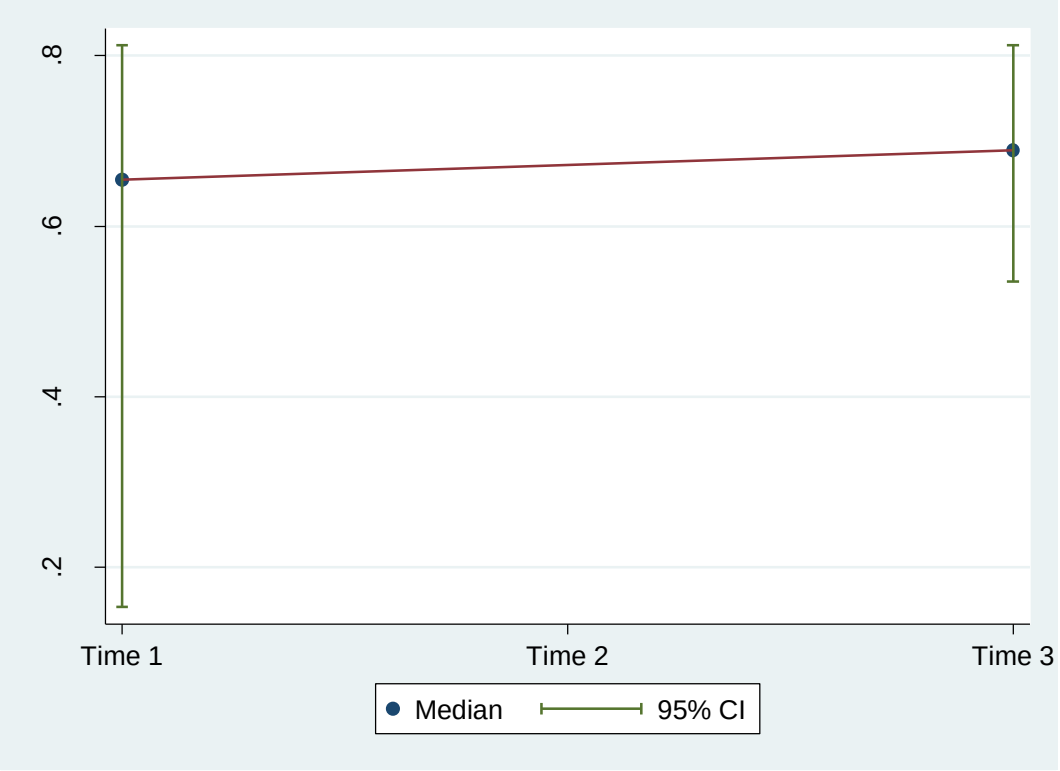


Figure 32- EQ-5D

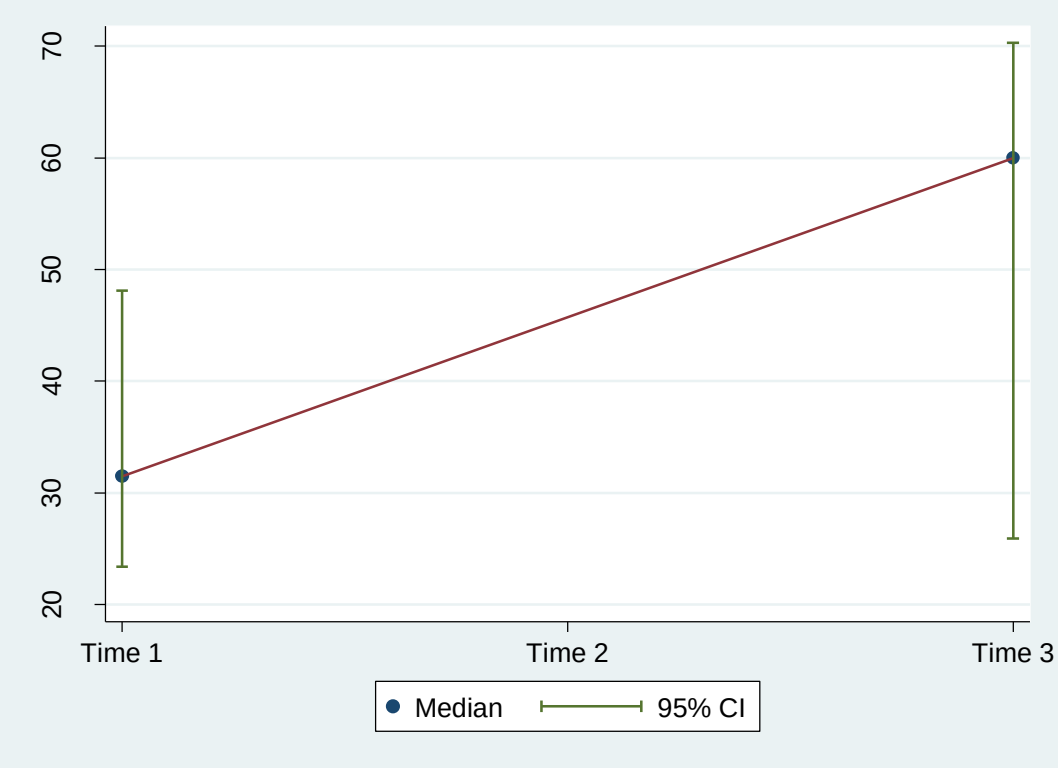


Figure 33 – EQ VAS

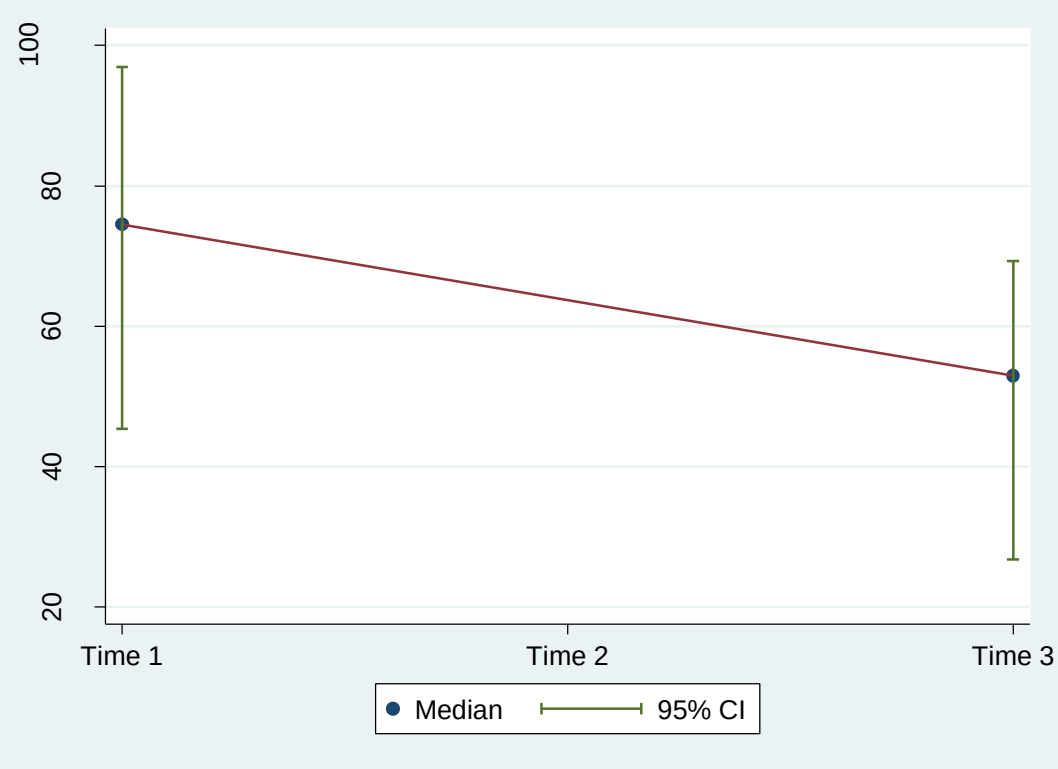


Figure 34 – IIP 32

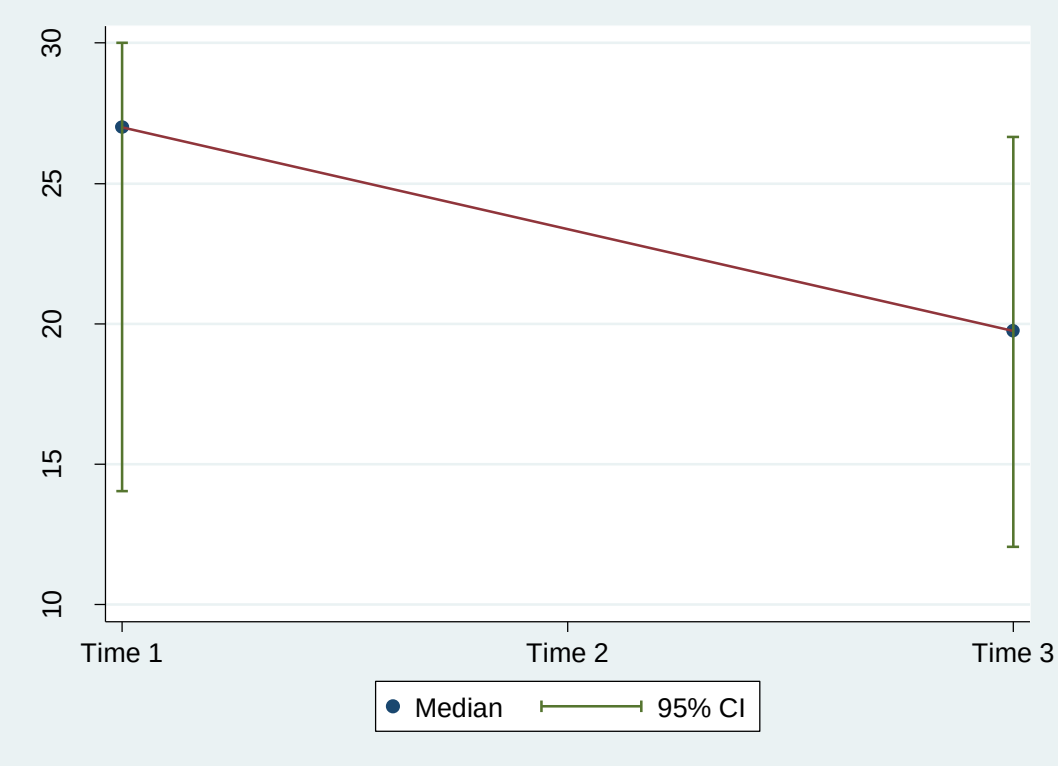


Figure 35 – W&SAS

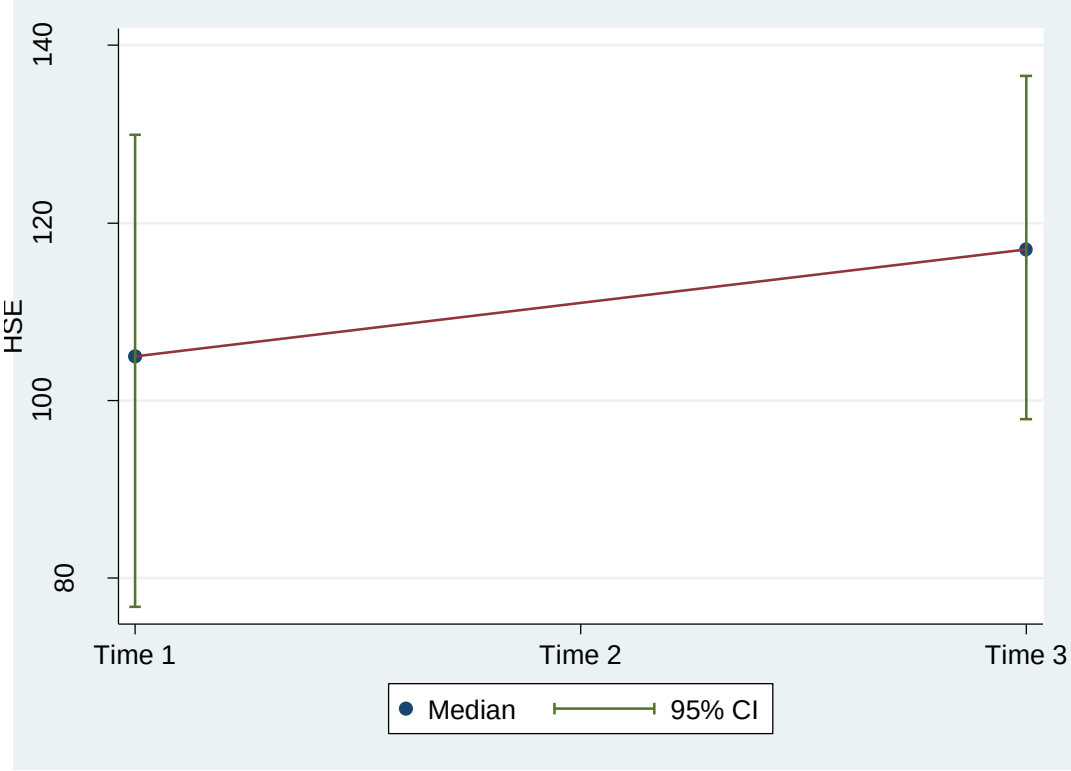


Figure 36 - HSE

54.2 DATA / STATISTICAL ANALYSIS OF INDIVIDUAL SCORES

Data from a single group of subjects were collected and the aim of the analysis was to compare outcomes for individual participants at different time-points.

Graphical illustrations of these results were produced in the form of a line graph showing the individual results for each patient.

Table 104 – Colour code for graphs

031		**Mandy worse**
032		**Jill better**
033		**Christine better**
034		**Harriet better**
035		**Paula worse**
036		**Annabel better**
037		**Betty better**
038		**Naomi better**

Two people in unskilled occupations and one person in a skilled occupation did not provide follow up data.

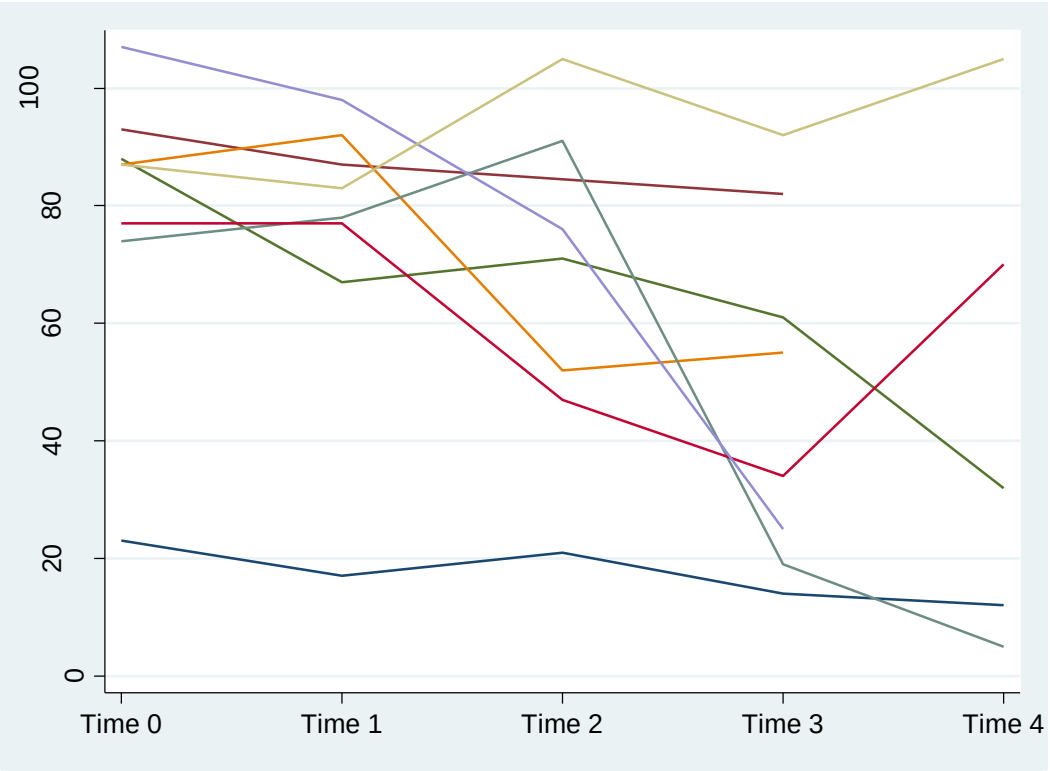


Figure 37 – CORE-OM

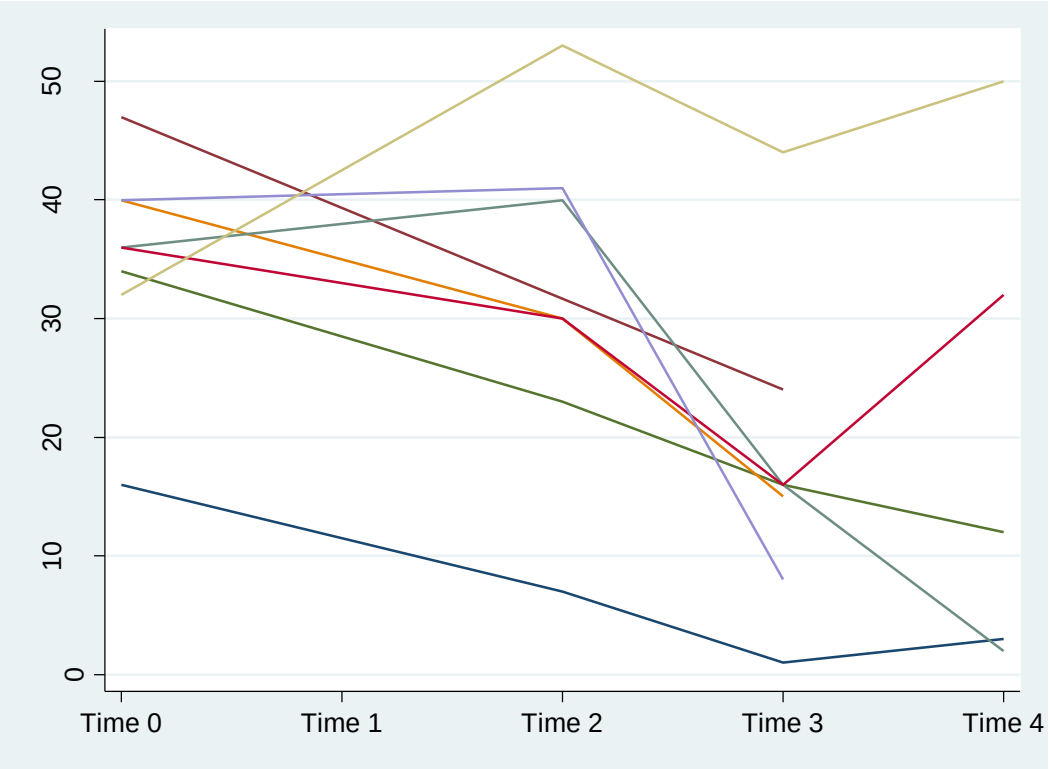


Figure 38 – BDI II

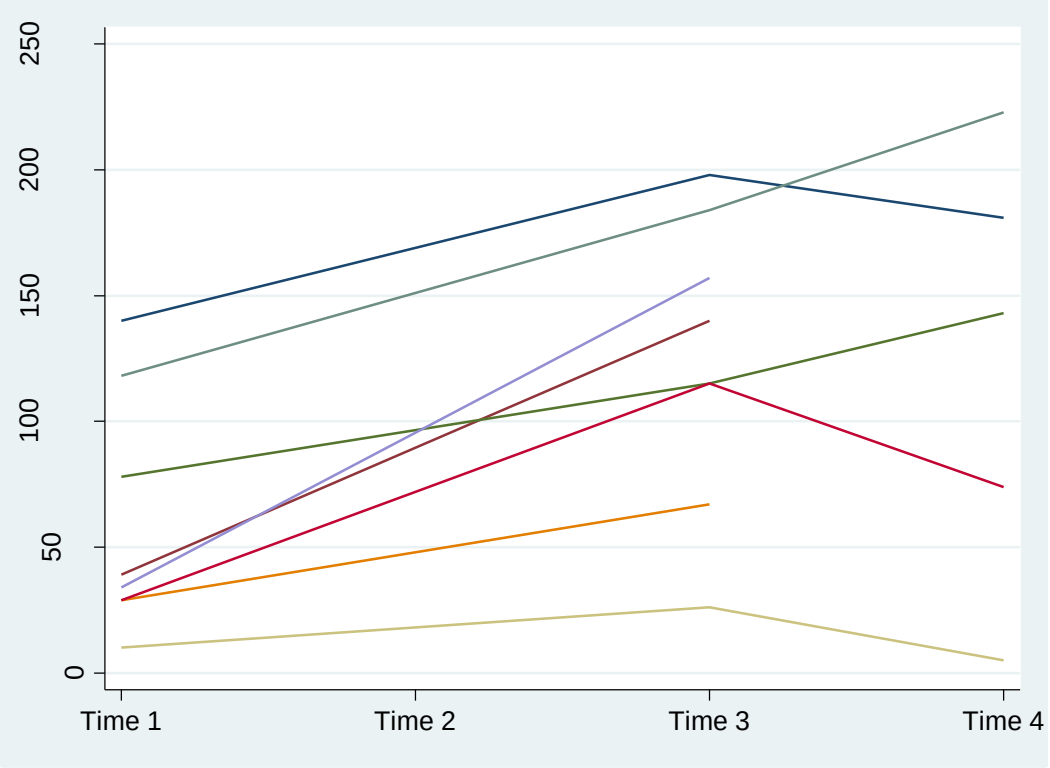


Figure 39 - CSES

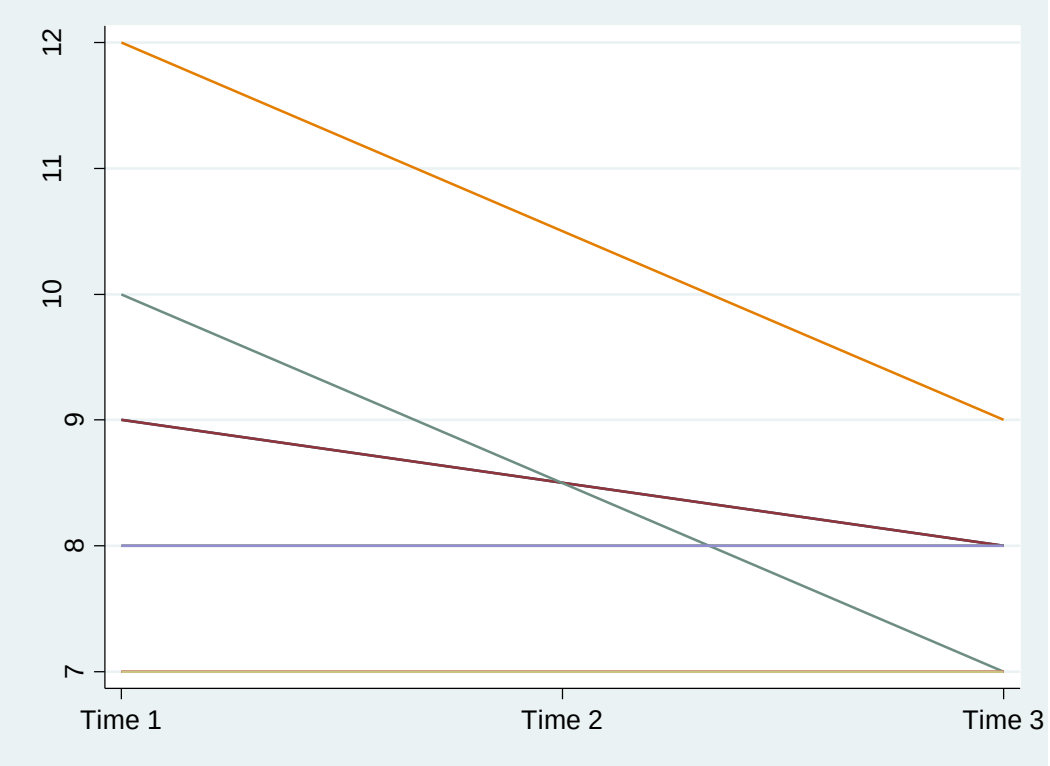


Figure 40 – EQ-5D

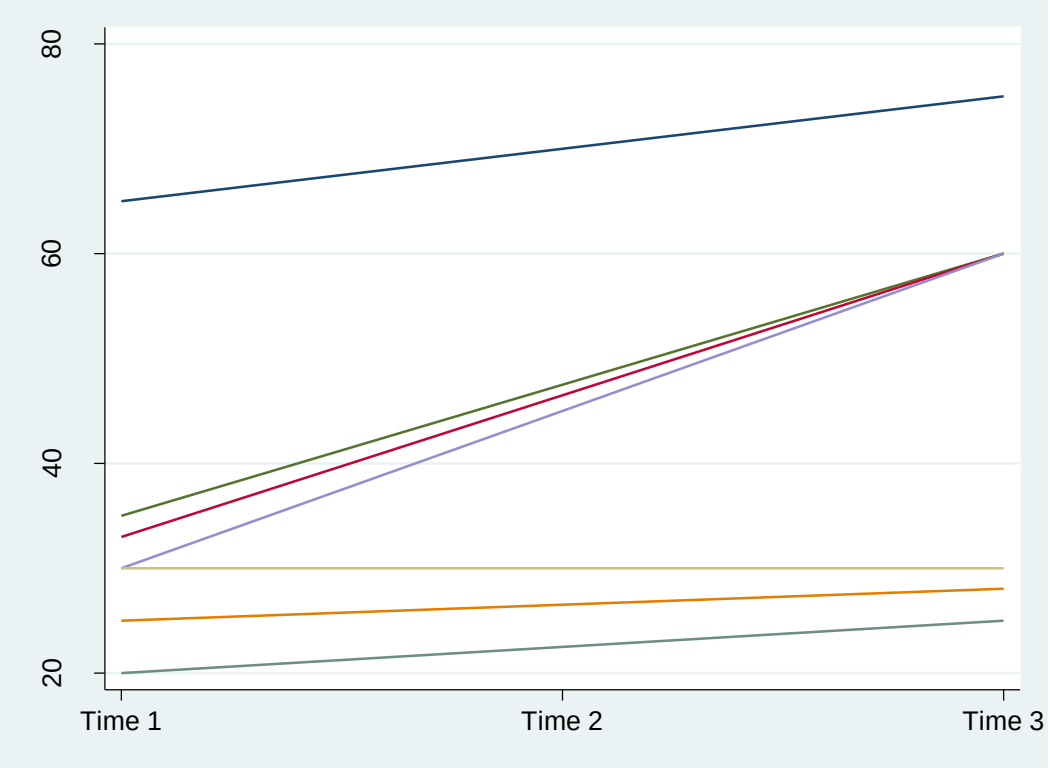


Figure 41 – EQ VAS

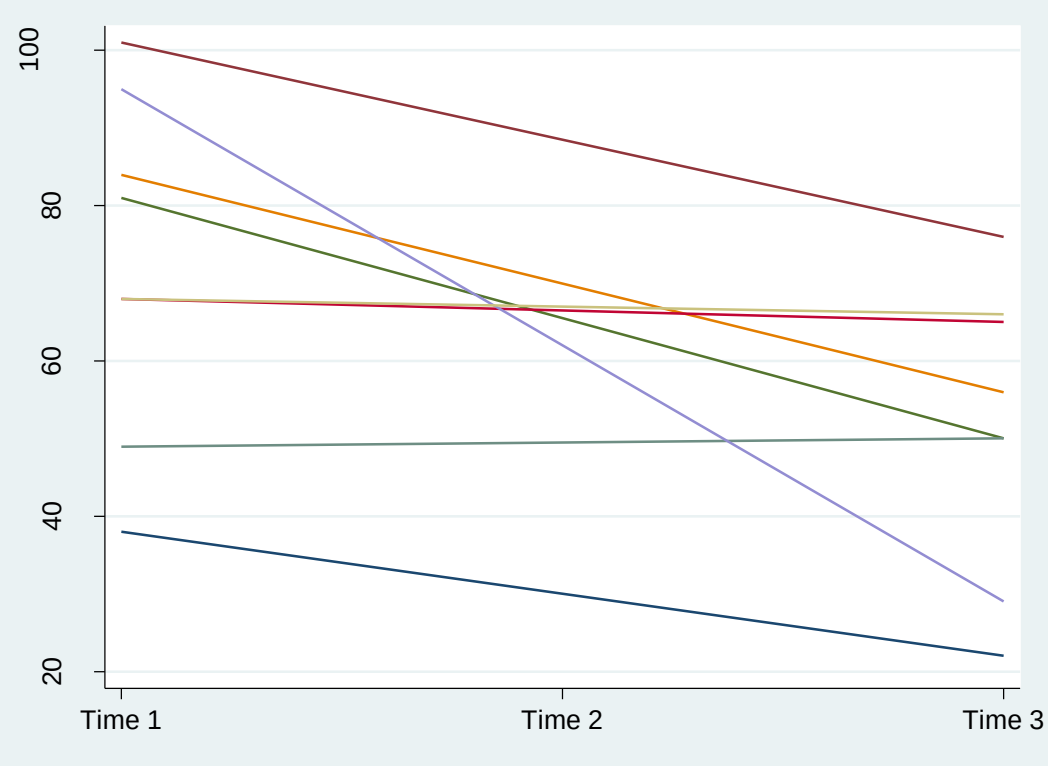


Figure 42 – IIP 32

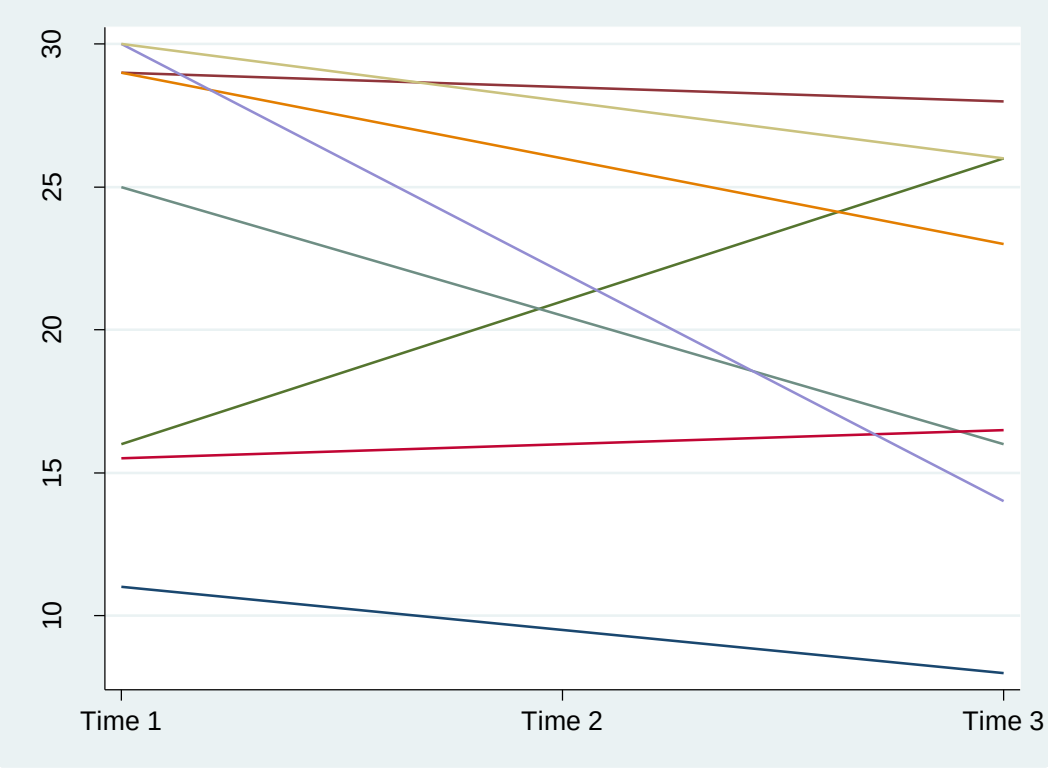


Figure 43 – W&SAS

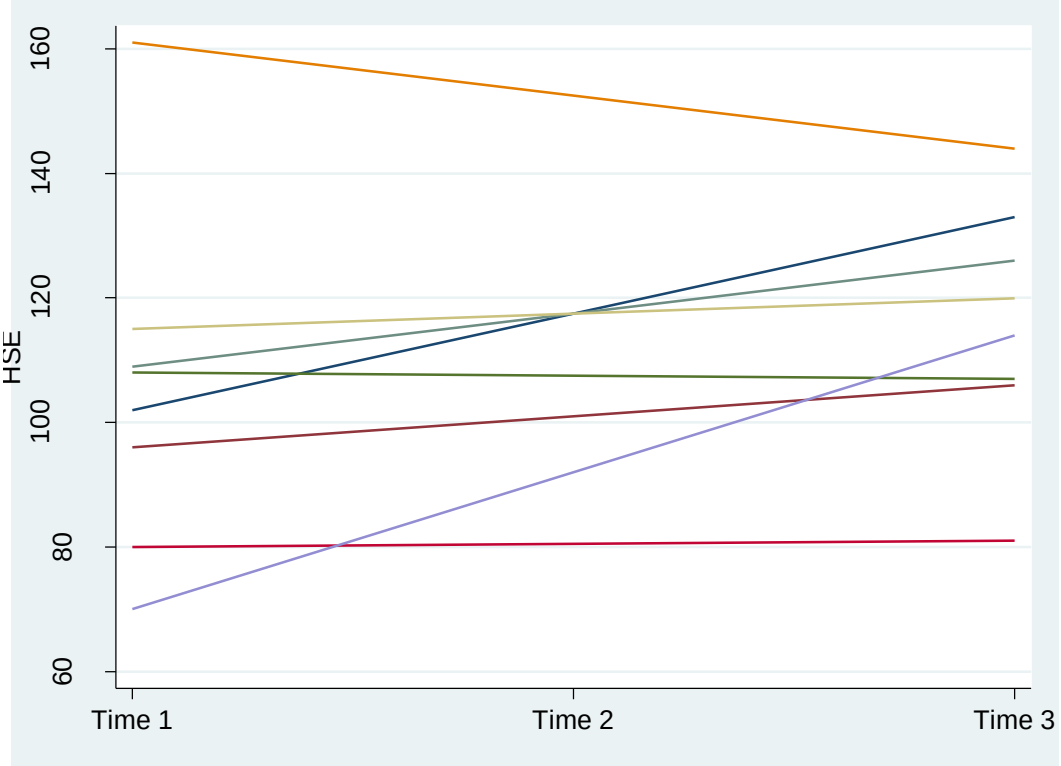


Figure 44 - HSE

APPENDIX 55: WORK OUTCOMES

The secondary outcome was job retention. Information about working hours (or work-related activity for people off sick) was collected each week. Information was also collected about "intention to quit" as an indication of job satisfaction and level of commitment.

55.1 JOB RETENTION

The number of people who stayed in work is shown in Table *

55.2 WORKING HOURS

The work situation of participants at the first group-CBT session (T = 1), the last group-CBT session (T = 3) and at 12 week follow up (T = 4) is shown in Table 26.

It can be seen that the focus on job retention seemed to be helpful in most cases.

55.3 INTENTION TO QUIT

Intention to quit was measured on a 5-point Likert scale. Participants who were in employment were asked:

"Do you intend to quit your job?"

Table 105 – Intention to quit scoring

Definitely NOT	**Probably NOT**	**UNSURE**	**Probably WILL**	**Definitely WILL**
Score = 1	Score = 2	Score = 3	Score = 4	Score = 5

Table 106 – Intention to quit clients' scores

	Individual Mean
031	n/a
032	1.0
033	3.0
034	1.3
035	2.0
036	n/a
037	1.0
038	1.8
TOTAL MEAN (SD)	**1.72 (0.71)**

Table 27 shows that no participant had any plans to quit. All, with the exception of one who was unsure, would probably or definitely not quit.

Table 107 – Clients' Work Situation

	WORK SITUATION		
	T = 1	T = 3	T = 4
031	At the start of the intervention Mandy had recently been dismissed from her job as a catering assistant due to long-term sickness absence due to stress. She had previously worked as a healthcare support worker. Mandy was in receipt of Employment Support Allowance and participating in The Work Programme though an independent provider.	By the end of the group-CBT programme Mandy was continuing to participate in The Work Programme. Mandy used her job retention goals to tackle avoidance of seeking work caused by severe anxiety.	At the 12 week follow up Mandy had made no progress having had to cope with negative life events (eviction, bereavement) which she believed took priority over seeking employment.
032	At the start of the intervention Jill worked as a fulltime Human Resources Business Manager for the NHS. She was on restricted duties due to stress.	By the end of the group-CBT programme Jill had a phased returned to work full time. Jill used her job retention goals to disclose her mental health problems, to negotiate reasonable adjustments and to communicate more openly with her manager and Occupational Health. She also tackled a pattern of over-commitment and was no longer a "workaholic".	At the 12 week follow up Jill writes to me, "Work is still busy but I'm really enjoying what I'm doing and am getting positive feedback. I actively check how things are going so the feedback is good and I'm far more able to ask for help and support if I need it, which seems to make everyone happier… When things go wrong I accept they sometimes do and focus on the solution and learning for next time."
033	At the start of the intervention Christine was off sick due to stress. She worked part-time as a doctor's receptionist and she also ran her own gift shop. She was still managing to cope with some work in the shop.	By the end of the group-CBT programme Christine had met several times with her line manager and Occupational Health. The OH consultant encouraged Christine to remain on sick leave until she was asymptomatic before returning to work. Christine used her job retention goals to stay in touch with the workplace when her tendency was to avoid contact.	At the 12 week follow up Christine is still receiving support through mental health services. She has decided to return-to-work as a receptionist and continue to run her own gift shop.
034	At the start of the intervention Harriet was off sick due to stress. She worked as a part-time healthcare support worker for adults with severe learning disabilities.	By the end of the group-CBT programme Harriet had returned to work but was struggling to attend reliably as she often had physical health problems which required treatment. Harriet used her job retention goals to improve	No information provided

		her team work skills.	
035	At the start of the intervention Pam worked as a full-time cleaner in a residential home for people with mental health problems. She was occasionally subject to verbal abuse from the residents.	By the end of the group-CBT programme Pam was struggling to maintain her employment as she was beginning to consider other jobs that would be more suited to her interest and skills. Pam used her job retention goals to disclose her mental health problems, to negotiate reasonable adjustments and to communicate more openly with her manager.	At the 12 week follow up Pam writes to me, "Off work sick. Should have gone back last Friday but couldn't do it. Finding it increasingly difficult to make myself do anything".
036	At the start of the intervention Annabel had left her job after finding it triggered memories of her previous job when she lost her temper and threw an object at her manager. She was volunteering as a gardener at a local national Trust property.	By the end of the group-CBT programme Annabel had taken up extra voluntary hours at a charity garden centre. Annabel used her job retention goals to write her CV and to reprocess the trauma of losing her previous job.	At the 12 week follow up Annabel writes to me, "I have been asked to become Membership Secretary [of charity garden centre]. I have also joined the Borrowdale Organic Nursery in the last 6 weeks as a volunteer. The biggest step forward I suppose is that I actually applied for a paid job there which came up just as I joined them…I was hesitant but having talked myself out of applying I was persuaded to change my mind…I did get an interview but didn't get the job…I don't know if I'm kidding myself that I can really find work". Later Xmas 2014, "I finally have a paid job!"
037	At the start of the intervention Betty was working as a full-time cleaner for a local business. She had worked there for many years. The owner of the business had a sister who had severe mental health problems and was verbally abusive towards Betty on a daily basis. Betty tended to swear in response and often got into an altercation which affected the quality of her work.	By the end of the group-CBT programme Betty had more understanding about her abuser's needs and did not retaliate when provoked. Betty used her job retention goals to disclose her mental health problems, to negotiate reasonable adjustments and to communicate more openly with her manager.	No information provided
038	At the start of the intervention Naomi had	By the end of the group-CBT programme Naomi	No information provided

	recently started work as a part-time Social Worker in child protection. She found the work very stressful.	was coping better at work. Naomi used her job retention goals to improve her time management skills, cope with deadlines and to ask for support from colleagues.	

APPENDIX 56: WEEKLY QUESTIONNAIRE

NAME..... DATE.....

What was your Job Retention / R2W plan?

What adjustments were agreed last week?

"Do you intend to quit your job?" Please indicate by ticking below:

Definitely NOT	Probably NOT	UNSURE	Probably WILL	Definitely WILL

Please indicate how many days and what times you worked last week (e.g. 9am-5pm on Monday; 10am-2pm on Tuesday):

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

If you had contact with the workplace last week, how did you find it? (Describe any difficulties or problems. Describe any effective coping strategies you used):

How many times did you visit your doctor or other health professional last week? (Please give details of any treatment offered and accepted):

APPENDIX 57: OCCUPATIONAL THERAPY SESSIONS

Table 108 – OT sessions

	Session 1	Session 2
031	Did not request any Occupational Therapy sessions (in Work Programme)	
032	Discussed problems with over-commitment and perfectionism at work. Agreed to try taking time out and more regular breaks away from the office. Jill plans to 'buy' 10 days annual leave for next year and have a 'me' day each month. Jill also agreed to try more home-working to reduce time spent commuting to Manchester. Also discussed how to use the journey time effectively by using imaginal rehearsal and positive affirmations to reduce anticipatory anxiety. Jill to ensure that she has more regular supervision with her manager, as this gives her an opportunity to ask for clarity about any work tasks.	
033	Christine asked for OT to accompany her to a meeting with her line manager and HR to review her sickness absence. OT agreed to meet with Christine at her house beforehand to offer emotional support.	The OT helped Christine prepare for the meeting with her line manager, HR by clarifying what outcomes she wanted from the meeting, and how to achieve these outcomes. At the meeting Christine informed her line manager that she was being encouraged by the Occupational Health consultant to take more time off work to ensure a full recovery. Christine also checked out the reduction in her sick pay: she is now on half pay plus statutory sick pay because she has been absent for more than 6 months. Christine's line manager agreed to her maintaining contact with her teammates by visiting the workplace as the first step of a slow phased return. Christine stated she was anxious about working with members of

		the public but this would not be expected on an informal visit. Another meeting was arranged for after the group-CBT course ends.
034	Harriet wanted some support with an upcoming meeting with her line manager due to on-going sick leave. Harriet asked the OT to check out what the meeting was about as she did not know and was anxious about it. Harriet had been back at work for some weeks now, but unfortunately had had a chest infection and has had to take one day's leave and felt she was adversely affected by one session at the group which had led to another days leave.	The OT rang Harriet's line manager and clarified that the meeting was a routine requirement of the return-to-work process. The OT discussed with Harriet how she could improve her teamwork skills, to fulfil her role without exceeding the tasks outlined in her job description so as not take on too much responsibility which she has a tendency to do. Harriet will also negotiate reasonable adjustments such as a more regular shift pattern. Harriet was encouraged to build a good working relationship with her manager so that she could ask for help at work if required.
035	Did not request any Occupational Therapy sessions (eventually went on short-term sickness absence)	
036	Annabel wanted to discuss her 'phobia' about going back to work. The OT talked about how the unrealistic demands made on Annabel in her last 2 jobs caused Annabel severe stress. Annabel was unaware that she was being asked to do too much and tried to carry on without complaint. Ultimately Annabel was unable to cope with the heavy workload and this caused her to feel like a failure which she then hid by trying even harder to succeed. Annabel discussed some ways to manage traits of perfectionism better such as ensuring any future job has adequate supervision in place which would enable her to manage this aspect of her personality more effectively. Annabel also expressed the desire to work in horticulture as this is a job she would enjoy. She accepts that due to previous back surgery she may require reasonable adjustments and training for employment in horticulture to be a realistic goal. It was agreed that the OT would find out whether there are any opportunities in a charity garden centre for volunteers.	The OT accompanied Annabel to the charity garden centre to meet with the manager. Agreed to start volunteering in the gift shop once a week, with the possibility of becoming more involved in administrative tasks over time which may help her overcome one of her 'phobia' of working in an office environment again. .

037	Betty wanted some support to resolve the problem of being verbally abused by the sister of her employer. The OT agreed to set up a meeting with Betty and her boss to negotiate a resolution.	The OT accompanied Betty to a meeting with her employer to discuss the bullying and harassment Betty was experiencing at work. They agreed that Betty would in the first instance remove herself from the situation and inform her boss immediately when his sister was being verbally abusive towards Betty The employer agreed to talk to his sister and to tell her that she would not be allowed on the premises if her behaviour did not improve. He took Betty's concerns seriously and she was therefore satisfied with the outcome of the meeting.
038	Did not request any Occupational Therapy sessions	

APPENDIX 58: WRITTEN FEEDBACK FROM CLIENTS

Clients were invited to provide written feedback at the end of each session, and at the end of the Treatment Programme.

58.1 POSITIVE POST-SESSION FEEDBACK

After every session participants were asked to provide written feedback about their experience of the session. There were two questions related to acceptability:

"What did you find helpful/relevant today?"
"What did you find unhelpful/irrelevant today?"

Analysis of participants' responses revealed eight themes regarding what was helpful and/or relevant:

1. Disclosure
2. Feedback
3. Discussion
4. Sense of universality
5. Hearing others' stories
6. Understanding self and others
7. In-session and out-of-session goals
8. Joining in

58.1.1 Disclosure

Participants found talking about their thoughts and feelings was helpful:

"Getting to know others have similar feelings"

"Talking to others"

"The session this morning when we shared stuff about childhood"

"The group this morning, I found a lot of us opened up"

"Being able to speak about this week's events"

"Sharing feeling that my mum elicits"

"Small group, being able to admit my addiction"

"[The] 'Telling my Story' [exercise]"

58.1.2 Feelings

"It made me feel anxious but I empathised with disclosures"

"Talking to others about how I feel"

"Talking about how I feel when [partner] drinks"

"It felt good"

"[I] felt more comfortable"

"I found it all deeply moving and quite anxious"

"Regulation of emotion diagram, understood the way this is set out"

58.1.3 Feedback

Receiving feedback was valued as it provided people with confirming or disconfirming evidence from another source:

"Talking and sharing with others. Building a sense of closeness and getting feedback"

"It was helpful to discuss my disclosures with my parents and to receive compliments and recognition for my achievement"

"Constructive feedback from the group"

"Feedback from 'The Hot Seat' exercise, assertiveness for me to look at"

"Small group is always useful, giving feedback in a constructive way"

"My feedback [from 'The Hot Seat' exercise]"

"'The Hot Seat' feedback"

"Feedback in small group to remind me that others would have found my job difficult to do"

58.1.4 Discussion

Generally discussion helped people different perspectives and challenged their view of themselves and others:

"Small group discussion"

"Group discussion…to admit it [relationship with son] was a problem"

"Talking together as a group"

"Discussing certain issues"

"Small group is useful to dig deeper into issues"

"Talking in small group"

"Discussing issues, different points of view"

58.1.5 Sense of universality

Initially most of the feedback related to this important group therapy specific factor by which the group offers emotional support:

"Knowing I'm not alone, how I feel"

"Listening to others, realising you're not alone"

"Many people have similar feelings"

"Sharing problems with other group members and knowing I'm not on my own"

"Realising you are not the only one who has overdosed"

58.1.6 Hearing others' stories

It was helpful for other participants to hear about others' experiences:

"Listening to others was helpful"

"I feel I am in a better place than many in the group so it made me feel like I have little to moan about"

"Hearing others explain their relationship circles, and the impact of family and friends"

"Meeting other group members and hearing their stories. I am not alone"

"I hate to see people upset but sharing is so important"

"I can relate to things others have disclosed"

"Listening to everyone else's experiences helps me"

58.1.7 Understanding self and others

The various presentations, demonstrations, experiential and expressive exercises were valued as they allowed new understanding to develop. The Double Donut provided people with evidence about their inter-personal impact on others:

"I found the exercise when we wrote our biggest fear was very enlightening"

"Demonstrations [were helpful]"

"I like to understand the background, the why"

"I found the pie chart/pictures useful, was easier to express [my]self"

"The 'good me'/'bad me' circle exercise [was helpful]"

"The collage was very good. I think it helped me cement the good feelings and beliefs and put down what still worries [me]"

"A really good session, it made me think about my relationships with others or lack of them"

"Drawing picture as to how I'm doing"

"I am learning all the time and seeing more core beliefs in others and how they are/are not handling them"

58.1.8 Inter-personal problem-solving

"The 'yes/no' debate, I feel I am much better at considering the other's point of view even if I don't agree"

"The inter-personal problem-solving and that [partner] has a right to feel how she does"

"The inter-personal problem-solving' [exercise]"

"The double donut exercise, reflecting on 'healthy' thinking"

58.1.9 New ideas

"Every session I pick up something helpful"

"Initial double donut gave me some new ideas on coping with [son]"

58.1.10 In-session and between-session goals

Some participants found the group helpful as a time to practice new behavioural and cognitive skills:

"Got some confidence speaking in a group"

"Not to pre-empt and think that things aren't going to be as bad as what you think they are"

"Discussing goals"

58.1.11 Joining in

Just being motivated to attend the group was important for some participants:

"Getting out of the house and talking with others"

"It was very helpful, just being here today, after isolating myself for 2 years"

58.2 NEGATIVE POST-SESSION FEEDBACK

There were very few negative comments. Analysis of participants' responses revealed five themes regarding what was unhelpful and/or irrelevant:

1. Problem with equipment
2. Difficulty concentrating or understanding
3. Content not suitable
4. Timing of session
5. High expressed emotion in the group

58.2.1 Problem with equipment

The sound quality of a video presentation was poor:

"The bad recording was difficult to follow and irritating"

58.2.2 Difficulty concentrating or understanding

Some participants found saying focused and taking in information difficult:

"I think I went off in my mind more this week and not able to concentrate as much"

"Nothing [unhelpful] but I was zoning out a bit with the [presentation]"

"I was a bit lost with our morning activity but winged it I think"

58.2.3 Content not suitable

Although all participants took part in every activity, some did not find the content or exercise particularly helpful or relevant:

"I don't panic so this [panic induction exercise] didn't apply to me but it did to others"

"Didn't like doing the 'good me'/'bad me' exercise"

58.2.4 Timing of session

Regular break times were necessary for participants' comfort and sessions may have been too long for some participants:

"Needed a bit of a break in the morning session"

58.2.5 High expressed emotion in the group

Participants sometimes became critical, hostile or over-involved with each other which has the potential of causing other people in the group to feel distressed:

"Another member's reaction towards another, too much for me to handle"

58.3 POSITIVE POST-PROGRAMME FEEDBACK

At the final session participants were asked to provide written feedback about their experience of the whole course. There were five questions related to acceptability:

"Name one positive thing that stands out in your mind about the programme"

"Name one negative thing that stands out in your mind about the programme"

"Is there anything that you think should be included in the programme?"

"Is there anything that you think should be removed in the programme?"

"Please give any other feedback which could contribute to a re-design of the programme"

Analysis of participants' responses provided further evidence of how acceptable the course was overall:

Most people found being in a group and talking together about problems was positive:

"[Finding out] that there are some people who genuinely do care"

"Meeting new people"

"I think that I have benefitted from the programme, because I've been able to talk about my problems (especially in small group), which is a good base on which to resolve things, you only get out what you put in"

"The support given by everyone"

"Sharing experiences with other service-users"

For one person the resolution of conflict in the group was ultimately positive:

"The group member who I find difficult has been an important part of the learning"

For one person the need to join in and participate fully was positive:

"Not being allowed to hide"

Some participants appreciated the style of facilitation:

"The way Nicola worked with the group to involve everyone, whilst controlling input from those who were prone to go off subject"

"The balance and speed were good for me, I also liked the balance of theory with practical"

"I've found it has worked really well, it was uncomfortable at the start but that was part of the point"

58.4 NEGATIVE POST-PROGRAMME FEEDBACK

Things that participants found unacceptable include:

"[The course was] very repetitive"

"The book we were working from was very dry, and read more like a manual for professionals in psychotherapy than for patients"

"I found some of the slides quite complicated and I think there is a lot of jargon. A bit more plain English explanation might help"

"Too many goals to achieve each week"

"Going over goal programme twice"

58.5 SUGGESTIONS FOR IMPROVING THE NEW INTERVENTION

Suggestions for re-designing the new intervention included:

"More help when in a crisis"

"I think it would be good to revisit some of the theory from the earlier weeks and discuss what coping strategies are working and how people were adapting these; what was working and why which might help those still looking for the right one"

"12 weeks wasn't long enough, CBT gives the knowledge on how to change our reactions to situations but trying to do this in twelve weeks and keeping up with the changes we try to make until they become natural responses is hard with just 12 weeks support"

58.6 WRITTEN FEEDBACK MANDY_031

	Weekly questionnaire:
1	ITQ = 5 HCU = 0 Involved with work rehabilitation agency
2	ITQ = 5 HCU = met with surgeon, he recommended an operation for GerD within the next 3 months Involved with work rehabilitation agency
3	ITQ = 5 HCU = 0 but did try to make appointment but doctor not available. Involved with work rehabilitation agency
4	ITQ = 5 HCU = 1 at Castlehill about operation Involved with work rehabilitation agency
5	ITQ = 5 HCU = 2 GP on Monday, Hospital on Tuesday Involved with work rehabilitation agency
6	ITQ = 5 HCU = 0 Involved with work rehabilitation agency Walked to town to job centre
7	DNA
8	ITQ = 5 HCU = 2 at the nurse, once at GP Involved with work rehabilitation agency To go to the job centre and talk to someone – task not done.
9	ITQ = 5 HCU = 0 Involved with work rehabilitation agency Attended Pertemps, job club
10	ITQ = 5 HCU = 0 Involved with work rehabilitation agency
11	ITQ = 5 HCU = 0 Involved with work rehabilitation agency
12	ITQ = 5 HCU = 1 on Monday Involved with work rehabilitation agency

	Weekly session review:
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	Final feedback form
	1. The support given by everyone. 2. Too many goals to achieve each week. 3. More help when in a crisis. 4. Going over goal programme twice. 5. .

	Client satisfaction questionnaire
	No comments

	Follow up letter
	Hi Nicola, Just a brief overview about me and my life, these past three months. It's been a particular trying

	time for me. Firstly we had the upset and grief of the loss of Rose's father. It was a terrible thing to have to deal with, watching someone die in front of you. He passed away Feb 27th. A day I will never forget. I also had notice served to move away from the property I share with Ro, as her mum needs to sell because of financial problems relating to her life. I am currently bidding for a council property and somewhere else to live which in itself is draining and such an upheaval. I still attend Pretemps via Job Centre requests. I go on a monthly basis and am being supported via work coach to do a CV. I tend to burst into tears a lot with this activity – but coach is supportive and takes his time with me. I've tried to maintain contact with some other group members but I've found it difficult as I have no interest in their problems (can't listen to it) so I've been isolating myself again. I need some time to get my head around my own problems. Anyway I trust my letter finds you well and it was lovely to hear from you. Glad you're settling in OK. Kind regards, Mandy x

58.7 WRITTEN FEEDBACK JILL_032

	Weekly questionnaire:
1	ITQ = 1 HCU = 0 Full time [working from home due to stress] Difficult beginning to the week – had been taken off a project – talked to manager. Picked up another project later in the week. Spent most of the week working from home.
2	ITQ = 1 (but definitely would if I could) HCU = 0 Full time [working from home due to stress] Didn't attend work, couldn't face it, have shared [assessment letter] with line manager although by email.
3	ITQ = 1 (but would if I could) HCU = 0 Full time [completed 2 full days and 2 short days at work] It's been another difficult week – I'm taking on more responsibility which is good but is using my "too caring" response – I must do this so don't let others down and make them reject me. I found being in the office with other too much yesterday. Filling in my journal has made me realise how much tension I'm holding in my body – particularly my jaw. I'm now actually making myself aware of this on a regular basis. I hope it will reduce my feelings of exhaustion. I've shared quite a lot with my line manager about how I'm feeling.
4	ITQ = 1 (probably would if could) HCU = 0 Full time [completed 4 full days at work] Much better this week I had, staff, union and client meetings this week – made progress with planning.
5	ITQ = 1 (probably would if I could afford to) HCU = 0 Full time [completed 4 full days at work] Okay, getting bored because I'm on restricted duties – have arranged to meet with manager to agree to pick up more.
6	ITQ = 1 (would if I could) HCU = 0 Full time [completed 4 short days at work] I've felt a bit de-motivated this week, but delivered a plan I'd been struggling with on Wednesday and felt more confident on my Thursday call. Have challenged and stated my case this week which has been accepted.
7	ITQ = 1 (DEFINITELY WOULD IF I COULD) HCU = 0 Full time [completed 2 full days and 2 short days at work] Had a bad afternoon Monday and bad day Tuesday. Line manager has expressed concern that I am not capable is going to refer again to OH – was very concerned about keeping role, coped by keeping busy, making more frequent contact with her [manager]
8	DNA
9	ITQ = 1 (probably would if I could) HCU = 0 Full time [completed 5 full days at work]

	Okay – I've been practising listening to positive feedback and being mindful but challenging of my negative thoughts.
10	ITQ = 1 HCU = 0 Full time [completed 5 full days at work] Okay – coping strategies are working.
11	ITQ = 1 HCU = 0 Full time [completed 4 full days at work] I had a bad day on Thursday but managed to successfully use a coping strategy to stop spiralling negative thoughts and talked to my manager about how I had felt. She gave me positive reassurance.
12	ITQ = 1 HCU = 0 Full time [completed 4 full days at work] Okay week this week.

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	Final feedback form
	1. Not being allowed to hide. 2. There hasn't been anything, even the group member who I find difficult has been an important part of the learning. 3. No the balance and speed were good for me. 4. No I liked the balance of theory with practical. 5. I've found it has worked really well – it was uncomfortable at the start but that was part of the point.

	Client satisfaction questionnaire
	No comments.

	Follow up letter
	Nicola, I hope everything is going well for you. As you will see from my responses I am very well still. Work is still busy but I'm really enjoying what I'm doing and am getting positive feedback. I actively check how things are going so the feedback is good and I'm far more able to ask for help and support if I need it, which seems to make everyone happier. When things go wrong I accept they sometimes do and focus on the solution and learning for next time. Paul and I still talk a lot more that we did and I share more about how I'm feeling. Although that's good now it won't always be. Being realistic there are bound to be challenging times. On a health note I've started running and am being more mindful of what I eat. So far this year I've lost nearly 1 stone and can run 5K now. It's made me feel much better altogether. I still only have one voice in my head and it's a much nicer voice now. It doesn't expect me to be perfect, I don't expect me to be perfect. My mum told me a story recently that resonated but didn't upset me. When I was 5 we moved from Doncaster to Here. I had apparently a favourite draft excluder toy that I took everywhere. Mum took the move as an opportunity to throw the dirty old toy away, but we had to go back

	because I cried so much about my lost toy. It was another piece of the jigsaw of understanding where my problems had come from, but it was a long time ago and doesn't define me now. I can never really thank you enough for the support you've given me. You showed me how Paul was feeling and you didn't let me hide. You made me realise I don't have to do it all on my own. Thank you and very best wishes, Jill x

58.8 WRITTEN FEEDBACK CHRISTINE_033

	Weekly questionnaire:
1	ITQ = 3 HCU = GP once, OH review Part-time, plus self-employed Look to RtW 4-6 weeks once started CBT course
2	ITQ = 3 HCU = GP Part-time, plus self-employed Met with OH, suggested RtW 4-6 weeks starting with lower hours and doing paperwork in back, not directly onto reception. Working in own shop 2 ½ days.
3	ITQ = ? HCU = saw GP, OK now need to review in 3-4 weeks, sick note for 4 weeks Part-time, plus self-employed Working in own shop/from home 6 days.
4	ITQ = 3 HCU = 1 for chest infection – not for depression, antibiotics/steroids Part-time, plus self-employed Difficult – met manager and HR representative. Discussed returning to work at the end of October on a phased return. They want me to go in before that to socialise/get used to workplace again for a couple of hours a week.
5	ITQ = ? HCU = 0 Part-time, plus self-employed Working in own shop/from home 6 days.
6	ITQ = ? HCU = 0 Part-time, plus self-employed 3 x ½ days in own shop
7	ITQ = 3 HCU = 1 agreed to give up all tablets and just collect from chemist twice a week [following overdose], to see GP again next week. Part-time, plus self-employed 6 days in own shop Spoke to manager regarding returning to work. Explained wasn't ready yet, would see GP next day. GP agreed and signed off for another month.
8	ITQ = ? HCU = 3 for chest infection Part-time, plus self-employed 2 days in own shop
9	ITQ = ? HCU = 1 Part-time, plus self-employed 4 days in own shop
10	ITQ = ? HCU = 2 GP plus OH consultant Part-time, plus self-employed 3 days in shop plus 2 hours at home Met with OH consultant Tuesday morning. Agreed not fit for work – to review again 17/12/13. Met with manager and HR Thursday afternoon (with Maddie). Agreed to go into work for a coffee etc. to get familiar with surroundings etc. again.
11	ITQ = ? HCU = 1 Part-time, plus self-employed 2 days in shop plus 2 x 2 hours at home
12	ITQ = ? HCU = 1 Part-time, plus self-employed 4 days in shop

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	Final feedback form
	1. I think that I have benefitted from the programme, because I've been able to talk about my problems (especially in small group), which is a good base on which to resolve things. You only get out what you put in. 2. Nothing specific, there were more positives. 3. I can't think of anything. 4. I can't think of anything. 5. .

	Client satisfaction questionnaire
	No comments.

	Follow up letter
	Hi Nicola, I'm glad you are settling in well. I hope you are seeing lots more of your grandchildren etc. It does seem to us like you have moved abroad! I can't write too well as I've just had carpal tunnel surgery, it feels much better though, was driving me mad at night etc. As for progress, James and I are 95% better than before. We understand each other for the first time thanks to him being involved in my therapy. Because of this, we are happier as a couple and a family. I am now almost back to full time work and it has been tough but I'm beginning to enjoy the Health Centre more, which is building up my confidence and sense of humour! In general some things are difficult to put into practice but I feel like I've made steady progress and will continue for the foreseeable future. I no longer isolate myself and I have more ups than downs which is good for me! I have had some extra therapy through the GP practice but it's not for me, I have to say that your course was the best thing I could have attended and thanks you for everything. Best regards, Christine

58.9 WRITTEN FEEDBACK HARRIET_034

	Weekly questionnaire:
1	ITQ = 2 HCU = GP once due to chest infection On sick at the moment Work needing me back due to shift cover. Nice to feel needed but felt quite upset due to feeling well after on an even keel with my medication and taking me 4 months to get there. I have been on sick for 4 months.
2	ITQ = 1 HCU = GP once for antibiotics Off sick Great
3	ITQ = 1 HCU = 0 On the sick

	Very good
4	ITQ = 1 HCU = 1 needed antibiotics Partial RtW [completed 3 x ½ days]
5	ITQ = 1 HCU = 1 due to chest infection on my day off, had to go for a lung x-ray Part-time shifts 4 x ½ days Dealt with things calmly and did one thing at a time
6	ITQ = 1 HCU = 1 antibiotics Part-time shifts 3 x ½ days plus 1 day sick Very positive saying that I am doing well.
7	ITQ = 1 HCU = 0 Part-time shifts 2 x ½ days plus 2 days sick Hard due to therapy session telephoned 24 hour helpline
8	ITQ = 2 HCU = 0 Part-time shifts 2 x ½ days plus 4 days annual leave Got reprimanded for not cleaning rooms. I was sent out on shift to do recycling and Tescos for milk. What was the priority? Bed making, recycling or shopping?
9	ITQ = ? HCU = 1 for antibiotics and to check burn Part-time shifts 4 x ½ days plus 1 day annual leave
10	ITQ = ? HCU = 1 once antibiotics, chest infection, sinusitis, tonsillitis, oral thrush Part-time shifts 4 x ½ days
11	ITQ = 1 HCU = 1 once for more antibiotics Part-time shifts 3 x ½ days plus 2 day annual leave Fine
12	ITQ = ? HCU = 1 flu jab Part-time shifts 3 x ½ days plus 1 day annual leave Fine

	Weekly session review:
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	Final feedback form
	1. meeting new people 2. very repetitive 3. n/a 4. all very valuable 5. all went very well, can't think of anything that needs to be re-designed

	Client satisfaction questionnaire
	No comments

	Follow up letter

58.10 WRITTEN FEEDBACK PAULA_035

	Weekly questionnaire:
1	ITQ = 2 HCU = 0 Part time Difficult at times. Just got on with it.
2	ITQ = 2 HCU = 0 Part time Stressful didn't want to be there. Didn't ask to leave. Just got on with it.
3	ITQ = 2 HCU = 1 prescription Part time
4	ITQ = 2 HCU = 0 Part time Hard
5	ITQ = 2 HCU = 0 Part time Didn't want to be there but was working on my own for 4 days, so was easier
6	ITQ = ? HCU = ? Part time Didn't want to be there wanted to be alone, sick of making myself go.
7	ITQ = ? HCU = ? Part time Really struggled this week. Threatened twice by patients. Just walked away.
8	ITQ = 2 HCU = ? Part time Annual leave – only popped in to see NVQ assessor
9	ITQ = 2 HCU = ? Part time Extremely difficult. Didn't use the right coping strategies, self-harmed twice just to give me the buzz enough to go to work.
10	ITQ = ? HCU = ? Part time Stressful – patient kicked off, too many new patients.
11	ITQ = ? HCU = ? Part time Off sick this week. Upset stomach.
12	ITQ = 2 HCU = 1 Meds review. Given drops for thrush in mouth Part time Stressful week. Very busy. Patient kicking off. Jumped in between him and another patient to stop him hitting the other one.

	Weekly session review:
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	Final feedback form
	1. That there are some people who genuinely do care 2. 12 weeks wasn't long enough, CBT gives the knowledge on how to change our

	reactions to situations but trying to do this in twelve weeks and keeping up with the changes we try to make until they become natural responses is hard with just 12 weeks support. 3. . 4. . 5. .

	Client satisfaction questionnaire
	Wish I'd been offered CBT years ago.

	Follow up letter
	Hi Nicola A quick update for you. I've been going to a creative writing group, finding it difficult. New people freak me out, which is freaking me out because it's never been this bad. Only 2 more classes to go then back to doing nothing. I have cut down on the self-harm. Not doing it as often and not as much. I'm just too damn old. Trying not to be so stupid. Everything else is in a downward spiral. Off work sick. Should have gone back last Friday but couldn't do it. Finding it increasingly difficult to make myself do anything. I'm seeing the mental health worker at my doctor's. He's going to refer me to MIND. I've never heard anything from them since Bren said she had. Presume she never actually did. I hope that life in Guernsey has more ups than downs. I didn't actually know where it was until I googled maps. Here's something I wrote for my creative writing homework. I've sent it just to show you I can do something. It's not that good but it's something. It's not for you to analyse, think this, that or the other. Just to read. Flashbacks are my memories, Of times from long ago. They haunt my waking moments, I wish that they would go. If only I could build a box inside my head, Fill it with these pictures that only I can see. Seal the lid down tightly, So it can be more like me. If only you could take a peek, A gentle look inside. You would understand me And be right by my side. But you don't understand me. Or simply just don't care. Yet I am right beside you, When your troubles are hard to bear. Where does all this leave me? I often ask myself. Right here on my ownsome, Sitting on a dusty shelf. Forgotten and unwanted. Till you need a helping hand To get you back on track, To where you want to be. Where does this all leave me? I often ask myself.

58.11 WRITTEN FEEDBACK ANNABEL_036

	Weekly questionnaire:
1	ITQ = 1 HCU = 0 Part-time, voluntary work Haven' t really got one [RtW plan] at the moment. Did clear 1500 emails and eventually turned the computer on which I haven't done in weeks. Not sure we agreed on any [adjustments] as such. I keep things locked away in boxes so thinking about things that upset me has been a start Only my place of voluntary work and I am very happy there and have got to know other staff.
2	ITQ = 1 HCU = 0 Part-time, voluntary work To start a journal Read mindfulness hand-out and listen to relaxation CD Make small behavioural change Have heart-to-heart with husband, do timeline (job) Was in contact with my old colleagues and have agreed to meet the person who at work caused me a lot of upset! Out of work she is much nicer and it will only be the 2nd time I have seen her since I left.
3	ITQ = 1 HCU = 0 Part-time, voluntary work I was in contact with 3 people I used to work with in a social context. It was fine and one was the person who made my life very difficult at time at work. I was cautious of not discussing certain things but was generally relaxed.
4	ITQ = 1 HCU = 0 Part-time, voluntary work None as was ill couldn't go I rang in to Middlethorpe to tell them on both days that I was not well and wasn't going in. Had a really bad cold and it had gone on my chest.
5	ITQ = 1 HCU = 0 Part-time, voluntary work I have had contact with some ex work colleagues which was fine. I met with my old boss from Superbreak for lunch. I had a great afternoon and it reminds me of happier times and a boss I trusted.
6	ITQ = 1 HCU = 1 dentist cracked tooth Part-time, voluntary work I had a good week and really enjoyed the interaction with the new volunteers a good experience. One lady was dyslexic and we discussed our approach to our problems which was good.
7	ITQ = 1 HCU = 0 Part-time, voluntary work Due to the weather, I rang and asked if I could work indoors on Monday as my style for gardening on my knees means I get wet through. Head gardener was fine about it and found me work to do inside.
8	ITQ = 1 HCU = 0 Part-time, voluntary work No contact as I have been away on holiday.
9	DNA
10	ITQ = 1 HCU = 2 GP urine infection, opticians for dyslexia sight test, new glasses ordered Part-time, voluntary work
11	ITQ = 1 HCU = 0 Part-time, voluntary work [Started new voluntary job at Portland Nursery Gardens] 2 full days (4 x ½ days worked together) I felt confident and not anxious at all. I was working on Xmas decorations which I love anyway and talked to all those I met. I picked up on the politics of the site but have the attitude that I won't be sucked in I am there t garden for me.
12	ITQ = 1 HCU = 0 Part-time, voluntary work [Started new voluntary job at Portland Nursery Gardens]

	2 full days (4 x ½ days worked together) plus ½ day. It has been good. I am meeting lots of new people and have enjoyed what I have done so far.

	Weekly session review:
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	Final feedback form
	1. The way Nicola worked with the group to involve everyone, whilst controlling input from those who were prone to go off subject. **2.** The book we were working from was very dry, and read more like a manual for professionals in psychotherapy than for patients. **3.** No I can't think of anything. **4.** I found some of the slides quite complicated and I think there is a lot of jargon. A bit more plain English explanation might help. **5.** I think it would be good to revisit some of the theory from the earlier weeks and discuss what coping strategies are working and how people were adapting these; what was working and why which might help those still looking for the right one.

	Client satisfaction questionnaire
	I thought Nicola was excellent. She had really prepared and had taken on all that I had told her. She helped me tackle things that I have carried throughout my life and has helped me understand myself much better. I feel more accepting of my position and I feel positive about going forward. I found the group very supportive and I learnt a lot. A very worthwhile experience.

	Follow up letter
	Dear Nicola, Please find enclosed the completed forms. It was great to hear from you and I hope this work out for you in Guernsey. I have made some progress since we last met despite a short period of panic and despair in January which was probably down to Winter blues and the anniversary of my leaving my last job on March 2013. I have expanded my voluntary work. I am still volunteering at Middlethorpe Hall and Portland Railway Nursery which Maddy introduced me to. I found Portland rather overwhelming at first due to the large amount of politics on site and to the fact that there is a woman in charge from the NHS side of things whom I don't really care for as she reminds me of my former boss. Whilst initially thinking I would give it up as I found it quite stressful and anxiety provoking I found myself imagining what you would have said and that it was test of how I could cope with this type of situations. I was invited quite early on to become more involved in the running of the site as I have been asked to become Membership Secretary. Initially again I was very hesitant in agreeing but thought it would be good for me to get my hand in again with some form of administration. Attending the committee meetings has been challenging as the committee has some members with strong personalities who end up clashing frequently. I have taken on attending the open days to recruit new members and redesigned the membership forms, improved signage and produced some name badges which were sadly lacking. My next real big change is to take over the day to day processing of membership records and to try and

	get them back into some semblance of order as the current membership secretary has dementia and has not been coping with the job for some time I am quite nervous of this and sometimes doubt if I can do it but know if I must push myself to have a go. Have also joined the Brunswick Organic Nursery in the last 6 weeks. They support "workers" with learning difficulties in horticulture and crafts. I have been supporting workers in the craft workshop and in the nursery's potting shed. I am hoping to go out with the contract gardening team shortly. I was supposed to be going out with them last Friday but due to my inner ear infection and my badly cut finger this has not been possible. The biggest step forward I suppose is that I actually applied for a paid job at Brunswick which came up just as I joined them as a volunteer. The role was as a relief staff worker covering illness and staff holiday. It was a zero hours contract which I was hesitant about but was told that may of the staff are on this kind of contract. Having talked myself out of applying I was persuaded to change my mind and apply by the volunteer co-ordinator at Brunswick. I did get an interview but didn't get the job. I asked for feedback and spoke to the Director of the site last Monday. He said many complimentary things but said that he was nervous of my interaction with the two members of the interview panel who had learning difficulties. I found this quite shocking as I think I have been doing really well developing relationships with the team members I support. Initially this feedback upset me but on reflection I think a lot of it came down to him not explaining what he wanted from me in the interview with regards to some scenario questions. My inexperience with learning difficulty workers can only continue to improve the longer I am there. I was encouraged to apply for any other positions that come up and I will fi they are suitable. I feel I can do well in this area and think I can make a difference to the experience the workers have in sessions that I help in. I don't know if I'm kidding myself that I can really find work I this area that allows me to combine my love of crafts, gardening and communication but I think I am in as good a place as I can be to try. I think I am still avoiding looking hard for work but I am using my computer much more and reading my emails more frequently. I have even started doing some digital card design again and it is a year since I last did that. I have a friend who has started doing crafts to sell and she has asked me if I want to take some cards along to sell at an event in a month's time. I have been toying with the idea of trying to sell my cards and this might just give me a nudge in the right direction. Relations with my parents have been up and down since I last saw you. Due to tensions still present between me and my parents since I told them about the abuse in November, I decided not to go up to spend Xmas with them. Paul's work was a convenient excuse which I could hide behind. Whilst I hosted Xmas dinner for my sister's family and cooked the whole thing myself it was actually quite relaxed and I did enjoy it. In January my parents dropped the bombshell of deciding to make my sister executer on their wills but not me. I was totally shocked and felt very much that this was born out of indirect punishment for my having told them about the abuse. When I decided to question their reasoning they decided to respond in the form of a formal email rather than talking to me which I was even more insulted by. The main reason given for not picking me was said to protect me from stress and that they didn't want 3 executers as in Scottish law one has to be a solicitor. I feel that my parents are using "my stress" as a convenient excuse and still feel very hurt by the whole thing. More upsetting was the fact that they told my sister of the plans a week earlier and she had said nothing to defend my position or said to them that she disagreed with their decision which she told me she did. This has put a bit of a rift between me and my sister as I really expected that she would have stuck up for me but she hasn't. I have to come to terms with that and the realisation that she is really a coward and didn't want the hassle. My initial reaction when my parents told me about their wills was to feel that I wanted nothing more to do with them and I would not visit them in Scotland again. However having let it lie for a while I just decided to accept the situation and see how it all plays out in the end. At the same time as this was going on my parents were letting me sort things out at their house in There which they rent out, which I felt was very two faced of them. Since then they have said that they will be giving me power of attorney which is far more important in my opinion and had they not agreed to this then I think relations would have been beyond saving. I do feel a bigger distance from my sister than ever and I think she realised it recently. She actually came round for a chat and brought me some flowers when I cut my finger. I think it is

	because I actually asked her the other day if we would be friends if we weren't sisters. She said it was a very loaded question which she wasn't prepared to answer. Unfortunately what my sister thinks of me bothers me a lot but I have come to realise that this can be quite destructive as she isn't the caring person that I am and she isn't prepared to be. I am now seeing Belinda as very much a carbon copy of my mother and I don't think I had really seen it clearly until now. I am the carbon copy of my dad which makes for a fractious relationship as he can make me cross very quickly and we are both prone to respond too quickly with hurtful, childish responses. At least dad does respond this way and I know he cares. After much soul searching I have agreed to go and stay for a week at my parents for Easter but will have Paul with me which is a good thing. My parents are making a rare visit south in July and are staying for several weeks. It is their 50th wedding anniversary whilst they are down with us. I am pleased they are making the effort to come down. Nothing further has been said about the abuse since November and I don't think it will be mentioned again somehow. I only ever wanted to get rid of the secret. I had hoped for a better response from them and a more appropriate one, but I think that was down to the shock and the guilt that they were feeling at the time. I think my parents see me as permanently damaged goods and likely to break down again at any moment. This makes me cross and knocks my self-confidence a bit but I think I just have to accept that is how they feel. I am not sure if I believe I have made massive progress and I was very down in January and did text you but thought you had probably given back your old work 'phone. I have picked up since then but find it quite easy to put off doing things I don't want to face. Having got an interview did boost my confidence and putting in my first application in a year was quite a big thing for me too. I was upset not to get the post but it may well have been too early and I will keep going at Brunswick in the hope it leads somewhere. If I can't get work at Brunswick then I think there is a good chance that I can pick up carer work on a one to one basis and my Brunswick experience should help there. I hope I can incorporate gardening into the equation but we will see. Paul remains financially supportive and I feel much more at ease with this than I used to do. Too much if I really think about it, as I would quite like my life to remain like this if it were really possible. I like the fact that at the end of the day I am only volunteering and if I want to take time out I can without being tied to a holiday calendar and working for set periods of time. I do regard my volunteering as work and juggling 3 volunteer jobs is hard work. If I had an income of £10,000 a year coming in, which is what I need to tick over, I wouldn't change a thing. I still feel like I am playing at life and in an unrealistic bubble in which I feel safe and happy, but what I do makes a difference to me and to others, I just don't earn any money! I have found it quite helpful to keep in touch with the other girls in the group and to have met up with a few of them – PR, CA, JB and MM. It is nice to be able to keep the link with the others as we don't have to explain our situation and we went through a personal experience together. I think it is very sad that our course ended with your departure as I feel we could all have benefited from having you here. I use my 3,4,3 breathing exercise whenever I'm distressed, can't sleep or need to relax and shut the world out for a bit. It helped when I was having my finger worked on in A&E. I think it would be useful to be able to go to group somewhere I could express my thoughts and emotions and would appreciate it if you know any I could join. I hope your research brings useful outcomes and would love to keep in touch if you would like, once your professional involvement has concluded. Kind regards, Annabel Xmas card 2014 To Nicola Hope the job is going well and that you completed your studies. I finally have a paid job – hope you are proud! Still in touch with many of the girls a year on which isn't bad!

58.12 WRITTEN FEEDBACK BETTY_037

	Weekly questionnaire:
1	ITQ = 1 HCU = 0 Full time, on holiday
2	ITQ = 1 HCU = 0 Full time [over 6 days] Had a problem with boss's sister, just said go away and leave me alone
3	DNA
4	ITQ = 1 HCU = 1 water infection, tablets Full time [over 6 days] A little stressed, just went quiet
5	ITQ = 1 HCU = 1 have to go for a blood test given medicine tablets may have to have a scan of my abdomen Full time [over 6 days]
6	ITQ = 1 HCU = 0 Full time [over 6 days]
7	ITQ = 1 HCU = 1 Full time [over 6 days] Monday visited doctor given tablets, have to go and have a camera to look inside my stomach
8	ITQ = 1 HCU = 1 Full time [over 6 days] Antibiotics chest infection
9	DNA
10	ITQ = 1 HCU = 1 went for smear Full time (on holiday)
11	ITQ = 1 HCU = 0 going to hospital 29.11.2013 Full time [over 6 days] OK
12	ITQ = 1 HCU = 1 went to hospital 29.11.2013 for camera, didn't work, waiting to have an x-ray. OK

	Weekly session review:
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	Final feedback form

	Client satisfaction questionnaire

	Follow up letter

58.13 WRITTEN FEEDBACK NAOMI_038

	Weekly questionnaire:
1	DNA
2	DNA
3	DNA
4	ITQ = 2 HCU = 1 saw GP once on Friday – not related to low mood Part time [worked ½ day] I was very anxious to meet everyone, however the team members were very welcoming. Kept myself busy sorting out papers. I volunteered to supervise contact – out of the office from 3.30-5pm.
5	DNA
6	ITQ = ? HCU = ? On annual leave
7	DNA
8	ITQ = 2 HCU = 0 Part time [worked 3 x ½ days] Work is stressful at the moment, got a new team manager, colleagues stressed because of too much to do – workloads getting higher every day. Still trying to find my feet.
9	DNA
10	ITQ = 2 HCU = 1 had a flu jab not seen doctor Part time [worked 1 x full day plus 2 x ½ days] Very pressured, not enough hours to do work.
11	ITQ = 2 HCU = 0 Part time [worked 1 x full day plus 2 x ½ days] Very fast paced. No time to drink coffee.
12	ITQ = 2 HCU = 0 Part time [worked 3 x full days] Work is fast paced, nature of the job is stressful – matters made worse by lack of decisions from senior management. I have coped well. I know my job.

	Weekly session review:
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	Final feedback form
	1. Sharing experiences with other service-users. 2. . 3. . 4. . 5. .

	Client satisfaction questionnaire
	No comments.

	Follow up letter

APPENDIX 59: ABSENCES FROM WORK & HEALTHCARE USE

Data about other health and social care use, as well as welfare benefit payments were collected so that the overall economic costs of providing support and treatment for this group of patients could have been evaluated.

Whilst on the waiting list for psychological therapy 1 participant had lost her job and 1 participant had resigned from her job due to mental health problems.

At the start of the course 2 participants were off sick from work due to a mental health problem or stress. During the course several participants took time off work for physical illnesses and hospital tests shown in Table *.

Participants made high use of Primary Care services for minor illness and infections shown in Table *. Some participants' mental health worsened: 1 participant took an overdose (without suicidal intent) requiring assessment and treatment in hospital and 1 participant made use of the 24/7 crisis helpline.

Table 109 – Absences from work & Healthcare received

Participant number	Absences from work	Healthcare received
031	**Session 1-12:** Unemployed (on ESA benefit, attending the Work Programme) **Session 7:** Absent for 2 weeks due to inpatient treatment for long-standing physical health condition (Gastro-oesophageal Reflux Disease: GERD)	**Session 2:** Hospital outpatient appointment re GERD **Session 4:** Hospital outpatient appointment re GERD **Session 5:** GP visit Hospital outpatient appointment re GERD **Session 7:** Hospital inpatient treatment (3 days) for planned procedure for GERD
032	**Session 1-2:** On restricted duties due to stress working from home **Session 3-8:** On phased return to work **Session 9-12:** Working fulltime	NONE
033	**Session 1-12:** On long-term sickness absence due to mental health problems Able to work in own shop (self-employed) **Session 10:** Visited workplace to meet up with colleagues socially as first step in return to work process	**Session 1:** GP routine recall **Session 2:** GP routine recall Occupational Health Nurse **Session 3:** GP routine recall **Session 4:** GP antibiotics and steroids for a chest infection **Session 7:** Hospital inpatient treatment (1 day) following over-dose **Session 8:** GP antibiotics and steroids for a chest infection **Session 9:** GP routine recall **Session 10:** GP routine recall Seen by Occupational Health Consultant

		Session 11: GP routine recall **Session 12:** GP routine recall
034	**Session 1-3:** Absent from work due to mental health problems for last 4 months **Session 4:** Began phased return to work **Session 6:** 1 day off sick due to chest infection	**Session 1:** GP chest infection (antibiotics) **Session 2:** GP chest infection (antibiotics) **Session 4:** GP chest infection (antibiotics) **Session 5:** Chest X-Ray **Session 6:** GP chest infection (antibiotics) **Session 7:** Phoned 24 hour helpline due to distress **Session 9:** GP burn on arm **Session 10:** GP chest infection, sinusitis, tonsillitis, oral thrush (antibiotics) **Session 11:** GP routine recall (antibiotics) **Session 12:** Practice nurse ('flu jab)
035	**Session 11:** Absent all week due to an upset stomach	**Session 12:** GP thrush (Nystatin drops), medication review
036	**Session 1-12:** Working 2 days per week in a voluntary job having resigned from previous employment due to mental health problems **Session 4:** Absent all week due to a cold	**Session 10:** GP urine infection (antibiotics), Opticians for dyslexia (sight test, new glasses ordered)
037	NONE	**Session 4:** GP urine infection (antibiotics) **Session 5:** GP abdominal pain (blood test) **Session 7:**

		GP referral for endoscopy **Session 8:** GP chest infection (antibiotics) **Session 10:** Practice nurse (smear test) **Session 12:** Radiology dept: endoscopy
038	**Session 1-3:** Absent for 3 weeks due to severe rash on face	**Session 4:** GP severe rash on face (steroid cream) **Session 10:** Practice nurse (‘flu jab)

APPENDIX 60: RECRUITMENT DIFFICULTIES

The main recruitment difficulty was related to identification of potential participants. In Here secondary care psychological therapies service, the author was given access to the waiting list related to people who had not been assessed (i.e. new referrals). However, in There, the clinical lead of the service acted as a 'gatekeeper' and only allowed the author to write to people on an existing waiting list who were judged as suitable (i.e. only placed on the waiting list after having already undergone a first-line assessment by a psychotherapist).

In Here assessing eligibility by screening referrals without meeting face-to-face in the first instance was problematic due to lack of information about severity of depression and employment status. This meant that letters were sent to people who would not actually meet inclusion criteria. For the people who expressed an interest but were found to be not suitable, their expectations were raised about being able to get treatment more quickly and then they were disappointed. This was also a problem in There when people responded to the initial enquiry but were found to be not suitable.

The main reason for non-participation following initial screening was either that the potential participant did not meet inclusion criteria in terms of severity of depression or did not meet inclusion criteria in terms of being in employment and wanting to remain in work.

Recruitment via a direct referral from the client's clinician as intermediary could make an unreasonable demand on frontline staff as it could be time-consuming and disrupt their usual practice. In this study approaching clinicians by email to offer information about the study in order to elicit referrals had very little effect. However, one manager invited the author to a team meeting so that practitioners could meet her in person and ask questions directly. Following this meeting, five appropriate referrals were made and all of these clients completed the therapeutic intervention.

For people who met inclusion criteria, gave informed consent and were actually assessed, three people were withdrawn because they required or requested a different form of therapy (e.g. DBT, EMDR) and this was immediately available.

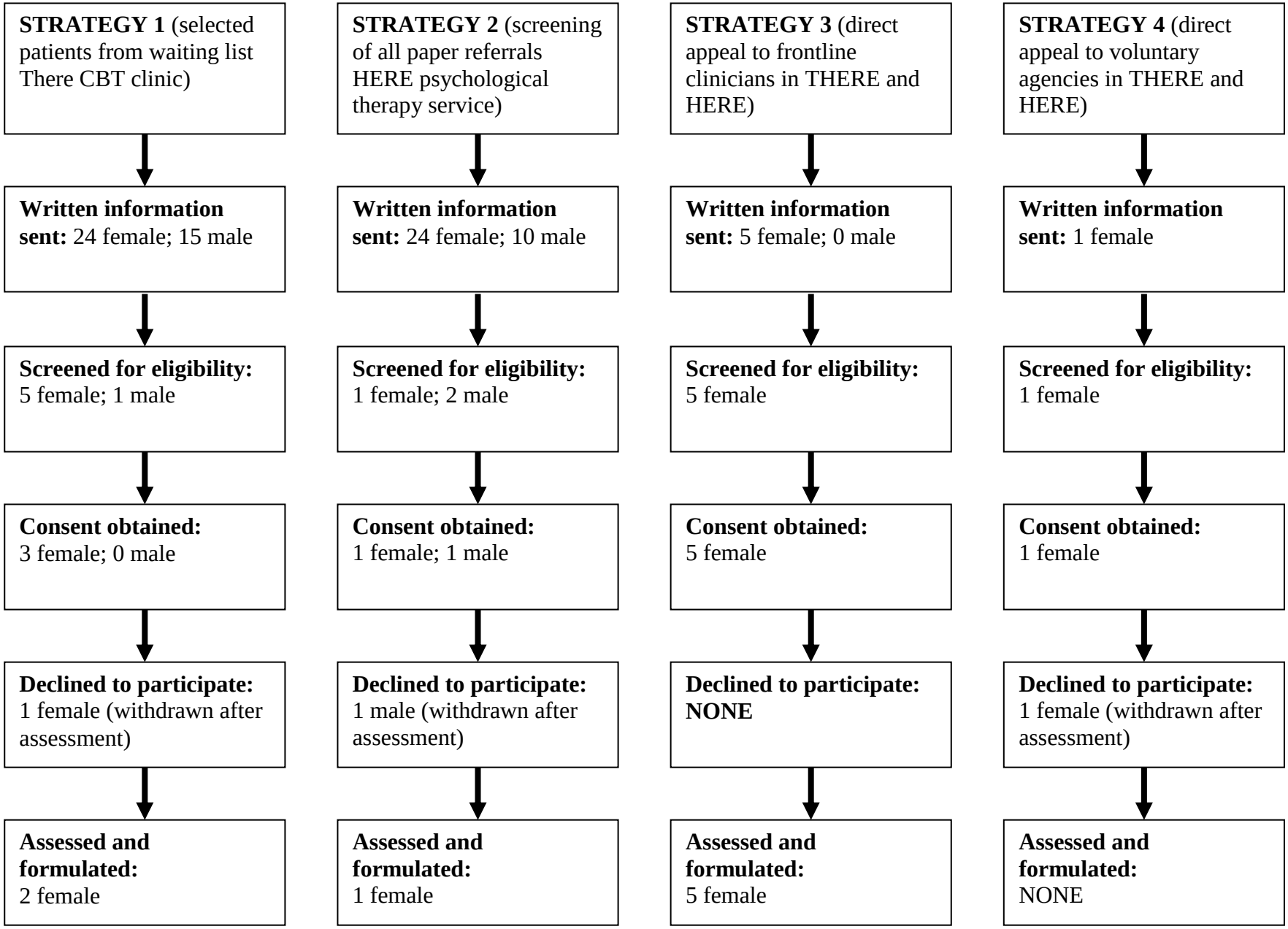
Five clients were referred directly after the author visited the CMHT, which involved describing the intervention in detail, answering questions, and clarifying the care pathway.

The percentage success of the different recruitment strategies are shown in Table 4.

Table 110 – Percentage success of different recruitment strategies

	STRATEGY		**Percentage recruitment**
1	New referrals	Psychology and Psychotherapy Service Here	5.1%
2	Waiting list assessed clients	Specialist CBT Clinic There	2.9%
3	Direct approach to clinicians in CMHTs email only	Here CMHTs	0%
	Direct approach to clinicians in CMHTs email plus team meeting	There CMHTs	100%
4	Direct approach to 3rd sector organisations	Workplace Here	0%
		There MIND	0%

Figure 45 – Flow chart



APPENDIX 61: GROUP ATTENDANCE

The programme register (see Table 1) shows the pattern of attendance. Overall 88.5% of group sessions were attended by all participants and the reasons for missed sessions appeared to be unrelated to the intervention. Two participants missed 1 session each due to holidays planned before joining the study. One participant missed several sessions at the beginning due to illness and family problems but wanted to continue so this was agreed. One participant warned the author before the start of the programme that she was waiting for a date for an operation. She missed 1 session while she was in hospital and returned on a highly restricted diet. Another participant missed 2 sessions in the middle due to the sudden death of a close relative. She was contacted between sessions to offer emotional support and wanted to re-join the group once the funeral had taken place so this was agreed.

Mean number of sessions attended = 10.63 (SD 1.87)

Mean number of participants per session = 7.08 (SD 0.95)

Table 111 – Group attendance

Session	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**BREAK**	**8**	**9**	**10**	**11**	**12**	**TOTAL sessions per participant**
Date	**13.09**	**20.09**	**27.09**	**04.10**	**11.10**	**18.10**	**25.10**	**01.11**	**08.11**	**15.11**	**22.11**	**29.11**	**06.12**	
031	Present	Present	Present	Present	Present	Present	Absent		Present	Present	Present	Present	Present	**11**
032	Present	Present	Present	Present	Present	Present	Present		Absent	Present	Present	Present	Present	**11**
033	Present	Present	Present	Present	Present	Present	Present		Present	Present	Present	Present	Present	**12**
034	Present	Present	Present	Present	Present	Present	Present		Present	Present	Present	Present	Present	**12**
035	Present	Present	Present	Present	Present	Present	Present		Present	Present	Present	Present	Present	**12**
036	Present	Present	Present	Present	Present	Present	Present		Present	Absent	Present	Present	Present	**11**
037	Present	Present	Absent	Present	Present	Present	Present		Present	Absent	Present	Present	Present	**10**
038	Absent	Absent	Absent	Present	Absent	Present	Absent		Present	Absent	Present	Present	Present	**6**
TOTAL participants per session	**7**	**7**	**6**	**8**	**7**	**8**	**6**		**7**	**5**	**8**	**8**	**8**	

APPENDIX 62: BETWEEN-SESSION CONTACTS & PLANNED INDIVIDUAL SESSIONS

Clients were encouraged to contact the author by 'phone, text or email between sessions if the intervention had triggered distress or if they were uncertain about any aspect of the programme. They were informed that this contact should not be used as an out-of-hours emergency service. They were also informed not to expect an immediate reply and not to ring overnight or weekends. Participants were advised that if they could not cope to use the Crisis Contingency Plan agreed in session 1.

Table 1 shows that between session contacts were not evenly distributed with 2 participants making the most contacts. Both participants were at moderate risk with past histories of impulsivity and deliberate self-harm so between session support had been anticipated which is nothing out-of-the-ordinary in secondary mental health care. It is interesting that other participants did not make more use of the between-session contact when they had obviously been in distress but chose not to text, email or 'phone the author.

62.1 PLANNED INDIVIDUAL SESSIONS

Table 1 shows the number of 1:1 sessions attended by each participant. In total this required 3,510 minutes. Although providing 1:1 sessions before, during and after a group programme makes it more therapist-intensive, it has been shown that group preparation with the individual helps to build the therapeutic alliance and improves treatment initiation and treatment completion of group therapies (AGPA, **). It was decided to involve significant others by offering carers' or couples' sessions in order to provide information about depression and the treatment programme. The intended purpose was to improve the client's network of social and emotional support, as well as to offer some support for the carer if appropriate (as required by the Trust).

Table 112 – Individual sessions and other contacts

	1:1 assessment (60 minutes)	Couples/ Carers' session (60 minutes)		1:1 follow up (60 minutes)	OT session (90 minutes)	Text (10 minutes)	Email (20 minutes)	Phone (30 minutes)
Mandy	2	**Female partner**	1 assessment 1 therapy 1 follow up	couple	0	3	0	0
Jill	2	**Husband**	1 assessment 1 follow up	couple	1	0	0	0
Christine	2	**Husband**	1 assessment 1 follow up	couple	2	16	2	5
Harriet	2	**Husband**	1 assessment	individual	1	1	1	0
Paula	2	**Support worker**	1 assessment	individual	0	9	0	0
Annabel	2	**Sister**	1 assessment	individual	2	0	2	0
Betty	3	**Male partner**	1 therapy	individual	1	0	0	0
Naomi	3	**Husband**	1 assessment 1 follow up	couple	0	0	0	0
Total number contacts	**18**	**13**		**8**	**7**	**29**	**5**	**5**
Mean number contacts (SD)	2.25 (0.433)	1.625 (0.7)		1 (0)	0.875 (0.78)	3.625 (5.5)	0.625 (0.86)	0.625 (1.65)
Total time required in minutes	**1080**	**780**		**480**	**630**	**290**	**100**	**150**

APPENDIX 63: ECONOMIC ANALYSIS

It was impossible to compare the costs of providing the new intervention with a control or comparison group because not enough participants were recruited to allow for randomisation.

However the direct and indirect costs of providing the intervention were estimated using HFMA (2014) guidance.

One approach to health economics is for all ***resource inputs*** to be identified, measured and valued to calculate the cost of the ***output*** (i.e. recovery).

Another approach is to estimate the unit costs. This can be done in 2 ways:

- "Bottom up" calculation (e.g. by working out the value of each element of the intervention and then adding on a percentage for overheads.
- "Top down" calculation (e.g. working out how much is spent on the overall service and dividing this figure by the number of patients referred for any intervention)

Monitor (2015) prefers providers to supply patient-level information (i.e. bottom up calculation) which details all the resources required to deliver an intervention.

Costs are made up of different expenses such as:

- Pay and benefit costs: mid-point pay scale PLUS 22% uplift for on-costs (employer National Insurance and pension contributions)
- Non-pay costs: 10% of total staff costs (training and development, office consumables, travel and subsistence, IT and communications equipment etc.)
- Incremental corporate overheads: 30% total staff costs (HR, finance, payroll, and IT; office furnishings, office space etc.)

Table 16 shows how many minutes each client received in terms of staff time. This figure was used to calculate the cost per minute / hour, and hence the direct costs of the intervention per participant.

This shows that direct costs (clinical care) represent approximately 70% of the overall costs of providing this intervention.

Table 113- Staffing costs

	Cognitive Behavioural Therapist (CBT)	**Staff costs (mid-point PLUS 22%)**	**Occupational Therapist (OT)**	**Staff costs (mid-point PLUS 22%)**	**Consultant Clinical Psychologist (Supervisor)**	**Staff costs (mid-point PLUS 22%)**
Annual salary (mid-point)		*Band 8a = £44,261*		*Band 5 = £25,047*		*Band 8c = £59,016*
Plus non-staff costs (22% total staff pay)	*£9,737.42*	*£53,998.42*	*£5,510.34*	*£30,557.34*	*£12,983.52*	*£71,999.52*
Hourly rate = annual pay / 46.58 weeks / 37.5 hours		*£30.91*		*£17.49*		*£41.22*
Cost per minute		*£0.52*		*£0.29*		*£0.69*

Table 114 – Direct costs

COMPONENT	**CBT minutes**	**Staff costs in £ x £0.52**	**OT minutes**	**Staff costs in £ x £0.29**	**CBT supervisor minutes**	**Staff costs in £ x £0.69**	**TOTAL STAFF COSTS in £**
Assessment / formulation 1:1	1080	*£561.60*					*£561.60*
Couples'/carers' sessions 1:1	780	*£405.60*					*£405.60*
Occupational Therapy 1:1			630	*£182.70*			*£182.70*
Other contacts	540	*£280.80*					*£280.80*
Group-CBT programme 2 facilitators	36000	*£18,720.00*	36000	*£10,440.00*			*£29,160.00*
Follow up and discharge 1:1	480	*£249.60*					*£249.60*
Clinical supervision	360	*£1,872.00*			540	*£3,709.80*	*£5,581.80*
Total clinical activity	**38880**	**£22,089.60**	**36630**	**£10,695.60**	**540**	**£3,709.80**	**76050 minutes**
Total direct costs							**£36,422.10**
Mean direct cost per client							**£4,552.76**
Cost per clinical minute							**£0.48**
Cost per clinical hour							**£28.63**

Table 115 – Non-clinical costs

Activity		**Cost for CBT**		**Cost for OT**	
Preparation / Clear up	720 x £0.52	*£374.40*			*£374.40*
Administration	360 x £0.52	*£187.20*	360 x £0.29	*£104.40*	*£291.60*
Total non-clinical activity	**1080**		**360**		**1440 minutes**
Total indirect costs		**£561.60**		**£104.40**	**£666.00**
Cost per non-clinical minute					**£0.46**
Cost per non-clinical hour					**£27.75**

Table 116 – Total costs

Costs	**CBT**	**OT**	**Supervisor**	
Total staff minutes i.e. clinical + non-clinical	**38880**	**36630**	**540**	**76050 minutes**
Total clinical costs	**£22,089.60**	**£10,695.60**	**£3,709.80**	**£36,422.10**
Total non-clinical costs	**£561.60**		**£104.40**	*£666.00*
Non-pay costs (10% total staff pay)				*£3,642.21*
Overhead costs (30% total staff pay)				*£10,926.63*
TOTAL COST OVERALL				**£51,656.94**
Mean total costs per client				**£6,457.12**

APPENDIX 64: ACCEPTABILITY TABLES

64.1 CLIENT SATISFACTION QUESTIONNAIRE

The CSQ-8 asks participants to rate their level of satisfaction with the service they have received overall and whether they would recommend the programme to a friend:

Table 117 – Mean client satisfaction per client

Client	Mandy	Jill	Christine	Harriet	Paula	Annabel	Betty	Naomi
CSQ-8 score	25	29	29	27	26	29	missing	24
TOTAL MEAN = 27.0 (SD 2.08)								

64.2 ARM-5

The ARM-5 was used after each session to collect data about any problems participants were experiencing in undergoing therapy especially with regard to the therapeutic relationship.

Scores are shown in the following tables.

Table 118 - Mean therapeutic alliance per session

Session number	1	2	3	4	5	6	7	8	9	10	11	12
Mean ARM-5	33.1	33.0	34.8	34.9	34.7	34.1	34.5	34.7	35	34.8	34.5	34.9
TOTAL MEAN = 34.4 (SD 0.68)												

Table 119- Mean therapeutic alliance per client

Client	Mandy	Jill	Christine	Harriet	Paula	Annabel	Betty	Naomi
Mean ARM-5	35	35	34	34.8	35	35	31.7	34.7
TOTAL MEAN = 34.4 (SD 1.14)								

APPENDIX 65: WRITTEN FEEDBACK FROM THE OCCUPATIONAL THERAPIST

The OT provided written feedback at T = 2 and T = 3.

At T = 2 she wrote:

> *The group has helped me to develop my skills in encouraging individuals to talk by asking reflective questions. I have thoroughly enjoyed being involved in the sessions and the challenge of 'stopping' individuals talking so that others can be brought into the conversation.*
>
> *In my view Nicola has engaged the clients well. It has been a pleasure to watch individuals learn/realise the consequences of their actions and explore more positive interactions. It has been interesting taking a 'back seat' in the sessions as it has enabled me to recognise more widely group dynamics and explore non-verbal interactions in more depth.*
>
> *I think I now have more of an understanding of the CBT process and am looking forward to relating it more directly to individuals' work experience.*

At T = 3 she wrote in answer to specific questions:

Please outline any problems or difficulties you encountered in delivering the programme:

> *There were no problems in delivering the programme as it was supervised and planned well and consequently any potential problems were discussed in advance of the session.*

Please describe which elements of the programme do you think were most effective:

> *I think that using CBT techniques with clients facilitated them to feedback to each other effectively and then they valued that feedback more than they would have done if it was from the course leaders.*
>
> *Clients were able to work together to identify problems and solutions using interventions/ conversations guided by the course facilitators proved far more effective than had it been the course leaders identifying the issues.*

Is there anything that you think should be included in the programme?

> *I think that on reflection having some sessions that were solution based but specific about individuals management of issues at work and ways to resolve them would also have been beneficial as the group worked well together to come up with solutions for each other.*

Is there anything that you think should be removed from the programme?

No not that I can think of.

Please give any other feedback which could contribute to a re-design of the programme:

It has been a pleasure to support the planning and implementation of this group, I think it could have been led for a longer period of time and continued to benefit the clients further and a review session 6-8 weeks post group may be beneficial in future programmes.

APPENDIX 66: MIND MAP POST-INTERVENTION REVIEWING FOCUS GROUPS 'C'

Each focus group had a different discussion guide to cover the issues the author wanted to consult upon. The mixed group (C) were asked to consider questions related to the feasibility of implementing the intervention in a real-world community setting (Appendix 35).

Immediately following each focus group, the Mind Mapping Method was used to identify and summarise participants' concerns and advice that emerged from the discussion. This was later circulated to participants by email to verify the main themes and responses. Illustrative quotes are provided here, attributed to the person who said it; their place of work; gender; participant code; with focus group number and time point.

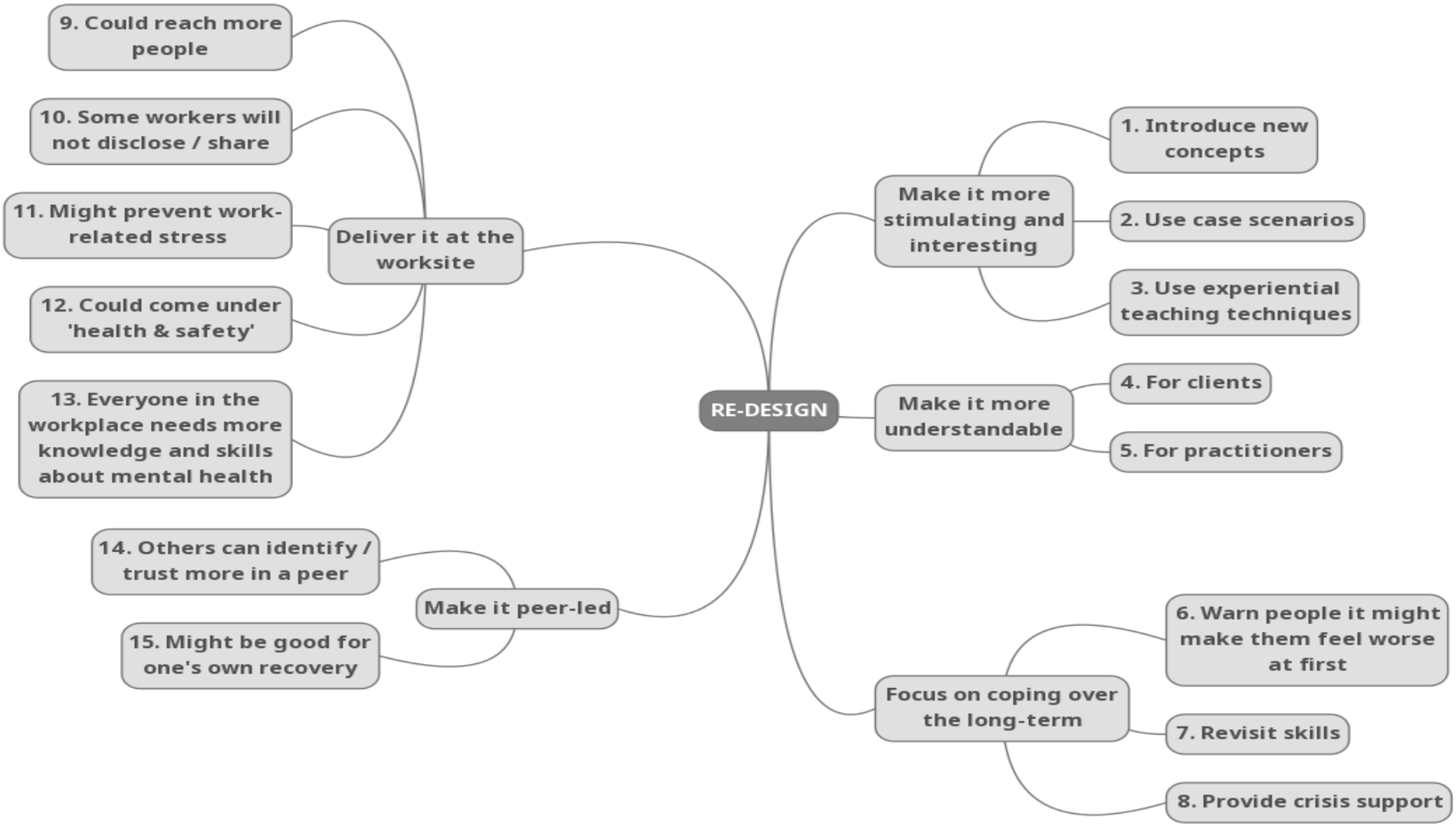


Figure 46 – Mind Map Re-design

Table 120 – Re-design Sample Quotes

	Modification	Sub theme	Attribution	Concerns raised / advice offered by participants of Focus Group C
RE-DESIGN	Make it more interesting and stimulating	1. Introduce new concepts	Male, Former SU, Financial Manager LA, Union Rep **028:FGC2:134**	*I felt that by reading some of it, although I've learned quite a lot from when I went through my therapy, there were new concepts and new ideas in there, and I thought, I'll get in touch. And I thought, oh, so that's I do. Nicola delivered that, oh we did that. I understand the reason behind that, so I thought, oh yeah, and that's why it's…*
			Male, Former SU, Traffic Manager LA **027:FGC2:48**	*I'm quite pleased with the result. … I found it interesting and stimulating, and I've read similar pieces of books that I've read, to find all that resource in one place, was really good.*
			Male, Psychologist/Manager, LYPFT, Union Rep **007:FGC1:144**	*Well we've said that, I mean it's quite comprehensive, and there's a lot of stuff in there, and there's a lot of good stuff in there. I mean I was a bit concerned that there's a lot of stuff and you know, myself, reading it, I was sort of thinking, well how is it actually for you to sort of engage with it. To sort of groups with it, you know. That was, I suppose, one of my just concerns. But [016], you've been saying that it's actually, it's quite good, and it works well and you know the stuff in there is really effective.*
		2. Use case scenarios	Male, CBT/Manager, LYPFT **002:FGC1:308**	*But yeah, I mean I always think examples are useful. It sounds like you go through them, in the session then as well.*
			Male, CBT/Manager, LYPFT **002:FGC1:40**	*I found it really informative and lots of really good stuff…there's lots of good examples and stuff like that, and illustrations and analogies.*
			Female, Former SU, Financial Assistant **016:FGC1:216**	*Yeah, because they apply to so many different scenarios don't they, of what stages people are. Whether it's bereavement, you know, different kinds of depression, and things like that, so it can, yeah. Yeah, it is good. I mean I understood it because I've done it before. But I must admit when you read it in that…*
			Male, CBT/Manager, LYPFT **002:FGC1:1111**	*Yeah, the other thing as well, you give lots of examples, but it be useful to give an example of somebody that's gone through treatment with depression and done well, because it's, I know we focus more on the negatives don't we, but just might be useful to have one that's, somebody that's done well, is using those techniques and instil a bit of hope.*
		3. Use experiential teaching techniques	Male, Former SU, unemployed, volunteer LYPFT **030:FGC1:260**	*I think it'd be a good idea to have the DVD watched in the group as well.*
			Female, Former SU, Civil Servant **013:FGA2:400**	*One of the activities could be either by drawing or using the stone things that we did to map out the things that are causing you stress…and that would give you insight into what you think is where the bigger problems are.*
	Make it more understandable	4. For clients	Male, Former SU, IT Manager **012:FGC2:354**	*Oh yeah, I mean yeah, I think everything…makes sense, at each of the different areas that you cover are all going to be helpful. Totally.*
			Male, Psychologist/ Manager, LYPFT, Union Rep **007:FGC1:76**	*That's, that's my concern. Yeah, I thought there's a lot of stuff in here. You know, it's like a treasure trove isn't it? There is lots and lots of good stuff from different kind of approaches and you know, together it's a very good resource, but you know, it's how someone's going to be able to engage with it really, you know. Because for me, you know, it's*

				getting the balance right between something big, you know, teaching, didactic or training question and answer and something being about your own particular experience and actually translating, you know, what's being said here into your own practical sort of day to day experience of whatever, you know the symptoms, the behaviours, the experiences are, you know, and it's kind of like getting the balance between those two and making it kind of comprehensible really. But I thought it was very good, but quite dense, because there's quite a lot of stuff in there and I don't know, practically, sort of how people are going to find sort of engaging with it, but what you're saying is kind of like reassuring, because you know, you're getting a lot of out of it aren't you? You know, so, you know, I hear what you're saying. That was my one concern at it.
			Female, Psychologist, LYPFT **006:FGC2:76-80**	*I think the way, given what it started as, and the way you've pulled it together is really good. It's really… It's quite exciting, really. But I was like, four sessions, really? I don't think I could learn all this in four sessions.*
			Female, Former SU, Financial Assistant **016:FGC1:32, 36**	*[You] put it very, in words that people could understand… because when I first started there was a lot of things that just went over my head, but this really breaks it down for you… the [case studies, analogies] apply to so many different scenarios …but I just quickly read why I understood it,… so it makes more sense to me that way…it's telling people, showing people, …and the diagram's all, like that, are good, because they, like you say…yeah, see it straight away.*
			Male, Former SU, IT Manager **012:FGC2:1290**	*I thought the [DVD] was really good. I thought that explained it really well…It just explained it, its clearer. It just explained it a lot clearer than it did by reading it.*
			Male, Former SU, IT Manager **012:FGC2:1298**	*It just explained it. It's clearer. It just explained it a lot clearer than it did by reading it. Obviously if you've been in the group then you're getting the same thing I suppose, but certainly compared to reading it, it was very clear.*
			Male, Former SU, Traffic Manager LA **027:FGC2:27, 52**	*[Previously you think] you're born and you are what you are. If you're a worrier, you're a worrier, and you kind of feel cursed…I found it very useful to understand, as an engineer, why the machine wasn't working effectively and there was some really good information…I thought it was very helpful and I'd read about it, but seeing it [in the DVD] made it more accessible, that information, and it helped, it kind of gave a sense of hope, that there is… neuroplasticity allows you to actually consider the possibility of not actually being that person anymore.*
			Female, Former SU, Financial Assistant **016:FGC1:276**	*I think it would be helpful. If that's what it's giving, if that's what it's telling people, showing people, and in an informed way as well, I think it would be good to see it. I think I'd have liked to have seen something like that, because it took years for me to find out what I know now sort of thing, so.*
			Written feedback (AK)	*I found some of the slides quite complicated and I think there is a lot of jargon. A bit more plain English explanation might help.*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGC2:440, 444**	*Just seeing it written there, what had caused these problems, just seeing it there, in black and white…because everything had been a bit of a, to that point, sort of putting a haze around me like this…why do I behave this way? Why do I feel this way? Why am I doing this? And to see it in black and white…and I kept referring back to that saying, 'Well there were times when it was challenging, distressing to go through these things, that's what it's about'.*
		5. For practitioners	Female, OT/Manager, LYPFT **009:FGB4: 36, 270**	*I mean I was thinking, I think it is sort of getting service users to use sort of more looking at literature, manuals, there's so many books, there is so much literature out there you know I think is it a really positive thing really and perhaps sort of by using something like a manual within a group it then sort of maybe whet's the appetite if you like for service users independently accessing it, more sort of on their own.*

			Male, Psychologist/Manager, LYPFT, Union Rep **007:FGC1:180**	*You could, yes. I mean, you know, maybe that would be a way, because you know, this is a great resource isn't it? There's a heck of a lot of stuff in there, but it's kind of like making it more, it's kind of like generalising it to the person isn't it? So it's like making it more real for the person. Tying it in to the person's experience. You know, these are my symptoms.*
			Female, RMN, OH **011: FGB4:34**	*I think because there are so many different guides out there but similarly I think it can be quite confusing as well so if we stuck to the same thing, it almost kind of, you know if you run with the same themes and give it a title each week from the same manual, I think it does make things easier. But also I suppose finding out in the first session what would people really want, what their main issues and then focusing on those.*
			Female, OT, LYPFT **020:FGB4: 36, 270**	*Yeah I think that's a really good point because I find a lot of people working with at the moment I'll say, you know there's all these books and I'll give them a list of different books and they will go away, find this book and they will come back and say I'm really confused about this part of this book but I don't know what the book is so it's quite hard then to kind of work with them on their understanding of the book, so if there was one that you were all doing together, regularly, it would be more effective I would imagine, especially people that are new to CBT concepts, it can be quite confusing, can't it? Often these sort of books accompany, don't they, a manual, just sort of user friendly bit which has just the hand out saying there is a textbook so it gives detail as well….*
			Female, Psychologist, LYPFT **006:FGB4:44**	*It would be much easier, all kind of being on the same page. I think the problem is when people obviously don't just have one issue. They'll come to the group and that's the primary issue… but obviously there's other issues come up and then it's kind of how much attention do you pay to other issues because you really need to, or because you know that's impacting on this issue.*
			Male, CBT/Manager, LYPFT **002:FGC1:74**	*I mean because again it's like you say, you can pick and choose can't you. But I suppose for me, you know, well not seen the attachment bit, I haven't seen it through, but again, that's important to some people isn't it? But there's lots of good examples and stuff like that, and illustrations and analogies like that sieve and sponge and stuff, so. So again, that was really useful.*
	Focus on coping over the long-term	**6. Warn people it might make them feel worse at first**	Female, Former SU, Financial Assistant **016:FGC1:832**	*The feel of this, kind of, CBT therapy, is it opens a can of worms and it's the kind of worms that you've got to deal with afterwards. Because you're so used to bottling it all up and then all of a sudden it's like, I've got to deal with my feelings now, and it's like all these emotions now are different to what they were before, but it's a different, well you know, you've got to start learning again, how to deal with these feelings, instead of, you know. It's like, right I know what's going on, but…*
			Male, Former SU, Traffic Manager LA **027:FGC2:278**	*And there is that sort of threshold level about, where do we go, how far do we go, it might trigger something else and there's a need to refer elsewhere.*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGC2:44**	*That it was more key towards a more general approach to people with anxiety and depression, rather than saying, 'How are you coping with the stuff at work boys and girls?'*
			Male, Former SU, Traffic Manager LA **027:FGC2:1018**	*I think it's kind of that myth isn't it? It's that myth that's perpetuated…whereby you have to think it through and deal with it, because if you don't and you lock it away, or whatever else you do with it, then it grows and festers and becomes something unhealthy. And the idea of sponging something up is a little bit like that, you have to confront your demons and do all this business, and it can be very corrosive. Whereas actually some of the demons, it's alright to let them through the sieve.*
			Female, Former SU,	*It'd scare me to death. Mostly on a problem is, it's a no win situation. If you tell people it's going to get worse. They're*

			Financial Assistant **016:FGC1:947**	*going to think, why am I doing it then? But I don't think you realise anyway, even if somebody had told me it were going to get worse, just how worse it would get. You know, because you're used to hiding behind this mask, and then once that mask slips, because you've poured your heart and soul out…You can't put it back on.*
			Male, Former SU, unemployed, volunteer LYPFT **030:FGC1:923**	*You get worse before you get better…Yeah, well I think that it is true…Well I only know because of, from an anxiety point of view. I don't really, I wouldn't know as much from sort of depression kind of thing…Because I had to face it, without any, without like cheating, you know, behaviours and things.*
			Male, Psychotherapist/Manager, LYPFT **001:FGB1:138**	*So I see some really you know skilful stepping here that will be essential because if someone's signed up to deal with aspects associated with the work you know you could inadvertently stray into areas they didn't sign up to.*
		7. Revisit skills	**Written feedback (AK)**	*I think it would be good to revisit some of the theory from the earlier weeks and discuss what coping strategies are working and how people were adapting these; what was working and why which might help those still looking for the right one.*
			Female, Former SU, Financial Assistant **016:FGC1:852**	*But that's it. There isn't an alternative, but sometimes you just wish that you were a computer and you could turn it off, yeah. You know, because I could cope for like two years at a time, and now it's like, get off, no.*
		8. Provide crisis support	Male, Psychologist/Manager, LYPFT, Union Rep **007:FGC1:764**	*You can do work like that, yeah. Around crisis planning and you know, how to recognise, you know, the signs maybe that things are getting out of hand and, you know, what the best things to do, what sort of support would be appropriate. You know, that kind of thing, it can work in a crisis.*
			Male, Former SU, unemployed, volunteer LYPFT **030:FGC1:788**	*I mean, I don't know, more advice on who they can get in touch with, if they have a crisis.*
	Deliver at the worksite	**9. Could reach more people**	Male, Former SU, Traffic Manager LA **027:FGC2:254**	*If it's all in one go then it separates them an awful lot from the daily life of their work, so it's not actually given in the workplace.*
			Male, Psychotherapist, LYPFT **004:FGB1:230**	*Why not? Why could I not if I was struggling, feeling depressed approach my manager and sort of say look, in management supervision [and] 'I need some help. I don't want to go and see CHMT because I feel uncomfortable, I don't want to go via my GP, it feels awkward going to primary health care, you know is this open, could I go please?'*
		10. Some workers will not disclose / share	Male, Psychotherapist/Manager, LYPFT **001:FGB1:222**	*I guess there's a hell of a lot of people within this organisation who have got mental health problems and they don't come forward.*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGC2:298**	*Obviously when I was in a group with, once again, we don't know each other, there is anonymity. I would reveal that, but to work colleagues, there's no way.*

			Male, Former SU, IT Manager **012:FGC2:300**	*At work, I don't see how you can do anything other than higher level concepts and I don't think you can go into any of this because straightaway you're not going to start disclosing stuff in front of work colleagues. No chance!*
			Female, RMN, OH **010:FGB3:130**	*Just in relation to that discussion, obviously if we are having people coming who are potentially CMHT patients and staff, I've experienced this, staff might have an issue there in attending a group so I suppose we would have to be careful in relation to, you know, that filter because that could cause an issue, for both parties.*
			Female, RMN, OH **011:FGB4:362**	*[Does OH provide group therapies?] Not currently but we are looking into it…. just because our remit is so large and also we found as well the stigma attached with colleagues, being in groups with [people who] could be accessing services but that's one sticking point.*
			Male, CBT/Manager, LYPFT **002:FGB1:238**	*But that would be different with staff I suppose so again I don't know whether the same thing looking at them because actually it's different isn't it, if it's for staff.*
		11. Might prevent work-related stress	Male, Former SU, Traffic Manager LA **027:FGC2:302**	*To some extent actually… there's almost an element to this that is preventative, that is not a separate person that is depressed, but is stressed and this captures them before they… because they start to recognise and develop skills, before they actually collapse into that state and it's kind of almost like middle management.*
			Male, Former SU, Traffic Manager LA **027:FGA4:18**	*The possibility of catching people before they get too bad …where they are actually off work for an extended period of time to try and deal with severe depression.*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGC2:264**	*I was thinking of it in another way Nicola, using relatively healthy population, I was thinking maybe it was more that it would be self selecting, in the sense that people who need that, have got to the point where they're not coping and they've got either bad coping strategies. You name it, they hold them up. That they only know too well and at that point they need something to help them and the people will be sat in that room…*
			Female, RMN, OH **011:FGB4:58**	*Well I was going to say we're starting to do a lot of work with teams now because of obviously projected stress and with the amount of changes in the Trust, a lot of HR managers are looking at potential stress within teams across the board so we're actually going in and recommending that managers carry these out [HSE assessments] with their staff members and then we will come in once the results have been numerated and then we can look at the main problem areas and figure out ways to sort of address those.*
			Female, OT, Job Ret Specialist, Voc Rehab Service **008:FGB2:100**	*I think just from my experience and the referrals I get there probably is a demand for both because I would say a large section of the clients that I work with work within the NHS so that's quite telling I suppose…the problem is you've got to look at the bigger picture and a lot of places don't look at the bigger picture and the fact that you know when I start to look at statistics and it's very easy to look at stats, is, you know, Here City Council, 30% of their staff's illness is stress. That's a huge amount of people off sick. I would imagine I have to say within the NHS it is probably pretty similar and if they don't do something about it in a positive way then it's just going to get worse.*
			Female, Psychologist, LYPFT **006:FGB2:434**	*It's why we run reflective practice groups within our Trust, I mean that is … trying to reduce stress, most of the things talked about is how…*
		12. Could come under 'health & safety'	Male, Former SU, Traffic Manager LA **027:FGC2:258**	*Yeah, we do, health and safety is a big thing. It costs us a fortune now to do health and safety, because people are getting killed physically. This is a similar kind of thing, but it's delivered in the workplace with a higher responsibility.*
			Male, Former SU, Traffic Manager LA	*But it de-stigmatises it as well. I think if it's delivered in the workplace, we get presentations on health and safety, we get presentations on stress awareness. This becomes another part of that, de-stigmatises it. Makes people think about*

			027:FGC2:262	*trying to catch it early, when they start to feel this and recognise it in themselves, and look for help early.*
			Female, Former SU, Retired HE Lecturer **019:FGA4:206**	*I mean there are health and safety workers but they are only looking at physical health and whether it's a dangerous environment physically, there should be health and safety workers who are emotionally trained and who are responsible for checking people's feelings and how, you know how they are feeling in their workplace.*
		13. Everyone in the workplace needs more knowledge and skills about mental health	Male, Former SU, Traffic Manager LA **027:FGC2:52**	*And having something in the workplace that allows you to use, to some extent, transferable skills and recognisable skills, because anyone that's kind of working and trying to hold a job down has a certain level of skilling. You know, understanding technical things, and presenting it in this way, and in a familiar way they might be able, you know, they might be familiar with it, going into meetings and having other tasks to do. It's not frightening, it's not alarming. It doesn't make you feel… it kind of makes you feel ordinary…you know what I mean? So it makes it more accessible and not frightening…its part of the workplace and part of a, just a way of dealing with your life, and new skills sort of thing.*
			Female, Former SU, Retired HE Lecturer **019:FGA3:1027**	*But managers being trained how to deal properly with workers…I mean I just see so much misery in work places which is unnecessary because of untrained poor managers…..*
			Male, Former SU, Traffic Manager LA **027:FGA4:306**	*There isn't really an 'Us and Them', there is just an 'Everybody'.*
			Female, Former SU, Bank Worker **024:FGA4:300**	*Just saying well there's a lot of people in roles that they shouldn't actually be in because although they can do certain things. How are you managing a team when you can't even deal with people? You are not dealing with just robots. That's all you are, you are a figure, you are a number because people with depression and stuff, it's a lot more difficult to keep level headed when it's like that.*
			Male, Former SU, Traffic Manager LA **027:FGC2:314**	*That's the really good thing about going through a process like this, because it's a self learning thing, and I was touching on the person that's not depressed as well, the middle manager might be getting some of this, in an executive role, so to speak. You develop a compassion that's not necessarily there or has been allowed to be released or you feel safe with. And if you're not a compassionate manager, or compassionate about yourself, or treat yourself more fairly when you're depressed, then you've a better chance in the workplace of surviving, and assisting other people that might be in your care.*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGA4:290, 298**	*Emotional intelligence…it's great if people have it…[some managers] have got none of the so called soft skills.*
			Male, Former SU, Traffic Manager LA **027:FGA4:82**	*I'm very lucky in that our employer has over the past couple of years, even longer, been very proactive in promoting that into the website and identifying training sessions for managers to recognise stress and depression issues, initially they have only got stress issues, now they are actually upping the level to look at mental health in the workplace.*
			Male, Psychologist/Manager, LYPFT, Union Rep **007:FGB2:481**	*I mean it's got a chapter here, 'changing the way you relate to your work' okay which is all about the way you appraise the environment isn't it. So you could have an extra bit which says you know trying to change the way work relates to you, which is about what we have been talking about here, isn't it.*
	Make it peer-led	**14. Others can**	Male, Former SU, Traffic Manager LA	*You couldn't do it without. When I was reading it the ideas going through my head, that, to realise you go through four sessions, I was thinking of an eight week programme, or two hour sessions, facilitated by someone who's been through*

		identify / trust more in a peer	**027:FGC2:160**	*the process, who's got a backstop of support to them, because it can be stressful, this kind of thing anyway. And effectively, you know ultimately you've almost got a level of peer support there, and maybe some of those people, as they come through it and recover and have learned coping strategies, then go on to other groups. With occupational health almost taking a bit of a background support, because the occupational health is not that, are almost and administrative role in some ways.*
			Male, Former SU, Engineer **014:FGA3:688**	*The [peer] support worker could be very valuable, you will get quite different conversations between a [peer] support worker and the group.*
			Female, Former SU, Parent **023:FGA3:540**	*I would like to give back what I've suffered because I think you have to go through something like I did to really understand it. I think they would offer more support because they would understand better. They would understand what a person's been through better…if somebody's already been through something similar you relate better to them don't you.*
			Male, Former SU, Traffic Manager LA **027:FGC2:122**	*It almost needs somebody who's, from my point of view, been through the process a little bit. Who is being supported by you, but being a facilitator who has maybe had a bit more training themselves, to understand some of the terms…But if it's so in tune then I think they need that compassion element to it because if you're going to explain something at that level you need to understand what the client base is feeling like and how, you know, they'll be at different levels. And some will come in tired or not wanting to be there, having been referred there, or grasping, or not coming there, this is not…'I hope this is going to do something for me'. So you get all these different levels.*
		15. Might be good for one's own recovery	Female, Former SU, Parent **023:FGA3:642**	*I could sit and say what had happened to me. I would be able to say it now, where before I wouldn't have been able to say it*
			Male, Former SU, Financial Manager LA, Union Rep **028:FGA4:186**	*It can help; you can feel better as well. You can put a hand out and help a fellow sufferer. I feel better for it as well.*
			Male, Former SU, Traffic Manager LA **027:FGA4:190**	*I would be very willing to do some of these sort of training sessions to come in as a person that has suffered and explain some of the issues as a sufferer… someone like a peer that would be able to help you and sit alongside you and say what you are doing there isn't helping you, slow it down and you know what you are going through is bullying and this sort of thing.*
			Male, Service-user representative, LYPFT **025:FGA4:180**	*I think a group where you have got people that have got these things in common validate each other's experiences in a way that sometimes Clinicians, Doctors, Nurses, all respected….but that they might not you know they sort of see symptoms and missing the negative stuff where your peers can recognise and validate your experiences and that is a very important thing.*

APPENDIX 67: GROUP-CBT HANDOUTS AND EXERCISES

67.1 FAMILY HISTORY QUESTIONNAIRE

Your Name:	**Date of Birth:**
Father's name:	**Age (now):**
Occupation:	
Mother's name:	**Age (now):**
Occupation:	
Step-parent/s name/s:	**Age (now):**
Occupation/s:	
Reasons for any family break-up:	

Children in your family of origin (i.e. brothers & sisters/ step-siblings, ½ -siblings, adoptive siblings etc (Please list in order of age & include yourself. Continue on separate sheet if necessary).

Name	Male/Female	Age now	Occupation	Close/Distant?

Before school
What was life like for you at this time?
Primary School
What was life like for you at this time?

Secondary School
What was life like for you at this time?
Other Education
Type of education e.g. college, university, vocational training, professional qualification
Did you have any emotional / behavioural/developmental problems or disabilities during your childhood/adolescence?
e.g. withdrawn, depressed, anxious, hyperactivity, tantrums, shyness, bed-wetting, nail biting, hair pulling, nightmares, sleep walking, speech problems, oppositional behaviour, stealing, school refusal, learning difficulty, sexual precociousness, aggressive, fussy eating, bingeing etc
Parenting Style: Please describe how your parents treated you in general during your childhood and teenage years. Include how you were rewarded and disciplined

Work History: Start with your current or most recent job		
Occupational Role (e.g. joiner, hairdresser, nurse, manager, cleaner)	**Year/s**	**How did you get on? Why did you finish this job?**

Relationship History: Start with your current or most recent relationship		
Person	**Year/s**	**What was this relationship like for you? How did it end?**

Children: Please list any children you have care of or contact with		
Name	**Age**	**Relationship to you**

Professionals Involved: Please list any statutory or non-statutory agencies and support services that are involved or have been involved with you and/or your family e.g. Social Services, Young Carers, Youth Offending, Special Education	
Positive/Negative Events: **Please describe the main events in your life, indicating which has had the biggest effect on you**	
Event **e.g. childhood abuse or neglect; bullying; domestic violence; accidents, divorce; illness; losing a job; marriage, childbirth, self harm, suicide attempts, legal issues, drug/alcohol problems etc**	**Effect on you**
Social Situation: Please describe your social situations e.g. people you live with, owned/rented, living conditions, neighbourhood, finances, occupational issues, cultural factors	

Genogram: draw your family tree from your grandparents to your grandchildren

67.2 SCREENING CHECKLIST

Please use the prompts below to indicate which problems bother you most, and in what ways.

PROBLEMS WITH Unhelpful Thinking Patterns
1) Unhelpful thinking patterns: **(e.g. black & white/all or nothing thinking, jumping to conclusions, magnifying/minimising, taking things too personally, emotional reasoning, "awfulising", catastrophic misinterpretations)**
2) Irrational beliefs & assumptions: **(e.g. thinking no-one likes me; if I make a mistake then I will get in big trouble; the world is a dangerous place; if I upset anyone then I will be punished; /if I think something, it must be true)**
3) Rumination & worrying: **(e.g. dwelling on "whys?", "what ifs?", brooding, holding a grudge, winding myself up, worrying about uncertainties, obsessive thoughts, holding a grudge)**
4) Rigid rules & expectations: **(e.g. I must never disagree with anyone; don't ever show weakness; men ought to be strong, women ought to be caring; life should be fair and just; making negative predictions, labelling/mislabelling)**
5) Focussing my attention on painful sensations/thoughts: **(e.g. becoming engrossed by physical pain/fatigue; nursing a grudge, reinforcing embitterment; discounting positives; using a negative filter)**
6) Low self esteem: **(e.g. holding negative core beliefs, sense of worthlessness, feeling unlovable, ashamed, inadequate, defective, not good enough, inferior)**
7) Lack of self efficacy: **(e.g. having a sense of powerlessness/external locus of control, believing I can't do anything to help myself, struggling to cope with the demands of adult life)**

8) Perfectionism:
(e.g. setting myself & others unreasonably high standards, trying too hard, striving for success at all costs)

9) Self condemnation:
(e.g. beating myself up, criticising myself unfairly all the time; "bad me" versus "good me", disowning aspects of my personality)

PROBLEMS WITH Unhelpful Behavioural Patterns

10) Avoidant strategies:
(e.g. avoiding stressful situations, running away; excessive sleeping; abusing alcohol or drugs; hiding away at home in the comfort zone, sticking to the familiar; using safety behaviours, making things worse by not problem-solving effectively, not dealing with issues)

11) Self-harming:
(e.g. cutting or burning your body; overdosing; swallowing poisonous substances or sharp objects; taking dangerous risks)

12) Procrastination:
(e.g. putting things off, delaying tactics, fearing the consequences so doing nothing)

13) Acting on impulse, low frustration tolerance:
(e.g. not thinking or not considering the consequences before I react, doing things in the heat of the moment I later regret;)

14) Lack of basic self-care routine, unhealthy lifestyle:
(e.g. not looking after myself, poor personal hygiene, poor diet, poor sleep pattern, no exercise)

15) Lack of motivation, behavioural inhibition, passivity:
(e.g. inhibiting myself from taking action, not wanting to take the initiative, feeling hopeless, pointless, thinking I can't be bothered, given up trying; letting others decide all the time)

16) Over-compensating:
(e.g. trying too hard, taking on too much responsibility; having to prove myself; acting the opposite of someone I don't want to be like)

17) Over-talking:
(e.g. whining/moaning/complaining/exaggerating/interrupting)

18) Compulsive behaviours:
(e.g. over-cleaning/tidying, performing rituals, keeping busy all the time, hoarding, checking, counting, ordering)

19) Problems with food and body image:
(e.g. binge/comfort eating; restricting diet/weighing myself; self-induced vomiting; b*ody checking, using laxatives, over-exercising)*

PROBLEMS WITH Unhelpful Emotional Coping Patterns

20) Difficulty regulating emotions:
(e.g. becoming overwhelmed by how I feel, struggling to contain myself when stressed, needing a long time to calm down, being at the mercy of my moods; feeling sorry for myself, self-pity; never letting it drop, going on and on)

21) Experiencing high levels of anxiety:
(e.g. breaking down, falling apart; panicking, being hyper-vigilant, never able to relax/drop my guard, dissociating, escalating fear, dread and irritability; compulsions, regressing to a younger age)

22) *Internalising my emotions:*
(e.g. difficulty identifying and expressing how I feel; just going through the motions, using humour as a defence, compartmentalising my feelings; somatising)

23) Externalising my emotions:
(e.g. losing control when upset, dramatic displays of emotion, having to show people how I feel, make them feel how I feel)

24) Suppressing my emotions:
(e.g. being in denial; putting on a brave face all the time, hiding my feelings from everyone, pretending everything's OK, shutting down/blocking out my emotions, numbing; intellectualising/rationalising/over-thinking)

25) Traumatic memories:
(e.g. not coping with bereavement; not wanting to think about things that have happened in my life, experiencing flashbacks, nightmares, hallucinations; holding onto family secrets/taboos etc.)

PROBLEMS WITH RELATIONSHIPS (with partners, parents, siblings, children, workmates, managers etc)

26) Hard to be assertive, conflict avoidance:
(e.g. unwilling to ask for or accept help, difficulty telling others what I think about them or listening to what they think about me, problems giving and receiving criticism, too compliant or submissive; being submissive/giving in; excessive people-pleasing; not communicating effectively)

27) Hard to be supportive:
(e.g. focusing on my own problems, being selfish or self-centred, not considering others' needs)

28) Hard to be involved:
(e.g. can't trust people, feeling insecure, difficulties with emotional or physical intimacy, ambivalent about commitment, frightened of getting close to people, can't maintain or deepen relationships; distancing myself emotionally; acting independent/being too self-reliant)

29) Hard to be sociable:

(e.g. loneliness, shyness, awkwardness, withdrawing from others, retreating, isolating myself, I don't know how to make friends)

30) Too aggressive:

(e.g. becoming argumentative, provocative; being abusive/insulting/bullying; shaming/blaming/criticising others ; using verbal/physical aggression; pressurising/controlling others; being contemptuous, looking down on others, devaluing them, difficulty controlling anger, making hostile attributions)

31)Too open:

(e.g. problems associated with maintaining personal boundaries, getting over-involved/enmeshed, being intrusive; forming intense relationships very quickly, trusting too easily, disclosing too much information, taking on other people's problems inappropriately; promiscuity)

32) Too caring:

(e.g. putting others' needs first, compulsive care-giving, can't say, "No", unwilling to ask for/accept help, rescuing; idealising people/refusing to see negativity in them)

33) Too dependent:

(e.g. seeking reassurance all the time, needing approval; if frustrated, sulking/manipulating ; being excessively clingy; demanding help/sympathy/attention)

MOTIVATION TO CHANGE

34) To what extent do you plan in advance?

35) What do you think you need to change?

(e.g. something you do TOO MUCH, or something you do TOO LITTLE?)

36) To what extent have you been successful in making any behavioural changes in the past?
(e.g. giving up smoking, getting fit, taking on a new role at work, adapting to family changes, learning to control your anger, developing a healthy bedtime routine?)

37) If you DO NOT change, what will your life be like 5 years from now?

38) If you DO change, what will your life be like 5 years from now?

39) Have you had counselling or psychotherapy before?
(If so, in what ways did you change as a result? How did it help and what did you learn?)

40) Physical & Mental Health: Please list any physical or mental health problem, illness or disability, allergies etc.

MEDICATION

a. What medications are you on?

b. Dose?

c. What effect is your current medication having on your mental state?

ALCOHOL

a. How many drinks might you have in a typical week?

b. Are you concerned about your alcohol use?

c. Have you ever tried to cut down?

d. Do you ever feel guilty about your drinking?

e. Have you ever had a drink first thing in the day to feel better?

SUBSTANCES

a. Do you use any drugs or substances?

b. What? How often?

c. Are you concerned with your substance use?

RISK OF SUICIDE

a. Suicidal thoughts – how would you rate your thoughts on average these days (1 = thinking about suicide all the time and 10 = not thinking about suicide at all):

b. Do you have a plan?

c. Have you got the means to carry out suicide?

d. What keeps you going and/or gives you hope?

e. Suicidal intent – how would you rate your intent (1 = "I am definitely going to do it, you cannot stop me", and 10 = "I have thought but don't intend to do it"):

f. Have you attempted suicide in the past?

g. When? How?

PHYSICAL / MENTAL HEALTH DIAGNOSES

Please list any physical or mental health illness or disability, allergies etc

SUPPORT QUESTIONAIRRE

Who can offer you support?

We suggest that you find someone who you could help you change your unhelpful patterns. It doesn't have to be a family member. It should be someone who can see you regularly. We have written a checklist of qualities that you should try to look for in a helper.
Could X be your support? Answer the following questions:

1. **How easy is it to talk to X about your problem?**

Very easy:	5	Quite difficult:	2
Quite easy:	4	Very difficult:	1
Not sure:	3		

2. **Is X critical or easily upset about your behaviour? Does X take your behaviour personally?**

Always:	1	Rarely:	4
Often:	2	Never:	5
Sometimes:	3		

3. **Could you talk to X even if you weren't making progress.**

Definitely:	5	Probably not:	2
Probably:	4	Definitely not:	1
Maybe:	3		

4. **Can you trust X to be always there when you need someone – with no strings attached? No moral blackmail?**

Definitely:	5	Probably not:	2
Probably:	4	Definitely not:	1
Maybe:	3		

5. **If you changed your unhelpful behaviour permanently, what would X's likely response be?**

Threatened: (They would have to find a new role and way of living):	0
Lost: (I would become more independent and successful with my life):	1
Slightly jealous: (I may start to achieve new goals in life):	3
Very pleased for me:	5

6. **How often are you in contact with X?**

At least once a week:	3
At least once a fortnight:	2
At least once a month:	1
Less than once a month:	0

Total no of points:

19 – 23: you are in the lucky position of having a perfect supporter near you. You should definitely ask person X to help you in your efforts to change your aggressive behaviour.

12 –18 points: it is uncertain whether X should be your supporter. It is possible that they are too many emotionally involved to be of help. It may be too hot an issue.

4 – 11 points: look for someone else or go it alone.

67.3 GROUP-CBT CARE PLAN NAME DATE

Problem 1					**Goal**						
Criteria for Success					**Interventions Planned**						
Comments					**Comments**						
Rate how much this **PROBLEM** has bothered you during the last month:					Rate how much **PROGRESS** you have made towards dealing with the problem during the last month:						
1	2	3	4	5	-3	-2	-1	0	+1	+2	+3
This has not been a problem	This has been a mild problem	This has been a moderate problem	This has been quite a severe problem	This has been a serious problem	It's a lot worse	It's moderately worse	It's a little worse	No change	A little progress	Moderate progress	A lot of progress

Problem 2	**Goal**
Criteria for Success	**Interventions Planned**
Comments	**Comments**
Rate how much this **PROBLEM** has bothered you during the last month:	Rate how much **PROGRESS** you have made towards dealing with the problem during the last month:

1	2	3	4	5	-3	-2	-1	0	+1	+2	+3
This has not been a problem	This has been a mild problem	This has been a moderate problem	This has been quite a severe problem	This has been a serious problem	It's a lot worse	It's moderately worse	It's a little worse	No change	A little progress	Moderate progress	A lot of progress

Problem 3	**Goal**
Criteria for Success	**Interventions Planned**
Comments	**Comments**
Rate how much this **PROBLEM** has bothered you during the last month:	Rate how much **PROGRESS** you have made towards dealing with the problem during the last month:

1	2	3	4	5	-3	-2	-1	0	+1	+2	+3
This has not been a problem	This has been a mild problem	This has been a moderate problem	This has been quite a severe problem	This has been a serious problem	It's a lot worse	It's moderately worse	It's a little worse	No change	A little progress	Moderate progress	A lot of progress

Problem 4	**Goal**
Criteria for Success	**Interventions Planned**
Comments	**Comments**
Rate how much this **PROBLEM** has bothered you during the last month:	Rate how much **PROGRESS** you have made towards dealing with the problem during the last month:

1	2	3	4	5	-3	-2	-1	0	+1	+2	+3
This has not been a problem	This has been a mild problem	This has been a moderate problem	This has been quite a severe problem	This has been a serious problem	It's a lot worse	It's moderately worse	It's a little worse	No change	A little progress	Moderate progress	A lot of progress

67.4 CRISIS PLAN

NAME: **DATE:**

Understanding the difference between setbacks, crises and emergencies

A SETBACK occurs when something triggers what people sometimes call a "blip" or a "wobble". The thoughts and feelings may be intense but do pass with time. Sometimes old coping strategies are used in response to the trigger but the person is able to break the cycle and get back on track. Otherwise a little lapse could turn into a full-blown relapse.

A CRISIS is any serious deterioration of a person's ability to cope with everyday life. It can be a turning point, for better or worse.

Even the best planning can't always prevent a relapse. Sometimes a relapse develops into a crisis. A crisis may also occur with little or no warning.

It does not necessarily involve a danger of serious physical harm. A crisis develops when people feel they cannot cope with their feelings or control their behavior.

Their functioning is seriously impacted such that they do not fulfil their normal roles and day-to-day responsibilities.

People in crisis may experience extreme despair, sorrow, terror or anger. They may not be able to sleep, they may hear voices or they may believe that they have superhuman powers.

Although people in crisis are not necessarily a danger to themselves or anyone else, in many crisis situations, outside help (the person's doctor or therapist, a home treatment, crisis service or helpline) is needed.

An EMERGENCY is a situation in which there is an immediate danger that the person will harm either him- or herself or someone else.

Examples of emergencies:
Threats of suicide or attempted suicide
Threats of physical violence or actual violence
Extreme impaired judgment caused by problems such as psychosis, intoxication or dissociation
Putting oneself at serious risk
Being extremely vulnerable to serious abuse by others

What am I like when I'm feeling well?

Include personal qualities, abilities, strengths and positive traits:

What might be helpful to know about my past when I DID COPE WELL?

Include historical incidents and events:

What might be helpful to know about my past when I DID NOT COPE WELL?

Include historical incidents and events:

What is a "set-back" for me?

Include what you might FEEL (emotions, impulses, physical sensations) and what you might THINK (black & white, paranoia, obsessive thoughts, rumination, excessive worrying):

What is likely to cause a "set-back"?

Include potential negative life events and/or familiar triggers:

Possible triggers for setbacks:

Spending too much time alone
Anniversaries of loss or trauma
Bad news
Being teased or bullied
Boredom
Doing work that is too hard for me
Being very over-tired
Family conflict or arguments
Forming new romantic relationships
Financial problems
Physical illness and/or pain
Sexual harassment
Feeling left out or excluded
Reminders of abandonment
Getting close, intimacy
Excessive stress at work or at home
Guilt, shame
Criticism
Difficult relationship with co-workers
Benefits being questioned or denied
Being compared to others
Feelings of powerlessness, injustice
Being misunderstood, judged
Making a mistake

What is a "crisis" for me?

Include what you might feel (emotions, impulses, physical sensations) and what you might think:

What is likely to cause a "crisis"?

Include potential negative life events and/or familiar triggers:

What is an "emergency" for me?

What might I SAY and/or DO that does not help/makes things worse?

Include previous unhelpful coping strategies:

Possible unhelpful coping strategies:

Avoidant/impulsive patterns

Over-compensating

Withdrawing and isolating myself

Acting submissively or passively

Being domineering or controlling to get my own way

Not dealing with problems

Blaming others or moaning instead of confronting the issue

Self-pity

Obsessive behaviours to take my mind off things e.g. exercising, cleaning

Going to bed and not getting up

Binge-eating or restricting diet

Risk-taking (driving too fast, shoplifting etc)

Self-harm or self-destructive behaviours

Acts of aggression against property or other people

Absenteeism from work or workaholism

Excessive help-seeking behaviours

Increase in substance misuse (cigarettes, alcohol, drugs etc)

Cancelling appointments

Spending money impulsively

Promiscuity

What might I THINK that does not help/makes things worse?

Include catastrophic misinterpretations or hostile attributions:

What happens to turn a "set-back" turn into a "crisis"?

Include your interactions with other people:

What are my early warning signs and symptoms?

Possible warning signs and symptoms:

Forgetfulness
Anxiety or nervousness
Inability to feel any pleasure doing what used to be enjoyable
Lack of motivation
Feeling slowed down or speeded up
Unable to keep still, pacing, fidgeting
Neglecting chores and responsibilities
Being irritable or unkind to people I care about
Being obsessed with things, Increase in worrying, ruminating, procrastinating
Unable to control compulsive behaviours
Feeling unconnected to my body
Can't be bothered, apathetic
Aches and pains
Feelings of helplessness and hopelessness
Thinking irrationally
Feeling over-sensitive and fragile
Neediness in relationships
Sleep disturbed
Eating pattern disturbed
Dissociation
Not looking after my personal hygiene

How will I now manage a "set-back"?
Include new helpful coping strategies:

<u>Possible helpful coping strategies:</u>
Daily planning – chunk the day
Setting SMARTER goals
Reaching out to others for support (within limits)
Checking in with a care provider
Grounding exercises
Leisure, creative or educational activities
Doing chores and responsibilities as required
Journal writing
Eating healthily and exercising (within limits)
Ensuring I get enough day light
Getting enough sleep or rest
Keeping myself safe
Spiritual beliefs and practices
Building friendships
Attend a self-help support group
Looking after a pet
Quality time with family
Heart-to-heart with someone I trust
Planning for holidays and special events
Pamper myself
Get out and about
Appreciation exercise, positive data log
Reality check – ask a few good friends what they think of the situation
Go easy on myself, be self-compassionate

<u>What can I do if I cannot pick myself back up after a "set-back"?</u>

What can help me get back on track if I go into "crisis"?

Include what has helped in the past and previous helpful problem-solving/coping strategies:

Helpful thoughts to keep in mind:

Include positive coping statements/affirmations:

Possible helpful thoughts:

Stop, and breathe, I can do this
This will pass
I can be anxious/angry/sad and still deal with this
I have done this before, and I can do it again
Short term pain for long term gain
This is difficult and uncomfortable, but it's only temporary
These are just feelings, they will go away
This won't last forever
Thoughts are just thoughts - they're not necessarily true or factual
This feels bad, but it's a normal body reaction - it will pass
I have survived before, I will survive now
I don't need to rush, I can take things slowly
Don't try to do everything at once, break it down I can use my coping skills and get through this
I can feel bad and still choose to take a new and healthy direction
I will learn from this and it will be easier next time
Right now, I am not in danger. Right now, I'm safe
It's okay to feel this way, it's a normal reaction
I'm not going to let it beat me!
I feel this way because of my past experiences, but I am safe right now
Don't give up, keep calm and carry on!

People I can contact Monday-Friday 9am-5pm

Include family/friends/professionals:

People I can contact on an evening/weekend/overnight

Include family/friends/professionals:

People I DO NOT want to be involved:

What can professionals do or say to help me get back on track when I'm in crisis?
Include what professionals should NOT do or say:

	HELPFUL	UNHELPFUL
GP		
Care Co-ordinator		
Psychiatrist		
Probation Officer		
Housing Provider		
Police		
Ambulance		
A&E		
Inpatient unit staff		
Other		

How can family and friends help me to get back on track when I'm in crisis?

Include what they can say or do that is supportive and not likely to escalate your distress:

Possible ways family and friends can help:

Listen to me without criticising
Let me cry
Lead me through a relaxation exercise
Take me for a walk
Provide materials so I can draw or paint
Entertain the children for a while
Take me to meet up with family/friends/professionals
Text me, email me, ring me regularly
Lend me some money
Help me express my feelings
Don't talk to me, just be there
Leave me alone for a short while so I can compose myself
Accept my apologies, forgive me for anything I said or did that was unhelpful
Encourage me to have a shower and get dressed
Reassure me
Make me something to eat or drink
Stop me from hurting myself
Let me cut/burn myself without judging
Help me pay my bills or buy groceries or tidy up
Watch a movie with me or listen to some inspiring music
Make me laugh
Offer practical help

Who do I intend to share this plan with?

Include family/friends/professionals:

What other things can I do to keep myself well?

My 6 month wellbeing and recovery plan:

My 12 month wellbeing and recovery plan:

My 5 year wellbeing and recovery plan:

67.5 GROUP-CBT SESSION STRUCTURE

10-10.30
TEA & COFFEE: Will be provided free of charge. Before the group starts you will be asked to fill in some questionnaires about your mental health and work status during the week. You will receive written observations from the facilitators regarding your last session.
IN-SESSION BEHAVIOURAL TARGETS: Everyone chooses a target which fits with your formulation to practice in the group.

10.30-11.15
SELF HELP GOALS: There will be time to review your goals at the beginning of the session to ask yourself: "how did my plans go?", "what could I do differently?", "what did I learn?"
PEER-SUPPORT: "Think, pair, share" task where partners help each other through active listening, asking thought-provoking questions, reflecting together and empathising.
FEEDBACK PLENARY: You will be asked to report back on your partner's progress and other group members can help to encourage and motivate other group members.

11.15-11.30
JOURNAL WORK: You will have time to examine your journal/s and to choose a stressful interaction from either at work or at home. Use the "double-donut" to Identify emotions evoked during this interaction in yourself and other person.

11.30-12.30
SMALL GROUPS: The group may be split up depending on members' needs. People will take turns to present the stressful interaction they have chosen and to describe how they coped with it. If appropriate, alternative strategies and different points of view may be suggested by group members to help you develop more effective interpersonal problem-solving skills. Enactive techniques such as role play or "empty chair" may be used.

12.30-13.00
SOCIAL BREAK: There will be 30 minute lunch break. This unstructured time is part of the course so that you can practice your behavioural targets during breaks.

13.00-13.30
THE HOT SEAT: Members will take turns to have a personal Q & A session, and to receive feedback on their interpersonal impact using worksheets which enable you to give constructive feedback to each other.
TELLING MY STORY: Members will take turns to share their formulation. This will help everyone to understand how unhelpful patterns developed in the There & Then and how they are maintained in the Here & Now.

13.30-14.00
SELF HELP GOALS: Using your care plan you will complete monthly self-assessment by scoring your progress. Self-help goals will be prescribed by the therapists based on identified unhelpful patterns. Interventions may include relevant chapters to read, behavioural experiments, communication exercises, specific worksheets.

14.00-14.30
REVIEW PLENARY: We ask for written comments about the session. This can help you to reflect on what you have contributed to the session, and what you have got out of it. The session finishes with an open large group where you can give feedback to the facilitators.

67.6 INFORMATION ABOUT COGNITIVE BEHAVIOUR THERAPY (CBT)

Adapted from Taylor, S (2000) Understanding and Treating Panic Disorder: cognitive behavioural approaches [Wiley]

1. **CBT is based on a model that emphasises the relationship between thoughts, behaviours and emotions.**

Given that there is bidirectional interplay between our thoughts, behaviours and emotions (that is, subjective affect and physiological responses); effecting change in one area can lead to changes in the others.

As such service-users can wilfully alter their cognitive, behavioural and emotional reactions to situations when provided with the proper tools to do so. However service-users will primarily focus on changes to their thoughts and behaviours throughout the course of therapy, as they are the most amenable to direct intervention (i.e. it is more difficult to manipulate or change one's emotional state in a volitional manner).

2. **CBT provides a new way of understanding problem/s.**

Many service-users begin treatment with the perception that their problem is impossible to control because it is the direct result of their genetic make-up or deep-seated unconscious conflicts. CBT is designed to give service-users a greater sense of control and mastery by helping them to understand their problem in a new way. This is done through gradual process of guided discovery, where new concepts are presented to service-users as hypotheses that they can test using behavioural experiments.

CBT is therefore a very empowering therapeutic approach, as service-users are not simply "given" an explanation of their problem, but rather encouraged to test the validity of different hypotheses (with a gentle nudge in the right direction from the therapist).

3. **CBT relies on active collaboration between service-users and therapists.**

Some service-users might come into treatment with the expectation that therapists will "cure" them of their problem/s with little effort on their part. This is certainly not the case with CBT. Both service-users and therapist work together in order to effect change. If service-users do not participate in their own treatment, it is very unlikely that they will see any permanent or significant improvement in their symptoms.

4. **CBT aims to provide service-users with tools that allow them to deal with the problem independently.**

In keeping with the collaborative nature of treatment, one of the tasks of the therapist is to assist service-users in acquiring skills that will help them with their problems. Of course, it is the service-user's responsibility to learn and to practice the skills taught in session. Symptom reduction is largely due to the effort service-users put into acquiring the necessary skills and implementing them accordingly.

There is no magic cure for mental health problems, and service-users need to be aware that it is only through their own hard work and perseverance that they will get better.

5. **CBT is brief and time-limited.**

The number of sessions of CBT typically ranges from 12-20, depending on the particular diagnosis and severity of the problem. This is done for a very good reason: the ultimate goal of CBT is to teach service-users ***to become their own therapist***. As such, treatment should last long

enough to ensure that they have acquired the necessary skills, but not so long as to foster dependency. By encouraging autonomy in service-users, CBT enables them to leave treatment with a clear and concrete plan for maintaining their gains (with the possibility of further progress).

6. CBT is structured and directive.

Given that CBT is a skills-based protocol that is also time-limited, sessions are relatively structured. As such, therapists set an agenda for sessions that typically includes reviewing the exercises carried out in the time between sessions, revisiting material discussed in previous sessions and discussing new ideas, and assigning exercise to do outside sessions.
Given that the format of treatment may seem unfamiliar to certain service-users, it is important to make them aware of the typical session plan.

7. CBT is based on the "here and now".

A central tenet of CBT is that treatment focuses on factors that contribute to maintaining the problem (for example, what the service-users is doing, thinking and feeling ***now***), rather than emphasizing the factors that contributed to the development of the problem (e.g. **"there and then"** childhood traumas etc.).

The reason for this is that identifying the origins of a problem does not, in and of itself, ***solve*** the problem. This is particularly true in respect to anxiety disorders, as what is maintaining the anxiety in the present might be very different from what originally led to its development.

This is not to say that the therapist should never devote time to a discussion of the origins of the problem, only that it is often not necessary to do so in order to help service-users with their current problem/s.

8. Between session exercises are an integral part of CBT.

The hallmark of CBT is the prescription of exercises to all service-users from session to session (we will use the term "between session exercises" rather than "homework" because the latter term has negative associations for many service-users). It is important that service-users be made aware at the outset, and queried about their willingness to devote time and attention to home practice throughout the duration of treatment.
Service-users who are unwilling to complete between-session exercises are unlikely to make substantial progress in therapy.

Since CBT is skill-based, mastery of the skills discussed in treatment will only occur through repeated practice between sessions and in vivo.

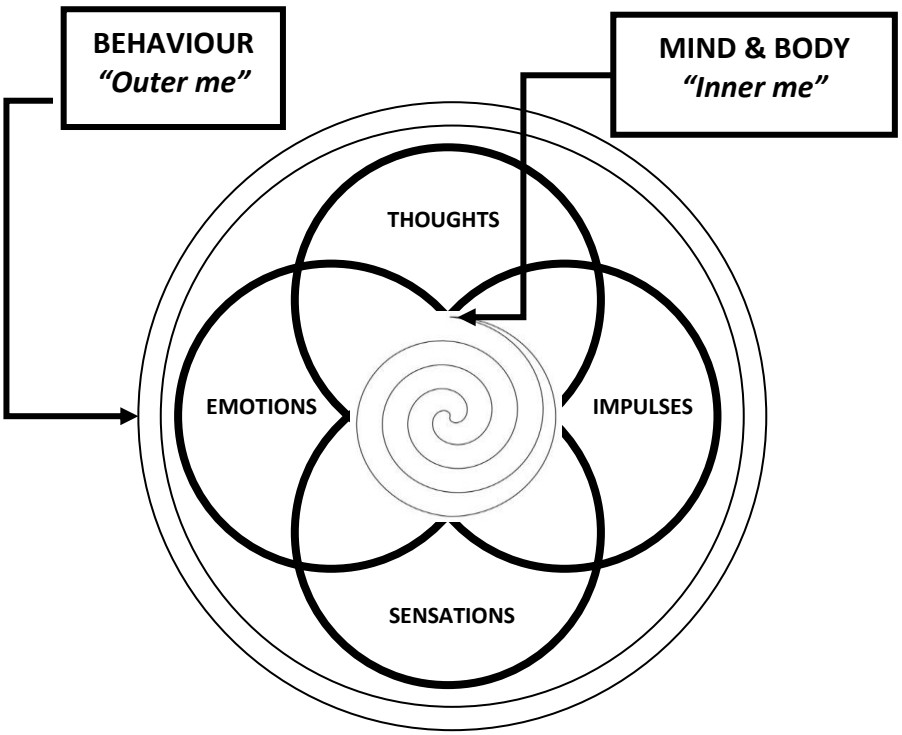
Without the completion of home exercises, any symptom reduction that occurs may be tenuous at best because the skills are likely to be poorly acquired, rendering the service-users vulnerable to relapse following cessation of treatment.

67.7 GROUP-CBT THERAPY JOURNALS

While you are in therapy you are advised to keep a journal:

1. **HERE and NOW** – record any interactions when **HOT** thoughts and feelings (i.e. emotions, sensations, and impulses) were triggered during the week. Reflect on what happened and ask yourself the following questions:

a) Did I **REACT AUTOMATICALLY** or did I make an **INTENTIONAL CHOICE**?
b) Did I **BREAK** a vicious cycle or did I **REINFORCE** it?
c) What were the **CONSEQUENCES** of my behaviour?
d) Was the **OUTCOME** what I really wanted?
e) What was the **IMPACT** of my behaviour on others (how did I make them feel)?

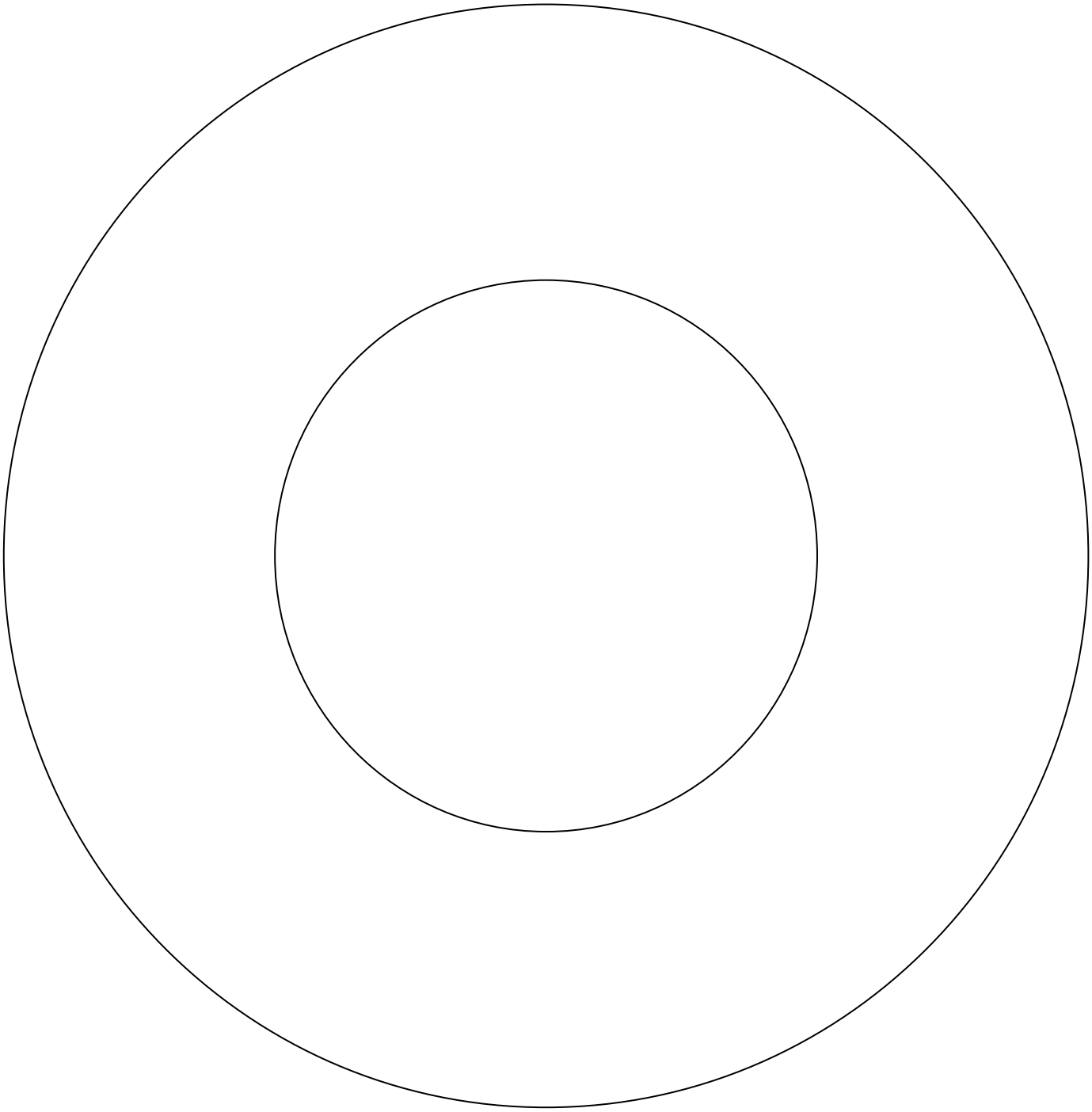


2. **THERE and THEN** – write no more than one or two A4 pages about past work or home situations/incidents that you struggled to cope with at the time. Follow these guidelines:

a) Be aware that you may feel worse temporarily when thinking and writing about events which were distressing
b) Practice stabilisation techniques before and after this exercise if necessary
c) Bring your journal to the next group and read (or ask someone else to read) out loud what you have written
d) It may be helpful to write a letter when there is something you want to say to someone but haven't been able to face them (don't give it to them, bring it to the group to share) or to ask to do the "empty chair" technique in small group
e) Sometimes group members bring old photos, greetings cards or sentimental objects that help them express something they might find difficult to talk about

67.8 RELATIONSHIPS

Please use the space below to depict your CURRENT home / social network (PERSONAL). Include family, friends and any other significant people in your home life.

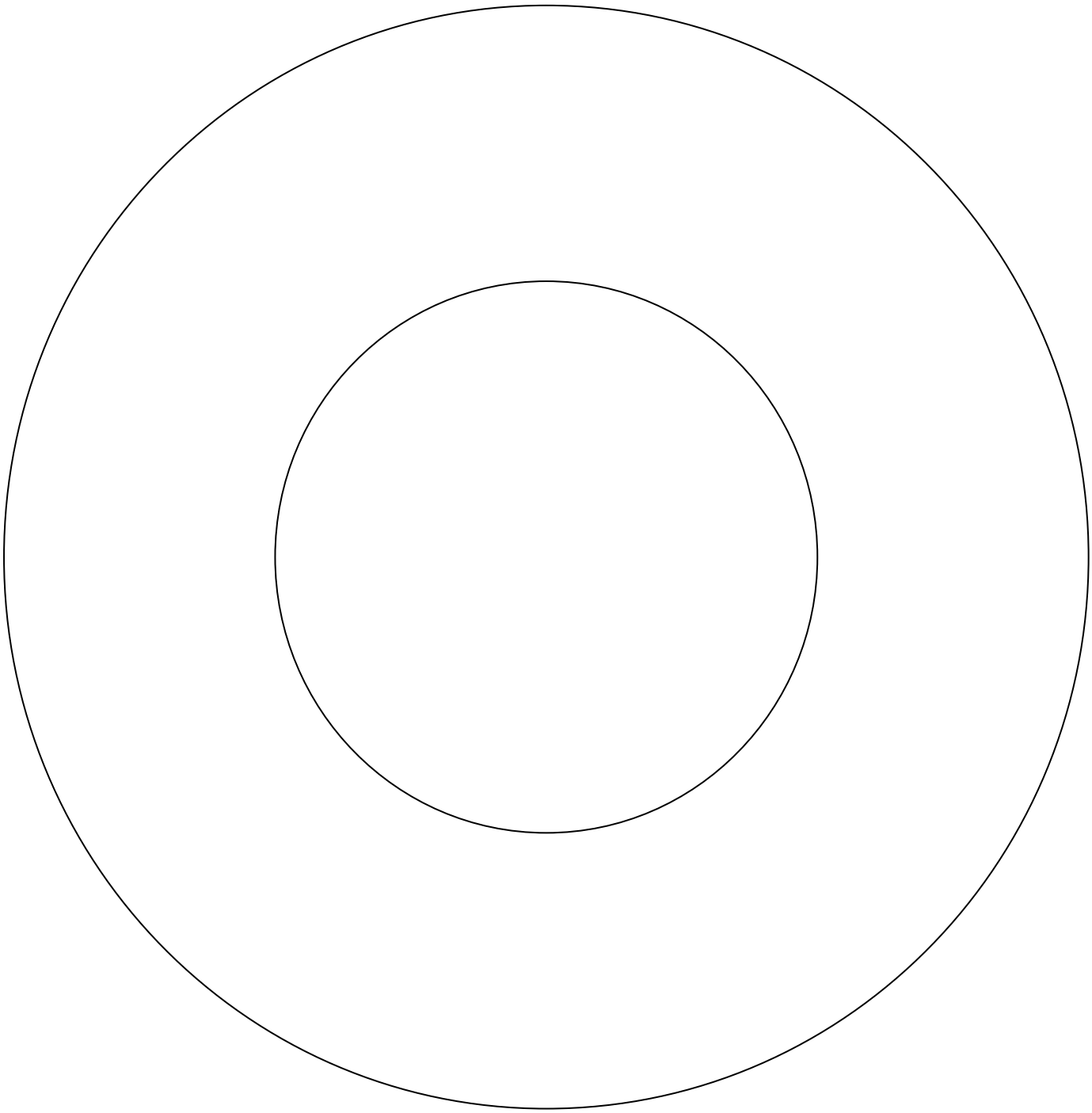


SIGNIFICANT PEOPLE

Please list the most significant people (maximum 6) from your HOME / SOCIAL LIFE and describe what impact (positive & negative) they have had on you and your life.

RELATIONSHIPS AT WORK

Please use the space below to depict your work life (PROFESSIONAL). Include colleagues, managers, subordinates and any other significant people in your work life.



SIGNIFICANT PEOPLE

Please list the most significant people (maximum 6) from your WORK LIFE and describe what impact (positive & negative) they have had on you and your life.

SIGNIFICANT PEOPLE from the PAST

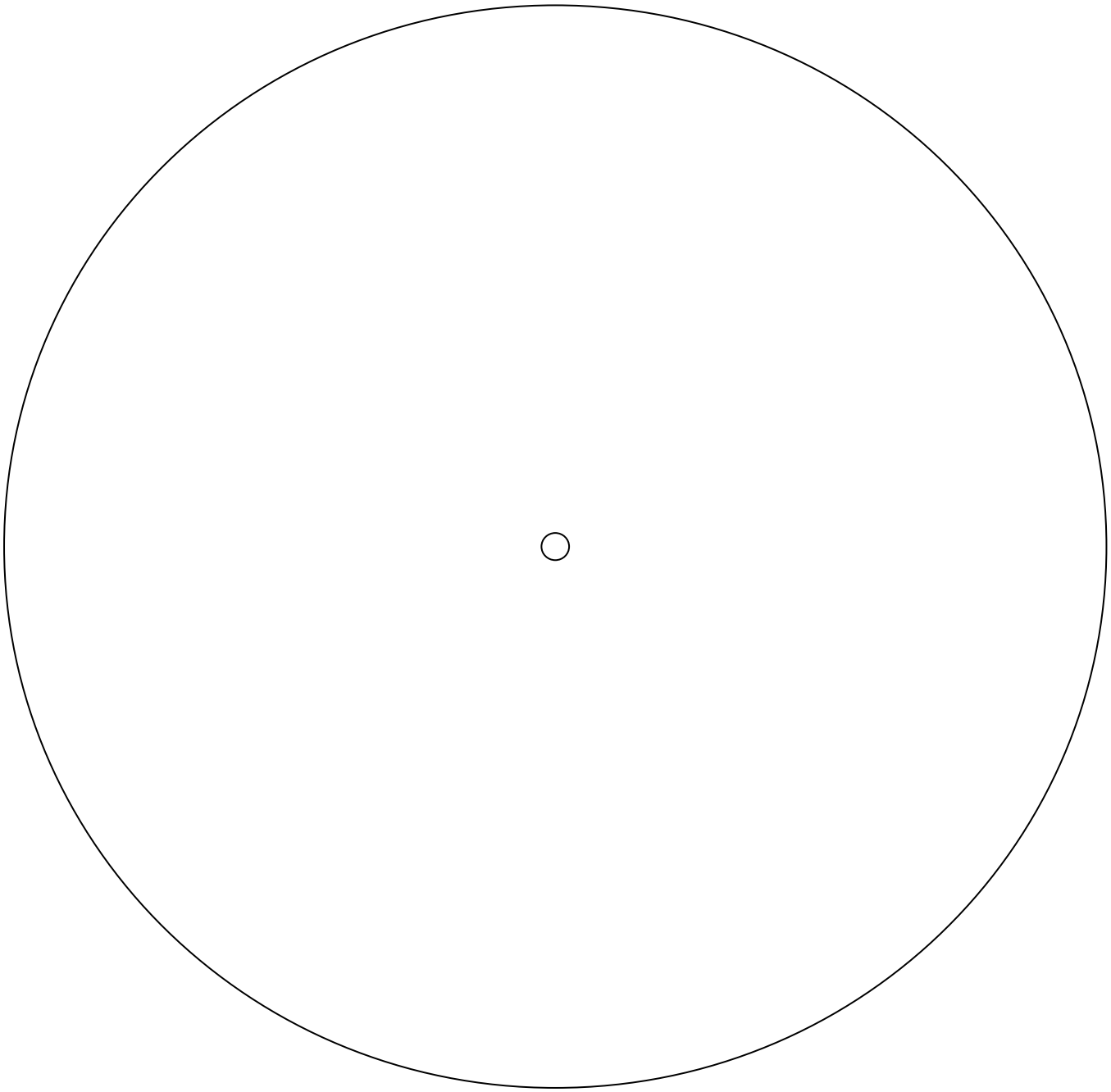
Please list the most significant people (maximum 6) from your PAST and describe what impact (positive & negative) they have had on you and your life.

GENOGRAM:

Please use the space below to portray your family tree:

WORK / SOCIAL / LEISURE / HOME BALANCE:

Please use the pie chart below to indicate how much time and energy you invest in Work activities (including education), Leisure / Social activities and Home (including family & friends) activities. Use symbols or words within the circle to show what the activities are.



RELATIONSHIPS 3

Please choose 5 words to describe your childhood relationship with your MOTHER.

Please choose 5 words to describe your childhood relationship with your FATHER.

To which parent did you feel the closest & why?

Why isn't this feeling with the other parent?

When you were upset as a child, what did you do?

What is the first time you remember being separated from your parents? How did you and they respond? Are there any other separations that stand out in your mind?

Did you ever feel rejected as a young child?

Were your parents ever threatening with you in any way – maybe for discipline, or maybe just jokingly?

Were there any other adults with whom you were close as a young child, or any other adults who were especially close to you?

Did you experience the loss of a parent or other close loved one while you were a young child?

Please describe your relationship/s with your sibling/s.

How do you respond NOW, in terms of feelings, when you separate from your CHILD?

Please choose 5 words to describe your adult relationship/s with previous partner/s.

How intense were these relationships and how did they end?

Please describe your parents' relationship (including step-parents).

How close were they? How did they deal with conflict?

Please choose 5 words to describe your relationship with your current partner.

How satisfied are you in this relationship?

If you do not have a partner at the moment, how do you feel about that?

Please choose 5 words to describe what you value most in a relationship.

67.9 HOW I SEE MYSELF & MY WORLD

1.	I often think of myself as……
2.	Others often treat me like……
3.	I love……
4.	I hate……
5.	My main strengths are……
6.	My main weaknesses are……
7.	My main emotions are……
8.	I believe the world is……
9.	When I look to the future, I see……
10.	My life so far has been……
11.	I think what the matter with me is…….

12. What I like most about myself is……

13. What I dislike most about myself is……

14. The best aspect of my personality is…….

15. The most difficult aspect of my personality is……

16. Someone who likes me would describe me as……

17. Someone who doesn't like me would describe me as……

18. The person/people I live with complain that I……

19. The person/people I live with appreciate that I……

20. People say I'm good at/praise me for……

21. People say I'm bad at/criticise me for……

22. When I get close to someone……

23. The one single event that has had the biggest impact on my life is……

24. The way I make problems worse is……

25. The way I cope with my feelings is……

26. The things I find easiest to talk about are……

27. The things I find hardest to talk about are……

28. What I'd like to change about the way I behave is……

29. What I'd like to change about my present lifestyle is……

30. The most difficult feeling for me to express is……

31. The most important thing in my life right now is……..

32. The thing in life that gives me the most pleasure is……

33. The thing in life that upsets me the most is……

34. If I could be anything I want, I would be……..

35. If I could have anything I want, I would have……

36. If I could do anything I want, I would do……..

37. I would like to learn…….

38. What I regret the most is……

39. What I am proud of most is……

40. What I am ashamed of most is……

In the space below draw or symbolise how you think you appear to others:

ENVIRONMENT – TRIGGER **what happened?**

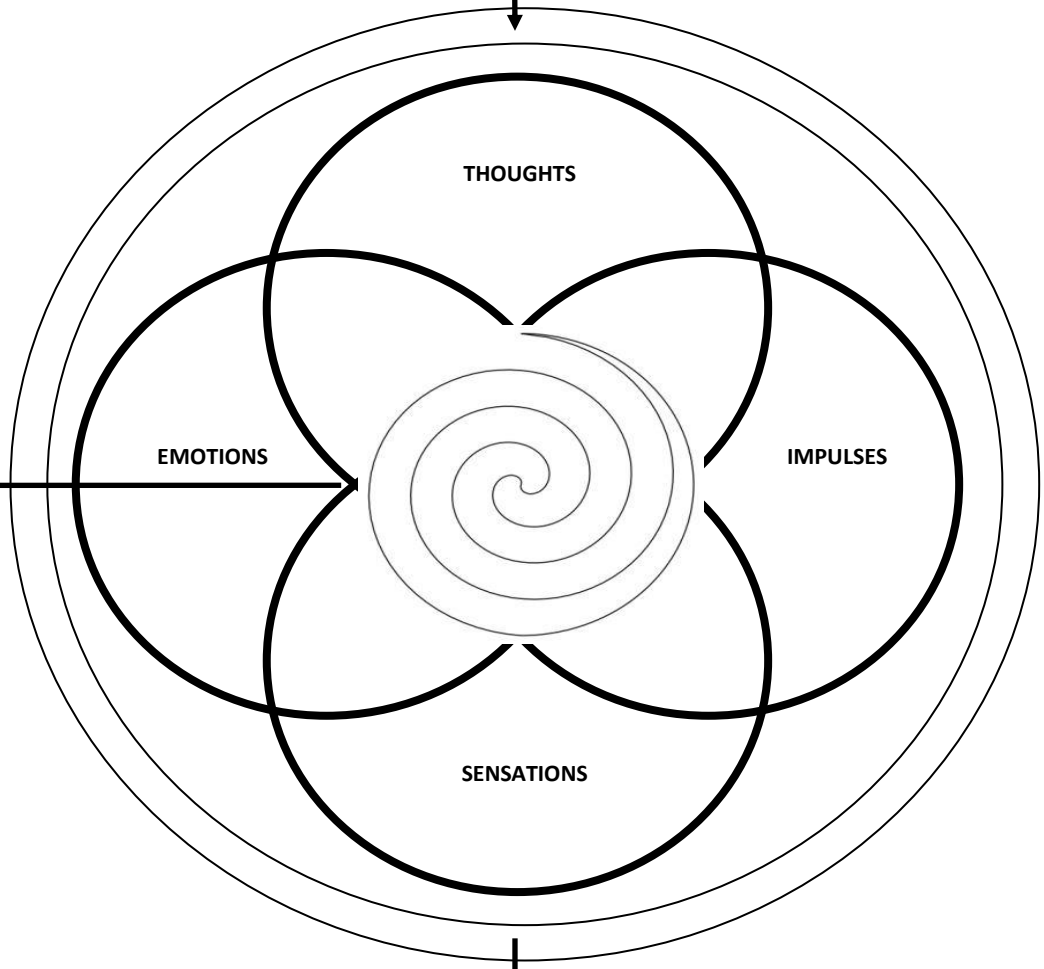
INNER ME - MIND and BODY **– thoughts and feelings**

THOUGHTS – what went through your mind?

EMOTIONS - How did you feel emotionally?

SENSATIONS - How did you feel physically?

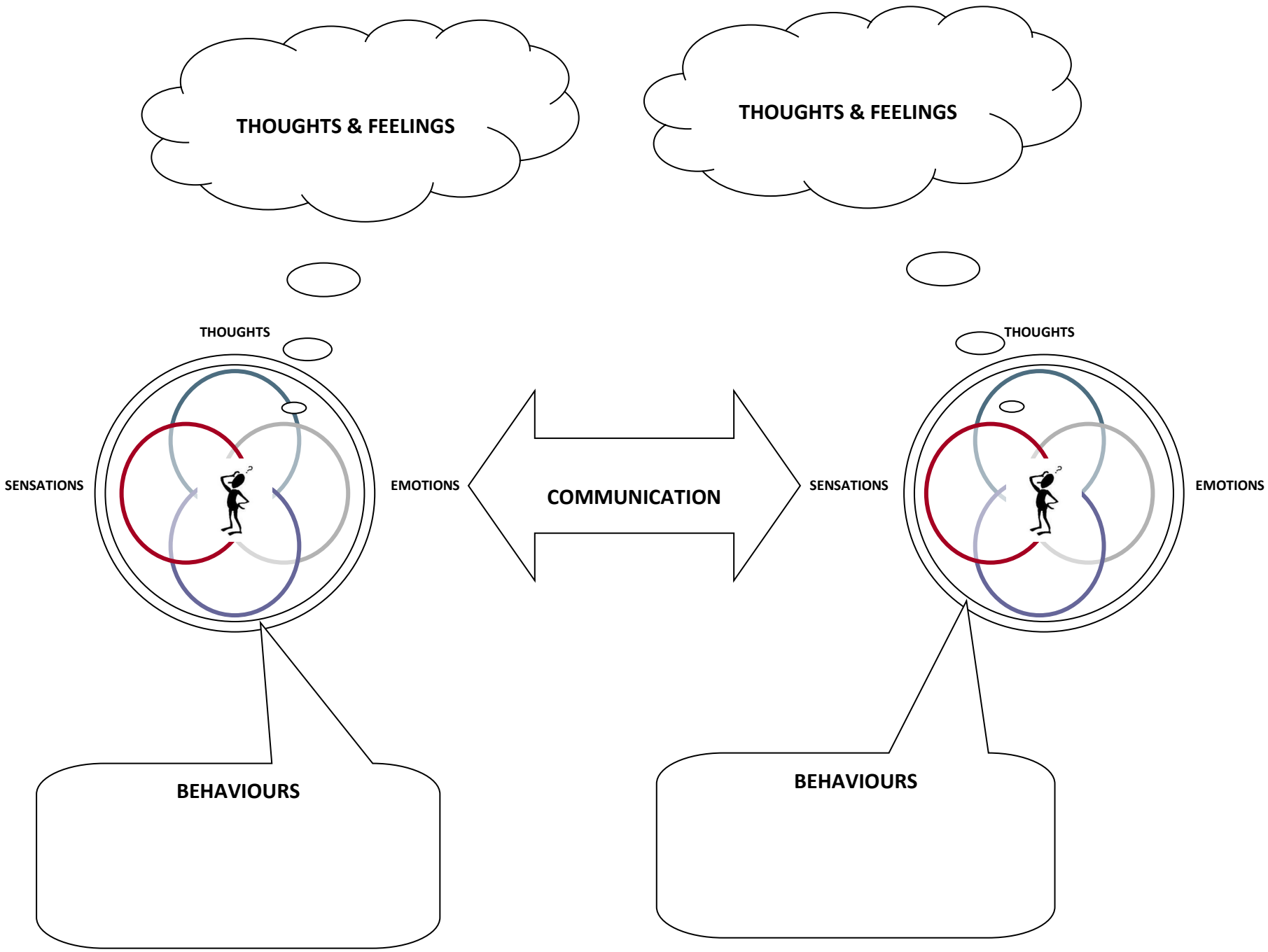
IMPULSES – what did you want to do?



OUTER ME - BEHAVIOUR **– what did you actually say / do? Did you REACT AUTOMATICALLY or did you make an INTENTIONAL CHOICE?**

67.10 DONUT DIAGRAM

67.11 DOUBLE DONUT DIAGRAM



67.11 INTER-PERSONAL TARGETS

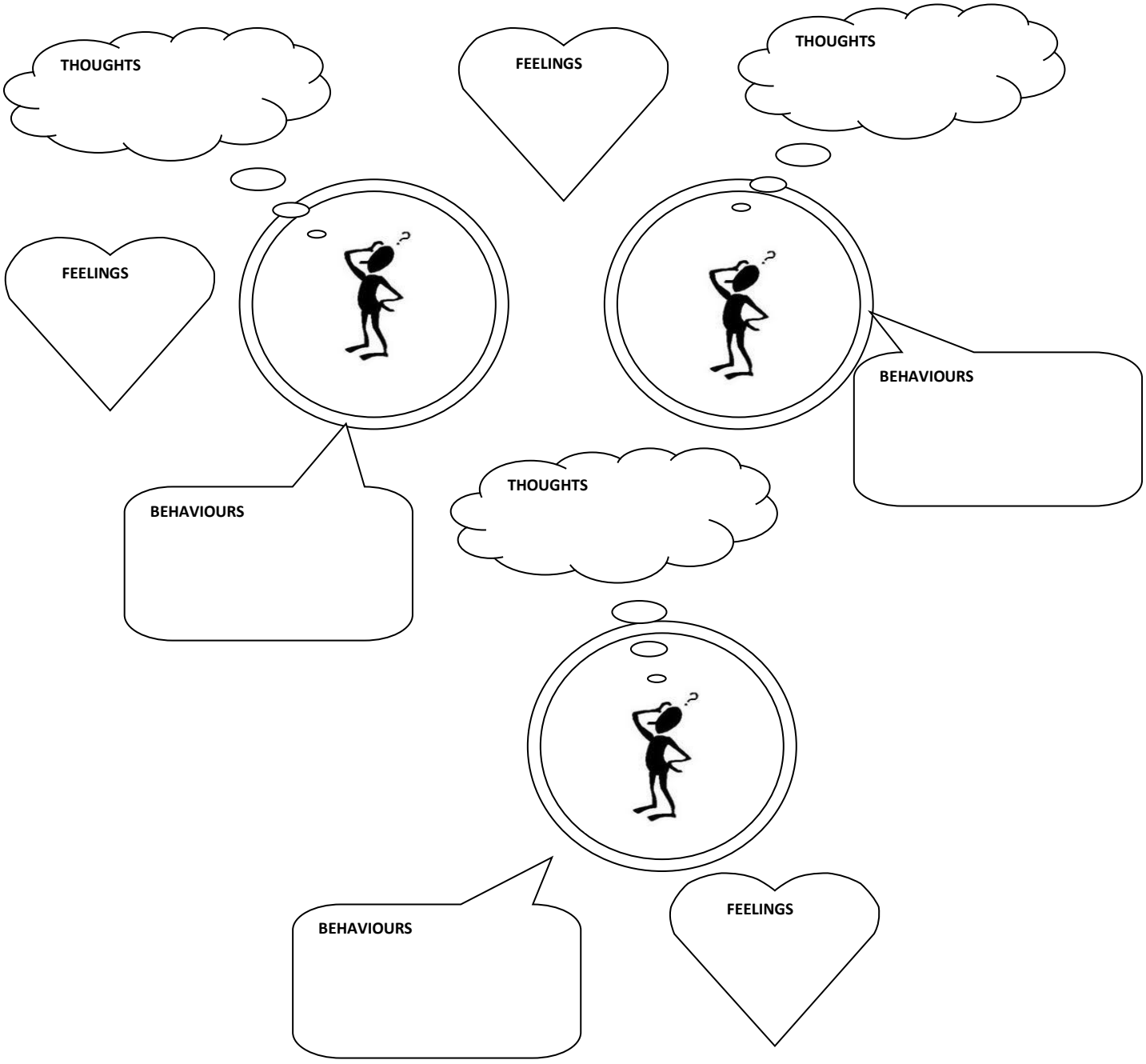
Ask someone if they like you	**Make small talk about trivial issues at an appropriate time**	**Check out what people may be thinking or feeling about you or something you have said**
Share something personal with someone you do not know very well	**When explaining something, be brief and specific**	**Show an interest in what others have to say**
Tell someone you don't like something they are doing or saying	**Pause before you speak**	**Show understanding of someone else's experience**
Say, "Thanks"/show your appreciation/gratitude (verbally)	**Tease someone in a playful and respectful manner**	**Show that you have taken on board constructive criticism**
Say something that shows you do not take yourself too seriously/make fun of yourself	**Tell someone how they made you feel**	**Mediate between two other people who have been in conflict**
Create space for someone else who has been quiet to contribute to a discussion	**When appropriate ask the group for a few minutes silence**	**Ask people to speak louder/quieter**
Make an observation about someone else's behavior	**Use body language to show others you are interested in them**	**Make a suggestion**
Offer support to someone else	**Do not interrupt, wait your turn to speak**	**Tell someone you like them**
Take charge of a situation	**Give someone constructive feedback about his/her behaviour**	**Express 2-3 feelings in the group (verbally)**
Criticise someone constructively	**Talk with someone about his/her personal problems (without sharing your own)**	**Make eye contact when someone is talking to you**
Express empathy for someone	**Join in an argument and state your view**	**Focus your complete attention on someone**
Show warmth and affection to someone	**Pay someone a compliment**	**Accept a compliment**

Disagree with someone	**Speak first, initiate a conversation**	**Disclose some private facts about yourself**
Say, "No" if asked to do something/refuse to do something someone has asked you to do	**Apologise if appropriate/say, "Sorry"**	**Show you accept someone has a conflicting opinion to yourself**
Interrupt someone	**Only use one short sentence (less than 30 seconds) at a time**	**Listen without speaking**
Make a decision with others/negotiate a plan	**Ask someone a personal question**	**Ask someone for help, support or advice (without excessive reassurance-seeking)**
Ask someone to clarify what he/she said	**Tell people you are confused or do not understand if appropriate**	**Ask someone to stop doing something that's irritating you**
Make a complaint (without moaning or nagging)	**Tell someone you cannot do what they expect or want you to do**	**Express anger if appropriate**
Tell people what you want to do	**Ask someone to do you a favour**	**Offer to do someone a favour even if it puts you out**
Let someone else go before you	**Back down in an argument**	**Seek an alternative viewpoint to your own**
Give honest feedback about how another person makes you feel	**Ask for honest feedback about how you make others feel**	**Express sadness if appropriate**
Check out if your perceptions are shared by others	**Ask for a heart-to-heart with someone**	**Set up a family/group meeting to discuss an issue that is worrying you**
Make contact with an old friend/family member you have not spoken to in a while	**Find out something interesting about another person**	**Confide your deepest fears/desires to someone else**
Show vulnerability by sharing personal feelings	**Compromise with someone when you have different ideas**	**Challenge someone in authority if appropriate**

67.12 INTER-PERSONAL AWARENESS

TOO CARING	
TOO DEPENDENT	
TOO AGGRESSIVE	
TOO OPEN	

HARD TO BE SOCIABLE	
HARD TO BE ASSERTIVE	
HARD TO BE SUPPORTIVE	
HARD TO BE INVOLVED	



WHAT IMPACT MIGHT YOUR INTERPERSONAL PATTERNS HAVE IN THE THERAPY GROUP?

WHAT DO YOU WANT/NEED FROM OTHERS?

HOW DO YOU TRY TO GET WHAT YOU WANT/NEED FROM OTHERS?

HOW DO OTHERS RESPOND TO YOUR WANTS/NEEDS?

IN WHAT WAYS DO YOU PUSH OTHERS AWAY (REPULSE)?

IN WHAT WAYS DO YOU PULL OTHERS IN (ATTRACT)?

HOW DOES YOUR BEHAVIOUR MAKE OTHERS FEEL?	
• *Happy* • *Valued* • *Proud* • *Understood* • *Attractive* • *Supported* • *Connected* • *Safe* • *Protected* • *Helpful*	• *Criticised* • *Abused* • *Humiliated* • *Smothered* • *Hurt* • *Jealous* • *Repulsive* • *Guilty* • *Lonely* • *Helpless*

67.13 GOAL FORM

Name: **Date:**
Session number: **Sessions remaining:**

GOAL REVIEW **from last week:**

GOAL number 1:
What did I learn from trying this gaol (about myself/others/the future)?

GOAL number 2:
What did I learn from trying this gaol (about myself/others/the future)?

GOAL number 3:
What did I learn from trying this gaol (about myself/others/the future)?

GOAL number 4:
What did I learn from trying this gaol (about myself/others/the future)?

GOAL PLAN for this week:

GOAL number 1: what are you going to do?

TARGET - what unhelpful pattern is this goal trying to change?

PREDICTION - if you complete this goal what do you think could happen?

GOAL number 2: what are you going to do?

TARGET - what unhelpful pattern is this goal trying to change?

PREDICTION - if you complete this goal what do you think could happen?

GOAL number 3: what are you going to do?

TARGET - what unhelpful pattern is this goal trying to change?

PREDICTION - if you complete this goal what do you think could happen?

GOAL number 4: what are you going to do?

TARGET - what unhelpful pattern is this goal trying to change?

PREDICTION - if you complete this goal what do you think could happen?

RE-FORMULATION: what pattern has changed this week?

Unhelpful Thinking Patterns
Unhelpful Behavioural Patterns
Unhelpful Emotional Coping Patterns
Unhelpful Interpersonal Patterns
Unhelpful Self Concept

SESSION REVIEW

Please reflect on the following questions and answer as many or as few as you wish. Your feedback will form part of your clinical record and you will get a copy at the next session with feedback from the therapists.

What interpersonal skills were you practising today? With what results?
What did you find helpful/relevant today?
What did you find unhelpful/irrelevant today?
What did you learn in terms of effective coping skills?
Did you experience any disturbing/unsettling thoughts & feelings today?
Was there anything you were reluctant to say in the group?
Is there anything you need to deal with or clarify before and/or in the next session?

67.14 INTER-PERSONAL FEEDBACK FORM

NAME……DATE……

In the session today I observed you using the following interpersonal skills:

1	**Asking someone if they like you**	
2	**Making small talk about trivial issues at an appropriate time**	
3	**Checking out what people may be thinking or feeling about you or something you have said**	
4	**Sharing something personal with someone you do not know very well**	
5	**When explaining something, being brief and specific**	
6	**Showing an interest in what others have to say**	
7	**Telling someone you don't like something they are doing or saying**	
8	**Pausing before you speak**	
9	**Showing understanding of someone else's emotional experience**	
10	**Saying, "Thanks"/showing your appreciation/gratitude (verbally)**	
11	**Teasing someone in a playful and respectful manner**	
12	**Saying something that shows you do not take yourself too seriously/ making fun of yourself**	
13	**Telling someone how they made you feel**	
14	**Mediating between two other people who have been in conflict**	
15	**Creating space for someone else who has been quiet to contribute to a discussion**	
16	**When appropriate asking people for a few minutes silence**	
17	**Asking people to speak louder/quieter**	
18	**Making an observation about someone else's behavior**	

19	**Using body language to show others you are interested in them**	
20	**Making a suggestion**	
21	**Offering support to someone else**	
22	**Not interrupting, waiting your turn to speak**	
23	**Telling someone you like them**	
24	**Taking charge of a situation**	
25	**Giving someone constructive feedback about his/her behaviour**	
26	**Expressing how you feel (verbally)**	
27	**Criticising someone constructively**	
28	**Talking with someone about his/her personal problems (without sharing your own)**	
29	**Making eye contact when someone is talking to you**	
30	**Expressing empathy for someone**	
31	**Joining in an argument and stating your view**	
32	**Focussing your complete attention on someone**	
33	**Showing warmth and affection to someone**	
34	**Paying someone a compliment**	
35	**Accepting a compliment**	
36	**Disagreeing with someone**	
37	**Speaking first, initiating a conversation**	

38	**Disclosing some private facts about yourself**	
39	**Saying, "No" if asked to do something/refusing to do something someone has asked you to do**	
40	**Apologising if appropriate/saying, "Sorry"**	
41	**Showing you accept someone has a conflicting opinion to yourself**	
42	**Interrupting someone**	
43	**Only using one short sentence (less than 30 seconds) at a time**	
44	**Listening without speaking**	
45	**Making a decision with others/negotiating a plan**	
46	**Asking someone a personal question**	
47	**Asking someone for help, support or advice (without excessive reassurance-seeking)**	
48	**Asking someone to clarify what he/she said**	
49	**Telling people you are confused or do not understand if appropriate**	
50	**Asking someone to stop doing something that's irritating you**	
51	**Making a complaint (without moaning or nagging)**	
52	**Telling someone you cannot do what they expect or want you to do any more**	
53	**Expressing anger if appropriate**	
54	**Telling people what you want to do**	
55	**Asking someone to do you a favour**	
56	**Offering to do someone a favour even if it puts you out**	

57	**Letting someone else go before you**	
58	**Backing down in an argument**	
59	**Seeking an alternative viewpoint to your own**	
60	**Giving honest feedback about how another person makes you feel**	
61	**Asking for honest feedback about how you make others feel**	
62	**Expressing sadness if appropriate**	
63	**Checking out if your perceptions are shared by others**	
64	**Asking for a heart-to-heart with someone**	
65	**Setting up a family/group meeting to discuss an issue that is worrying you**	
66	**Making contact with an old friend/family member you have not spoken to in a while**	
67	**Finding out something interesting about another person**	
68	**Confiding your deepest fears /desires to someone else**	
69	**Showing vulnerability by sharing personal feelings**	
70	**Compromising with someone when you have different ideas**	
71	**Show that you have taken on board constructive criticism**	
72	**Challenge someone in authority if appropriate**	

How I have felt working with you today:

How I imagine you would be like to work with:

67.15 EXPERIENTIAL EXERCISES

The Hot Seat Exercise

Prepare:
Print out ten copies of the inter-personal feedback form (page 59).

Instructions:
Ask all clients, including the person who has chosen to be in the Hot Seat and the co-facilitators, to complete the form. Give approximately 10-15 minutes.

Then ask the person to sit in the Hot Seat and invite others to give feedback based on what they have observed during the group sessions.

Start with one of the co-facilitators to model how to give feedback sensitively, constructively and positively.

At the end ask the person to appraise their own inter-personal skills, including which they would like to improve and why.

Telling My Story Exercise
Prepare:
At the end of the previous session explain to the person who has chosen to tell their story about different media that they might use to tell their story – in words, in pictures, in dramatic form, in poetry, in music etc. Offer support between sessions in case this exercise is upsetting.

Instructions:
On the day, check with the client who has chosen to tell their story if they need anything. Otherwise ask the group to sit in a circle and hand over to the person.

Good Me / Bad Me Collage
Prepare:
Provide large white paper, glue, scissors, and a selection of colour magazines.

Instructions:
Ask clients to draw a line down the middle of the paper.
Ask them to write on one side title Good Me, and on the other Bad Me.

Select images and words from magazines to depict aspects of their personality / body that they perceive as 'good' (acceptable) and aspects of their personality / body that they perceive as 'bad' (unacceptable).

Cut them out and stick them on the paper.

In pairs discuss what your collage means taking turns equally.

Share in large group plenary.

Reflect on what needs to change on how you see yourself, and how that change might be brought about.

Yes / No Debate

Prepare:

Ask clients to write down what they would do if their child (age nearly 16) wants to go on holiday with their friends. What would they say / do, and why?

Instructions:

Ask the group to split into a Yes group and a No group.

Each group has to put forward their argument and try to persuade the other group to compromise.

Reflect on what needs to change about how you resolve conflict, and how that change might be brought about.

Climbing a Mountain Drawing / Painting

Prepare:

Provide large white paper, colour pens / paints.

Instructions:

Ask clients to imagine that what needs to change is a mountain that they need to climb in order to reach their goals.

Draw / paint using symbols rather than words what progress they are making towards their goals.

Reflect on what barriers / obstacles clients might have to overcome, and how that change might be brought about.

Stone Sculpt Exercise: Private / Public Selves

Prepare:

Selection of stones different shapes, sizes, textures.

Instructions:

Ask clients to choose one stone to represent their INNER ME (private self) and one stone to represent their OUTER ME (public self).

Share in pairs and then summarised for the large group.

Reflect on what needs to change about how you share your thoughts and feelings, and how that change might be brought about.

Something I'm Afraid of / Not Afraid Of

Prepare:

Give each client a piece of paper with 'Something I'm afraid of…' and another one with 'Something I'm not afraid of…'.

Instructions:

Ask clients to write down an example of something you're afraid of and something you're not afraid of (that other people might be, or that you used to be but you've overcome the fear.

We're going to get into pairs now and I'm going to ask you to take it in turns. One will be the **Speaker** who will talk about one thing s/he is afraid of and one thing s/he is not afraid of, trying to communicate clearly and briefly. The other person will be the **Listener** who will pay attention to what their partner is saying, can ask 1 or 2 questions to get as much detail as possible, and will try to empathise with any emotions their partner expresses; try not to give any feedback or advice at this point. You will have 3 minutes each to cover both subjects. You must use the whole 3 minutes for one person, so if you run out of things to say, try and keep going by revealing or seeking more information.

When both partners have spoken I will ask you to report back to the whole group what your partner is afraid of and what they are not afraid of, so try to remember as much detail as you can.

[When everyone has had a go re-convene the large group and ask people in turn to tell the group what their partner said, and also ask them what they thought about what their partner said. Check out if their partner wants to add or clarify anything. Move on briskly to keep all group members engaged and use summarising skills to make links with different people's accounts.]

Let's reflect on this exercise: How did people find it? What did you discover?

You will notice that we will put you in slightly anxiety-provoking situations to help you build confidence in dealing with stress. This is part of the way the group works – by challenging you to practice existing skills, start re-using skills that may be a little rusty, or learn new skills.

Introduce concept of **TRIGGER**.

Something I'm afraid of...	**Something I'm not afraid of...**
Something I'm afraid of...	**Something I'm not afraid of...**
Something I'm afraid of...	**Something I'm not afraid of...**

Potential Triggers

Prepare:

Cut out the following list into different potential triggers.

Instructions:

Ask clients to choose one from a hat and complete the sentences.

You are on your own and fast asleep in bed. It is the middle of the night when you are suddenly awoken by the sound of breaking glass.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

When you wake up you feel a sharp pain in your abdomen. It gets worse as the day progresses.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

You partner is away for the night. You try ringing him/her but there is no answer.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

You are driving over the speed limit on the motorway. You see flashing blue lights in your rear view mirror approaching fast.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

You have to do a big presentation at work when you start to feel breathless and faint.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

You wake up and it is cold and dark. Your mood is really low.

1) What is the first thought that goes through your mind?
2) What would you feel?
3) What would you do?

You've had a flood at home and have to move out temporarily. You ask a friend if they meant it when they said you could come and stay with them anytime. They hesitate…..

1. What is the first thought that goes through your mind?
2. What would you feel?
3. What would you do?

At your annual appraisal, your manager tells you that some of your colleagues have complained about your sense of humour which they find offensive at times.

1. What is the first thought that goes through your mind?
2. What would you feel?
3. What would you do?

You find out that your colleague's purse has gone missing from their locker at work. You have been working alone in the office recently.

1. What is the first thought that goes through your mind?
2. What would you feel?
3. What would you do?

You lose control of your eating / drinking / spending although you had promised yourself you wouldn't.

1. What is the first thought that goes through your mind?
2. What would you feel?
3. What would you do?

Ask clients to take turns to read out what their potential triggers was and what they have written.
Open it up for discussion – Is this a trigger or not? What makes a trigger threatening for some people but not others?

Reflect on what needs to change about how you appraise situations, and how that change might be brought about.

List of Feelings

Prepare:

Prepare cards with different feeling words on them.

HUNGER	**GUILT**	**JEALOUSY**	**GRIEF**	**SEXUAL DESIRE**
WARM	**DESPAIR**	**WANTING TO HIT SOMEONE**	**NAUSEOUS**	**FLASHBACKS**
SADNESS	**TIREDNESS**	**DEJA VU**	**WANTING TO CRY**	**RESTLESS**
DIZZINESS	**SHAME**	**ANGER**	**PAIN**	**WANTING TO RUN AWAY**
FEAR	**COLD**	**BLOATED**	**HATRED**	**JOY**
WANTING TO SCREAM	**VISIONS**	**HOPE**	**WANTING TO SMASH SOMETHING**	**BREATHLESS**

Instructions:

Ask clients to work together to classify feelings as either:

- **Emotional feelings i.e. subjective mood states**
- **Physical feelings i.e. somatic sensations**
- **Imaginings i.e. dreams, fantasy, images**
- **Urges i.e. reflexes, impulses, action tendencies**

Explain how sometimes what we do is based on trying to avoid certain feelings such as anger / fear / shame. Use clients' feedback to explain the concepts of 'distress tolerance' versus 'experiential avoidance'.

Reflect on what needs to change about how you cope with feelings, and how that change might be brought about.

My Ten Commandments

1. **I should always**

2. **I must never**

3. **I ought to be**

4. **Men should always**

5. **Men should never**

6. **Men ought to be**

7. **Women should always**

8. **Women must never**

9. **Women ought to be**

10. **I will be severely punished/deeply ashamed/really guilty if I:**

Personal Boundaries

Prepare:

Make plenty of space in the room.

Instructions:

Ask clients to stand opposite each other with at least 3 metres between them.

Ask one group starts to towards your partner until you feel you have just crossed their physical boundary.

Ask them a personal question which you feel has just crossed their psychological boundary.

- Tell me you're your most disgusting habit
- How much debt are you in?
- What do you earn after tax?
- What is your guiltiest secret?
- Have you ever taken drugs?
- When did you last have sex?
- How much do you weigh?

Swap roles.

We define ourselves as independent adults by our personal physical and psychological boundaries.

Personal boundaries can be defined as knowing what is me and what is not me – in terms of our sense of physical and psychological privacy.

If someone has been abused or neglected their sense of physical and psychological privacy may have been violated such that they may not be really sure how close to allow others to get or how close other people want them to get.

Reflect on what needs to change about how you maintain your own boundaries / respect other people's boundaries, and how that change might be brought about.

Inter-personal Roles

Prepare:

Make plenty of space in the room. Give each client a chop stick or similar. Play different types of dance music e.g. https://www.youtube.com/watch?v=rc-0BCSyWtc

Instructions:

Ask group to get into pairs.

Hold sticks between you by pressing it between one person's index fingertip to the other person's index fingertip.

Dance together with words / without words.

Which role did you take on?

Leader	**Over-powering**	**Perfectionist**
Follower	**Fun lover**	**Guider**
Competitor	**Risk taker**	**Over-powered**
Negotiator	**Odd one out**	
Dirty-dancer	**Class clown**	
Saboteur	**Rule-breaker**	

Identify how you responded to the potential for closeness and distance, power and control.

Ask clients to stand in a large circle.
Fix your eye on a spot just outside the circle on the opposite side.
All start walking at once.

How did you negotiate the potential for conflict? By giving way? By barging through? By finding a circuitous route that did not involve anyone else?

Do the exact opposite.

How did you feel? What did you think? Why does this matter?

Reflect on what needs to change about which role you tend to take on in relationships, and how that change might be brought about.

Sweets Experiment

Prepare:

Three bowls: of Jelly Babies, Maltesers, and Extra Strong Mints.

Instructions:

- Ask clients to choose just one bowl
- Help yourself to as many as you want
- Notice and record thoughts and feelings that are elicited by this experiment

- What did you FEEL?
- What did you THINK?
- What did you SAY?
- What did you DO?

- What did you want me to say / do?
- How did you make sense of what was happening?
- What meaning did you attribute to your behaviour?
- How does this fit in with your assumptions (psychological beliefs systems)?
- How did you behave?
- How does this fit in with your rules for living?

Ask people to share what happened to their INNER ME and OUTER ME

- Describe primary APPRAISAL – is it dangerous? If “yes” = THREAT!!
- Describe secondary APPRAISAL – can I cope? If “no” = THREAT!!

Use clients’ feedback to also describe ASSOCIATIONS e.g. Jelly Babies associated with childhood, Extra Strong Mints associated with adulthood; ASSUMPTIONS e.g. an experiment may be painful, embarrassing and ATTRIBUTIONS e.g. how you explain the cause of events

So let’s think things through together about your responses to this experiment.
Did anyone find this exercise anxiety-provoking? Which bits?

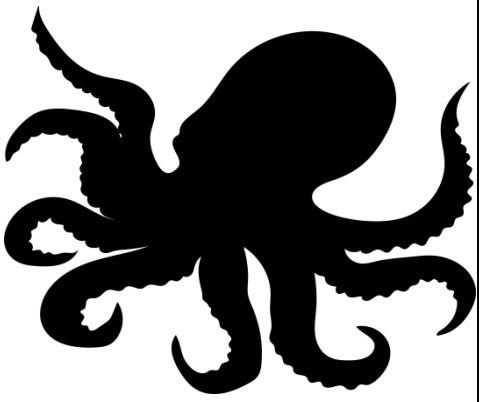
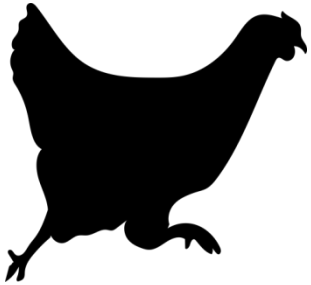
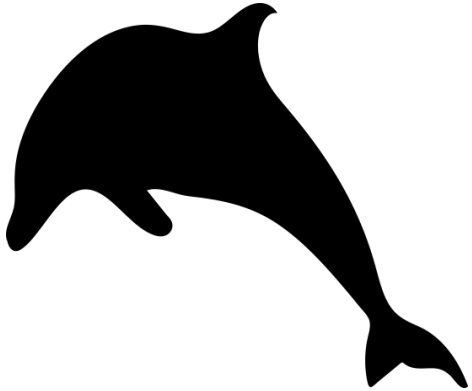
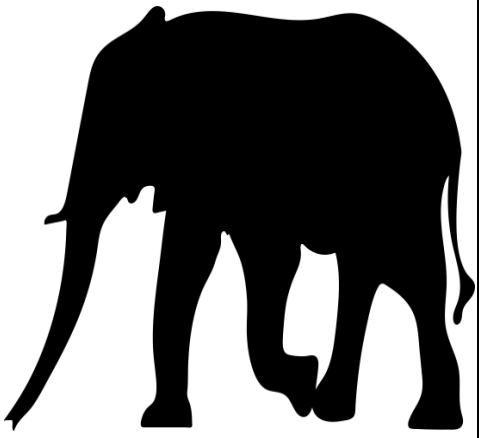
What else did you discover?
We tend to seek patterns or tell stories based on previous experience or myths to make sense of a confusing, complex and unpredictable world.

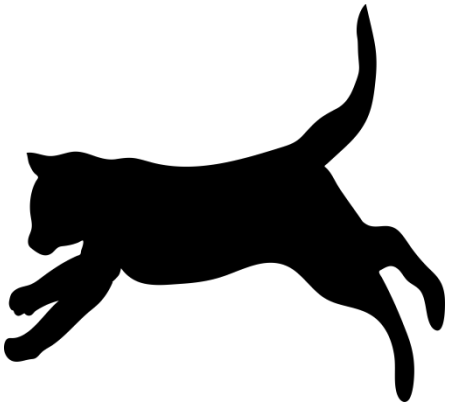
Discuss effects AMBIGUITY, uncertainty
A few guidelines but no rules

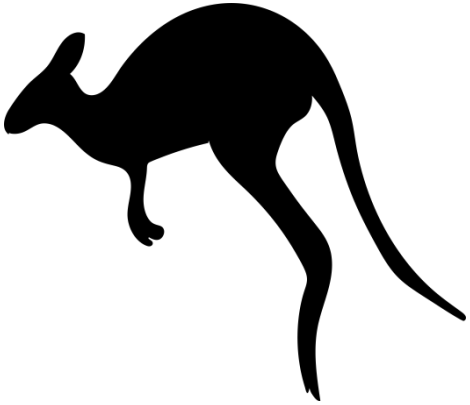
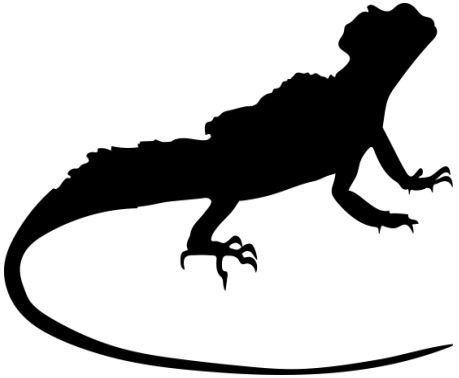
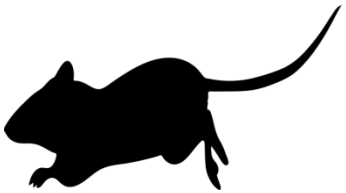
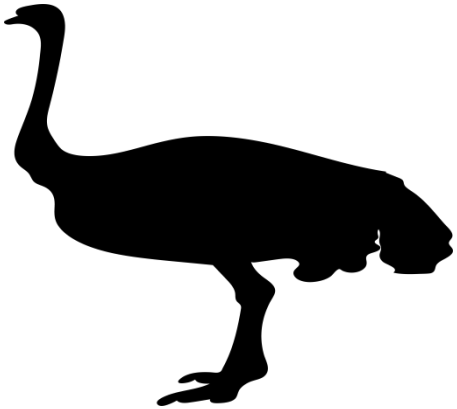
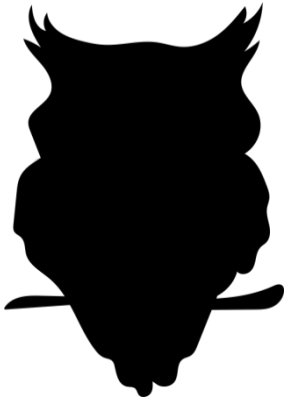
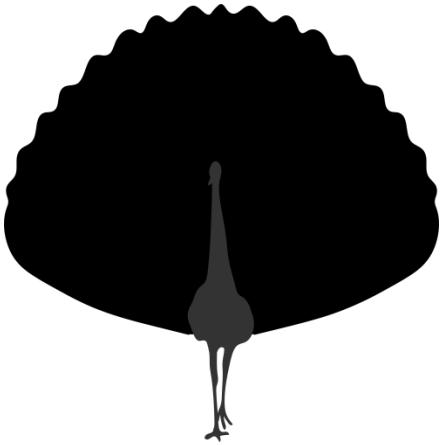
- Who was watching what other people said / did?

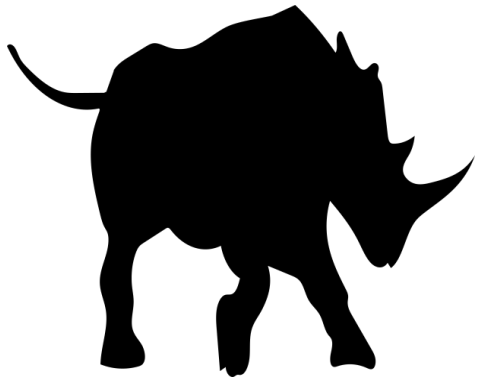
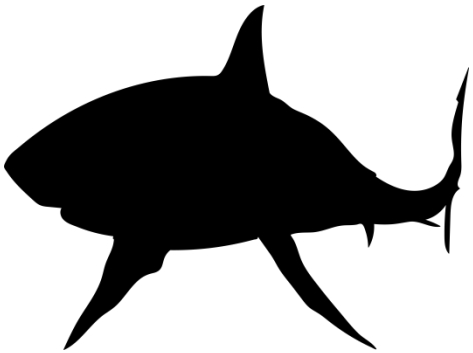
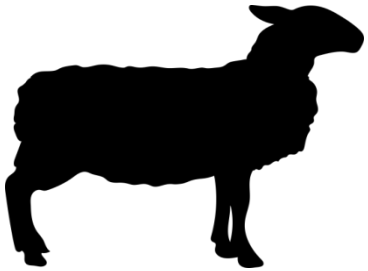
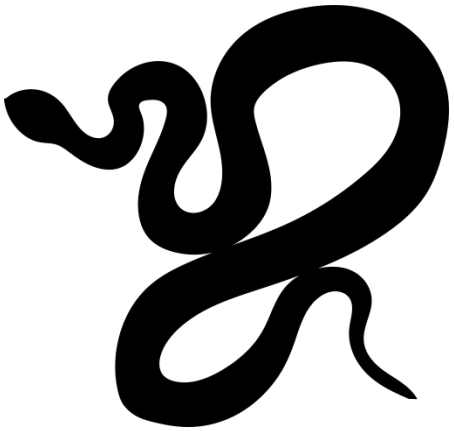
Social comparison
Social convention
Looking for guidance: following, leading

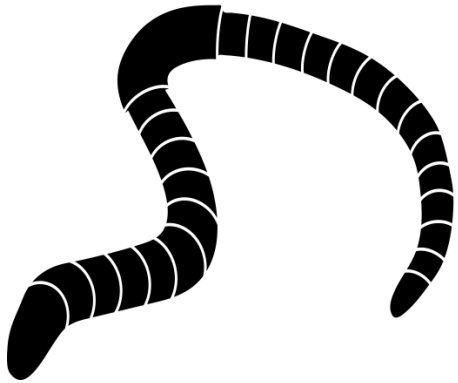
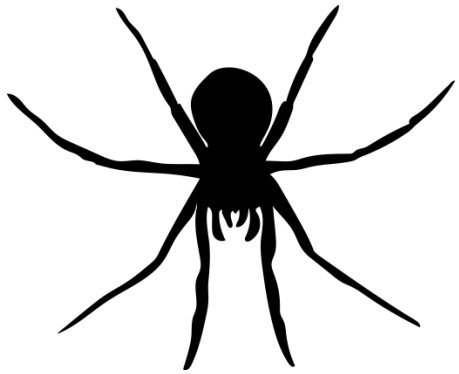
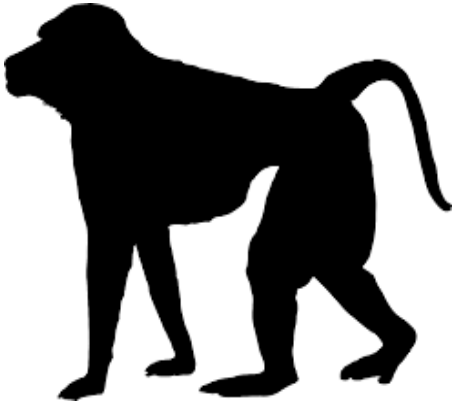
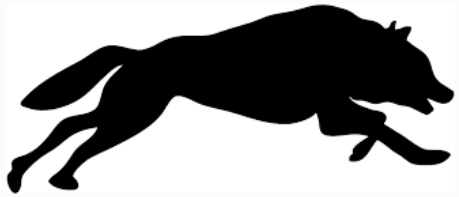
67.16 ANIMAL METAPHORS

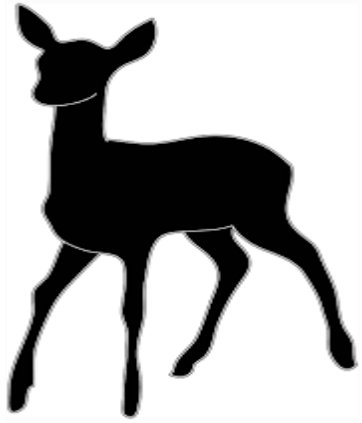
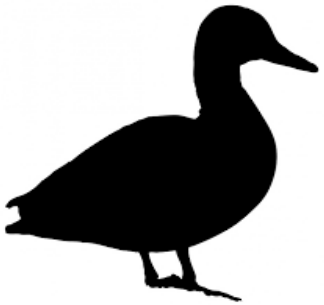
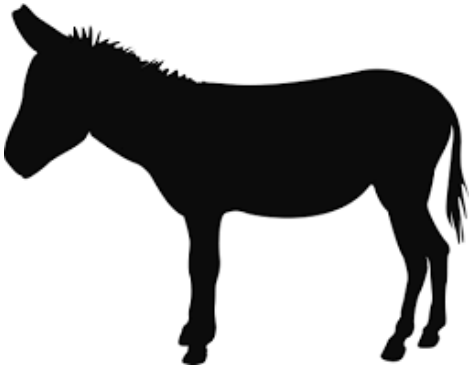
OCTOPUS	CHICKEN	DOLPHIN	ELEPHANT
			

DOG	CAT	DOVE	JELLYFISH
			

KANGAROO 	**KOALA** 	**LIZARD** 	**MOUSE** 
OSTRICH 	**OWL** 	**PARROT** 	**PEACOCK** 

RHINOCEROS 	**SHARK** 	**SHEEP** 	**SNAKE** 
GORILLA 	**SNAL** 	**BEAR** 	**CROCODILE** 

WORM 	**SPIDER** 	**LION** 	**MONKEY** 
TORTOISE 	**WOLF** 	**WASP** 	**RABBIT** 

DEAR 	**DUCK** 	**GIRAFFE** 	**STAG** 
TIGER 	**CAMEL** 	**FROG** 	**DONKEY** 

FIND SOMEONE WHO.....

Can touch their toes without bending their knees **[…….]**	**Has knitted an article of clothing** **[…….]**	**Who plays Peggy Mitchell in East-enders** **[…….]**
Can name the Deputy Prime Minister **[…….]**	**Can name an arachnid** **[…….]**	**Can name Wayne Rooney's wife** **[…….]**
Can name the capital city of Russia **[…….]**	**Can name the manager of Here United** **[…….]**	**Can change a car tyre** **[…….]**

FIND SOMEONE WHO.....

Can stand on their head **[…….]**	**Can name the Chancellor of the Exchequer** **[…….]**	**Who plays Bianca Jackson in East-enders** **[…….]**
Can name the lead singer of 'Take That' **[…….]**	**Can name the capital city of Hungary** **[…….]**	**Has made a Christmas cake or pudding** **[…….]**
Can name Princess Anne's 2nd husband **[…….]**	**Can name the manager of Manchester United** **[…….]**	**Can put up a tent** **[…….]**

FIND SOMEONE WHO.....

Can raise one eye brow **[…….]**	**Can name the capital city of Ireland** **[…….]**	**Can name the Duchess of Cornwall** **[…….]**
Can say, 'Hello' and 'Goodbye' in French **[…….]**	**Can name the lead singer of 'Roxy Music'** **[…….]**	**Has run a marathon** **[…….]**
Can name the manager of Chelsea **[…….]**	**Can name the Home Secretary** **[…….]**	**Can fix a bicycle tyre puncture** **[…….]**

FIND SOMEONE WHO.....

Can whistle with their fingers **[…….]**	**Who plays Ken Barlow in Coronation Street** **[…….]**	**Has made something made of metal** **[…….]**
Can name the Foreign Secretary **[…….]**	**Can name a crustacean** **[…….]**	**Can say, 'Hello' and 'Goodbye' in Spanish** **[…….]**
Can name the capital city of Finland **[…….]**	**Can change the washer on a tap** **[…….]**	**Can name the Duke of There** **[…….]**

FIND SOMEONE WHO.....

Can touch the tip of their nose with their tongue **[…….]**	**Can name the capital city of The Netherlands** **[…….]**	**Has grown their own vegetables** **[…….]**
Who plays Liz McDonald in Coronation Street **[…….]**	**Can name the manager of Arsenal** **[…….]**	**Has been to America** **[…….]**
Can name Princess Anne's 1st husband **[…….]**	**Can say, 'Hello' and 'Goodbye' in German** **[…….]**	**Has got a degree** **[…….]**

FIND SOMEONE WHO.....

Can tap their head, and rub their tummy at the same time **[…….]**	**Can name the capital city of Switzerland** **[…….]**	**Has wall papered a room** **[…….]**
Can name the Duke of Wessex **[…….]**	**Can name the lead singer of 'Happy Mondays'** **[…….]**	**Has worked in a shop** **[…….]**
Can name a winner of 'Britain's got Talent' **[…….]**	**Can say, 'Hello' and 'Goodbye' in Italian** **[…….]**	**Can name an amphibian** **[…….]**

FIND SOMEONE WHO.....

Is double jointed **[…….]**	**Can name the 2nd in line for the throne** **[…….]**	**Can do Sudoku** **[…….]**
Can name Jordon's new husband **[…….]**	**Can name an invertebrate** **[…….]**	**Has changed a plug** **[…….]**
Has worked in a factory **[…….]**	**Has been to India** **[…….]**	**Has worked in a restaurant** **[…….]**

FIND SOMEONE WHO.....

Has played in a pub quiz team **[…….]**	**Can name Prince Andrew's 2 daughter's** **[…….]**	**Has made something made of wood** **[…….]**
Can name the author of 'Great Expectations' **[…….]**	**Can touch type** **[…….]**	**Can name the director of E.T.** **[…….]**
Has been to Australia **[…….]**	**Can play a musical instrument** **[…….]**	**Can name Christine Bleakley's boyfriend** **[…….]**

FIND SOMEONE WHO.....

Can do cryptic crosswords **[…….]**	**Can name Prince William's girlfriend** **[…….]**	**Can use a sewing machine** **[…….]**
Has written a poem or a story **[…….]**	**Has been to Africa** **[…….]**	**Can row a boat or paddle a canoe** **[…….]**
Can name the Pope **[…….]**	**Has seen Romeo & Juliet on the stage** **[…….]**	**Can name a winner of 'X-Factor'** **[…….]**

FIND SOMEONE WHO.....

Can do ballet or ballroom dancing **[…….]**	**Can name who wrote 'Rule Britannia'** **[…….]**	**Has put up shelves** **[…….]**
Can name who painted 'The Mona Lisa' **[…….]**	**Can name Prince Harry's girlfriend** **[…….]**	**Can name a marsupial** **[…….]**
Can name a reptile **[…….]**	**Has sung in a choir** **[…….]**	**Can roll their eyes** **[…….]**

FIND SOMEONE WHO.....

Has laid a carpet **[…….]**	**Can do the spilts** **[…….]**	**Has baked bread** **[…….]**
Can name Alex Curran's boyfriend **[…….]**	**Has worked in a hairdressers** **[…….]**	**Can ride a motor bike** **[…….]**
Has played golf **[…….]**	**Can name who wrote 'The da Vinci Code'** **[…….]**	**Can dive off a diving board** **[…….]**

FIND SOMEONE WHO.....

.

Can play cricket **[…….]**	**Can wiggle their ears** **[…….]**	**Can use chop sticks** **[…….]**
Has done pottery **[…….]**	**Can name who wrote the 'Harry Potter' books** **[…….]**	**Can name 5 planets** **[…….]**
Can name Abigail Clancy's boyfriend **[…….]**	**Has made jam or chutney** **[…….]**	**Can use a video camera** **[…….]**

APPENDIX 68: BARRIERS AND FACILITATORS OF IMPLEMENTATION

Following piloting of the treatment programme, it was assessed using the SAFE (Structured Assessed of Feasibility) tool which was developed to evaluate the feasibility of complex intervention for use within NHS mental health services (Bird et al. 2014). There are eight items related to barriers to implementation (called "blocks"), and eight items related to facilitators of implementation (called "enablers").

Table 121 – Blocks of implementation

BLOCKS	
Do staff members require training to deliver the intervention?	**YES:** staff members i.e. a psychological therapist and an Occupational Therapist, would require more than 4 hours of extra training to deliver the intervention
Is the intervention complex?	**YES:** there are more than three interacting components including assessment, formulation, carer support, low key liaison with employer, 1:1 and group sessions
Is the intervention time-consuming to provide?	**YES:** clients would attend for more than 2 hours per week on average
Does the intervention include / require ongoing support and supervision?	**PARTIAL:** staff members would require an additional monthly supervision session
Does the intervention require additional human resources?	**PARTIAL:** more than one member of the multidisciplinary team are involved in providing the intervention but no professionals not in the standard MDT are required
Does the intervention require additional material resources?	**PARTIAL:** the intervention requires additional but readily available resources e.g. group room, projector, photo-copying
Is the intervention costly?	**PARTIAL:** the main costs are related to staff time i.e. two MDT members for one-day per week
Are there known *serious* or adverse events associated with the intervention?	**PARTIAL:** it is known that between 5-10% of service-users deteriorate in high intensity psychological therapy (Lambert & Archer, 2006)

Table 122 - Enablers of implementation

ENABLERS	
Is the intervention applicable to the population of interest (i.e. adults using CMHTs)?	**YES:** the intervention was specifically designed for employed people with moderate-severe depression i.e. CMHT patients
Is the intervention manualised?	**YES:** all components of the intervention are manualised
Is the intervention flexible (can it be tailored to the context and situation)?	**PARTIAL:** elements of the intervention can be tailored to the context and situation
Is the intervention likely to be successful (i.e. evidence-based and expected to produce positive outcomes)?	**PARTIAL:** there is some evidence of effectiveness (e.g. case studies and a small pilot study)
Is the intervention cost saving?	**NO:** the intervention incurs more costs in terms of additional staff time required
Do the intended goals of the intervention match the prioritised goals of the NHS?	**YES:** job retention in employees with moderate-severe depression will improve their quality of life
Can the intervention be piloted?	**YES:** the intervention can be introduced incrementally with only two members of staff and a few service-users
Is the intervention reversible?	**YES:** it is possible to stop the intervention without harmful, or unwanted effects when a case tracking approach is used (Harmon et al, 2007)

It can be seen that despite several enablers, most blocks to implementation were scored as **YES** or **PARTIAL** which suggest limited feasibility for the original intervention in NHS mental health services. The intervention might therefore be more readily implemented within a worksite setting as opposed to a clinical setting especially considering the focus group feedback.

APPENDIX 69: SOCIAL ACTION PSYCHOTHERAPY

Social action psychotherapy (Holland 1992) is based on the idea that emotional distress arises from 'past and present personal, social, and political obstacles to mental health' especially in contexts where people are economically disadvantaged, marginalized and oppressed, and therefore the root cause of emotional distress is not individual psychopathology (https://en.wikipedia.org/wiki/Psychotherapy_and_social_action_model). Holland (1992) designed and evaluated a model of intervention to alleviate 'depression' based on a pathway with 4 steps corresponding to Burrell & Morgan's 'social theory' (Burrell, G. and Morgan 1979): step one: 'patient on pills'; step two: 'person-to-person psychotherapy'; step three: 'talking in groups'; and step four: 'taking action'. The steps move from is expert-led, client-led, peer-led to social action. The principles of social action psychotherapy was taken up and further developed by critical psychologists to create community based groupwork (Holmes 2010), and social theory has also been used to create a model of health promotion (Caplan, R. and Holland 1990). These models are compatible with work-focused group psychotherapy that aims not just to treat depression but to empower employees.

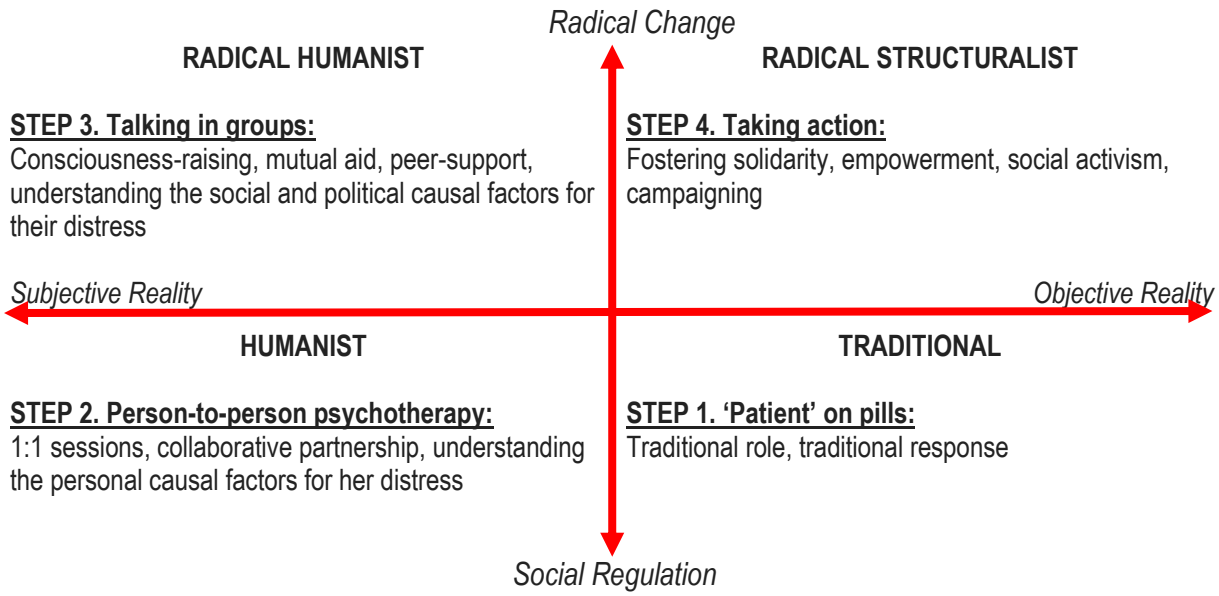


Figure 47 – Social Action Psychotherapy

The philosophy of this type of groupwork aligns with that of the disability movement in terms of politicising needs and demanding rights, and of the psychiatric survivor and recovery movements which 'reject representation, so-called professionalism, charity and help 'from above' in favour of direct democracy and self-management' (Apsych 2015). In aiming to create a democratic learning space which engenders true dialogue, the new intervention may be emancipatory as described in the 'Pedagogy of the Oppressed' (Friere 1970). Likewise, other research describes

how serious mental health problems intersect with a wide range of social and political factors such as inequality, class, gender, race, sexual orientation (Elliott 2016), and that any work-focused psychotherapeutic intervention should broaden its perspective on depression.

Table 123 – Human Being Human

	STEP ONE	STEP TWO	STEP THREE	STEP FOUR
HEALTH PROMOTION MODEL	Expert-led	Client-led	Peer-led	Social action
	Aim to change individual's behaviour	Aim to improve understanding and development of self	Self-help networks	Challenge inequality
UNIVERSAL RELATIONAL TRAINING & STAFF SUPPORT PROGRAMME	Workplace screening 1:1 discussion of stress vulnerabilities	Trauma-informed educational-experiential Workshops	Base Groups using an inter-personal problem-solving and coping process model	Negotiate environmental improvements / reasonable adjustments
	I'm only human	We're all human	We look after each other in the workplace	We stick up for each other in the workplace

However, 'empowerment' has been sometimes been enacted in vocational rehabilitation in ways that result in unintended effects. Van Hal et al (Van Hal et al. 2012) claim that the concept has been 'devalued' when it is used as a 'patient activation' strategy, to transform passive recipients of care into active participants in the labour market. Similarly, anti-stigma campaigns which involve employees speaking out about their mental health have sometimes backfired when others are asked to suppress their negative attitudes and assumptions resulting in 'rebound' prejudice (Corrigan et al. 2012). Social inclusion of people with disabilities may become a tool of neo-liberalism rather than a way of truly empowering people with chronic mental health problems (Oute et al. 2015). Therefore, implementation of the new intervention in the workplace should be very alert to the potential to make matters worse for employees with depression.

APPENDIX 70: EVIDENCE FOR CIMOS

70.1 WRITTEN FEEDBACK

The ***sense of universality*** whereby clients were able to see they were not alone, not the only one with problems etc. provides evidence of the activation of the **REALISE** mechanism through a shift in perception about oneself.

The opportunity for ***discussion*** whereby clients received different perspectives which challenged their view of themselves and others by digging deeper into issues and listening to different points of view etc. provides evidence of the activation of the **REALISE** mechanism through a shift in perception about one's problems.

Making a ***disclosure*** whereby clients talked about their thoughts and feelings by sharing personal information, opening up, and being able to admit problems etc. provides evidence of the activation of the **REFLECT** mechanism through learning from each other.

Likewise, ***hearing others' stories*** and ***awareness of self and others*** whereby clients found out about others' experience by listening to everyone else, and engaging in expressive and exploratory exercises etc. provides evidence of the activation of the **REFLECT** mechanism through understanding each other.

Being able to experience and express a range of ***feelings*** whereby clients turned towards others for emotional support, or were moved by listening to others and empathising with them etc. provides evidence of the activation of the **REGULATE** mechanism through co-regulating and learning new ways to 'manage my mood'.

Getting ***new ideas*** for dealing with problems whereby clients were offered suggestions or heard about them from listening to others etc. provides evidence of the activation of the **REGULATE** mechanism through learning new coping strategies.

Undertaking prescribed ***in-session and between-session goals*** whereby clients could practice new behavioural and cognitive skills by speaking up in the group and learning through trial and error etc. provides evidence of the activation of the **RESOLVE** mechanism through goal-setting and learning new ways to 'manage my behaviour'.

The ***inter-personal problem-solving*** exercise whereby clients worked through a distressing and stressful interaction at home or at work by their partner taking the place of and speaking for a family member or colleague etc. provides evidence of the activation of the **RESOLVE** mechanism through resolving conflict.

Receiving ***feedback*** whereby clients were given compliments and recognition for their achievements and use of inter-personal skills during the session etc. provides evidence of the activation of the **RELATE** mechanism through two-way feedback.

Moreover, ***joining in*** whereby clients actually attended the group by getting out of the house and talking with others rather than isolating themselves etc. provides evidence of the activation of the **RELATE** mechanism through helping each other.

70.2 FOLLOW UP CLIENTS' LETTERS

Evidence from clients' letters at follow up suggested that the **REFLECT** and **RELATE** mechanisms may have been activated at home for three clients through talking a lot more with their partners which gave rise to two-way feedback and this led to understanding each other and feeling more at ease etc.

Likewise, written feedback at follow up suggests that the **RETAIN** mechanism may have been activated at work for some two clients through staying-at-work by negotiating ongoing support and returning-to-work by negotiating a phased return. Of the two clients who had lost their job while waiting for CBT, one client had found work and one client was still unemployed.

APPENDIX 71: THE ART OF GOOD CONVERSATION

71.1 OVER-ARCHING STRATEGIES

These strategies are an essential aspect of deciding what to do next, which may be a relational task as opposed to a practical task.

a) **Setting things up** e.g. establishing a working relationship, collaborating, engaging, motivating, assessing, observing, reviewing, reporting, contracting, getting down to business

b) **Thinking things through** e.g. facilitating the art of **good conversation** at all levels, talking together, playing with ideas, using metaphors, re-processing trauma in dialogue

c) **Checking things out** e.g. using immediacy to reflect on what's happening between people, maintaining relationships when things go wrong, working through misunderstandings, promoting connectedness, strengthening bonds, and reducing defensiveness between people

d) **Ending things well** e.g. planning for when the conversation / relationship is over, making preparations for moving on, transitioning between different services

71.2 TWELVE BUILDING BLOCKS OF STRESS-REDUCING COMMUNICATION & INTERACTION

1. Taking turns, or one at a time
2. Speaking clearly, with feeling when appropriate, pausing to let others respond
3. Listening actively, with full attention
4. Asking reflective questions, helping each other think
5. Staying focused, interrupting when appropriate, slowing things down
6. Naming & validating each other's feelings
7. Engaging each other in problem-solving & decision-making
8. Encouraging intentional choices
9. Giving honest feedback
10. Setting limits, clarifying expectations of each other
11. Providing an alternative point of view, disagreeing when appropriate
12. Naming & commending each other's positive behaviour

APPENDIX 72: ACCESSIBILITY FACTORS

Table 124 – Accessibility factors

ACCESSIBILITY FACTOR	DEFINITION
Physical accessibility	*The availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.*
Economic accessibility or affordability	*…a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work).*
Information accessibility	*The right to seek, receive, and impart information and ideas concerning health issues.*

Ref: WHO, 2013 p.546

APPENDIX 73: TENTATIVE THEORY & PRACTICE OF RELATIONAL GROUP-CBT

73.1 PRACTICE

73.1.1 Making time for clients to talk together

Peer effects were highly valued by former service-users in the focus groups and clients in the pilot study, and this was the most striking finding. Former service-users in the focus groups thought that having time to talk together might be helpful in the design of a new intervention, and clients in the pilot study wrote that talking and sharing with others, and hearing others' stories was helpful and relevant. In practice, setting up opportunities for discussion required the skilful facilitation of peer interaction. This was achieved by teaching peers the art of 'good conversation' which gave rise to the three group-specific therapeutic processes: Peer learning, Peer feedback and Peer support, which were identified through realistic evaluation of the focus group data (see section *). Good conversation is defined as a form of discussion, disclosure, debate, and dialogue which can bring about cognitive, behavioural, and emotional change. It was created by clients taking turns, sharing personal information, listening actively, questioning, probing, challenging, giving feedback etc. Interestingly, service-users thought that accepting help is equally important to giving help especially when clients show a pattern of compulsive care-giving and self-sacrifice. Turn-taking, which reciprocating pair work entailed, ensures clients cannot neglect their own needs.

Good conversation created an enabling inter-personal context in which the six hypothesised mechanisms might be activated i.e. acquisition of basic CBT concepts and skills: these being the ability to ***realise*** (acknowledge problems), ***reflect*** (on thoughts and feelings) ***regulate*** (emotions and behaviour), ***resolve*** (ambivalence and conflicts), ***relate*** (to self and others), and ***retain*** (stay-at-work or return-to-work). The main implication being that new intervention required the skilful facilitation of peer interaction.

73.1.2 Making group sessions and group programmes longer

Former service-users in the focus groups suggested that delivering the group component as twelve full day sessions over a period of three months with no more than eight group members and two co-facilitators might be helpful in the design of a new intervention, and one client in the feasibility study wrote that '12 weeks wasn't long enough…[to learn] how to change our reactions to situations'. Moreover, former service-users spoke positively about the value of booster groups to provide support over the longer-term.

Service-users thought that working people would find full days acceptable as they were used to working 9am-5pm, and for those off sick it might help with them get back in the swing. Several

service-users liked the breaks in the full day sessions because they got to know each other better, and they could try and befriend quieter members of the group with small talk about normal stuff. Furthermore, having a maximum of eight clients is important to because former service-users needed to 'feel comfortable' and to 'trust others' and to 'open up'. One service-user found that it helped to do his goals in a longer group session rather than as between-session assignments because he lost focus once he got home.

Two service-users who had attended an intensive course for anxiety / panic thought that having 2 sessions per week was 'brilliant' and 'very helpful', although another stated it was 'it wasn't no easy rider, cake walk…it was very, very tough'. The same person stated he was surprised at the low level of drop-out because he had thought at the beginning of the course. However, one service-user who had previously negotiated ½ day per week off as sick leave and took ½ day as annual leave to attend the group programme warned that attending more than one session per week is a 'serious decision' for working people. One practitioner thought that clients need time between sessions to 'make links' and to 'process material'.

The main implication is that the new intervention should provide a high dose of therapy. In practice this was helpful because clients in Community Mental Health Teams (CMHTs) have moderate-severe and enduring mental health problems so it is likely that they will need high intensity therapy over a longer period to address their underlying problems and possible personality disorder traits.

The dose of the therapy is influenced by variables such as the intensity of the intervention (high or low), the length of the treatment programme as a whole (short-, medium- or long-term), the frequency and duration of sessions, the size of the group, and the number of facilitators. So whilst some group-based interventions are designed to accommodate more people, this inevitably means that clients get a lower dose of therapy especially if the peer interaction is not counted as an active ingredient. Equally, driving down the cost by reducing the dose and shortening the length of the treatment programme as a whole might make an intervention cheaper but not necessarily cost-effective, as it is possible that some clients will relapse and re-present for more therapy.

Nevertheless, CBT is based on the principle of parsimony, and this dictates that the choice of therapy should be the most effective, most efficient, least intrusive, least aggressive, least complicated, and least expensive option available. Shorter group-based interventions may be sufficient, and less likely to elicit dependence, especially if trust is not really necessary. They can also be useful as an introduction to group-based interventions, or they may be part of a care pathway which includes other interventions. On the other hand, having shorter group sessions means there is usually not enough time for clients to acquire and consolidate skills in-session, so

skills practice is usually negotiated as between-session assignments. In some cases, clients may not be motivated or focused enough to do this.

Most service-users who had attended other intensive courses (2 full days per week for 4 weeks) supported the idea of full day sessions because they thought there was 'a lot of material to work through' and therefore doing full days might shorten the overall duration of the course. Some thought working people would find full days acceptable as they were used to working 9am-5pm, and for those off sick it might help with them get back in the swing. One person stated, 'It's like when you've had a bad day at work, you know, and you're, oh thank God that's over, sort of thing. But it's a nice feeling'. Another thought longer sessions give plenty of time for Q&A. Several liked the breaks in the full day sessions because they got to know each other better, and they could try and befriend quieter members of the group with small talk about normal stuff. One person said, 'You're having lunch with people that you don't really know, you only know them in your group thing, and it puts you under a little bit of pressure to sort of bring yourself forward to talk to other people…It's just chit chat. So I think that's a good idea, for the full, when it's the full day. In the six hours we used to have a break and that, and it used to be nice to be able to sort of like just talk to people. And if somebody's looking a bit shy, try and bring them in, sort of thing'. One practitioner was worried that clients might find full days too much because 'I think if I have a whole day meeting I'll just explode, you know', and other practitioners were concerned that clients would get too tired or too bored, would not be able to concentrate or tolerate too much information, and would have to take too much time off work.

73.1.3 Balancing psychoeducational content and inter-personal group process

Former service-users in the focus groups also appreciated how opportunities were set up for them to consider the psychoeducational material as a group, and clients in the pilot study wrote that understanding why they were depressed was helpful and relevant. One implication is that skilful facilitation of peer interaction is also required to achieve an optimal balance of content components (the *what*) and process components (the *how*). In addition, balancing content and process requires a structured-directive group leadership style, and group sessions may have to be longer to ensure that clients receive an adequate dose of therapy.

73.1.4 Encouraging clients to take on the 'therapist's role'

Former service-users in the focus groups thought that being given the 'therapist's role' was important because they could learn basic CBT concepts and skills to use as help-givers, and that they could then apply these skills to themselves, and one client in the pilot study wrote that '*listening to everyone else's experiences helps me'.* In practice this was helpful because it improved self-efficacy and promoted a culture of self-help in the group with clients exhorting each other to undertake between-session assignments for example.

73.1.5 Using pairs, triads, small subgroups, and large group plenary

Former service-users in the focus groups thought that having different size groupings was helpful because some people have problems speaking out in the large group plenary, and clients in the pilot study wrote that small group was useful for '*digging deeper into issues'* and was *'deeply moving'.* In practice this was achieved by co-facilitators splitting the group up into reciprocating pairs (couple-sized) to review and set goals, small subgroups (family-sized) to explore issues in more depth, and large plenary groups (team-sized) to make time for Q&A, reflections and clarifications.

73.1.6 Scheduling a range of interesting activities

Former service-users in the focus groups suggested that having a range of interesting activities might be helpful in the design of a new intervention, and clients in the pilot study wrote that the different experiential and expressive exercises were helpful and relevant. In practice, setting up opportunities for these activities and exercises required a structured-directive group leadership style. This was achieved by the leader following a timetable and an agenda in order to deliver treatment based on personalised care plans, provide information, teach skills, and stimulate discussion. Activities and exercises included enactive techniques such as role play or the 'empty chair', and expressive techniques with different media such as drawing and sculpting which helped group members to explore their problems and experiences, and to represent them in symbolic form.

There were several advantages of using a structured-directive group leadership style including how each client was allotted time to talk, and there were degrees of privacy by working in reciprocating pairs and small subgroups, as well as the opportunity to make things more public in the large plenary sessions. Deliberately involving different partners in different pairings and small subgroups meant that everyone got to work with everyone else, and misunderstandings and irritations were often ironed out as clients perceived each other's real strengths and qualities as well as each other's weaknesses and flaws. Silences were used deliberately as reflective spaces and quiet times for writing in one's journal, for slowing down the pace of the group's interaction, or for providing extra support for an individual who was struggling with applying the concepts and skills.

Former service-users in the focus groups thought that it was important for the leader to engage the whole group and motivate individual clients, and clients in the pilot study wrote that being prescribed in-session and between-session goals was helpful and relevant.

73.1.7 Creating a group-psychotherapy culture

Former service-users in the focus groups spoke about the relationships they built with the therapist and with each other in group-CBT as real and meaningful even though they followed the

guidelines and did not meet outside the group sessions until therapy was completed, and one client in the pilot study wrote that *'[Finding out] that there are some people who genuinely do care'* and this stood out in her mind as the most positive thing about the treatment programme. Some clients continued to meet for up to 12 months after the end of treatment programme.

73.1.8 Using the 'double donut' to promote clients' perspective-taking

Former service-users in the focus groups suggested that talking about how they experienced bullying at work or arguments at home for example, and hearing about how others had coped with similar situations might be helpful in the design of a new intervention, and clients in the pilot study wrote that seeing things from significant others' points of view was helpful and relevant. In practice, setting up opportunities for inter-personal problem-solving required focusing on relationships in the real world of work and home. This was achieved by using the 'double-donut' exercise (see **).

73.1.9 Building and strengthening the therapeutic alliance in 1:1 sessions

Only one service-user in the focus groups mentioned problems getting on with the therapists. She stated, '*It took me ages to build the trust up with Nicola'.* Including 1:1 sessions both before and during the group sessions meant that the therapists could build rapport with each client individually. The 1:1 sessions were used to prepare clients for the group sessions and to maintain them in therapy so that they all completed treatment with an adequate dose and potentially better outcomes. In addition, by strengthening and deepening the relationship between the client and the therapists in 1:1 sessions, it was possible to repair the any ruptures in the therapeutic alliance during treatment, and this might have been a factor in preventing drop-out. This is helpful because ruptures in the therapeutic alliance are common with clients who have pre-existing inter-personal problems, and is more likely to be the case in secondary mental healthcare because clients have often experienced early relational trauma and to have traits of personality disorder (Safran, J.D. and Muran 2000; Safran, J.D. and Segal 1990; Greenberg 2002).

73.1.10 Understanding and minimising relationship distress in the group

Former service-users in the focus groups suggested that delivering the group component as twelve full day sessions over a period of three months with no more than eight group members and two co-facilitators might be helpful in the design of a new intervention. Several service-users liked the breaks in the full day sessions because they got to know each other better, and they could try and befriend quieter members of the group with small talk about normal stuff. Furthermore, having a maximum of eight clients is important to because former service-users needed to 'feel comfortable', to 'trust others', and to 'open up'. None of the clients in the pilot study mentioned that the full day sessions were too long although they appreciated regular breaks.

73.2 THEORY

73.2.1 Good conversation

There is no integrated theory for GCBT, and whilst current models of GCBT acknowledge that awareness of group processes and group dynamics is vital, there is little evidence regarding potentially different processes occurring within structured CBT groups compared to unstructured, longer-term, interpersonal or psychoanalytic group psychotherapies from where the data about therapeutic factors has been derived.

Long ago Satterfield (Satterfield 1994) proposed a hybrid model which would systematically integrate group dynamic processes into CBT group work. He described GCBT interventions which 'usually focus on treating the individual in the group rather than through the group' (p185) and made a convincing argument to incorporate strategies derived from inter-personal process group psychotherapies to promote group cohesion, work with group developmental stages and isomorphism i.e. the selective use of the multiple layers of interaction possible in a group: the individual, dyadic/pair, subgroups and group-as-a whole levels. Nevertheless, whilst Scott (Scott 2012) dedicates a whole chapter to balancing content and process in GCBT, attempts to integrate awareness of group dynamics and phases of group development into CBT groups (Bieling, P.J., McCabe, R.E. and Antony 2006), in practice this is often neglected as content is still prioritised over process (Spitz, HI., and Tschuschke 2008).

The integrated findings from this study suggest that cognitive, behavioural and emotional change takes place through a social process. This process is set in motion by the skilful facilitation of peer interaction which is based on the art of 'good conversation'. People with chronic depression often talk in a monologic fashion and they often struggle to express authentic inter-personal empathy (McCullough 2003), so the new intervention promoted 'good conversation' as a form of therapeutic dialogue.

In the field of organisational development, dialogue has been investigated to define how people talk when they are trying to solve problems together at work (Isaacs 1999). Four categories of communication were differentiated and specific inter-personal behaviours were associated with these ways of talking. In a group dialogue requires a balance between advocacy (seeking to be understood) and inquiry (seeking to understand). Advocacy uses the skills of *voicing* (speaking your mind with honesty and courage); and *respecting* (other people's integrity and perspective). Inquiry uses the skills of *listening* (openly and without resistance); and *suspending* (judgement and any prior certainties). Dialogue is when everyone is treated as an equal and when the quality of communication allows people to connect as peers. Dialogue is characterised by willingness to change and to be changed by the other. Good conversation as defined in this study has similar features, but needed skilful facilitation of peer interaction to realise the benefits described above,

perhaps because the employees in the feasibility study had moderate-severe symptoms of depression.

APPENDIX 74: CHANGES MADE TO THE NEW INTERVENTION AS A RESULT OF FEEDBACK

Table 125 – Changes made to the new intervention

Concern expressed	Suggested changes	Changes made	Staff	SU
Not enough information about thinking styles.	Incorporate more basic cognitive restructuring components.	Use concept of primary and secondary appraisals derived from coping process theory and dual processing theory.	√	
Confusing if concepts are only presented in written form or lecture.	Elaborate concepts / provide clear explanations using case studies, examples from real life, personal scenarios in the session.	Use adult learning techniques and experiential exercises; pair work and small group discussion ("fleshing it out").	√	√
Use of technical / academic terminology.	Make it less complicated, less dense, explain fewer ideas more fully, use less technical language; simplify how the concepts are described and depicted.	Present ideas using diagrams and more accessible language in the manual with fewer concepts provided i.e. focus mainly on inter-personal behaviour, and use of language from "stress management" literature.	√	√
Could be boring and off-putting.	Present concepts in a more interesting, stimulating and engaging way; provide less information in a clearer way using illustrations / animations / experiential / face-to-face in the group.	Use lots of different activities to energise participants and make learning more fun; notes for facilitators added to 4 x Power-Point presentations with notes on how to explain concepts in an accessible way.	√	√
Too many different potentially conflicting ideas ("conceptually not quite there yet").	Work at further conceptual integration or only focus on a few concepts.	Rely on group process components to convey concepts implicitly (versus explicitly) such as inter-personal reciprocity and emotional co-regulation.	√	√
Reading manual as it stands could be exhausting if given out at the beginning of the course ("I was getting a bit worn out").	Give manual out at the end of the programme with some between-session reading / tasks.	Make manual look more colourful and break up into digestible chunks so participants are encouraged only to read certain sections before or after specific sessions.		√
Possibility of crisis and relapse prevention ("getting worse before you get better", "opening can of worms", "plan for what happens when you have a blip").	Provide participants with relevant information about who to contact if they feel worse.	All clients developed personalised crisis and relapse prevention plans using coping process theory.	√	√

Concern expressed	Suggested changes	Changes made	Staff	SU
Using inter-personal theory of depression may result in guilt and self-blame ("go back to square one").	Support to make links between what person says / does and what others say / do; use compassionate feedback to improve awareness of how one's behaviour impacts on others.	Brief and debrief interactive exercises carefully to ensure all participants have a positive experience.		√
Using role play could be unhelpful if one person is using therapist role "in an aggressive manner".	Support to make links from "there & then" with "here & now".	Provide 1:1 assessment and formulation; treatment plan with personalised problems / targets.		√
Not enough processing time between sessions if they were delivered more intensively i.e. every day, twice-weekly.	Sessions to be full day delivered as weekly sessions.	Consideration given to frequency matching the intensity to participants' needs / capacities.	√	
Too many goals and between-session assignments.	Prescribe fewer goals and between-session assignments.	Goal-setting process simplified and personalised.		√
DVDs didn't work on some home computers; too much information if watched all at once.	Watch DVDs in the group, space them out.	DVDs watched together 2 per session with discussion.		√
Treatment Programme delivered in clinical setting is remote from the workplace.	Use it as a workplace preventative Training Programme, facilitated by peer mentors and / or OH staff.	Development of trauma-informed educational / experiential workshop using ideas and materials from sessions 1-4.	√	√
Some people may need more support after the Treatment Programme has been completed, if improvement in symptoms decays over time.	Make programme longer.	Development of asset-building peer support Base Group using format from sessions 5-12.	√	√
Some people may not understand the concept of self-help and may expect a "miracle cure" without making an active effort to change; some significant others may not know how best to support the person with depression.	Involve people who provide support / carers more (e.g. professional and personal).	Invite carers to attend educational / experiential workshop sessions with / without person with depression.		√
Some people may be triggered by confrontational or challenging feedback if it disconfirms their core beliefs.	Use compassionate feedback to improve awareness of how one's behaviour impacts on others.	Emphasise non-blaming approach understanding how people react automatically with perceived threat if they have experienced trauma i.e. maladaptive personal and interpersonal coping styles.		√
All of the clients had experienced childhood trauma, and may have had traits of personality disorder.	Need more information on how trauma affects people, and what they can do to cope with triggers.	Screen for trauma and traits of personality disorder at baseline to identify potential triggers in the 1:1 and group settings.	√	√

Ref: Basu et al 2017

74.1 TIDieR Checklists

The Treatment Programme is outlined in brief using the TIDieR checklist and guidance (Template for Intervention Description and Replication) Hoffmann et al. (2014).

Table 126 – The Treatment Programme

	BRIEF NAME
1	***Provide the name or phrase that describes the intervention.***
	A work-focused relational group-CBT ***Treatment Programme*** for employed people with moderate-severe recurrent depression.
	WHY
2	***Describe any rationale, theory, or goal of the elements essential to the intervention.***
	There is a lack of knowledge about indicated work-focused clinical interventions at the tertiary level (i.e. treatment and relapse prevention) to promote job retention. The intervention is based on the Inter-personal Theory of Depression. It targets dysfunctional communication and interaction patterns frequently seen in people with depression that predict relapse and recurrence. Group psychotherapy provides an activating environment where new skills can be acquired, consolidated and applied with the benefit of in vivo behavioural rehearsal, corrective peer feedback, contingent reinforcement, emotional co-regulation and stimulus discrimination. The goals of the intervention are improved clinical, inter-personal and occupational outcomes.
	WHAT
3	***Materials: describe any physical or informational materials used in the intervention, including those provided to clients or used in intervention delivery or in training of intervention providers. Provide information on where materials can be accessed (such as online appendix, URL).***
	For clients there is a range of psycho-educational resources including a manual, DVDs and recordings. For therapists there are Power-Point presentations which give clear details for the first four sessions which explains the approach. All of these materials are available at www.group-CBT.com.
4	***Procedures: describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.***
	The assessment and formulation process involves up to four 1:1 sessions undertaken by a Cognitive Behavioural Therapist. In the first session, clients complete a Family History questionnaire, Screening Checklist, Baseline Activity Tracking Diary, and a Crisis Plan. Clients are given some printed Information about Depression, and a Letter for their Employer about the programme. Each client is asked to identify someone who will provide on-going support for the therapy outside of the session, and to invite them to one of the assessment sessions. This person's perspective is sought about how depression affects their relationship, and they are asked to complete the Impact Message Inventory. A summary of the assessment is written in the form of a letter to the client, which includes a diagram depicting an ideographic formulation of how RD is perpetuated by behavioural

excesses or deficits which result in dysfunctional communication and interaction patterns at home and / or work. A treatment plan is agreed using a problems / goals format. One of the goals must specifically relate to job retention or return-to-work.

All group members sign a confidentiality agreement with behavioural guidelines made explicit to safeguard members' welfare.

The group psychotherapy programme comprises twelve full day sessions over 12 weeks with prescribed homework after each session and written progress reports provided about the last session at the beginning of the next. The first four sessions all start with ice breakers / warm up games to reduce anxiety and accelerate group cohesion. They are mainly used to socialise members to the treatment model, to provide psycho-educational via didactic talks, videos and experiential exercises based on adult learning principles, and to promote self-disclosure and mutual trust between members. This involves presentation of information about RD, the relevance of trauma, and dysfunctional personal and inter-personal coping styles. Group facilitators use a range of strategies such as reciprocating pairs, small groups and plenary sessions to orientate group members to take on an active role in their own therapy, and also to take an active role in other group members' therapy.

During the next eight sessions, group members are given an in vivo behavioural goal (e.g. ask someone for support, disagree with someone, offer an apology, or give someone a compliment), and other members guess what the person was trying to achieve at the end of the session.

Each group member can request up to four 1:1 sessions with the Occupational Therapist outside of the group sessions with a job retention / return-to-work focus. This may involve contact with the workplace, human resources or Occupational Health services.

Each group member is offered up to two 1:1 sessions with a therapist if required during the course for the purposes of crisis resolution at home / work.

Group members also prepare a worksheet at the beginning of the session about an inter-personal situation with a significant other (at home / work) that they found challenging during the preceding week. Members work in pairs to build understanding of what each person did / said, as well as each person's thoughts and feelings. Different perspectives are encouraged in a re-processing plenary slot, with the aim of developing communication and interaction skills, as well as empathic concern for the significant other. Group discussion is focused on how a stress-inducing dynamic can change into a stress-reducing dynamic by a process of reparation. Learning may be enhanced using role play or the "empty chair" technique.

Each session also involves "small group" facilitated discussion, when the whole splits into two halves for more intense psychotherapeutic work on individual goals / behavioural experiments / journal reflection for example depending on the individual's needs.

Members choose an activity in advance, and take turns (one for each of the last eight sessions), for either "Telling my Story" (presenting information about themselves and their recovery journey in whatever form they wish to), or "The Hot Seat" (asking other group members to give honest feedback and observations about the person using a worksheet based on inter-personal skills and strengths).

At lunchtime, group members are given a "Teamwork Challenge" which comprises of planning a celebratory event for the end of the programme together. Time is given after the lunchtime to reflect on how each member is engaging with this exercise, and with unstructured social contact, and how this relates to their individual work situations.

All sessions include time for goal review, and goal setting, with other group members encouraged to provide feedback and reinforcement as appropriate.

In session 11 group members are given a Discharge Plan worksheet to complete prior to the

	last session, and in session 12 group members complete a Relapse Prevention Plan. They are also is invited to write a post card addressed to themselves outlining what they have achieved in therapy, and including motivational affirmations. The post card is sent to each member by the therapists four weeks after the last session. A further 1:1 session (with the significant other if appropriate) is offered in the week following completion of the intervention to discuss the Discharge Summary which is written in the form of a letter to the person's referrer and GP reporting on progress towards goals with outcome measures.
	WHO PROVIDED
5	***For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given.***
	The intervention is delivered by a qualified CBT group psychotherapist and a qualified Occupational Therapist. Both should have significant experience in secondary care mental health service provision. Training in co-facilitation using behavioural and inter-personal process principles should be provided.
	HOW
6	***Describe the modes of delivery (such as face-to-face or by some other mechanism, such as internet or 'phone) of the intervention and whether it was provided individually or in a group.***
	The main mode of delivery is face-to-face group psychotherapy, with additional individual sessions. Group members are also encouraged to contact the therapists by 'phone, text or email between sessions if the intervention has triggered distress or if they are uncertain about any aspect of the programme. They are informed that this contact should not be used as an out-of-hours emergency service. They are also informed not to expect an immediate reply, and not to ring overnight or weekends.
	WHERE
7	***Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.***
	The 1:1 sessions are conducted in suitable accommodation such as within an outpatient or community mental health service. A power-point projector is required and capacity to photocopy handouts. The group psychotherapy programme takes place in a large room with a break out room, with facilities for refreshments and opportunity for unstructured social contact between group members.
	WHEN and HOW MUCH
8	***Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose.***
	The intervention comprises twelve full day weekly group sessions over a period of 3 months. In addition up to four 1:1 weekly or fortnightly assessment sessions of one hour duration, up to two 1:1 crisis resolution sessions of one hour duration (as required) one 1:1 discharge session of one hour duration and up to four 1:1 Occupational Therapy session of up to 3 hours duration, per each group member.
	TAILORING
9	***If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how.***
	The intervention is individually tailored through the optional addition of 1:1 sessions for crisis resolution, Occupational Therapy and carer support.
	MODIFICATIONS
10	***If the intervention was modified during the course of the study, describe the changes (what, why, when and how).***

	N/A
	HOW WELL
11	***Planned: if intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain fidelity, describe them.***
	Before and after each group session time was set aside for briefing and de-briefing with both co-facilitators using a group-CBT competencies checklist (adapted from Scott, 2012). Live supervision included the Acting Head of the CBT Service in There attending 3 group sessions for one hour each time to observe the co-facilitators' practice in vivo. This live supervision was intended to evaluate fidelity to the model through the use of the competencies checklist as above.
12	***Actual: if intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.***
	The intervention was delivered as per protocol and found to be feasible, although there was a low rate of recruitment because this intervention was delivered as a Treatment Programme in a clinical setting and relied on referrals from practitioners. Live supervision only took place on one occasion due to competing demands on the time of the Acting Head of the CBT Service in There.

The Training (and staff support) Programme is outlined in brief using the TIDieR checklist and guidance (Template for Intervention Description and Replication) Hoffmann et al. (2014).

Table 127 – The Training Programme

	BRIEF NAME
1	***Provide the name or phrase that describes the intervention.***
	A Training (and staff support) Programme informed by relational group-CBT for employees of health and social care organisations, and others who offer services to people with complex needs.
	WHY
2	***Describe any rationale, theory, or goal of the elements essential to the intervention.***
	There is a lack of knowledge about job retention interventions which aim to improve employees' communication and interaction skills in high-stress occupations such as nursing, teaching and social work, and whether they have an impact at individual, organisational and service-user levels. The intervention is designed to help employees gain knowledge about, skills to manage, and positive attitudes towards stress and trauma, and to enhance relational ways of working. It targets dysfunctional communication and interaction patterns, and maladaptive coping frequently seen in people with complex needs. Peer-led 'base-groups' for staff provide emotional and practical support, and a psychologically-safe environment where new ways of coping can be developed. The goals of the intervention are improved clinical, inter-personal and occupational outcomes for employees and service-users.
	WHAT
3	***Materials: describe any physical or informational materials used in the intervention, including those provided to clients or used in intervention delivery or in training of intervention providers. Provide information on where materials can be accessed (such as online appendix, URL).***
	For employees there is a range of educational resources including a manual, DVDs and recordings. There is a range of educational resources and a manual. These can also be used in

	direct work with families. For workshop facilitators there are Power-Point presentations which give clear details for the first four sessions which explains the approach. For 'base-group' peer facilitators there are suggested session-formats and handouts.
4	***Procedures: describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.***
	The preparation process for the educational workshop involves a 1:1 meeting with the workshop facilitator to orientate employees about the programme, and to screen for any mental health problems and current stressors using CORE-OM and the HSE risk tool. The Coping Self Efficacy questionnaire will identify what coping strategies the employee typically uses. The employee is given the manual and contact details of the workshop facilitator. All employees undertaking the training programme are asked to sign a confidentiality agreement. The educational workshops comprise four full day sessions over four weeks with assignments prescribed before / between / after each session. The workshops start with ice breakers / warm up games to reduce anxiety and accelerate group cohesion. The workshops are mainly used to socialise members to the relational ways of working model, to provide educational material via didactic presentations, videos and experiential exercises based on adult learning principles, and to promote self-disclosure and feedback processes between employees. This involves presentation of information about stress and basic neuroscience, the relevance of trauma, and dysfunctional personal and inter-personal coping styles, and opportunities to practice skills in vivo. Facilitators use a range of strategies such as reciprocating pairs, small groups and plenary sessions to orientate workshop members to take on an active role in their own learning, and also to take an active role in other employee's learning. Following completion of the four sessions, another 1:1 meeting with the workshop facilitator will be arranged to de-brief the employee, and to offer feedback about their participation. All employees who have completed the educational / experiential workshops will be invited to form or join a Base Group which has between 6-8 members who commit to attend reliably for 2 hours on a weekly / fortnightly / monthly basis. Membership can be agreed as part of employees' performance appraisals or personal development plans. Each Base Group has a stable membership of between six to eight people who make a commitment to meet regularly for no less than 12 months. At each one year anniversary, the members may decide to close the group, or to split in half to form two new groups inviting other staff members to join, or to continue with the existing membership for another 12 months. Each session starts with 30 minutes reflection time when group members prepare a worksheet at the beginning of the session about something they have found stressful, upsetting or disturbing between sessions which may be a work-related or a personal issue. Members work in pairs to build understanding of their triggers, automatic stress reactions, helpful or unhelpful coping strategies for example. In a plenary slot, members summarise what their partner disclosed, and then the group-as-a-whole decides who might need more time to talk about what has happened and what might be helpful. Group discussion for the next 60 minutes is focused on processes such as re-appraisal, re-attribution and re-processing. Before the end of the session members complete their worksheet outlining how they could cope in a more adaptive way with any current stressors. These commitments are shared with others in the final 30 minutes before the session ends. If anyone requires additional support between sessions this can be negotiated and agreed. The main goal of this group is to generate self-awareness and self-efficacy.

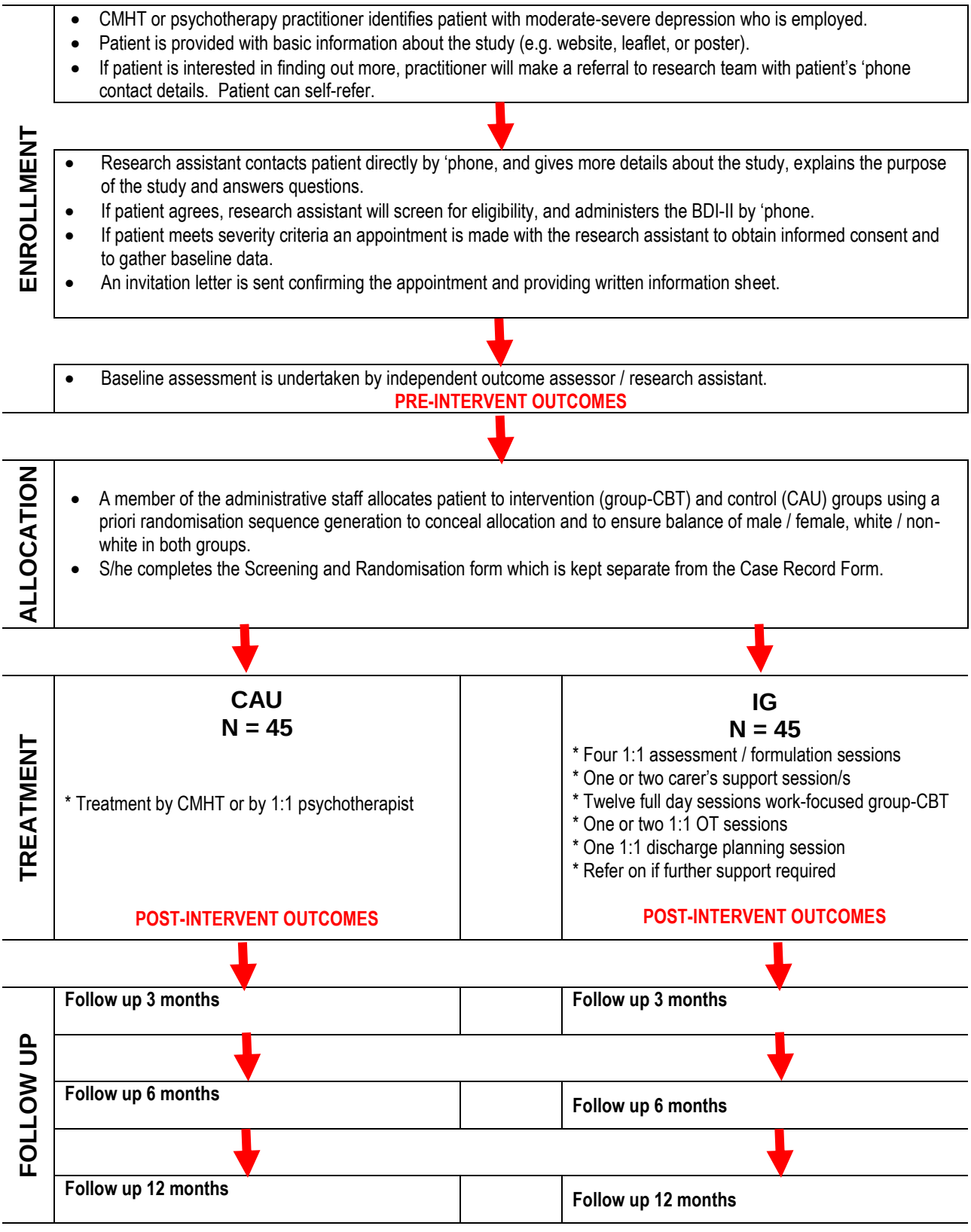
	WHO PROVIDED
5	***For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given.***
	The intervention will initially require qualified psychotherapists / psychologists or other experienced mental health practitioners to facilitate the workshops, and to support employees in setting up and running the peer-led Base Groups (which could involve attending the first 4 groups). The intervention involves a 'train the trainers' approach as all components will be undertaken by employees eventually as they gain basic CBT concepts and skills. Base Group peer facilitators will have on-going monthly supervision with a psychological therapist. These volunteers will also have the opportunity to co-facilitate further educational / experiential workshops, and in time run them on their own.
	HOW
6	***Describe the modes of delivery (such as face-to-face or by some other mechanism, such as internet or 'phone) of the intervention and whether it was provided individually or in a group.***
	The main mode of delivery is face-to-face workshops, with some 1:1 briefing and de-briefing sessions. Contact via email and 'phone with members of the project team would be available for trouble-shooting purposes. Employees accessing a Base Group may negotiate additional support by 'phone or text between sessions.
	WHERE
7	***Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.***
	The 1:1 briefing and de-briefing sessions will be conducted in suitable accommodation such as small meeting rooms. Privacy and confidentiality would be essential. The educational / experiential workshops should be conducted in suitable accommodation such as medium to large meeting rooms within buildings used by NHS or LA teams, or other free community venues. It is important for the room to be the same for every session, and for there to be no interruptions. Facilities such as lifts and accessible toilets would be required. A Power-Point projector would be required, and agreement within local teams to photocopy handouts. Refreshments would be dependent on what the facilitators could feasibly arrange but should ideally include lunch. The Base Group sessions should be conducted in suitable accommodation such as small to medium meeting rooms within buildings used by NHS or LA teams, or other free community venues. It is important for the room to be the same for every session, and for there to be no interruptions. Facilities such as lifts and accessible toilets would be required. Refreshments would be dependent on what the facilitators could feasibly arrange but should ideally include a cold or hot drink.
	WHEN and HOW MUCH
8	***Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose.***
	The intervention comprises one 1:1 orientation / screening session of one hour duration, four full day weekly workshops, and an optional weekly / fortnightly / monthly Base Group (depending on how frequently the group members what to meet). Preparation for the intervention comprises one 1:1 briefing before the workshops, and one 1:1 de-briefing sessions of up to 1 hour duration each session. The workshops comprise four weekly full day sessions over 4 weeks with up to 12 participants. The peer-led Base Group comprises one x 2 hour session on a weekly / fortnightly / monthly

	basis for minimum 12 months. Over 12 months the intervention will reduce from high intensity with psychotherapists / psychologists heavily involved in running the programme, to low intensity as peer facilitators working towards accreditation take over running the Training (and staff support) Programme under continuing supervision.
	TAILORING
9	***If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how.***
	The educational / experiential workshops should be mandatory to help all employees gain knowledge about, skills to manage, and positive attitudes towards stress and trauma. The intervention may be tailored in response to employee need e.g. the provision of work-focused or personal feedback using HSE checklist or CORE-OM, recommendation to join a peer-led Base Group for example.
	MODIFICATIONS
10	***If the intervention was modified during the course of the study, describe the changes (what, why, when and how).***
	The intervention has been substantially modified by re-designing it as a primary preventative Training (and staff support) Programme rather than a tertiary preventative Treatment Programme. This means that the original intervention has split into 2 components: 1) four weekly educational / experiential workshops, and 2) a follow up weekly peer support group.
	HOW WELL
11	***Planned: if intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain fidelity, describe them.***
	Before and after each educational / experiential workshops time should be set aside for shared reflection with both co-facilitators using the competency checklist. Any problems or concerns can be addressed in their own line management supervision or with members of the project team. Live supervision can be used to observe the co-facilitators' practice in vivo, to verify their competence, and to evaluate fidelity to the model through the use of the competency checklist as above. Quality assurance will be achieved over time through a process of peer evaluation by employees accredited as peer facilitators. Before and after each group session time should be set aside for individual reflection by the facilitator using the competency checklist.
12	***Actual: if intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.***
	Field testing of the Training Programme has taken place with the LA and Early Help workforce and found to be feasible, although there were problems in delivering the course to large teams and acceptability of the subject matter.

APPENDIX 75: OUTLINE PROPOSAL FOR A DEFINITIVE TRIAL

Here is an outline proposal for a definitive RCT to evaluate the Treatment Programme taking into consideration the results of the pilot study.

Figure 48 – Outline proposal



APPENDIX 76: MEASURING GROUP PSYCHOTHERAPY PROCESS

Research exploring group-specific mechanisms of change has developed a range of tools to measure whether and to what extent constructs of interest such member or leader behaviour influence the outcome.

One tool is the Group Psychotherapy Intervention Rating Scale which assesses the leader's competence across three domains which are thought to be important in fostering group cohesion as the context for activation of therapeutic factors (Fuhriman & Burlingame 1994; Chapman et al, 2010).

- **Group structuring:** e.g. creating and maintaining the boundaries of the group with clear boundaries and expectations.
- **Verbal interaction:** e.g. facilitating and modelling positive communication and interaction including personal disclosure, giving and receiving feedback
- **Emotional climate:** e.g. balancing challenge and support, encouraging the safe expression of feelings, displaying an empathic manner, and sensitive confrontation

Group member behaviour can also be assessed using validated scales such as the Hill Interaction Matrix (Hill, 1971; Chapman et al, 2010) which has two dimensions:

- **Content:** what the leader / members are talking about e.g. topic, group-focused, personal-focused, relationship-focused
- **Work:** how the leader / members are talking about the topics e.g. responsive, convention, assertive, speculative, confrontive

Objective evaluation can be achieved through non-participants observation or coding of transcripts by independent raters.

The Therapeutic Factors Inventory – Short Form (MacNair-Semands et al, 2010) is a self-report measure of clients' perceptions of what has been helpful in the group which has four general categories: instillation of hope, secure emotional expression, awareness of relational impact (of others on self, of self on others for example), and social learning (through observing others, comparing self to others, practising communication skills for example).

The Group Climate Questionnaire – Short Form (MacKenzie, 1981) is a self-report measure of clients' perceptions of the group-as-a-whole which has three sub-scales: engagement, avoidance and conflict.

The Group Questionnaire – Revised (Krogel et al, 2013) is a self-report measure of clients' perceptions of one's own, the leader's and other group members' behaviour in terms of 'positive

bonding', 'positive working', and 'negative relationship' which can be repeated every group session.

The Group Psychotherapy Intervention Rating Scale (Chapman et al, 2010) is an observer-rated measure of the group leaders' behaviours which has three clusters of similar therapeutic factors: group structuring, verbal interactions (facilitating member-member verbal interactions), and maintaining a therapeutic emotional climate (by using a warm and empathic inter-personal style).

APPENDIX 77: DISSEMINATION PLAN

77.1 IMPLEMENTATION FRAMEWORK

The Quality Implementation Framework (QIF) (Meyers et al, 2012; Flaspohler et al: 2012) which is a refinement of the Interactive Systems Framework (ISF) (Wandersman et al, 2008) has been used as the implementation theory for any future study of this intervention.

The ISF originally operationalised the role of three crucial systems that must be integrated for dissemination and implementation to be successful:

1. Synthesis and Translation System
2. Support System
3. Delivery System

The QIF facilitates how these systems work together and has four phases:

1. Initial considerations regarding the host setting
2. Creating a structure for implementation
3. Ongoing structure once implementation begins
4. Improving future applications i.e. learning from experience

Subsequent evaluation of the QIF has resulted in a toolkit (QIT) which identifies the six components of an implementation strategy by which an intervention is most likely to succeed in bringing about sustainable change:

1. Develop an implementation team
2. Foster supportive organizational / communitywide climate and conditions
3. Develop an implementation plan
4. Receive training and technical assistance
5. Practitioner–developer collaboration in implementation
6. Evaluate the effectiveness of the implementation

Each component is further broken down into well-defined associated action steps. The toolkit can be also used to monitor adherence across the six components, and as part of a process evaluation.

For practical purposes the author integrated the QIT with an empirically-supported 7-step strategy specifically designed for the implementation of worksite lifestyle interventions (Wierenga et al, 2016). Table illustrates what the next steps would involve.

Table 128 –Implementation plan

Formation of basic infrastructure	• Formation of a steering committee / working party which has responsibility for launching the intervention and embedding it in routine practice. The working party should include one or more senior executives / board members who have decision-making powers. A project leader will take day-to-day responsibility for liaising with all relevant stakeholders and will act as an intermediary between the working party and the workforce
Performing a needs assessment	• The needs assessment should include an analysis of the findings from measures such as sickness rates for mental health problems, Health and Safety Executive Management Standards for Work-Related Stress, Team Climate Assessment Measure and Staff Survey.
Creating solid support	• Meeting with senior management at strategic level / board of directors to elicit their backing for the initiative by providing them with information about the potential benefits / business case for investing in the intervention i.e. reduced sickness, improved productivity • Commissioning of the intervention for a trial period • Obtaining assurance in writing that employees can attend during work hours and when they are off sick if appropriate as part of a return-to-work plan • Meeting with middle managers to elicit their backing for the initiative by emphasising how it complements other mechanisms of staff support • Meeting with representatives from Occupational Health, Trade Unions, Human Resources, Health & Safety for example to elicit their backing for the initiative by highlighting the shared goal of enhancing staff wellbeing and performance
Development of the intervention alongside reviewing occupational health and workforce development policies	• The project leader should be able to demonstrate how the intervention can address the needs identified above • A project plan will be developed with clearly stated goals, timescales, budgets, facilities, resources and named individuals for specified tasks • A communication plan will be developed using marketing and social media strategies to promote the intervention and to ensure information about its implementation is distributed and circulated effectively within the organisation • These plans will be presented to the working party who have authority to give the final go ahead • A desk-top exercise / simulation with the working party will identify and address any possible glitches
Implementation of the intervention	• The intervention will be put into operation on the date agreed by the working party
Iterative tailoring to local context	• Regular consultation with frontline practitioners and service-users
Evaluation	• Short-, medium, and long-term quantitative (outcome) and qualitative (process) data will be collected from participating employees and other relevant stakeholders • This data will be analysed to check if any adjustments or improvements should be made to the intervention, the project plan or the communication plan • The working party will produce an evaluation report at regular intervals (e.g. quarterly) for senior managers at strategic level / board of directors
Embedding the intervention in the general occupational health and workforce development policies of the organisation	• Depending on the evaluation a decision will be made whether to incorporate the intervention in the general occupational health and workforce development policies • Ongoing support for intervention frontline implementers with further training and supervision • Ongoing monitoring of effectiveness and acceptability of intervention

77.1.1 Possible sequence of events

Successful implementation of the training programme will require clarity and agreement about the sequence of events (de Silva et al, 2014). The following steps should be taken in implementing the training programme:

STEP ONE: Write a research proposal

- Decide research design / methods
- Apply for ethical approval

STEP TWO: Develop a communications plan

- Set up 'expert reference group' for ongoing stakeholder consultation with frontline staff and service-users
- Discussion with teams about the training programme to promote engagement and ensure buy-in

STEP THREE: Develop a marketing plan

- Design information leaflets for frontline practitioners, support staff and line managers
- Use organisation's website to provide information for all employees

STEP FOUR: Develop a meetings strategy

- Clarify terms of reference for different implementation and sustainability meetings

STEP FIVE: Develop a staffing plan

- New job descriptions agreed, and re-contracting for posts of Peer Facilitators
- Further recruitment and training of volunteers

STEP SIX: Develop an operational policy

- Design an operational policy with clear guidelines on how to deliver the intervention

STEP SEVEN: Develop a competency-based modular training plan

- Select effective instructional design and appropriate teaching methods
- Align with priorities of continuing professional development and appraisal processes
- Introducing use of behaviour modelling, clinical simulation and interpersonal-process-recall (IPR) as tools to support practice development and critical thinking
- Introducing ways to maintain quality assurance and fidelity e.g. live supervision, coding standards
- Set up portfolio system of accreditation e.g. Peer Facilitators
- Set up "Train the Trainers" sustainability strategy

STEP EIGHT: Develop a resources plan

- Identify budget for training programme implementation
- Obtain digital video- and audio-recording devices
- Ensure all practitioners have mobile 'phones

STEP NINE: Develop administrative and evaluation systems

- Ensure procedures are in place for scheduling appointments and coordination with other intervention providers
- Determine which outcomes to use for monitoring impact
- Set up database to analyse outcomes
- Agree process measures and measurement methods

These steps will form the basis of several work plans whereby different activities will be undertaken by named people in preparation for the launch of the new initiative.

Table 129 – Example work plan (1)

OBJECTIVE ONE: Stakeholder consultation with frontline staff and service-users			
Measure for accomplishment: Report on key themes raised using a mind map approach			
Activity	**Person responsible**	**Purpose**	**Timeframe**

Table 130 – Example work plan (2)

OBJECTIVE TWO: Develop a competency-based modular training plan			
Measure for accomplishment: Authorisation by workforce development department to deliver the programme 2017-2018			
Activity	**Person responsible**	**Purpose**	**Timeframe**

Progress towards these objectives will be monitored in line management supervision or contract compliance meetings.

77.1.2 Example timeline

Implementation of the training programme could be tested in one locality. Launch will be achieved by January 2018:

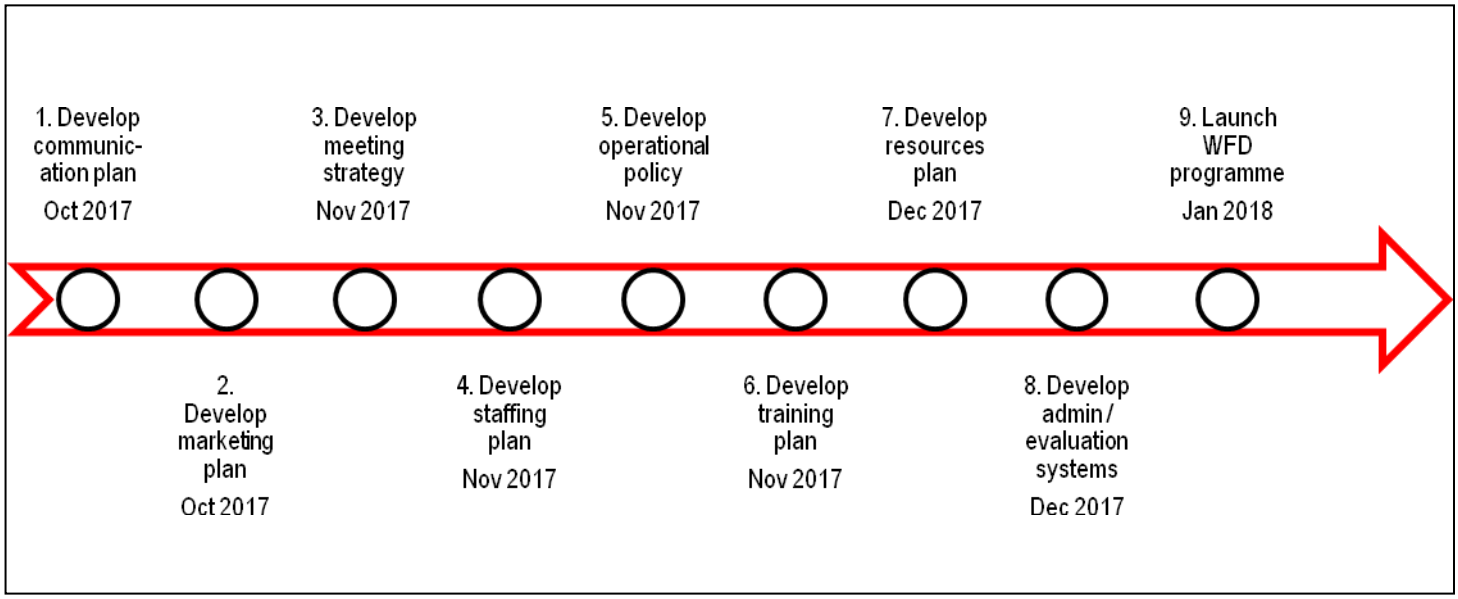


Figure 49 – Implementation timeline

77.1.3 Primary Fieldwork

Primary fieldwork has already been undertaken and evaluated using Survey Monkey. The Training (and staff support) Programme was incorporated into a whole-systems Workforce Development strategy across the children's workforce (statutory, voluntary and education services). This project was part of the grant-funded Healthy Relationships Partnership in Hartlepool. This involved training practitioners from the Early Help workforce such as social workers, health visitors, community nursery nurses and family support workers.

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