Mental health and employment: improving services and outcomes

Lauren Jones, Policy Lead for Mental Health and Employment, Department of Health
1. Why this is important
Mental health problems affect significant number of people both in and out of work.

<table>
<thead>
<tr>
<th></th>
<th>Proportions and approximate numbers of working age adults with mental health conditions</th>
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<tbody>
<tr>
<td>General population</td>
<td>18%</td>
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<tr>
<td>Jobseeker's Allowance claimants</td>
<td>23%</td>
</tr>
<tr>
<td>Sickness benefit claimants</td>
<td>46%</td>
</tr>
</tbody>
</table>

7.2m

0.3m

1.1m

Source: General population, APMS 2007; Jobseeker's Allowance claimants, National study of work-search and wellbeing and Labour Force Survey; Sickness benefit claimants, DWP admin data.
People with mental health conditions tend to have low employment and high inactivity rates

<table>
<thead>
<tr>
<th>Employment rates for selected groups</th>
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<tbody>
<tr>
<td>Mental health problems</td>
<td>42%</td>
</tr>
<tr>
<td>Musculoskeletal conditions</td>
<td>58%</td>
</tr>
<tr>
<td>All disabled people</td>
<td>45%</td>
</tr>
<tr>
<td>All people with a health condition</td>
<td>58%</td>
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<tr>
<td>Total (general population)</td>
<td>71.6%</td>
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</table>

- The employment deficit is largest for people with mental health conditions
- But evidence suggests that paid employment is generally beneficial, if the work is safe and accommodating for the mental health condition (Waddell and Burton, 2006)

People with mental health problems **fare worse in employment** at a group level, **but this is not the case for all individuals**
Mental health conditions are a key reasons for sickness absence and benefit claims...

Out of a total of 131.1 million days per year lost to sickness absence:

- 30.6m days are lost to musculoskeletal problems
- 27.4m days are lost to ‘minor illnesses’
- 16.2m days are lost to stress, depression, anxiety & ‘serious mental health problems’.

70% of new benefit claims relate to mental health & musculoskeletal (MSK):

- over 1.1m for MH problems
- around 400k people for MSK problems

…it seems that those with MSK are more likely to be ‘in work’ on sickness absence and linked to an employer, whilst those with mental health conditions are more likely to be ‘out of work’ and on benefits.

People with mental health conditions remain on sickness benefits for longer

Survival rates for Employment Support Allowance, to July 2014

Proportion of all claims still live

Months since claim started

Source: DWP admin data
We cannot ignore this…

- Mental illness costs the UK economy £70 - £100bn per year, 4.5% of GDP (OECD estimate)
- Since 2009, the number of working days lost to ‘stress, depression and anxiety’ has increased by 23%
- Since 2009, the number of working days lost to ‘severe mental illness’ has doubled
- Co-morbidity of mental disorder and physical disorder is common; of the 15 million people in England with a long-term (physical) condition, 30% also have mental illness.
- In 2013, almost 41% of Employment and Support Allowance recipients had a ‘mental or behavioural disorder’ as their primary condition:

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Percentage of Caseload Distribution</th>
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<tbody>
<tr>
<td>Mental disorders*</td>
<td>40.9</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>15.3</td>
</tr>
<tr>
<td>Circulatory system</td>
<td>6.2</td>
</tr>
<tr>
<td>Nervous system</td>
<td>6.6</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>5.3</td>
</tr>
<tr>
<td>Other</td>
<td>26.4</td>
</tr>
</tbody>
</table>

Many benefit claimants want to work – however they do not feel able to, with variations by benefit group

- People with same health condition can have different beliefs about their ability to work.

- However, we know less about drivers of these attitudes – there are likely to be a number of factors:
  - the perceptions of the individual & others around them (e.g. family, GPs);
  - hard ‘facts’ (e.g. presence of a health condition) and;
  - lack of knowledge (e.g. about available support).

Source: DWP (2013) Survey of disabled working age benefit claimants
Most people are not receiving specialist treatment for Mental Health conditions

Most mild to moderate mental disorders remain untreated
Share of people who sought treatment for their mental illness in the past twelve months, by type of treatment

Source: Data & figures from the Annual Report of the Chief Medical Officer, 2013 – Chapter 10, ‘Mental health and work’; (Max Henderson, Ira Madan); and OECD, 2014, ‘Mental Health and Work, UK’.
Access to Mental Health services is variable

- Some 60-70% of people with common mental disorders are in work
- Evidence shows that many of those with mental illness fail to take sick leave when they need it, yet untreated this reduces productivity, and leads to more presenteeism and longer sick leave by the time workers do take leave
- Those off work for more than 6 months have only a 20% chance of returning to work in the next 5 years

Source: DWP data on WRAG-MH, May 2013 (unpublished); Health and work report (2011); IAPT waiting times data Q2 2013/14.
Once people go onto long term sickness, they are likely to remain economically inactive

**Journey**

- **In work**
- **Presenteeism**
- **Short term sickness absence**
- **Long term sickness absence**
- **Economically inactive**

**Status**

- Healthy
- Ill at work
- Off < 4 weeks
- Off for 4 weeks +
- Not working

**Policy response**

- **Occupational health & Responsibility Deal**
  Workplace health initiatives and occupational health (in some organisations); Most big firms have occupational health services but smaller firms currently tend to offer less support. Responsibility deal promoting health and wellbeing at work.

- **Fit note**
  The fit note allows doctors to provide advice to their patient about the effects of their health condition and how they might be able to return to work while they recover.

- **Health and work service**
  This offers a work focused occupational health assessment and case management to employees in the early stages of sickness absence.

- **Jobcentre Plus Work Choice Access to work Work Programme**
  Various health & employment support initiatives but variability across the country – need for coordination and strategic approach

**Health services**
2. Psychological wellbeing and work

Examining and testing interventions to improve service provision and outcomes
Psychological Wellbeing and Work Report: Main Findings

For people who have common mental health problems:

- The interaction between mental health and employment is complex and unlikely to lend itself to a “one size fits all” solution;
- Health and employment services are often not joined-up and do not tackle either the mental health problem or the employment need discretely;
- Service provision is often delayed and problems can worsen as a result;
- The assessment of employment and health needs is poor and there are low rates of diagnosis or referral to specialist health and employment support;
- Timely access to psychological therapy varies significantly between areas;
- Work Programme employment outcomes are disappointing compared with those for other client groups;
- There is no systematic evidence that better health treatment alone will deliver employment outcomes; and
- Although there is some good evidence for what works to help employees retain work when mental health problems arise, evidence of what works for people in the benefit system is limited.
Report Conclusions and Recommendations

The Report concluded that effective support requires:

• Evidence-based models of service delivery that combine addressing employment needs and mental health support;

• More integration between existing treatment and employment services to improve outcomes in both areas;

• New applications of evidence-based models (or a combination of the preceding approaches); and

• Timely access to coordinated treatment and employment support for a greater number of people with common mental health problems.
Psychological Wellbeing and Work Feasibility Pilots

Aim - to explore and establish the evidence for:

1. A case to support, or otherwise, that the pilots should be taken forward into large-scale piloting;

2. Insight into the relative performance of interventions;

3. Learning from the implementation of the delivery models and issues for wider piloting.
## Pilot 1: Embed vocational support based on the IPS model in IAPT

<table>
<thead>
<tr>
<th>Client group</th>
<th>Referral mechanism</th>
<th>Intervention</th>
<th>Measures</th>
<th>Timelines</th>
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<tbody>
<tr>
<td>ESA WRAG claimants with a common mental health condition (12-17 month prognosis) who are: • not yet referred to the Work Programme (WP); • exempt from the WP; • WP returners; and • within the assessment phase who are likely to benefit.</td>
<td>Default referral from Jobcentres for new ESA WRAG entrants during an already scheduled adviser interview or during an already scheduled Work Focused Interview for existing ESA WRAG customers who consent to participation.</td>
<td>A specified model of integrated employment and mental health support</td>
<td>• Self efficacy for work • Wellbeing • Mental health • Customer journey experience • IPS job entries • Proportions referred / started / completed</td>
<td>June 2014 running for 6 months depending on referral numbers. Evaluation due January / February</td>
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Pilot 2: JOBS II model to build self-efficacy and resilience to setbacks that benefit claimants face when job seeking

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| Job Seekers Allowance claimants who are not participating in Work Programme attending adviser interview – flow and stock. | Discretionary referral at employment adviser interview. Single referral source (work coaches) | Facilitated workshop discussing job search skills and dealing with setbacks. | - Self efficacy for work
- Wellbeing
- Mental health
- Customer journey experience
- Proportions referred / started / completed | August 2014 running for 4 months. Evaluation completed in Spring 2015 |
**Pilot 3 – Jobcentre-commissioned third-party provision of combined telephone-based psychological and employment related support**

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<tr>
<td>Job Seekers Allowance claimants who are not participating in Work Programme attending adviser interview – flow and stock.</td>
<td>Discretionary referral at a suitable adviser interview using referral guidance provided.</td>
<td>Offering access to job search focussed advice with elements of CBT over the telephone</td>
<td>• Self efficacy for work&lt;br&gt; • Wellbeing&lt;br&gt; • Mental health&lt;br&gt; • Customer journey experience&lt;br&gt; • Proportions referred / started / completed</td>
<td>August 2014 running for 4 months.&lt;br&gt; Evaluation completed in Spring 2015</td>
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Pilot 4 – User research to inform online mental health and work assessments and support

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<tbody>
<tr>
<td>User research with:</td>
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<td></td>
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<td></td>
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<tr>
<td>• People in and out of work with common mental health problems.</td>
<td>Invitation to participate via stakeholder networks</td>
<td>Intervention design to be informed by user and design research</td>
<td>Feasibility stage will access and analyse qualitative data on user need, interest and preference. This will inform the design of the online service to be tested, including measures.</td>
<td>November 2014 – March 2015</td>
</tr>
<tr>
<td>• People in and out of work interested in improving their psychological wellbeing and building personal resilience</td>
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What we have learned so far

Design & set up

- Service mapping takes time.
- It’s a congested space – many existing DWP pilots, which affects volumes of eligible participants.
- Services are very keen to be involved

Delivery

Pilot 1: IPS/IPAT

- Interest and buy in from service managers and staff is critical
- Working relationships between services are very important
- Existing referral mechanisms can cause confusion
- Quick follow up after initial referral increases participation

Pilot 2: Group work

- Early feedback is very positive

Pilot 3: Telephone support

- The benefit of flexibility to adapt to client’s needs and preferences
What we want to get out of the second stage

• Scale up promising approaches.

• Understand the impact on benefit off flows and mental health and employment outcomes.

• Be able to build a convincing case for future investment.

• Balance what’s “worthwhile” with what is cost effective.

• Learn from local areas about what works.
Any questions?