BRIEFING

Centre for Mental Health

47: Barriers to employment

What works for people with mental health problems

Summary

The majority of people with mental health problems can be in paid work if that is what they want. This is the conclusion of service users, their families, clinicians and researchers who have witnessed the overwhelming evidence of the success of Individual Placement and Support (IPS): an approach to helping people with severe mental illness to get back into employment. While this is encouraging for those who have access to an IPS employment specialist, the option is still not available for large numbers of people who would like help and support in finding suitable work.

People with mental health conditions report numerous barriers to employment. These include discriminatory attitudes of employers, low expectations of health professionals and ineffective models of supported employment, including some provided by the Work Programme and Work Choice. But there is a growing awareness of the ways in which work is good for mental health and that better supported employment for people with mental health conditions must be a priority for commissioners and providers of both employment services and health and social care.

Raising the employment rate of people with mental health problems to a level somewhere near that of the general population is a job for health and wellbeing boards, GPs, mental health services, local authorities, employment services and Work Programme providers alike. Employers can also do a great deal to manage mental health in their workplaces and reap the business benefits.

This briefing identifies where the main barriers to employment still lie, what we know about which interventions work (and should be provided more widely), and where there are gaps in evidence-based interventions and what might be tested to develop that evidence.

Introduction

For most of us, having paid work is essential for wellbeing and financial security. But for many people who require some support to get into work, especially those with mental health problems, the right to employment support is not being upheld.

Unemployment and mental health problems appear to have a causal link both ways. People with mental health problems are much less likely to be in paid employment (Marwaha & Johnson, 2004; Rinaldi *et al.*, 2011) and people who have been unemployed for at least six months are more likely to develop depression or other mental health conditions (Paul & Moser, 2009; Diette *et al.*, 2012). McManus *et al.* (2012) found that one third of new jobseekers allowance (JSA) claimants reported that their mental health deteriorated over the period of the four month study, while those who entered work noted improved mental health.

Data on welfare benefit claims shows that mental health problems are keeping large numbers of people out of the workforce. In February 2013 over 724,000 people were claiming employment and support allowance (ESA) because of mental and behavioural disorders.

Research also indicates that work is good for our physical and mental health (Waddell & Burton, 2006) and many people who are using specialist mental health services want to work, and would like more help to get back into employment. The 2012 Care Quality Commission survey of community mental health service users found that 43% of the 2,780 respondents said they would have liked support to find or keep a job but did not receive any (Care Quality Commission, 2013).

This briefing paper describes supports which are currently available for people wanting to work, and calls for a more widespread implementation of best practice. Individual Placement and Support (IPS) is undoubtedly the most effective approach to helping people with serious mental health conditions to overcome the barriers to finding paid work. Its evidence-base is well-established, but its availability across the UK is still patchy. Centre for Mental Health strongly believes that anyone with a mental health problem who asks for help to gain or retain their employment should be able to access a locally commissioned IPS service with minimum delay.

Barriers to employment

This section sets out some of the key barriers to employment for people with mental health problems.

Stigma and discrimination in the workplace

The fear of being stigmatised and discriminated against either in the process of job seeking, or within employment is common among people with mental health problems. A study of 949 people with mental health problems found that 53% reported some experience of discrimination and the areas in which this most frequently occurred included employment, housing and criminal justice system interactions (Corrigan *et al.*, 2003).

A Mental Health Foundation study looking at return to work after sickness absence found almost half of employees off sick with physical health problems also experienced mild to moderate depression, but were more worried about telling their employer about their mental health issues than about their cancer or heart disease (Loughborough University/ Mental Health Foundation, 2009).

Danson & Gilmore (2009) found that employers are wary of employing people with a health condition. They found that while employers had sympathy towards people with disabilities, mental health problems, or those who had recovered from serious illness, they were also concerned that, as employees, their disability or illness might lead to future difficulties and financial pressures for the business.

Anti-stigma campaign

The continuing existence of stigmatising attitudes towards people with a mental illness remains a significant barrier for people seeking work. The Time to Change campaign in England, which has run since 2007, is aimed at both the general population and at specific target groups, such as employers and medical students. The campaign has made use of social marketing, advertising campaigns and events designed to deliver social contact between people with experience of mental health problems and various target groups. The funding for the first phase, across the four years to 2011, reached almost £21 million and the campaign has measured the effectiveness of its work. Some parameters showed a positive change, such as improved employer recognition of common mental health problems. Other measures, such as improved knowledge and behaviour among the general public, did not change (Smith, 2013).

Between 2006 and 2010, Time to Change measured encouraging reductions in discrimination in five areas of life, including finding a job and keeping a job (Corker *et al.*, 2013). However, these reductions in discrimination were not sustained in the 2011 sample.

Henderson *et al.* (2013) found that employers' attitudes toward potential employees with mental health problems improved during Time to Change. Whereas Biggs *et al.* (2010) had noted that employers were concerned that people with mental health conditions would need additional supervision, and would be less likely to use initiative or to deal confidently and appropriately with the public, Henderson *et al.* (2013) found employers had become less likely to perceive people with mental health problems as a risk with respect to their reliability, working directly with customers, or in terms of their colleagues' reactions to them.

Low expectations

When people with mental health conditions experience discrimination and therefore difficulty in finding and keeping work, it can reduce expectations that future employment experiences will be happier and more successful. Identification with the personal experiences of others may also spread a feeling of pessimism about the real possibility of work among jobseekers with mental health problems. Employers with no direct experience of employing someone with a mental health

condition themselves may also be influenced by the experiences of other employers, which, if negatively described, can dissuade them from giving a chance to anyone with a mental illness.

Low expectations can be reinforced by health professionals. Many people with mental health conditions report that their doctor, psychiatrist or nurse saw their illness as a genuine barrier to employment (Marwaha *et al.*, 2009). Bevan *et al.* (2013) found that clinicians tend to believe that people with schizophrenia who want to work would probably be capable of non-competitive work only (i.e. voluntary or sheltered work). Yet suggesting that people put their employment aspirations 'on the back burner' during months or even years of experiencing a range of therapies, drug treatments and social support (through day service attendance or participation in vocational training or sheltered work units) has been shown to result not only in lower levels of employment, which would be expected, but also in higher levels of psychiatric illness demonstrated by more frequent and longer hospital admissions over time (Bush *et al.*, 2009).

Even when mental health professionals do believe that the people they are supporting are capable of work, this does not necessarily translate into encouragement to find work or referrals to employment services. An investigation of the employment status of clients using a London community mental health service, found that while mental health staff rated 18.9% of their clients as capable of open market employment, the percentage actually in work was only 5.5% (Lloyd-Evans *et al.*, 2012). In the area under review, mental health service users did not have access to a supported employment service providing high-fidelity IPS although some other forms of employment support were available including voluntary sector employment services and Jobcentre Plus disability employment advisors.

Health and social care staff have regular opportunities to discuss employment with users of services; however, their encouragement of the individual's aspirations to work is not terribly useful if there are no high quality IPS supported employment services available to help achieve that goal.

Government policy

Welfare benefit caps and changes to benefit rules in recent times mean that anyone with a mental health condition who is unemployed and claiming benefits is highly likely to increase their income by entering paid employment, even where this is part time. Government policies over many years have disincentivised a life on benefits and vilified anyone considered to be capable of work for remaining unemployed. Patrick (2012) discusses the 'determined focus' of the three main political parties on work as the central duty of all 'good' citizens.

Universal credit (UC), being introduced in 2013, was designed to simplify the benefits system by replacing the six main out-of-work benefits and working tax credit. The earnings disregard changes to an annual amount, depending on personal circumstances, tapering the amount of UC received as earnings increase. Disability living allowance (DLA), a benefit payable to people with mobility and care needs, regardless of employment status or income, is being replaced by personal independence payment (PIP), with most existing claimants being reassessed in 2015. The first independent review of PIP will take place in 2014 and while disabled people worry about losing this benefit as a result of finding paid work, whether such fears are founded is as yet unknown.

Anyone found fit for work through the work capability assessment (WCA), or those put into the work related activity group (WRAG) of ESA and people who have claimed JSA for three months are usually mandated to the Work Programme. People with additional needs, including people in the support group of ESA, meanwhile, are able to engage voluntarily with the Work Programme or to use Work Choice, the specialist employment programme for disabled people.

The Work Programme gives providers wide scope to find their own creative and individualised support options for people with any disability or need which may place them at a disadvantage in the labour market. Employment support is funded through staged payments which the Work Programme provider draws down at engagement, job entry and successive points of job retention. A person previously claiming disability related benefits such as ESA attracts a higher rate of payment to the provider when they become employed, and maintain that employment, than a person who had been claiming JSA.

Unfortunately the figures to date for the Work Programme describe the lack of success that providers have had in helping people on disability benefits into work (House of Commons Committee of Public Accounts, 2013). Critics of the Work Programme say that people with additional support needs are not receiving the individualised support package they require and clients who are easier to help are being 'creamed' - helped more quickly and successfully into work, while those who need more intensive or specialist support are being 'parked' with very little expectation that they will ever find work (Newton *et al.*, 2012, Rees *et al.*, 2013).

In addition, few job outcomes for people with mental health problems have been reported by Work Choice, the DWP programme designed for people with additional needs. From October 2010 to March 2013 (33 months) Work Choice supported a total of 16,840 people into paid work representing 31.2% of those using the programme, but only 2,060 jobs starts were recorded for people with mild to moderate mental health conditions and just 130 for people with severe mental health problems (DWP, 2013b). This figure looks all the more paltry when compared with the 403 people with severe and enduring mental health problems supported into jobs by just one IPS service (Southdown, in Sussex) in the 20 months between April 2011 and November 2012 (Centre for Mental Health, 2012).

These DWP schemes are not succeeding in improving the current low levels of employment of people with mental health conditions nor are they addressing the inequality in employment rates between people with mental health problems and those with other disabilities, other health conditions, or no disability. A better targeted and evidence-based approach to supported employment is needed to meet the needs of this group of jobseekers.

Why aren't we doing what works?

The employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7.3% (HSCIC, 2013), and yet the research evidence on what works in supported employment for this group is particularly strong. Research shows that the most effective method of supported employment for people with severe and enduring mental health problems is IPS.

IPS was developed in the United States in the 1990s and has been replicated and successfully demonstrated in many other places including the UK, Norway, Denmark, Hong Kong, Canada, New Zealand and Australia. A six-centre randomised control trial (Burns *et al.*, 2007) found that IPS was around twice as effective as the best alternative vocational rehabilitation service at achieving paid work outcomes in all sites, and also noted that people entering work did so more quickly and sustained their employment for longer in the IPS services than the alternatives.

The spread of IPS services is still patchy. Today almost half of England's secondary mental health services still have no IPS workers or teams in place. Centre for Mental Health has recognised 13 sites as IPS Centres of Excellence, where fidelity to the evidence-based model, including excellent employer engagement strategies and effective partnership working between employment support workers and health professionals, are evident. But even in most of the high performing areas clinical teams do not all have an assigned IPS worker, and therefore there are still high numbers of people who are denied access to an IPS service. We know what is needed; we just need to see it implemented everywhere, so that having access to IPS services is not dependent on being lucky enough to live in the right area.

The evidence base for IPS is predicated on trials within secondary care settings. There are, however, promising examples of the success of using the IPS model with primary care mental health teams. There are IPS workers in some Improving Access to Psychological Therapy (IAPT) services, including Wolverhampton Healthy Minds and Wellbeing Service. A new study being undertaken by Centre for Mental Health and Enable (Shropshire) aims to demonstrate the value of using IPS with ex-offenders: a small team of IPS employment specialists will work alongside mental health professionals to support people with mental health needs being released from prisons in the West Midlands.

How to fund supported employment

In some locations, mainstream health and social care funding has established IPS services. However, provision is being cut back where budget reductions make this necessary, and in some areas supported employment is only funded by short-term grants to voluntary sector services. The local need for IPS services should be recognised by health and wellbeing boards and future funding for employment services should be considered within provision commissioned by both clinical commissioning groups and local authorities because employment for people with mental health problems is an expected outcome in the NHS, public health and adult social care outcomes frameworks (Department of Health, 2011; DH, 2012a; DH, 2012b).

The cost of an IPS employment specialist compares favourably with the level of payments made to Work Programme providers. The total cost of an IPS service, attributed per employment specialist, is about £50,000 per IPS worker (Sainsbury Centre for Mental Health, 2009). Evidence shows that each IPS worker would support at least 14 people into employment per year and maintain them in work (Centre for Mental Health, 2012), giving a cost per job outcome of £3,600. Payments to Work Programme providers for sustained work outcomes are set at

- £4,395 for jobseekers aged 25 or over who have been claiming JSA for a year;
- £6,600 for jobseekers with significant disadvantage;
- £13,720 for ESA claimants who had previously been claiming incapacity benefits and who volunteer for the Work Programme

Employment support for people with mental health problems is the responsibility of health, social care and DWP. It is a key element of health and social care intervention, and has been shown to save healthcare costs (Burns & Catty, 2008). It could also save DWP costs. Therefore an innovative local arrangement of pooling current budget al.locations from health, social care and DWP could fund enough IPS workers to meet the employment support needs of everyone with severe mental health problems, and would provide better outcomes at a lower cost than current funding arrangements.

Personal budgets

A possible option for funding IPS where there is currently no established service is through a personal budget.

Local authority social care services prioritise the care needs of people, including those with mental health problems, according to the criteria of the Fair Access to Care Services (FACS) framework. Someone who, without intervention, would not sustain their involvement in many aspects of work, education or learning is considered to have a substantial social care need in this area, and is likely to be eligible for support.

The Community Care (Direct Payments) Act 1996 gave local authorities the power to make direct cash payments to individuals instead of providing the community care services they have assessed those individuals as needing. People who receive the payments use the money for the purchase of support, services or equipment which will meet the assessed need.

Many local areas have trialled the use of personal health budgets which identify, through a similar process, the amount of funding available to be spent on an intervention for a healthcare need. A personal health budget is the provision of this funding to the individual to use in a way which suits their personal circumstances and aspirations better than the standard or 'mainstream' service on offer.

Personal budgets through health or social care (or possibly a pooled health and care budget) could enable an individual to buy the services of an IPS employment specialist with a proven track record in successful work outcomes for people with mental health problems.

However, this model may require additional funding to become viable. At present there are few areas where personal budgets for employment support are being used, or indeed could be used. This may be because either there are no local IPS services to purchase, or because the costs would have to be set at a relatively high level per person to cover the overheads of keeping the service sustainable i.e. running with a minimum number of staff, the amount of personal budget awarded not being sufficient to cover the cost of employment support (which may be needed for at least a year).

Greig & Eley (2013) have published early findings from their study of local authority and primary care trust spending on supported employment. They asked a specific question about personal budgets: whether people are allowed to spend their personal budgets on employment support and, if so, whether they do. 76% of respondents stated that people are allowed to use personal budgets for employment support; 12% responded that they were not and 11% did not respond. Only 28% of respondents actually knew that people were using their personal budgets for employment support; 17% knew that they were not and 35% did not know either way. The remainder did not respond. Additionally only 12% of respondents had any information about how much of people's personal budgets were being used for employment support; 44% did not have this information.

It may never be possible for IPS to be made available for everyone who needs it unless it is underpinned through at least some element of block funding provided by local joint commissioning. The added contribution of DWP funding would make the service available to larger numbers of people, but the national funding arrangement of DWP, in contrast to local authority and individual CCG local funding arrangements, will make pooled budgets from health, social care and DWP difficult to achieve without a new approach.

Where to go for additional support

In areas where there are still no IPS services attached to mental health trusts, and for people with mental health and employment needs who are not receiving secondary care, there are a number of other supports, some of which may not be generally well known and understood.

Disability employment advisers

Disabled people, including people with mental health problems, can contact the disability employment adviser (DEA) at their local jobcentre for information and advice on the specialist services available through the DWP. These include return to work programmes such as Work Choice, residential vocational training, and support in employment through Access to Work. A DEA can also make a referral to a specialist work psychologist, who will carry out an 'employment assessment' and recommend therapy or therapeutic activities. In some cases, grants also available for work-related expenses or training.

Access to Work

The Sayce report *Getting In, Staying In and Getting On* (2011) reviewed some of the specialist provision aiming to increase the employability of disabled people, by accessing employment which was available to them at the time. The report noted that Access to Work (AtW) was underused, widely unknown and yet had the potential to provide a tailored package of support which could enable people with disabilities, including those with mental health needs, to overcome their own barriers to work.

Similarly, Biggs *et al.* (2010) investigated employers' attitudes toward making reasonable adjustments to support employees with mental health needs. They commented that AtW could have been used more effectively for transport to and within work. They found that a significant number of employers stated that they would be prepared to allow flexible working hours, job sharing and temporary assignment of duties to other colleagues and to accommodate sick leave, but few were prepared to provide or pay for transport to get to work, to get to meetings or to visit clients.

In recognition of the different needs of people with a mental health condition, and the disproportionately low take-up of AtW by this group, the government tendered a contract to provide a specific mental health AtW service, for which Remploy was the successful bidder, and the new service became operational in 2012. The Remploy service is able to meet needs such as:

- advice and personal support to manage a mental health condition at work
- mediation with employers regarding reasonable adjustments and human resources processes
- information about ongoing sources of support
- signposting to other services.

The support generally takes the form of a number of face-to-face or telephone support meetings over a period of time, not exceeding 26 weeks.

Cognitive behavioural therapy

Almost all localities in England now have much shorter waiting lists for cognitive behavioural therapy (CBT) due to the IAPT programme. £3.7million funding was invested to set up demonstration sites in Doncaster and Newham in 2005, leading to a national roll-out across England in the years since.

Layard and colleagues (2007) calculated that timely access to up to 10 sessions of CBT for people with depression or anxiety would generate financial savings to the economy. This assertion was based on the evidence that CBT enables a significant number of people with mental health problems to recover sufficiently to return to work or to take fewer days of sickness absence because their health was improved.

They calculated that people completing CBT treatment were 4% more likely to be in work over the next two years, saving the Treasury around £1,200 in benefits payments and NHS costs, and from taxes and national insurance paid.

There is also growing evidence that combining psychological therapies with IPS can have considerable benefits. A randomised controlled trial in Nottingham has found that IPS plus tailored work-focused psycho-social support has delivered an overall employment rate of 57% for patients with a range of serious mental health conditions (*Mental Health Today,* 2013). Results are also awaited from ongoing trials of IPS plus motivational interviewing, which is a technique used in talking with clients to explore and resolve ambivalence towards being in employment, aiming to achieve an improvement in self-belief and motivation through the application of the client's own solutions.

Support for employers

Good communication, ongoing relationships and trust between employment services and employers are key factors in helping people back to work after unemployment. But it is equally important to ensure that people in employment, at risk of developing significant mental health problems, get the support they need before their sickness absence leads to job loss. Employers often need help in supporting their existing employees who develop mental health problems.

Health and Work Assessment and Advisory Service

In 2011, Dame Carol Black, expert adviser on health and work, and David Frost, former director general of the British Chamber of Commerce, were commissioned by the government to undertake an independent review aimed at reducing the cost of sickness absence. The recommendations of the report (Black & Frost, 2011) included:

- introducing tax relief on the costs of rehabilitation and treatment paid by employers to help their employees return to work
- retaining tax relief on employee assistance programmes
- the introduction of an independent assessment service to help employers support people back to work
- a job brokering service for employees on long-term sickness absence who are unable to return to their current employer.

In 2013, the government published its response (DWP, 2013a) which accepted most of the recommendations, although not the job brokering service. The government will set up a new Health and Work Assessment and Advisory Service, expected to begin in 2014. This will provide a nationally available occupational health advice service to help employers manage staff sickness absence lasting more than four weeks. It will also help GPs by providing independent advice on workplace adjustments to facilitate return to work as quickly as possible. The Government claims the service could save employers more than £80 million each year through reducing the costs of sickness absence.

Promoting wellbeing in the workplace

Mental health problems in the workplace can lead to high costs associated with prolonged absences, presenteeism (in work, but at reduced productivity levels through ill-health) and replacing/retraining staff. The cost of mental health problems to business is £25.9 billion across the UK economy, or £1,035 per employee per year (Sainsbury Centre for Mental Health, 2007).

A proactive organisation-wide approach to the management of mental health at work needs to include action at three levels: promoting a mentally healthy workplace, early identification of problems, and effective return to work. The middle level is neglected in both research and practice. Mental health problems need to be picked up at an early stage and managed well. A survey undertaken jointly by Great Place to Work and the Employers' Forum on Disability found 76% of the line managers asked had experience managing at least one person who they knew had a mental health condition but felt they lacked the confidence to act and approach an employee who may be showing signs of distress (Great Place to Work, 2009).

One solution is Centre for Mental Health's workplace training which gives line managers the skills and confidence to recognise and talk to their staff about the early signs of mental distress, and gives information on sources of further support. The training has been proven to have a long-term and significant impact on managers' knowledge, skills and confidence in dealing with all forms of mental health problems and distressing behaviour in the workplace (Lockett & Grove, 2010).

Conclusion

Each person's journey back to employment is unique, and for people with mental health problems flexible support to overcome their personal barriers should be available, not just from health and social care services but also from DWP Employment Services, and employers' human resource and occupational health services.

Centre for Mental Health is leading the call for health and wellbeing boards to:

- assess the level of supported employment needed for people in their area with mental health problems
- to support commissioners to develop pilot schemes in primary care to find out how best to achieve employment outcomes for people with common mental health conditions
- to establish evidence-based IPS supported employment services for everyone with a severe and enduring mental health problem who would like support to return to employment.

The current options are just not working and neither are enough people with mental health problems. We are letting down people who want to work when not enough evidence based services are available to help them overcome the barriers to employment.

Further information on the IPS model can be found in the Sainsbury Centre for Mental Health's *Briefing 37: Doing What Works*.

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Briefing 47: Barriers to employment

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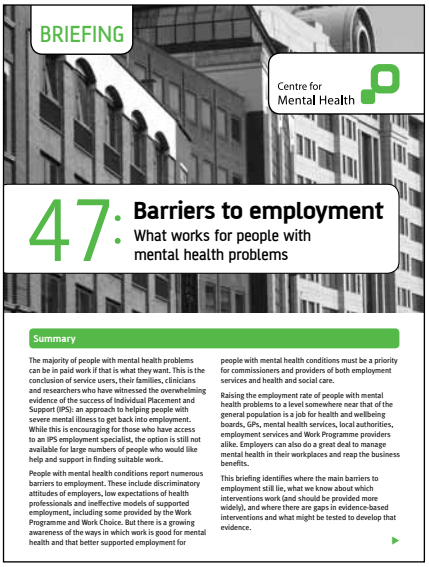
BRIEFING

Centre for Mental Health

47: Barriers to employment
What works for people with mental health problems

Summary

The majority of people with mental health problems can be in paid work if that is what they want. This is the conclusion of service users, their families, clinicians and researchers who have witnessed the overwhelming evidence of the success of Individual Placement and Support (IPS): an approach to helping people with severe mental illness to get back into employment. While this is encouraging for those who have access to an IPS employment specialist, the option is still not available for large numbers of people who would like help and support in finding suitable work.

People with mental health conditions report numerous barriers to employment. These include discriminatory attitudes of employers, low expectations of health professionals and ineffective models of supported employment, including some provided by the Work Programme and Work Choice. But there is a growing awareness of the ways in which work is good for mental health and that better supported employment for people with mental health conditions must be a priority for commissioners and providers of both employment services and health and social care.

Raising the employment rate of people with mental health problems to a level somewhere near that of the general population is a job for health and wellbeing boards, GPs, mental health services, local authorities, employment services and Work Programme providers alike. Employers can also do a great deal to manage mental health in their workplaces and reap the business benefits.

This briefing identifies where the main barriers to employment still lie, what we know about which interventions work (and should be provided more widely), and where there are gaps in evidence-based interventions and what might be tested to develop that evidence.

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