

Assessment and recommendations

Mental ill-health has become a major driver for labour market exclusion in the United Kingdom. Each year, mental ill-health costs the economy an estimated GBP 70 billion, equivalent to 4.5% of GDP, through lost productivity, social benefits and health care. Mental disorders have become the most common reason for a disability benefit claim, accounting for almost 38% of all new claims. But mental illness is also widespread among workers and the unemployed and those receiving other social benefits, in particular income support and housing benefit. At the same time, people with a mental illness face a considerable social disadvantage, reflected in a large employment gap and an unemployment rate which is double the overall rate for those with a moderate mental disorder and four times the overall rate for those with a severe mental disorder. Taken together these labour market disadvantages culminate in very high income poverty risks for people suffering from mental ill-health, higher than in other OECD countries.

The United Kingdom is more innovative in the area of “mental health and work” than most other OECD countries

The United Kingdom is quite advanced in the area of “mental health and work” in two ways. First, the level of awareness about the importance of employment for (mental) health and well-being and the detrimental impact of mental ill-health on employment outcomes has reached a high level. Stakeholders at all levels, including policy makers, public authorities and private service providers share this awareness and aim to address the issues arising from mental ill-health, more recently also with a focus on mild and moderate mental health problems. This increased awareness opens the door for reducing stigma and developing the right policies.

Secondly, needed integration of health and employment services is more developed than elsewhere. In particular, the health sector has also adopted the conclusion that employment is good for mental health and health in general and should, therefore, be part of any treatment plan. This is reflected in recent changes in the outcomes framework of the National Health

Service, which now includes as outcomes employment of people with chronic health conditions and of those with a mental illness, and in the employment service capacity that is currently being built in the health system through targeted funding.

These encouraging steps are the result of significant and consistent efforts made over nearly a decade. With its Health, Work and Well-being Strategy 2005, the government aimed to ensure that work is recognised by all as important and beneficial, and institutional barriers to remaining in and returning to work are removed. A broad evidence base was built through a multi-year research agenda, including reports demonstrating that work is good for health and identifying the various loopholes in the system.

Policy thinking is ahead of actual policies and practice

Policy rhetoric, policy thinking and policy documents are, however, more advanced than is the actual practice. There are still a number of problems that the United Kingdom will have to address. Importantly, sustainable funding for new and promising initiatives has yet to be secured. The United Kingdom has been very good in testing innovative schemes and approaches, but even successful pilots can disappear very quickly without being brought into existing policy structures. This is a significant risk again for recent initiatives, in view of the rather weak economic recovery and tight fiscal constraints, and the ongoing shift in some policy fields (especially health) towards local decision making.

A more general challenge for the United Kingdom will be to ensure that ongoing structural reforms are successful. All big sectors including the health system, the benefit system and employment services are under comprehensive reform. The impact of these reforms on people with mental ill-health is an open question, but the success of the reforms will hinge on their ability to deliver for this population.

Welfare reform shows mixed results in reducing benefit recipiency

Tackling high benefit dependency has been a major policy focus for the past two decades. The welfare system in the United Kingdom has gone through comprehensive reforms, including a series of disability reforms and a shift towards a more unified working-age payment (the Universal Credit). This will close the structural gap between disability and other benefits in terms of payment levels and participation requirements, with the potential to improve labour market participation and employment. However, the move to the new system is still ongoing and its actual impact on participation of people with mental health problems remains to be seen.

The aim of the disability reforms was to reduce the high disability benefit caseload by both lowering the number of new claims (through strengthened mutual requirements and stricter assessment and eligibility) and moving current claimants off benefit (through reassessment as well as means-testing and time-limiting of payments). The number of new claims has started to fall but, at 1% of the working-age population per year, remains the highest in the OECD, twice the OECD average. The disability benefit caseload has also shown a declining trend for nearly a decade, but continues to be high and above the OECD average, with almost 41% of the claimants affected by a mental disorder. At the same time, more people with (mental) health problems are now being moved onto unemployment benefits as a result of the reassessment process calling for a much stronger focus on health-related employment barriers as part of the activation agenda.

The right balance between responsibilities and sanctions is still to be found. The move towards stronger obligations also for disability benefit claimants is continuously evolving but more could be done; some claimants have to participate in employment services (the Work Programme) but without requirement to look for work; and for others interventions remain entirely voluntary. Sanctions for non-fulfilment of obligations, on the other hand, are overly severe. For example, sanctions at the level foreseen by the Universal Credit may not be justified until the provision of more effective employment services can be guaranteed.

Finally, despite improvements, the lack of early intervention especially in the sickness and disability schemes but also in the unemployment scheme continues to be an obstacle for a swift return to work. People with health-related employment barriers could still find themselves in the welfare system for a long while before their health and employment impediments are being addressed. This has a particularly negative impact on people with a mental illness for whom periods of inactivity can often be highly detrimental for recovery.

Reformed employment services failed to increase employment of many disadvantaged groups

Employment services for jobseekers have also been reformed fundamentally. The new Work Programme aims to reduce unemployment by a much stronger focus in service funding on sustainable employment outcomes. However, this change has so far not delivered for the harder-to-help clients. For instance, employment outcomes for Employment Support Allowance claimants still remain far below those for Jobseeker Seeker claimants. Outcome payments are still not large enough and provide significant incentives for “parking”, implying that weaker clients including

those with mental health conditions are frequently underserved. Moreover, the black-box approach which gives providers a free choice of service implies that very little is known about what and how much is being done, and for whom.

The Work Programme began in the context of weak economic growth making it difficult to achieve employment outcomes for more disadvantaged groups in the initial stages. However, even as the economy recovers, the reduction in beneficiary numbers in ESA claimants has yet to translate into higher employment. More attention has to be paid to new client groups being transferred to the Work Programme, including those who lost their disability benefit entitlement, many of whom will have been out of work for many years. Improving employment outcomes requires investments. Currently, spending on active labour market programmes is very low. Getting people off benefits without sufficient efforts to help them into employment could incur large societal costs in the long run.

Overall, the shift in the United Kingdom towards a more unified working-age payment and one Work Programme that serves virtually all jobseekers seems still incomplete. There is general agreement that Work Programme providers will have a more heterogeneous and difficult clientele in the future, with a high prevalence of (mental) health conditions. However, evidence so far suggests that they do little to identify these people and to provide tailored support to meet their health and employment related barriers. People on unemployment benefit in particular are unlikely to see their health problems addressed. Lack of attention to health interventions in parallel with employment interventions will be detrimental to return to work.

Acting earlier when people still have a job

The UK system lacks sufficient focus on job retention to prevent more people from needlessly moving onto benefits. At present, support for return to work will typically only come after 9-12 months on sick leave. A series of reforms are underway to intervene earlier, following the successful experimentation with Fit-for-Work Services and an Occupational Health Advice line which has generated considerable evidence on how people can best be helped to stay in their jobs or return to it very quickly. A Health and Work Service aiming at those passing four weeks of sickness absence will be put in place to facilitate their return to work in 2014. Among other things, this will include a holistic initial assessment and ongoing case management.

These changes are far-reaching and go in the right direction but given the size of the problem and the number of actors involved (employers, general practitioners and occupational health specialists), implementation remains a big challenge. Sustainable funding for the new service will have

to be assured as well as a strong mental health focus and sufficient mental health knowledge among caseworkers.

One shortcoming of recent policy changes is that they largely target those on sickness absence, while extensive research shows that productivity loss while at work is perhaps an even bigger issue among those with mental health problems. Employers should also be encouraged to play a greater role in the prevention of work-related diseases and the rehabilitation of workers who are less productive while at work due to work-related stress or mental ill-health. There are good tools available for employers relating to awareness of stress and actions to try to prevent and reduce them, but only few employers appear to be using them.

Employer obligations and incentives are critical to tackle sickness absence and job loss and assure full productivity while at work. While the government is leaping forward with new policies, employers are conspicuously absent from the policy process. The responsibilities of employers towards their employees are somewhat limited and generally it is assumed that bigger employers will, in their own interest, take care themselves of health and work issues and the detrimental impact ill-health has on productivity – assuming the business case is strong enough. In practice, however, a few bigger companies seem to be doing more than it is common in other OECD countries, but these are still exceptions.

Integrating employment into health services

The integration of health and employment services has seen a major advance in the United Kingdom when the Improving Access to Psychological Therapies (IAPT) initiative, initially aimed to provide access to evidence-based psychological therapies, was complemented with matching employment services. However, the scale of the service still seems to fall short with respect to the large burden of mental health problems in the country. Access to psychological therapies through IAPT services has improved but remains problematic as there are still some significant regional variations. More generally, there are concerns around the continuity and quality of IAPT in the new devolved policy context in which priorities are set at a local level. Similarly, there are questions whether the new employment service knowledge and capacity currently built into the health system will be sustained and grow in the long run, in line with rising demand. Further innovation is taking place with the hope that outcome-based contracts in IAPT will facilitate greater efficiency and choice in mental health services.

General practitioners (GPs) are key players in the mental health and work field in all OECD countries but even more so in the United Kingdom,

as the ongoing reform of the health sector in England will hand over most health service capacity decisions to local Clinical Commissioning Groups, (led by GPs), in consultation with Health and Well-being Boards. This will add to the other key roles of GPs as first contacts to detect mental health problems and refer patients to specialist services when necessary, and as gate-keepers to the sickness and disability schemes and employment support. The challenge will be to support and empower the current and future primary care workforce in line with its overarching responsibility.

In the United Kingdom, strengthening the link between mental health and work and providing integrated services is to a significant degree initiated by the health sector. However, with comprehensive welfare reform and the introduction of the Work Programme, the need for integrated services will become equally evident in the employment policy field. Both sides will need to become more alert to its counterpart: health services will need more of an employment focus since many players in the health sector are now accountable for employment-oriented outcomes, and employment services more of a health focus given the very high prevalence of (mental) ill health in their client population. A big challenge for the United Kingdom, however, will be to turn the many promising initiatives and pilot schemes into a more systematic structure to ensure that take-up of the new integrated services reach the desired level.