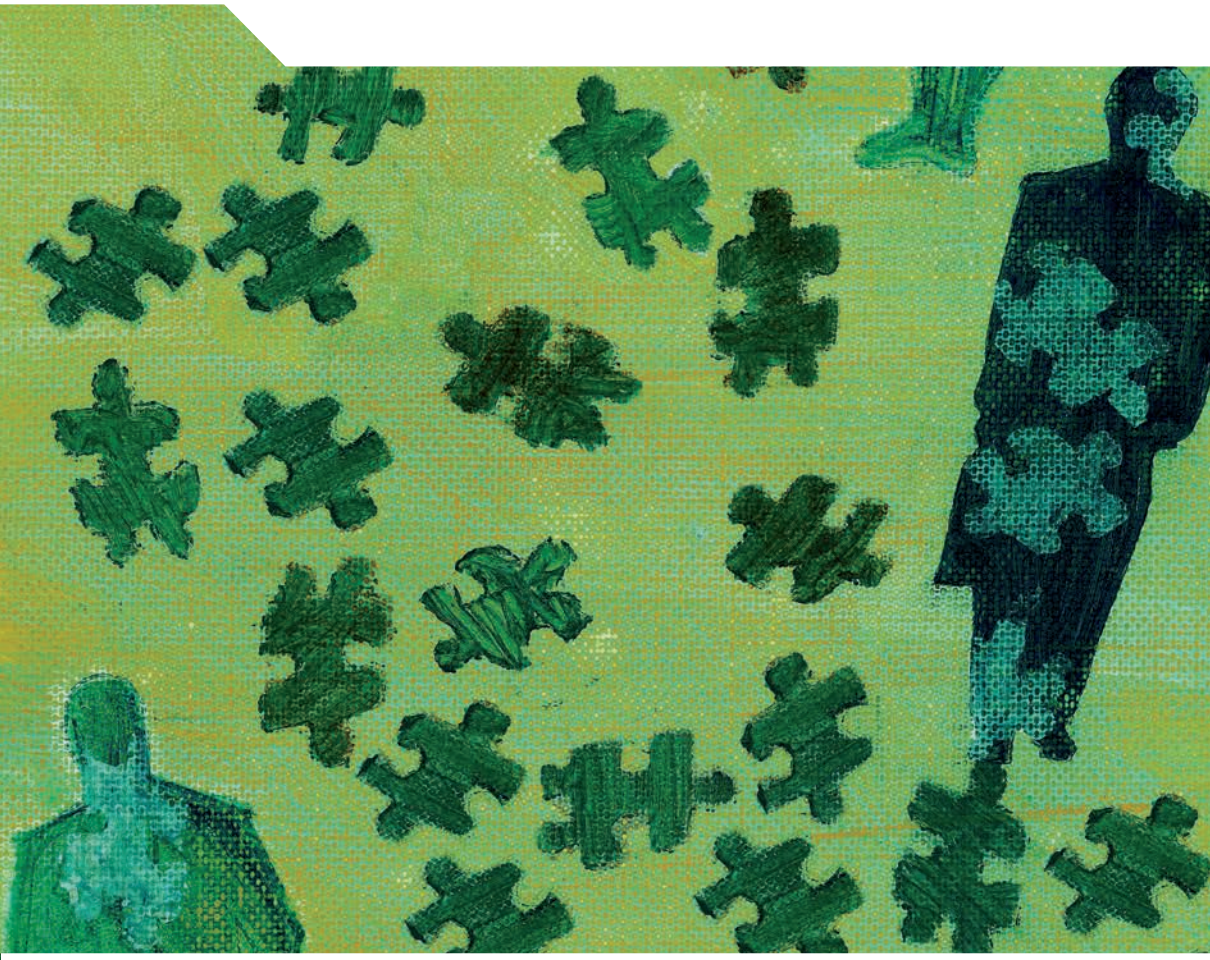
Mental Health and Work

UNITED KINGDOM



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Mental Health and Work: United Kingdom

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BETTER POLICIES FOR BETTER LIVES

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Foreword

Tackling mental ill-health of the working-age population has become a key issue for labour market and social policies in many OECD countries. It is an issue that has been neglected for too long despite creating very high and increasing costs to people and society at large. OECD governments increasingly recognise that policy has a major role to play in improving the employment opportunities for people with mental ill-health, including very young people; helping those employed but struggling in their jobs; and avoiding long-term sickness and disability caused by a mental disorder.

A first OECD report on this subject, *Sick on the Job? Myths and Realities about Mental Health and Work*, published in January 2012, identified the main underlying policy challenges facing OECD countries by broadening the evidence base and questioning some myths around the links between mental ill-health and work. This report on the United Kingdom is one in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the role of the workplace, the institutions providing employment services for jobseekers, the transition into permanent disability and the capacity of the health system. Other reports look at the situation in Australia, Austria, Belgium, Denmark, the Netherlands, Norway, Sweden, and Switzerland. Together, these nine reports aim to deepen the evidence on good mental health and work policy. Each report also contains a series of detailed country-specific policy recommendations.

Work on this review was a collaborative effort carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs. The report was prepared by Shruti Singh under the supervision of Christopher Prinz. Statistical work was provided by Dana Blumin and Maxime Ladaique. Valuable comments were provided by Mark Keese and Stefano Scarpetta. The report also includes comments from various UK experts, ministries and authorities, including the Department for Work and Pensions and the Department of Health.

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Acronyms and abbreviations

ALMP	Active Labour Market Programme
BIS	Department for Business, Innovation and Skills
CBT	Cognitive Behavioural Therapy
CCGOIS	Clinical Commissioning Group Outcome Indicator Set
CIPD	Chartered Institute of Personnel Development
CMP	Condition Management Programme
DH	Department of Health
DWP	Department for Work and Pensions
EA	Employment Adviser
ESA	Employment and Support Allowance
FFWS	Fit For Work Service
GBP	British Pound
GDP	Gross Domestic Product
GP	General Practitioners
HSE	Health and Safety Executive
HWS	Health and Work Service
IAPT	Improving Access to Psychological Therapies
IB	Incapacity Benefit
ICD	International Classification of Disease
IPS	Individual Placement and Support
IS	Income Support
JCP	Jobcentre Plus
JSA	Jobseeker's Allowance

LCW	Limited Capacity for Work
LCWRA	Limited Capability for Work-related Activity
MD	Mental Disorder
MDO	Mentally Disordered Offender
MHC	Mental Health Champions
MPL	Minimum Performance Level
NGO	Non-governmental Organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHS	Occupation Health Service
OSP	Occupational Sick Pay
PA	Personal Adviser
PbR	Payment by Results
PICU	Psychiatric Intensive Care Unit
QCF	Qualification and Credits Framework
RCGP	Royal College of General Practitioners
SG	Support Group
SME	Small and Medium-sized Enterprise
SSP	Statutory Sick Pay
UC	Universal Credit
WCA	Work Capability Assessment
WFHRA	Work Focused Health Related Assessment
WFI	Work Focused Interviews
WP	Work Programme
WRAG	Work Related Activity Group

Executive summary

Throughout the OECD, mental ill-health is increasingly recognised as a major problem for social and labour market policy; a problem creating significant costs for people, employers and the economy at large by lowering employment and generating substantial productivity losses. In an international comparison, the United Kingdom is among the most advanced countries in terms of awareness about the costs of mental illness for society as a whole, as well as the benefits employment brings for a person's mental health. Integration of employment and health services is also being developed gradually – the most controversial policy challenge in this field facing OECD countries. Recent reforms of the disability benefit system including tighter benefit eligibility and large-scale reassessments are moves in the right direction but more can be done; i) in terms of earlier identification of work barriers and early intervention; ii) in meeting the needs of claimants moving from disability to unemployment benefits as a result of the reassessment process; and iii) in the attempts to raise the take-up of employment supports to increase participation of disability claimants in the labour market. Addressing these challenges will be difficult given the tight fiscal constraints facing the United Kingdom, but poorly designed spending cuts can worsen the medium and long-term fiscal and social costs. Further improvements are needed to ensure that on-going reforms live up to their promise. Currently, incentives for improving outcomes are still weak for several important players, including employers, employment service providers and the health sector.

The OECD recommends that policy makers in the United Kingdom:

- Assure that reforms underway to improve intervention in the early phase of a sickness spell, in order to avoid the transition from sickness into disability benefit (Employment and Support Allowance), are implemented effectively.
- Increase the attention to mental health and its impact on employability and work capacity in all parts of the welfare system, including Employment Support Allowance, Jobseeker's Allowance and the new Universal Credit.

- Further refine the outcome payments for employment service providers to promote better employment outcomes for the most disadvantaged customers.
- Invest in active labour market programmes more generally to be able to provide adequate support for clients with mental health problems.
- Build on recently improved integration of health and employment services to make sure that successful pilot approaches are widely available.
- Further expand access to psychological therapies for those with a common mental disorder and boost mental-health knowledge of general practitioners who play a key role in the UK health and benefit system.

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.

Summary of the main OECD recommendations for the United Kingdom

Key policy challenges	Policy recommendations
1. Making the most of welfare reform with more attention to the challenges of people with a mental health condition	Increase attention to mental health problems in all benefit schemes, including Employment Support Allowance, Jobseeker's Allowance and Universal Credit. Strengthen early intervention in the welfare system, by giving Jobcentre Plus a more active role and by using (pre)screening tools e.g. during the work-focused interviews for ESA clients. Find a better balance between responsibilities (which are still weak for some ESA client groups) and sanctions (which are very severe) in view of the already high poverty risk.
2. Improving the effectiveness of the employment services for disadvantaged customers	Further refine the pricing model of the Work Programme based on a robust profiling tool, to assure better employment outcomes for more disadvantaged clients. Increase resources in the Work Programme in general to achieve lower caseloads and provide targeted resources. Improve work-related information generated by the Work Capability Assessment to offer right employment and health support early on e.g. by reintroducing a strengthened multidisciplinary Work Focused Health Related Assessment. Integrate employment and health measures by: i) including health specialists in provider's employment service delivery teams; and ii) jointly commissioning psychological therapies. Begin pilots using elements of the Individual Placement and Support model for ESA clients and those with mild and moderate disorders.
3. Tackling productivity losses at work due to mental ill-health	Make better use of available management tools and guidelines and strengthen capacity of Occupational Health Services to deal with mental health, not just physical health. Improve the take-up of individuals with mental health problems in the *Access to Work* scheme to address workplace stress and mental health problems. Extend the new Health and Work Service to those struggling at work and not yet taking sick leave including access to an early assessment and case-management services.

Summary of the main OECD recommendations for the United Kingdom *(cont.)*

Key policy challenges	Policy recommendations
4. Making sickness absence management a top priority for all stakeholders	Rigorously implement the new *Health and Work Service* and assure: • Sustainable funding of the new service; • Strong mental health focus and provision of integrated health and work services; • Good co-operation between main actors. Tighter obligations and sanctions for non-compliance for employers should be considered if they fail to co-operate with and implement measures recommended by the Health and Work Service. Facilitate information-sharing between the Health and Work Service and Job Centre Plus to help those who at end up on ESA and JSA later on in the sickness period.
5. Empowering general practitioners and closing the mental health treatment gap	Improve knowledge of current and future primary care doctors (through extension of GP curriculum) about mental illness as well as workplace matters. Issue sick-listing guidelines and train doctors in sick-listing and fit-for-work matters. Assure quick referral to adequate treatment and further expand the availability of quickly accessible psychological therapies.
6. Sustaining recent pilots by integrating key success features into the health care system and the ongoing reform	Sustain and expand funding for employment advisers in the health sector as successfully tested in recent pilot programmes. Include employment targets in the Outcomes Framework of the Clinical Commissioning Groups. Expand a promising "mental health and work" service available for doctors in London to other regions and other key professions.

Chapter 1

Mental health and work challenges in the United Kingdom

This chapter discusses the current labour market performance of people with a mental disorder in the United Kingdom in terms of their employment, unemployment and income situation. Building on the findings in the OECD report Sick on the Job?, *it highlights the key challenges ahead, such as the high share of people on different social benefits who suffer from a mental health condition. The chapter also provides a short description and assessment of the two main systems catering for people with mental illness: social security and health care.*

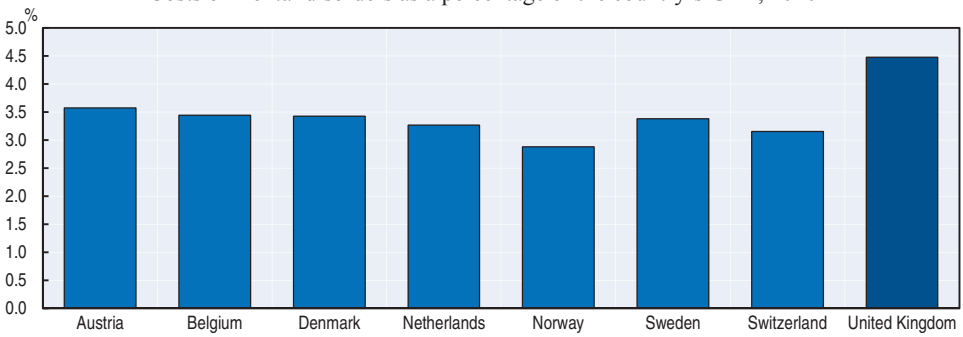
The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Introduction

Mental ill-health poses considerable challenges for the smooth functioning of labour market and social policies in the United Kingdom as much as in other OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos. The total estimated costs of mental ill-health for the British economy are large at 4.5% of GDP, which puts the United Kingdom at the top of the cost-range in the group of eight OECD countries shown in Figure 1.1.[1] Indirect costs in the form of lost employment and reduced performance and productivity are much higher than the direct healthcare costs: based on comprehensive cost estimates in Gustavsson et al. (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11% respectively, of the total costs of mental disorders for the economy. The high cost of mental illness is a direct consequence of its high prevalence in the population.

Figure 1.1. **Economic costs of mental disorders in the United Kingdom are enormous**

Costs of mental disorders as a percentage of the country's GDP, 2010



Note: Cost estimates in this study were prepared on a disease-by-disease basis, covering all major mental disorders. A number of cost items are not accounted for due to lack of data or lack of consistent valuation methods. Examples are indirect costs resulting from premature mortality, reduced well-being and crime.

Source: OECD compilation based on Gustavsson, A., M. Svensson, F. Jacobi et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, Vol. 21, pp. 718-779 for cost estimates and Eurostat for GDP.

StatLink http://dx.doi.org /10.1787/888932978550

Notwithstanding the evident major costs of poor mental health in many OECD countries, policies and institutions are not addressing mental ill-health sufficiently. As discussed, in the OECD report *Sick on the Job? Myths and Realities about Mental Health and Work,* understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are: an early age at onset; its severity; its persistence and

chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability associated with the mental disorder and the potential impact on the person's work capacity.[2]

The OECD report put forward two key directions for reform. First, policies should move towards preventing problems, identifying needs and intervening at various stages of the lifecycle; including at school, during the school-to-work transition, at the workplace, and when people lose their job or move into the benefit system. Second steps should be taken towards integrating health, employment and, where necessary, other social services. Several core priority areas were identified which needed urgent policy attention. These include:

- *Schools* to protect and promote the mental health of children and young people and of transition services to help vulnerable youth access the labour market successfully.
- *Workplaces* to protect and promote mental health in order to prevent illness and reduced productivity arising in the workplace and labour market exit of those still employed.
- *Employment services* for beneficiaries of long-term unemployment, sickness and disability benefits who are outside of the labour force.
- *Mental health services* which need to be designed and delivered in a way that assists people of working age in their return to work.

In the context of the on-going major reforms in the welfare, sickness and health system in the United Kingdom, this report focuses on three priority areas including workplaces, employment services and mental health services. Nevertheless, a long-term strategy to tackle mental ill-health should begin with intervening in the early stages of the life-cycle, for instance in schools given the early onset of mental disorders. The purpose of this report is to examine how policies and institutions in the United Kingdom are addressing issues of mental ill-health and employment:

- How are the critical institutions – workplaces, employment services and psychiatric services – organised and resourced to identify people with a mental disorder?
- What types of actions are taken, and how quickly, once a problem is identified?
- What general prevention policies are in place and what general support is available for those with unidentified mental ill-health?
- How are the different actors co-operating to ensure people get the right services quickly to access, keep or return to employment?

The structure of the report is as follows. In the rest of this chapter, the definition of a mental disorder and its measurement are presented followed by an examination of the key labour market outcomes for people with a mental disorder in the United Kingdom and a description of the main systems catering for people with mental illness in regard to social, employment and mental health policies. The remaining chapters of the report analyse the "mental health and work" policy challenges that the United Kingdom is facing by examining: first, the key moments when a person with mental ill health is at risk of falling out of the labour market and entering the benefit system and the subsequent pathways to return to work (Chapter 2); second, workplaces and interventions happening under the responsibility of the employer (Chapter 3); and third, the role and contribution of the mental health system (Chapter 4).

Definition and measurement of mental disorders

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems such as the International Classification of Disease (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Based on this definition, at any moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, with lifetime prevalence reaching 40-50% (Box 1.1).

Box 1.1. **The measurement of mental disorders**

Administrative data (e.g. clinical data and data on disability benefit recipients) generally include a classification code on the diagnosis of a patient or recipient, based on ICD-10 and hence the existence of a mental disorder can be identified. This is also the case in the United Kingdom. However, administrative data do not include detailed information on an individual's social and economic status and they cover only a fraction of all people with a mental disorder.

On the contrary, survey data can provide a rich source of information on socio-economic variables, but in most cases only include *subjective* information on the mental health status of the surveyed population. Nevertheless, the existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on aspects such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and the like.

For the purposes of the OECD review on *Mental Health and Work*, drawing on consistent findings from epidemiological research across OECD countries, the 20% of the population with the highest values according to the instrument used in each country is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

Box 1.1. **The measurement of mental disorders** *(cont.)*

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See www.oecd.org/els/disability and OECD (2012) for a more detailed description and justification of this approach and possible implications. Importantly, the aim here is to measure and compare the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such. For this report on the United Kingdom, two main population surveys are used:

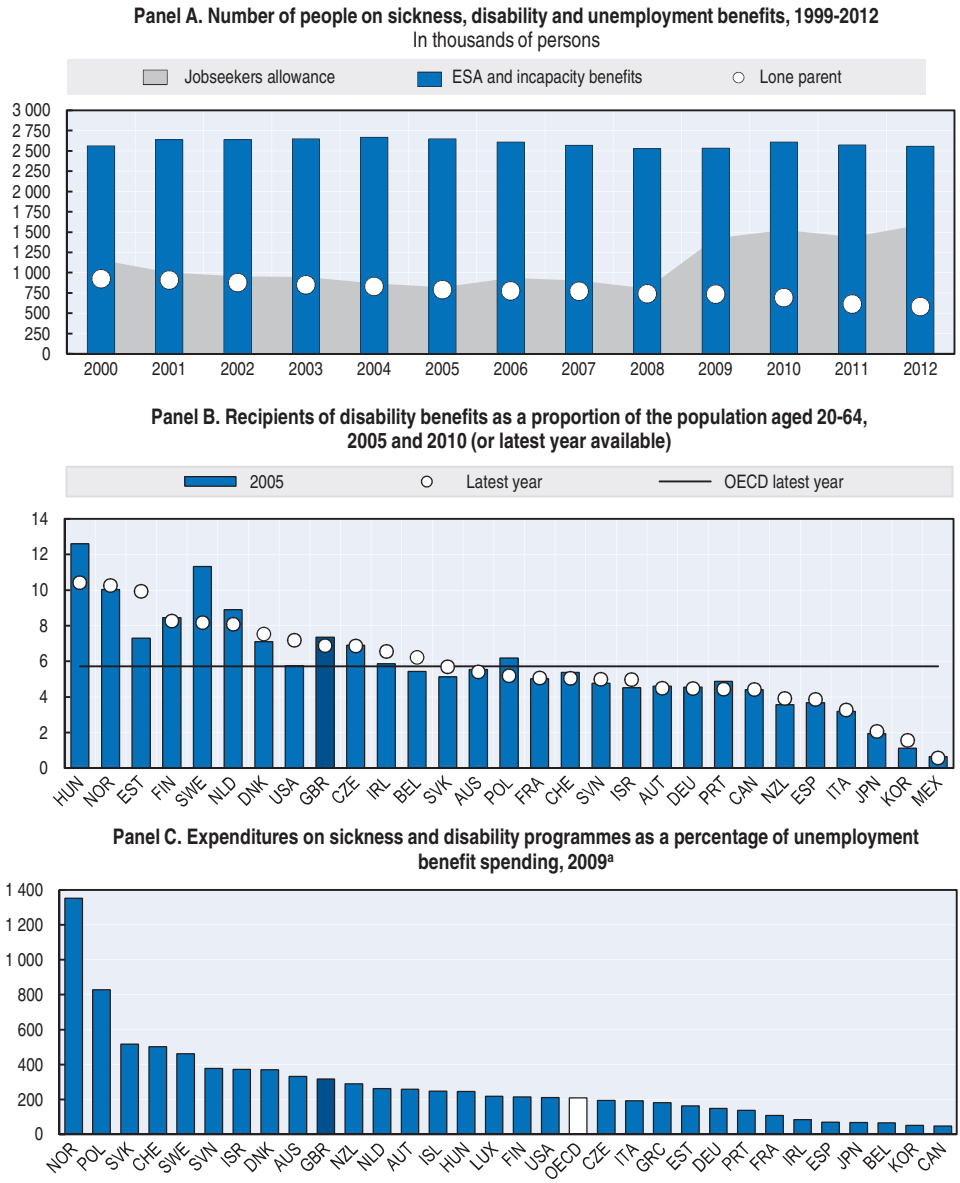
- The *Adult Psychiatric Morbidity Survey 2007*: the mental disorder variable is based on the CIS-R mental health assessment tool which focuses mainly on the week prior to interview. The scale uses 14 types of neurotic symptoms, a continuous scale that reflects the overall severity of neurotic psychopathology, and six types of common mental disorders. Symptoms include: depression, depressive ideas, worry, anxiety, phobias, panic, compulsions and obsessions.
- *Eurobarometer* for 2005 and 2010: the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired.

Labour market outcomes: where the United Kingdom stands

Too many people are out of the workforce due to sickness and disability

Despite the recent rise in unemployment, tackling the high level of inactivity among the working-age population has remained high on the political agenda for some time. In particular, a long-standing problem for the United Kingdom labour market has been the large numbers of the working-age population out of work due to sickness and disability. At the end of 2012, more than 2.5 million people (6.8% of the working-age population) were out of work and receiving a disability benefit, compared with 1.5 million (4.0%) on unemployment benefit (Figure 1.2, Panel A). The UK has the ninth highest rate of disability benefit claimants across 28 OECD countries for which data is available and stands above the OECD average of 5.7% (Panel B). Accordingly, spending on disability benefits has become a significant burden on public finances. In 2009, the United Kingdom spent GBP 13.8 million, equivalent to 1% of GDP on sickness and disability programmes and three times the budget spent on unemployment programmes (Panel C). Changes in the relative generosity of disability benefit compared with unemployment benefits; successive tightening of the job-search requirements for receipt of unemployment benefits and fall in labour demand in large parts of the country during the first half of the 1980s and again in the early 1990s have been important factors in the past in driving growth in the disability benefit caseload (OECD, 2010; Disney and Webb, 1991; Beatty and Fothergill, 2013).

Figure 1.2. **Most people are out of work due to sickness and disability**



a. Data for Switzerland refer to 2008 instead of 2009.

Source: Department for Work and Pensions quarterly statistical summary 14th August 2013 for Panel A; OECD questionnaire on mental health for Panel B; and *OECD Social Expenditure Database* (www.oecd.org/els/social/expenditure) for Panel C.

StatLink *http://dx.doi.org/10.1787/888932978569*

Mental ill-health is one of the leading causes of economic inactivity

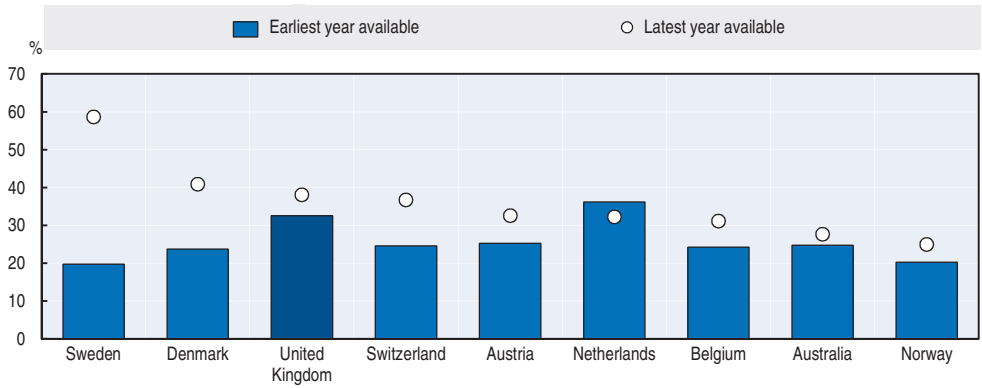
As in other OECD countries, mental ill-health accounts for a large and growing proportion of disability benefit claims in the United Kingdom (Figure 1.3). Almost four in ten of new disability benefit claims in 2010 were made on the grounds of mental ill-health, up from three in ten in 2000. But mental ill-health also presents a challenge for other working-age benefits: a large number of people with mental health problems rely on social assistance benefits i.e. income support and lone-parent benefit (Figure 1.4). For instance, receipt of income support and housing benefit is two to three times higher for people with a common mental disorder compared with those without and even five to six times higher for people with a severe disorder. The dependency of persons with mental disorders on a range of social benefits can be attributed to their poor labour-market integration.

The employment rate of people with a mental disorder in the United Kingdom varies considerably with the severity of the mental illness. In 2007, only about 40% of the population aged 15-64 with a severe mental disorder was employed; the second lowest employment rate among OECD countries for which data are available and around 33 percentage points below the employment rate of those without mental health problems (Figure 1.5, Panel A). With an employment rate of 64%, people with common mental disorders perform better in the labour market, but still fare relatively poor in comparison with their counterparts with no mental disorders, with an employment rate of 76%. While data by mental health status were not available for the years after the recent downturn, empirical evidence suggests that employment rates of persons with severe mental disorders are less responsive to the changes in the labour market than those with common mental disorders (OECD, 2012).

At around 19% in 2007 (i.e. before the jobs crisis), unemployment rates of people with a severe mental disorder are five times as high as for people without a mental disorder (Figure 1.5, Panel B). The unemployment rate of those with a common mental disorder is 7%, representing a gap of only three percentage points, but among comparator countries, this is the third highest unemployment rate. These higher unemployment rates may suggest that people with mental illnesses experience greater difficulty in finding jobs even when wishing to work.

Figure 1.3. **The share of disability benefit claims due to mental disorders has risen significantly**

New disability benefit claims due to mental disorders[a] (in % of total claims)



Note: Data refer to: 1995 and 2010 for Belgium, Norway and Sweden; 1995 and 2011 for Switzerland; 1999 and 2011 for Denmark; 2000 and 2012 for the United Kingdom; 2002 and 2009 for the Netherlands; 2004 and 2010 for Australia; 2005 and 2009 for Austria.

a. Data for Norway do not include the temporary disability benefit. Data for Belgium and Sweden include mental retardation, organic and unspecified disorders which on average account for 13.4% of the share of new claims for mental disorders. The Netherlands includes organic and unspecified disorders.

Source: OECD questionnaire on disability and OECD questionnaire on mental health.

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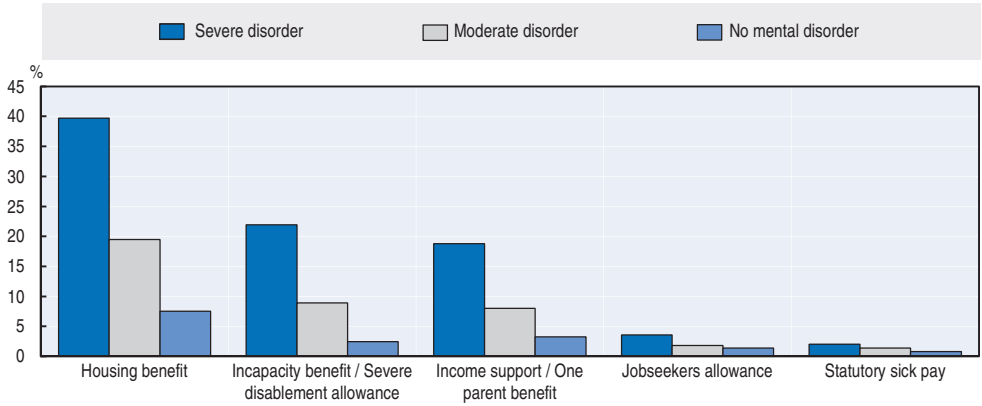
Figure 1.4. **People with a mental disorder in the United Kingdom are far more likely to receive a benefit than those without**

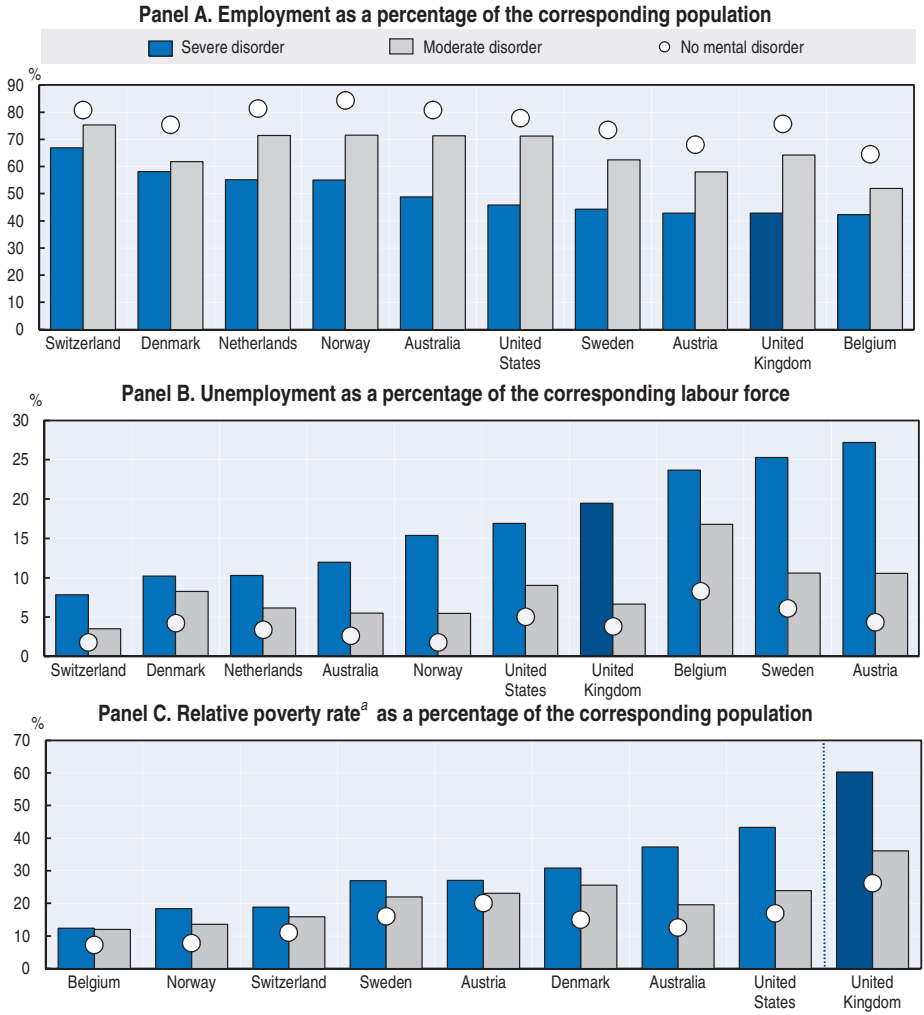
Proportion who receive a particular benefit, by type of benefit and by mental health status



Source: OECD calculations based on data from the Adult Psychiatric Morbidity Survey 2007.

StatLink http://dx.doi.org/10.1787/888932978607

Figure 1.5. **Labour market outcomes are relatively poor in the United Kingdom**



Note: The UK poverty risk is an over-estimate because the underlying data provide gross rather than net incomes (while net incomes are used for all other countries). However, net-income-based data from the Health Survey for England for 2006 confirm the high poverty risk, comparable to the level found in Australia and the United States.

a. The percentage of people living in households with equivalised incomes below the low-income threshold (defined as 60% of median equivalised household income).

Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey; United States: National Health Interview Survey 2008.

StatLink http://dx.doi.org/10.1787/888932978626

Reflecting their weak labour market integration, people with mental ill-health are at a higher risk of (relative) income poverty than their counterparts. The poverty risk for people with a mental disorder reaches 30-45% in several OECD countries (Figure 1.5, Panel C). People with severe mental disorders have the highest risk of living in poverty in the United Kingdom, with poverty rates of up to 60%, the highest compared with other OECD countries for which data are available (partly explained by the use of gross rather than net income in the UK data set). The poverty risk of people with a common mental disorder is also high. The high poverty risks among those with mental disorders in the United Kingdom should be taken into account in the context of the recent tightening in the eligibility for disability benefits in striking the balance between employment integration and the provision of adequate income security to prevent persons with mental health problems from falling into extreme poverty.

The context: systems and institutions

Key components of the benefit system in the United Kingdom

Over the past two decades, the role of the UK welfare state has changed radically. Successive governments have tried to reduce welfare dependency by cutting both the level of and access to welfare payments. The basic components of the social security system, however, remain intact and comprise old-age pensions, parental benefits, sickness and incapacity benefits and unemployment benefits. In what follows, sickness, disability and unemployment transfers are the most relevant and described in more detail.

Unemployment benefit

Jobseeker's Allowance (JSA) is a taxable benefit paid to unemployed people who are available and actively looking for work. There are two main types of JSA: contribution-based JSA paid to individuals who satisfy the national insurance contribution conditions and income-based JSA paid to claimants who satisfy a family income-based means test.

JSA contribution-based is payable for up to 182 days, (after a three day waiting period) in any one job-seeking period, which may be more than one award of JSA that is linked by a break in the claim of less than 12 weeks. After a break of 12 weeks or more in the unemployment spell, the unused entitlement to contribution-based JSA is lost, and cannot be claimed in a new job-seeking period. Once the period of contribution-based JSA has exhausted a jobseeker may continue with their claim to JSA as long as they

continue to meet the conditions of entitlement. If their income and capital is low enough, they may be eligible for income-based JSA.

Statutory Sick Pay

Employees who are absent from work through sickness have a right to be paid Statutory Sick Pay (SSP) by their employer following three "waiting days". SSP is paid at a flat rate, currently GBP 86.70 a week, for a maximum of 28 weeks. It is taxable and subject to national insurance contributions. SSP is administered and paid by employers through the payroll; but it is a statutory entitlement separate from any sick pay entitlement an employee may have under his labour contract. Employees can self-certify spells of sickness lasting four to seven days but will need medical evidence such as a doctor's certificate thereafter.

Disability benefits

Disability benefits in this report refer to Employment Support Allowance (ESA) which from October 2008 replaced a range of incapacity benefits: Incapacity Benefit (IB), Severe Disablement Allowance and Income Support for new claimants. The benefit is payable to individuals who cannot work due to sickness or disability. Claimants who were in receipt of IB at the time of this change kept their entitlement; however, the entire caseload will be reassessed.

Like JSA, there are two forms of ESA: a contribution-based form and an income-based form. ESA is divided into two phases, an assessment phase and a main phase. During the assessment phase which lasts for 13 weeks, the claimant is subjected to a Work Capability Assessment (WCA). The WCA in turn is made up of two components. The first component is the "limited capability for work test" which determines whether the claimant can be awarded ESA or should apply for other working-age benefits instead. The second component of the WCA distinguishes between those with Limited Capability for Work (LCW), and those who have Limited Capability for Work-Related Activity (LCWRA). Subsequently, individuals deemed to have LCW are placed into the Work Related Activity Group (WRAG), while those with LCWRA are placed into the Support Group (SG).

All claimants in ESA-WRAG and ESA-SG are given a prognosis of when a change in health status is expected. Both WRAG and SG claims run until the "prognosis period" ends, which is usually, but not always, a standard length of time such as 3, 6, 12, 18 or 24 months based on the individual claimant's health, followed by a reassessment. Individuals are

reassessed each time the prognosis period expires to ensure they are still eligible for ESA and allocated to the correct group.

In the assessment phase, claimants receive a lower rate of payment (equivalent to JSA) while their capability of work is assessed: GBP 56.80 if under 25 and GBP 71.70 if 25 or over. In the main phase, the amount payable for contributory ESA includes a basic allowance GBP 71.70 (Table 1.1). Claimants who are placed into WRAG are expected to take part in some work-related activity and receive a payment (a work-related component) on top of the basic rate of ESA. Those who are deemed unable to work and thus placed in SG receive the "support component" as an additional payment after the assessment phase.

Since April 2012, contribution-based ESA is time-limited to one year for those in WRAG. This time limit does not affect claimants in SG or any claimant who receives income-related ESA. Overall, this new scheme incorporates a stricter eligibility health test along with a redesign of the benefit rates and stronger means-testing

Table 1.1. **Current rates and premiums of Employment and Support Allowance**

Payment in GBP per week

	Rates		Premiums
	Assessment phase	Main phase	Components of ESA
Single person			
Under 25	56.80	71.70	..
25 or over	71.70	71.70	..
Lone parent			
Under 18	56.80	71.70	..
18 or over	71.70	71.70	..
Couple (income-based ESA only)			
One or both under 18	Varies[a]	Varies[a]	..
Both 18 or over	112.55	112.55	..
Work-related activity component	..	..	28.45
Support component	..	..	34.80

a. A higher rate may be paid if either member of a couple is responsible for a child or were they not a couple, each member would be entitled to Employment and Support Allowance, Income Support or Jobseeker's Allowance in their own right.

Source: DWP (2013), *Benefit and Pension Rates*, April 2013, Department for Work and Pensions, www.dwp.gov.uk/docs/dwp035.pdf.

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Universal Credit

Until recently, Income Support (IS) in the United Kingdom provided financial help to those whose net income fell below a set minimum level. This means-tested benefit was available to some persons who were not working or working less than 16 hours per week. Target groups included lone parents, carers and disabled people. However, all means-tested benefits including IS, income-based JSA and income-related ESA are planned to be replaced by a new benefit known as Universal Credit (UC) for new claimants over a four-year period to 2017.[3] This means that all ESA claimants who claim means-tested benefits will apply for UC in the future, while contributory ESA will continue as an independent benefit (Table 1.2).

Table 1.2. **ESA claimants will be affected in different ways by Universal Credit**

Type of ESA	Group	What is going to happen under Universal Credit (UC)
Contributory	Support Group	People assessed with a "limited capability for work-related activity" and sufficient National Insurance Contributions will continue to receive ESA indefinitely, even once UC is introduced.
	Work Related Activity Group	People assessed with a condition where they should be undertaking work-related activity to prepare them for work will have their ESA time limited to one year.
Income-related	Support Group	This group will be moved onto UC which has a "limited capability for work and work-related activity"
	Work Related Activity Group	This group will be moved onto UC which has a "limited capability for work"

Source: Carers UK (2013), "Changes to Benefits: Your Questions Answered", Carers UK: The Voice of Carers, March, www.carersuk.org/help-and-advice/focus-on/item/2479-changes-to-benefits-your-questions-answered.

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The mental health care system

Health care policy in the United Kingdom is a devolved matter and there are considerable differences in the way the public health care systems operate in the different territories (England, Northern Ireland, Scotland and Wales). The following section describes the structure of the mental health system in England. Details of the differences among the territories are provided in the report where necessary.

In England, the mental health system comprises primary care and community-based services supported by specialist in-patient care (Boyle, 2011). The services are largely provided by the National Health Service (NHS) and local authorities with increasing provision by voluntary and private-sector providers. Although there are multiple points of access to

mental health services, the most frequent gateway is through a patient's general practitioner (GP). This is particularly the case for people suffering from common mental disorders. As in other OECD countries, mental health policy in England has shifted away from hospitalisation in acute-based wards towards provision of care in outpatient clinics and local and community mental health care services.

Until 2012, Primary Care Trusts were responsible for commissioning and, occasionally, providing mental health services for their local populations. However, with the recent reforms introduced by the Coalition Government, the way health services and mental health services are commissioned is changing radically. Under the new reforms, commissioning responsibilities, and therefore a substantial share of the NHS budget, is handed over to GPs working together in local consortia of GP practices, known as Clinical Commissioning Groups (CCGs) to co-ordinate the commissioning of services for their areas. Most health service capacity decisions taken by CCGs are based on consultation with Health and Well-being Boards (HWBs) that bring together other local partners, such as Local Authorities, and overseen by NHS England (as NHS England determine allocation of funds to CCGs, and commission Primary Care services). While there are potential gains from localising health care, much of the results will depend on the implementation of the reform in the next years.[4] GPs will become more responsible for commissioning health services, but there are some concerns about their ability to do so. Some fear that they lack knowledge of local mental health services and treatment approaches, which typically rely on medication rather than psychological therapies.

Conclusions

In conclusion, the following key points emerge in comparing sickness and disability policy outcomes and the labour market situation of persons with mental disorders with those in other OECD countries:

- Tackling labour market inactivity due to sickness and disability has been a major challenge for the United Kingdom for the last decade. The number of people claiming disability benefits far exceeds the number claiming any other working-age welfare payment and costs the government three times more than unemployment benefit.
- Mental illnesses have become the major driver for labour market exclusion, accounting for up to 38% of all new claims for disability benefit in 2012. Mental health problems are also highly represented in other working-age benefits, especially income support and housing benefit.

- Labour market outcomes for people with a mental disorder are relatively poor, especially for those with a severe disorder. Poverty rates are among the highest compared with OECD countries for which data is available. This highlights the need to reach an appropriate balance in recent reforms that have generally tightened access to disability benefits.

Notes

1. Mental disorders, as defined in this report, exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.
2. The diagnosis also matters, but any mental illness can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including most mood and anxiety disorders.
3. National rollout of UC was originally planned to take place from October 2013 to October 2017. It is currently being tested in two areas of the north-west, with two other pilots starting by the end of 2013. The national roll-out will be comprised of three strands.
4. See two forthcoming OECD working papers (OECD, 2014a; OECD, 2014b) on mental health profiles for England and for Scotland for more details of the reforms.

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Chapter 2

Achieving higher labour market participation in the United Kingdom: The role of the welfare system

This chapter takes stock of the recent major reforms to the UK disability benefit scheme (now known as the Employment and Support Allowance) and addresses the challenges that remain including i) paying more attention to mental ill-health, ii) providing support that addresses both employment and health-related barriers; and iii) balancing rights and responsibilities. It also examines the employment support provisions delivered to disability and unemployment beneficiaries via the new contracted Work Programme; the incentives of providers to prioritise claimants with health problems; and more generally the ability of the system to deal with mental health issues in view of the high prevalence of mental illness among benefit recipients, including recipients of Jobseeker's Allowance.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Introduction

Income replacement benefits play an important role for people with mental health problems given their poor attachment and vulnerability in the labour market. With over one million people with a mental disorder claiming a disability benefit in the United Kingdom, the Employment and Support Allowance (ESA) alone represents a major source of income for these people. However, as in other OECD countries disability benefits frequently act as a form of passive compensation pushing those with partial capacity to work into long-term benefit dependency. This is despite evidence which shows that the majority of people with health-related problems want to work and that there are multifaceted positive returns for these people of having a job (Perkins et al., 2009, Stanley and Maxwell, 2004).[1]

Recent reforms in the United Kingdom have sought to address long-term dependency and reduce the very high disability benefit caseload. The reforms were built on an underlying premise that people with partial work capacity ought to be supported into employment. They also set out to tackle the long-term structural problem of unemployed people being diverted onto "inactive" disability benefits. The main components of the reforms were a tightening of benefit eligibility with the introduction of a new work capability assessment criteria; reassessment of the work capacity of current benefit recipients; an extension of means-testing; and a new employment programme paying for employment outcomes not service inputs. In addition, the United Kingdom is moving towards an integrated single working-age benefit.

These changes go in the right direction and are in line with policy trends in several other OECD countries. However, in view of the employment difficulties faced by people with reduced work capacity and those with long-term labour-market detachment, these reforms need to balance concerns over benefit dependency with effective labour-market integration. Recent reforms have emphasised benefit caseload reductions but these have not been matched with corresponding employment and health support for benefit recipients. Further substantive efforts need to be made to reintegrate people with health problems into the labour market and generate long-term savings for the UK economy.

This chapter takes stock of the major recent reforms, and addresses the challenges that remain for the benefit system. Four areas seem most critical for the future: i) paying more attention to the growing group of disability benefit claimants with mental disorders; ii) ensuring that benefit conditionality translates into active job search; iii) providing access to work-oriented support that accounts for both employment and health-related barriers; and iv) accounting for health-related problems in all parts of the benefit system.

Recent disability benefit policy developments and their impact

Very high beneficiary rates have provoked debates regarding disability policy in the United Kingdom. As a result a number of reforms have been implemented aimed at reducing the high disability caseloads. Changes in disability policy already started in the early 2000s. For instance, Pathways to Work introduced in 2003, was the first major programme targeted at moving new claimants off benefit through individualised support and obligations on claimants. Recent reforms have continued to build on the previous government's efforts while others have been intensified to reduce the large disability benefit rolls.[2] Major policy changes in the recent years include:

A new two-tiered disability benefit (Employment and Support Allowance)

The new Employment and Support Allowance (ESA) introduced in 2008 intends to be a temporary payment for the majority of claimants, rather than a permanent one. New ESA claimants potentially able to work immediately or in the future are placed in the Work Related Activity Group (WRAG), with work-related requirements. Those with the most severe or terminal conditions who are not able to work are placed in the Support Group (SG), facing no conditionality whatsoever.

A more stringent Work Capability Assessment

Central to the reforms was the development of the Work Capability Assessment (WCA) in 2008 which replaced the Personal Capability Assessment which was used to determine the eligibility for disability benefit. The new assessment takes place earlier (three months into the claim rather than six months); far fewer customers are exempt from assessment; and the threshold for benefit eligibility is higher. The WCA also aims to identify what people can do, rather than what they cannot.

Restricting benefit duration

ESA contributory claimants in WRAG have their benefit time-limited to twelve months, after which they may be eligible for ESA income-related benefit (in the future, Universal Credit) or JSA.[3] If they do not qualify for income-related benefits they become "ESA credits" only claimants. ESA Support Group (SG) claimants' contributory benefit is not affected. These changes also reflect the policy intention to make ESA an interim benefit for those who are expected to move into work.

Reassessment of the entire disability benefit caseload

Since 2010, the United Kingdom is reassessing all those on the disability benefit caseload according to the new WCA criteria.[4] This concerns around 1.5 million people on the old disability benefit. Along with the Netherlands, the United Kingdom is the only OECD country to reassess its entire disability caseload on new criteria.

People with mental disorders account for a substantial part of the disability benefit caseload

The disability benefit caseload in the United Kingdom peaked in 2004 at 7.7% of the working-age population, equivalent to about 2.78 million people (Figure 2.1, Panel B). From 2004, the caseload fell modestly until 2008 to 2.61 million, following a decline in the number of new claims since the turn of the century (Figure 2.1, Panel A). Both new claims and the total caseload increased in the initial crisis years but fell again after 2010. In 2012, there were 2.56 million claimants of disability benefits, lower than the number recorded just before the economic downturn. The latest drop in the caseload is a consequence of two factors, a reduction of new benefit claims and an increase of outflows from the disability benefit system.

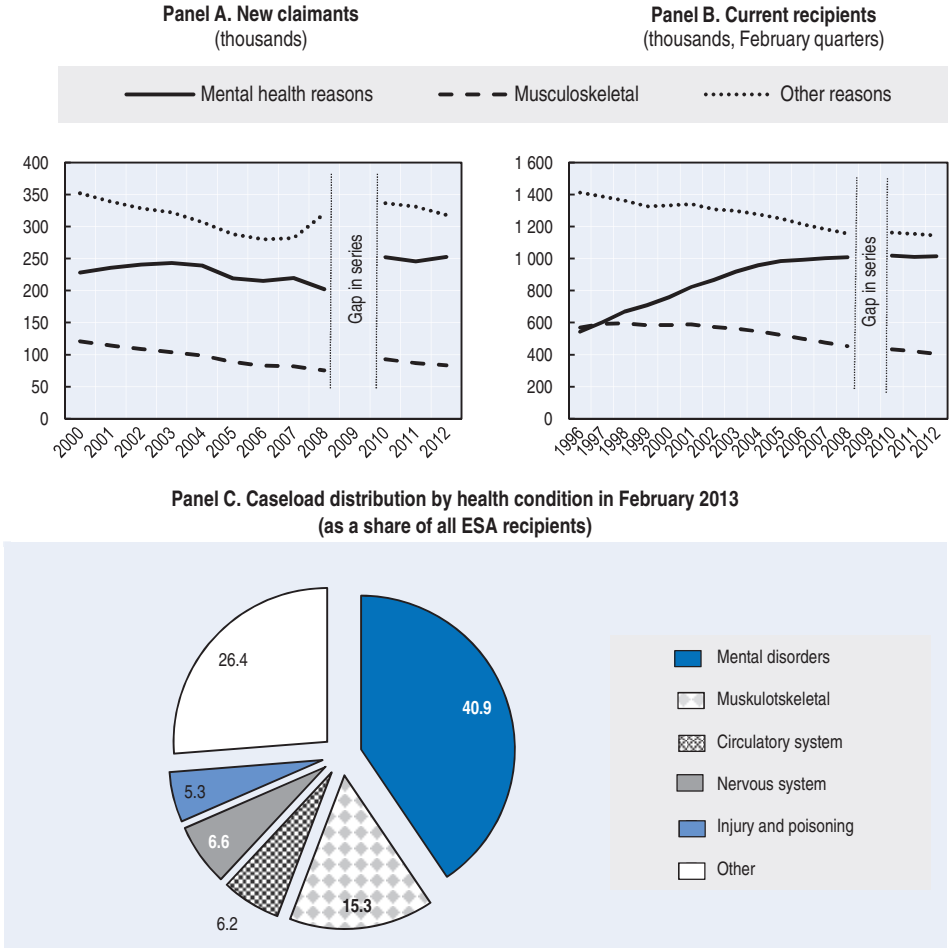
The encouraging overall trend, however, masks the continued increase over this period in the number of recipients with a mental disorder, at least until the 2008/09 reform; such claims doubled since the mid-1990s (Figure 2.1, Panel B). Like in other OECD countries, the increasing share of mental disorders is partly a reflection of better detection and disclosure of these issues. However, such improvements in identification of mental health problems have not yet translated into better support for this group, as reflected in poor labour market outcomes. General structural reforms do not seem to have been as effective for those with mental health problems. Mental and behavioural disorders are now by far the largest group, with roughly a million of people in late 2012 representing over 40% of the total disability benefit caseload (Figure 2.1, Panel C).

New claims for disability benefit have fallen only marginally

The new disability benefit and the revised WCA started at the end of 2008 but this also marked the beginning of the global recession. This largely explains why new claims for disability benefit under the new regime started at a higher level (Figure 2.2, Panel A). Four years into the new regime, the number of new claims still remains above the pre-crisis level. However, the reforms have been resilient to the economic crisis to a certain extent, as new claims continued to fall steadily during the downturn period.

Internationally the United Kingdom now stands out as having the highest rate of new claims among all OECD countries for which data is available, almost twice the OECD average. This is despite recent reforms aimed to tighten access to ESA (Figure 2.2, Panel B), indicating the need for a stronger focus on early intervention including in the sickness phase.

Figure 2.1. **Mental disorders make up the biggest share of the disability caseload**

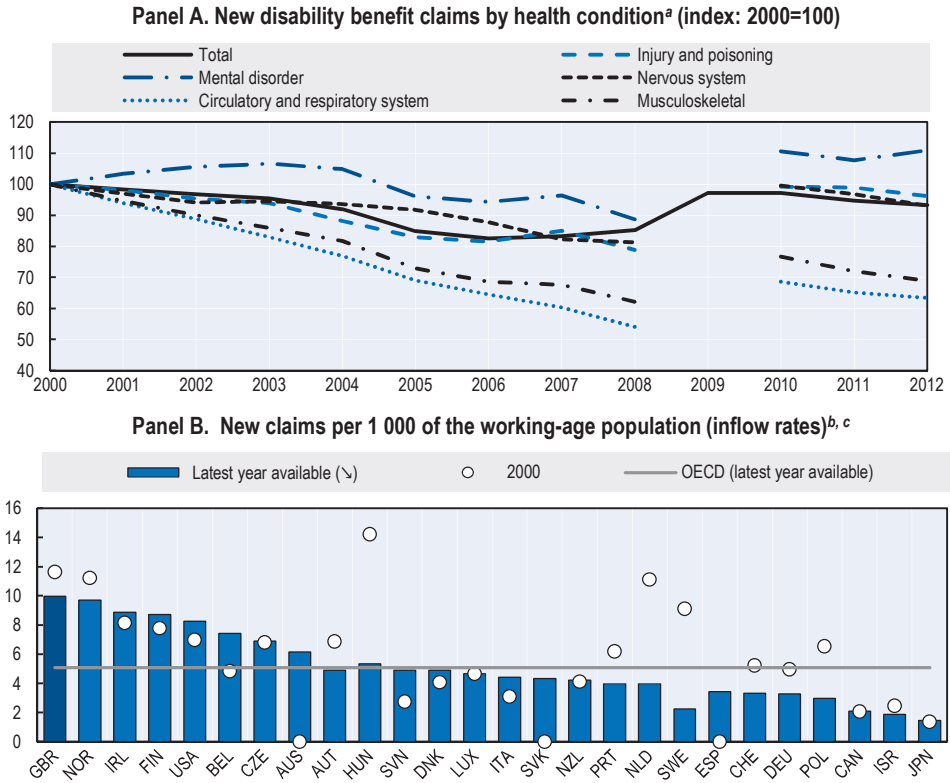


Note: Mental retardation, organic and unspecified mental disorders (accounting for 8.6% of all mental disorders in the past decade) have been removed from the "mental disorder" category and added to the group "other", in line with the definition of mental illness used by the OECD.

Source: OECD calculations based on data from the Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932978645

Figure 2.2. **New disability benefit claims have fallen but remain among the highest in the OECD**



Note: Rates of new claims for the United Kingdom were estimated by reducing the gross on-flow by the number of people who have been on disability benefit (previously IB, now ESA) for less than six months. This is a good proxy for eliminating those who, before benefit reform, used to receive IB short-term and therefore a good way to estimate the rate of new long-term benefit claims. This correction is necessary to make UK data comparable internationally because the unadjusted rate would include many people who leave the disability benefit rolls within a few weeks or months; people who in other countries would never become eligible for disability benefit. Moreover, data for 2012 exclude the on-flow of reassessed incapacity benefit recipients.

a. There is a gap in series due to no diagnosis coding in 2009.

b. Data for Ireland refer to 2001 and 2006; Japan to 2003 and 2008; Luxembourg to 2005; Canada to 2001 and 2007; Italy, Israel, Poland, the Slovak Republic and Spain to 2007; Austria to 2009; Belgium, Norway and Sweden to 2010, the United Kingdom to 2012 and 2008 for all remaining countries.

c. Data for Canada and Spain cover the contributory benefit only.

Source: OECD calculations based on data from the Department for Work and Pensions and the OECD questionnaire on mental health.

StatLink http://dx.doi.org/10.1787/888932978664

The recent drop in new claims can be partly explained by the stricter WCA. Initial estimates suggested that the proportion of new applicants who would be rejected by the medical test would rise from 39% under the previous regime to 50% under the new ESA regime (Kemp and Davidson, 2010). Results from the WCA to date show on average 56% of new claimants undergoing assessments are deemed fit for work while only 43% are eligible for ESA (see below).

Outflows have increased mainly due to reassessment efforts

The tighter access to disability benefit has gone hand-in-hand with greater efforts to increase outflows by reassessing entitlements of long-term beneficiaries. Reassessing the caseload on the grounds of new eligibility criteria – as is currently done in the United Kingdom – remains a controversial issue in many OECD countries, not least because it challenges deep-rooted mind-sets of beneficiaries who have often been out of work for a considerable period of time. Nevertheless, reassessments can identify substantial numbers of beneficiaries with productive work capacity that – with the right support – can be moved into employment. In the Netherlands, the only other OECD country where the work capacity of current disability benefit claimants is reassessed on the basis of changed entitlement criteria, some 40% of all beneficiaries were found to have at least partial work capacity or higher capacity than at the original assessment (OECD, 2013a).

Table 2.1. **Very high shares of disability benefit claimants are now identified as being fit for work**

Distribution of claimants by (re)assessment outcome, new ESA claimants versus reassessed IB claimants, total over the period 2008-12

	New ESA claimants	IB reassessed claimants
Work Related Activity Group	25%	41%
Support Group	18%	32%
Fit for Work	56%	27%

Note: Data refer to the annual average of the four quarters 2012.

Source: DWP (2013), "Employment and Support Allowance, Outcomes of Work Capability Assessment", *Quarterly Official Statistics Bulletin*, July 2013.

StatLink http://dx.doi.org/10.1787/888932979063

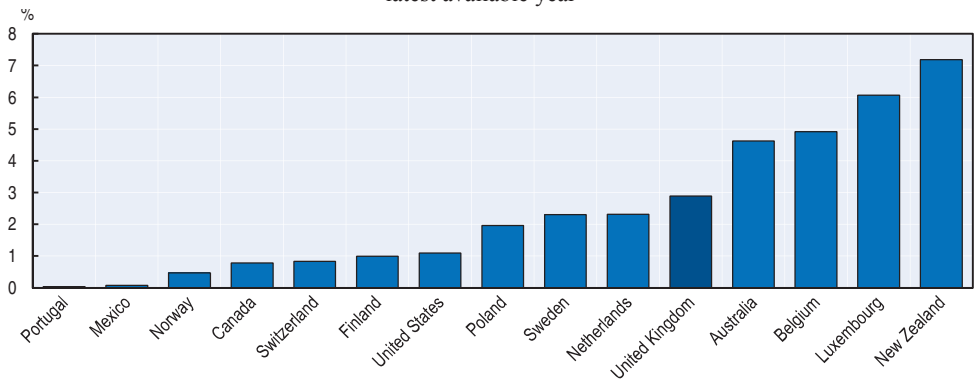
The results from the United Kingdom are not too different. Since the beginning of the reassessment process, around 841 000 former Incapacity Benefit (IB) recipients were referred for reassessment. Of all those that have completed a reassessment, 27% have been found to be capable of work and no longer eligible for disability benefit (with most of them being eligible for

JSA instead). This compares with a share of 56% found fit for work among new ESA claimants (Table 2.1). Over time, the share of those found fit for work at their initial (re)assessment has been falling due to various changes in the WCA process (see the WCA section of this chapter further below for more details on this).[5]

Outflows from disability benefit temporarily increased due to the large-scale reassessment of current IB claims. But outflows have also been occurring under the new ESA regime (including both new ESA claimants and former IB claimants who were transferred onto ESA following reassessment). The total outflow rate from ESA is 3% of the caseload every year, which places the United Kingdom just in the top third of 15 OECD countries shown in Figure 2.3. The difference in this rate between WRAG (3.3%) and SG (2.3%) is surprisingly small given the presumably large difference in work capacity between the two groups and correspondingly different conditionality regimes. Data by health condition further suggest that claimants with a mental disorder have lower chances to leave the benefit, irrespective of whether they are in WRAG or SG (Table 2.2), reflecting their greater disadvantage in the labour market and more complex labour market barriers.[6]

Figure 2.3. **ESA claimants rarely leave benefit rolls like elsewhere**

Annual outflows from disability benefits as a share of all disability benefit recipients, latest available year[a,b]



a. Outflows include moves into employment and into other inactivity, as well as a loss of eligibility, but exclude deaths and transfers into old-age pensions.

b. Data refer to: 2004 for Luxembourg; 2005 for Australia; 2006 for Finland; 2007 for Canada, Poland, Portugal and the United States; 2008 for Belgium, the Netherlands, New Zealand, Norway, Mexico, Sweden and Switzerland and 2012 for the United Kingdom. Data for Canada and the United States refer to contributory pensions only; data for Poland to the contributory farmers' scheme; and data for the United Kingdom to the Employment Support Allowance.

Source: OECD calculations based on the OECD questionnaire on disability and OECD questionnaire on mental health.

StatLink http://dx.doi.org/10.1787/888932978683

Table 2.2. **Claimants with a mental disorder are less likely than the average claimant to leave disability benefit**

Outflow from ESA by phase of the ESA claim and by mental health condition, as a percentage of total current claims, 2012

	Total	Other	Mental	Nervous	Circulatory	Musculo-skeletal	Injury, poisoning
WRAG (Work Related Activity Group)	3.3	4.1	2.7	2.5	4.1	3.5	6.5
SG (Support Group)	2.6	4.3	1.5	1.1	2.5	1.4	3.4

Source: OECD calculations based on data from the Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979082

In the medium term, outflows from disability benefit will also increase with the removal of eligibility to ESA for those claiming for more than one year. It is estimated that around 700 000 of claimants will lose entitlement to contributory ESA by 2014/15 (DWP, 2011a). However, not all of those affected will see a loss of income as *some* will continue to receive income-related ESA while others claim JSA.

Impact of reform package on employment is not known

Benefit outflows and reductions in benefit caseloads are not the only way of evaluating the success of the recent reforms. The extent to which those who exit the disability benefit system find employment is a fundamental question about which very little is known. It is difficult to quantify the net impact of these benefit changes on employment. The official impact assessment for the recent ESA (Amendment) Regulations 2011 which provides five-year estimates for its impact on administration costs and benefit expenditures does not account for employment sufficiently. It comments: "The benefits of earlier entry into the workplace have not been estimated in this impact assessment as there are currently limited data (...) around 30% of customers who are disallowed ESA do not claim another out-of-work benefit. This may be because they move into work but reliable data about the destinations of these customers is not available." The impact assessment describes employment-related benefits of the reform, but does not quantify them (DWP, 2010).

Both the tighter access to disability benefit and the reassessments have translated into lower disability beneficiary numbers. Going forward, monitoring the destinations of those who have moved off benefits would be

critical to better understand the full impact of the reforms. Some of the reduction in the disability benefit caseload will be offset by the increase in other working-age benefits. Some people will be moved back onto unemployment benefits (or, in the future, Universal Credit) and others will be excluded from benefits altogether. More could and needs to be done to ensure that the reforms live up to their promise which should be to reduce the reliance on disability benefits of people with mental health disorders by helping them move back into work.

Providing adequate employment support

Since 2011, the government introduced a new flagship "back to work" scheme – the Work Programme (WP) – replacing and encompassing a number of previous welfare-to-work programmes; in particular the New Deal and Flexible New Deal (which supported long-term unemployed jobseekers), the New Deal for Disabled People, and Pathways to Work (which supported those on IB and ESA).

The programme is contracted-out employment support with the aim to provide a tailored service to long-term unemployed and the most disadvantaged jobseekers in receipt of various income replacement benefits. This is being delivered primarily by the private sector, with some input from local authorities and the voluntary sector at subcontractor level. The WP follows a "black box" approach, meaning that that providers are free to provide any sort of service or set of interventions rather than being required to deliver specific elements as under previous labour market programmes. Jobcentre Plus (JCP) retains its responsibilities for benefit delivery; by monitoring job-search requirement and prescribing benefit sanctions. JCP has a central role to prevent clients from having to enter the WP by using their expertise in the first 12 months of unemployment.

Based on their benefit type, claim duration and some other factors, JCP refers claimants to the WP, randomly assigning them to one of two or three prime contractors in the area. Participants receiving different benefits access the programme at different times; for some, participation is mandatory, and others will be able to volunteer, with the agreement of their JCP adviser. Table 2.3 gives an overview for the different payment groups, including e.g. point of referral and participation requirements. New ESA claimants (income-related only) assessed as being able to undertake work-related activity (i.e. placed in WRAG) and considered likely to be fit for work in 3, 6 or 12 months are referred from the point their WCA outcome is known. The programme is also mandatory for ex-IB claimants with a three or six month prognosis. All claimants are referred by JCP advisers.

Table 2.3. **Outcome payments in the Work Programme give a strong weight to longer-term employment outcomes with considerable variation across groups**

Work Programme categories and corresponding benefit categories, referral points, participation requirements and payments (in GBP) made to the provider for attachments and reported outcomes

PG No.	Benefit	Attendance	Participant group	Referral point, from	Attachment fee (a)	Job outcome fee (b)	Week job outcome paid (c)	Sustainment fee per 4 weeks (d)	Max no. of sustainment payments (e)	Max. payments per participant in the first year of contract (a+b+d*e)
1	Jobseeker's Allowance recipients	Mandatory	Aged 18-24	At 9 months	400	1200	26	170	13	3810
2			Aged 25+	At 12 months	400	1200	26	215	13	4395
3			Early Access (also for 18 year old NEETS & JSA Repeaters)[a]	At 3 months	400	1200	13	250	20	6600
4			Ex IB	At 3 months	400	1200	13	250	20	6600
9			Prison leavers	Day one of release from prison	300	1200	26	200	20	5500
5	Employment and Support Allowance recipients	Mandatory or Voluntary	ESA Volunteers[b]	Once WCA outcome is known	400	1000	13	115	20	3700
6			New ESA claimants[c] (mandatory participation for those with 3, 6 or 12 month prognosis)	Once WCA outcome is known	600	1200	13	235	20	6500
7			ESA Ex-IB[d] (mandatory for those with 3 or 6 month prognosis)	Once WCA outcome is known	600	3500	13	370	26	13720
8	Income Support and incapacity benefits recipients[e]	Voluntary	All (England 2011-14 only)	From benefit entitlement	400	1000	13	145	13	3285

Note: PC: Pension Credit; PG: Payment Group; SG: Support Group; WCA: Work Capability Assessment; WRAG: Work Related Activity Group (of ESA).

a. Early Access is composed of: Ex-offenders; disabled people; people with mild to moderate mental health issues; care-leaver; carer on JSA; ex-carer; homeless person; former HM Armed Forces personnel; partner of current or former HM Armed Forces personnel; and person with current or previous substance dependency that is a significant barrier to work. JSA impacted by a benefit cap can join the WP from three months on a voluntary basis.

b. Voluntary participation: i) ESA WRAG claimants with a youngest child under 5 or who are full-time carers (for claimants of income-related ESA only for those with a 12 months+ prognosis), ii) ESA credits only claimants, iii) PC claimants with health conditions from the start of their claim. Access is optional for claimants of contributory ESA, however, once they opted in participation is mandatory for claimants in the WRAG (unless they have a youngest child under 5 or are full-time carers).

c. Voluntary participation: i) Claimants of income-related ESA WRAG (with a youngest child under 5 or full-time carers) with a three or six months prognosis, ii) both income-related and/or contributory ESA claimants in the Support Group.

d. Voluntary participation: i) ex-IB claimants income-related ESA WRAG claimants with a three or six months prognosis and a youngest child under 5 or full-time carers, ii) both income-related and/or contributory ex-IB ESA claimants in the Support Group, iii) none ex-IB income-related ESA claimants in WRAG with a 18 months prognosis.

e. For IB claimants prior to reassessment for ESA.

Source: OECD compilation based on information from the Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979101

The WP pricing model is heavily outcome-based, with an explicit expectation of up-front investment by WP providers, which are meant to be rewarded with high job outcome and long-term sustainment payments and partly funded by an innovative mechanism that "recycles" part of additional benefit savings accrued to the government at high levels of programme performance. Providers receive a small upfront "attachment fee" for programme starts in the early years of the contract – declining from GBP 400-600 in the first year to zero in the fourth year. They are then paid a job-outcome fee for every participant that remains in work for a specified period of time (three or six months), and ongoing sustainment payments for every additional four weeks of employment (usually for a maximum of eighteen months). Payments are incentive-based, the amount varying for the different types of claimants. Broadly speaking, payments for those on disability benefits and other disadvantaged jobseekers are greater than for other types of participants relatively closer to the labour market.

The Work Programme struggles to support those with health problems

The success of providers is measured against the criteria set out in their contracts, known as the Minimum Performance Levels (MPLs). This is defined as the number of people successfully helped into employment for three months or more in a year as a proportion of the number of jobseekers referred to the provider in the same year. Failure to achieve these MPLs can result in contract termination. Currently, MPLs are only set for three out of the nine groups of participants: Payment Groups 1 (JSA 18-24 year-olds), 2 (JSA 25+) and 6 (ESA WRAG).

Has the WP delivered? Table 2.4 shows actual performance of providers against the Department for Work and Pensions' (DWP) contractual measure by financial year. In the first year of its operation, WP providers failed to meet targets for each of the three participant groups, with performance being the worst for people on disability benefits. Only 0.6% of ESA claimants achieved a job outcome compared to the MPLs of 5.5% set for this category. Not a single job outcome was achieved for ESA ex-IB claimants in the first nine months of delivery. Interestingly, more jobs were secured for JSA ex-IB claimants relative to ESA ex-IB claimants despite similarly complex barriers potentially. These patterns continued in the second contractual year, albeit with slight improvements for some jobseeker categories. On average, job outcomes for JSA claimants of all ages hit close to the MPL with a number of providers actually meeting and even exceeding them. In contrast, only 5.3% of people out of the 57 960 ESA claimants secured at least six months of work in its second year of operation, well below the government's MPL of 16.5%.

Table 2.4. **Providers have failed to secure jobs for persons with a disability**

Claimant group	Referrals		Distribution of referrals		Achieved					
					June 2011 to March 2012			April 2012 to March 2013		
	June 2011 to March 2012	Arpil 2012 to March 2013	June 2011 to March 2012	Arpil 2012 to March 2013	Outcomes	Performance (%)	Minimum performance level	Outcomes	Performance (%)	Minimum performance level
JSA 18 to 24	131 030	92 400	19	18	1 250	1.0	5.5	29 520	31.9	33.0
JSA 25 and over	316 040	203 780	46	39	3 200	1.0	5.5	55 700	27.3	27.5
JSA Early entrants	177 110	76 470	26	15	4 300	2.4	..	31 960	41.8	..
JSA Ex-Incapacity	3 230	11 600	0	2	70	2.2	..	740	6.4	..
ESA Volunteers	10 550	28 180	2	5	90	0.9	..	940	3.3	..
New ESA claimants	41 300	57 960	6	11	260	0.6	5.5	3 090	5.3	16.5
ESA Ex-Incapacity	5 060	20 750	1	4	0	0.0	..	190	0.9	..
IB/IS Volunteers	1 820	800	0	0	30	1.6	..	250	31.3	..
JSA Prison leavers	1 370	24 380	0	5	0	0.0	..	310	1.3	..
Total	687 480	516 340	*100*	*100*	9 200	1.3	..	122 700	23.8	..

Source: OECD compilation based on information from the Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979120

There are no minimum performance levels set for specific health conditions, therefore actual performance targets cannot be compared against a set benchmark. Nevertheless, comparing actual job outcomes by health condition can provide meaningful information on the challenges faced by those with mental health problems. Table 2.5 shows the actual performance analysis by disability benefit claimants and health condition up to June 2013. Three key findings emerge:

- *First*, there is a big difference in the number of referrals to the WP by type of disability benefit. Far more new ESA claimants are referred to the WP compared to ex-IB claimants. The low number of ex-IB claimants is problematic as it implies that intervention for those who are reassessed is delayed. Other administrative data reveal (not shown in this table) that only 7% of all ex-IB claimants completing their WCA were referred to the WP between June 2011 and July 2012. In comparison, 55% of new ESA claimants were referred during the same period.
- *Second*, mental health problems are highly prevalent among disability claimants: 50-60% of all disability claimants referred to the WP to date suffered from mental health conditions, with the highest share among ex-IB claimants. This highlights the challenge and the need to pay particular attention to mental health issues among WP clients.

- *Third*, so far WP providers have particularly struggled to find employment for ESA clients with a mental health condition. Two years into the programme, only 2 680 job outcomes have been achieved for the 104 100 referrals of ESA claimants with a mental disorder – equal to 2.6% (lower than for other health conditions). It is also worth noting the relatively higher job outcomes among the ESA volunteer category compared to ex-IB claimants – probably a reflection of higher motivation among the former and, thus, illustrating the need for motivational strategies to encourage engagement in labour market programmes.

Table 2.5. **Claimants with mental disorders have the lowest job outcomes**

Performance analysis by claimant group and health condition

Claimant group	Health condition	To June 2013		Achieved to June 2013	
		Referrals	Distribution	Outcomes	Performance (%)
New ESA claimants					
	Mental disorder	59 740	51.3	1 950	3.3
	Musculoskeletal	15 510	13.3	540	3.5
	Other	41 140	35.3	2 010	4.9
	Total	116 390	*100.0*	4 500	3.9
ESA ex-IB					
	Mental disorder	20 320	60.8	160	0.8
	Musculoskeletal	4 460	13.3	40	0.9
	Other	8 640	25.9	110	1.3
	Total	33 420	*100.0*	310	0.9
ESA Volunteers					
	Mental disorder	24 040	51.3	570	2.4
	Musculoskeletal	7 170	15.3	250	3.5
	Other	15 610	33.3	590	3.8
	Total	46 820	*100.0*	1 410	3.0
Total					
	Mental disorder	104 100	52.9	2 680	2.6
	Musculoskeletal	27 140	13.8	830	3.1
	Other	65 390	33.3	2 710	4.1
	Total	196 630	*100.0*	6 220	3.2

Source: OECD calculations based on data from the Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979139

DWP also uses a One-Year Job Outcome Measure to evaluate WP performance. This indicator measures the proportion of claimants for whom providers were paid a job outcome payment at 12 months following referral to the WP, by monthly cohorts of referral.[7] Performance seems to improve according to this indicator, but the general picture for those on ESA remains disappointing.

Figure 2.4 illustrates that overall performance has been increasing steadily with each successive monthly intake of referrals. However, such improvement has not happened for ESA clients, although there has been some rise for IB/IS volunteers, and the gap in outcomes between JSA and ESA clients is therefore gradually increasing.

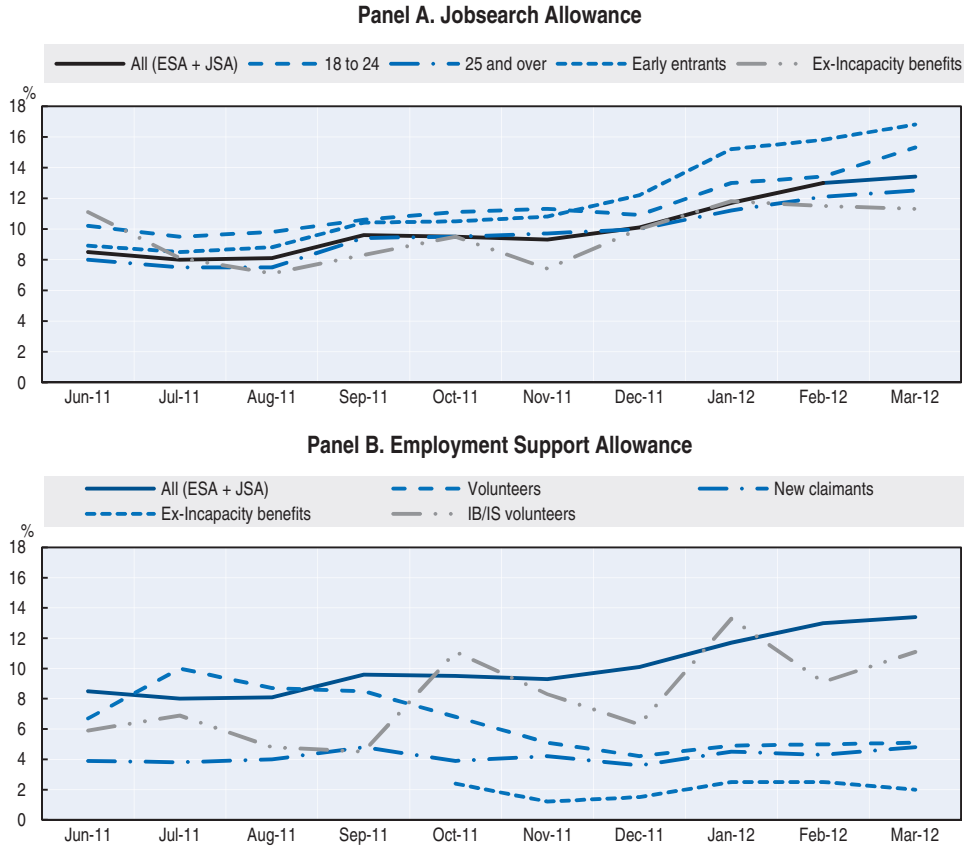
Data limitations do not allow a cohort analysis by health condition, unfortunately. Irrespective of the indicators used, the MPL or the One-Year Job Outcome, the bottom line is that on average providers have so far been rather unsuccessful in finding sufficient numbers of jobs for clients with long-term (mental) health conditions.

One major explanation for the under-performance of the new ESA claimant and ESA ex-IB group in comparison to JSA clients is the difference in conditionality. JSA clients are subject to full work-search conditionality, while ESA customers are only subject to work-preparation conditionality but cannot be mandated to take up suitable offers of employment creating an inherent challenge for the providers.

In order to drive up performance, from August 2013, DWP began referring more claimants to the better performing providers. In April 2013, DWP launched the Best Practice Group formed to help organisations delivering the Work Programme to find the best ways to help former incapacity benefit claimants, people claiming ESA, ex-offenders and other harder to help claimants overcome issues which are stopping them from getting a job. The latter initiative goes in the right direction as it could help to facilitate information sharing and leaning which is currently not possible given the black box feature of the WP.

Figure 2.4. **Job outcomes for ESA clients are poor and not improving over time**

Proportion of customers for whom providers have achieved a job outcome payment at 12 months on the programme, by payment group



Source: Department for Work and Pensions, Statistical Summary, First Release, June 27, 2013.

StatLink http://dx.doi.org/10.1787/888932978702

Disadvantaged jobseekers are not prioritised in the Work Programme

The first evaluation of the early stages of the Work Programme suggests that, despite the differential payment mechanism, frontline workers are prioritising more "job-ready" participants for support, ahead of those who are assessed as having more complex and substantial barriers to employment (Newton et al., 2012). A number of important findings emerged from this evaluation:

- The most job-ready are encouraged to rapidly take-up any support or training required, because they were seen by advisers to be easy to progress into work.
- Those who were less job-ready appeared to be challenged by advisers less frequently and less intensively about their job-seeking activities during meetings, and were booked into programmes of lesser intensity.
- Emphasis is given to standardised services, e.g. CV writing, job-matching and job search at the expense of a more personalised and tailored approach, e.g. supporting claimants to tackle literacy, debt and housing issues.

These findings imply that much of the needs of ESA clients and those with mental health problems are not being met. It is also argued that the low number of ESA referrals has made it difficult for providers to develop sufficient infrastructure and support for this group; including employing specialist staff, or investing in training courses and work placements tailored to this group and they are reluctant to make referrals to specialist provision (Rees et al., 2013; Newton et al., 2012; and Lane et al., 2013).

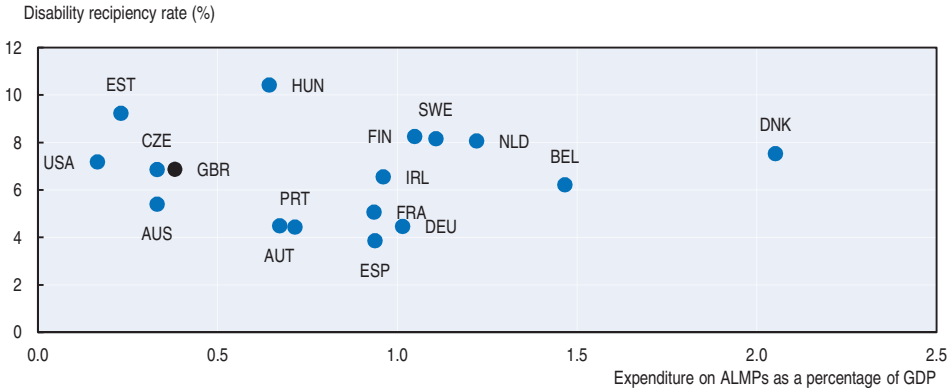
Inadequate funding will particularly hurt the most disadvantaged groups

Given the strong focus on outcome-based payments, the providers have already run into financial difficulties because they are not achieving the "results" on the scale required to generate sufficient payment to meet their costs (OECD, 2013b; Houston and Lindsay, 2010; and Lane et al., 2013). This combined with limited up-front funding given to providers has also led to reduced investment in resources for frontline services. One key indicator for the quality and intensity of services is the number of clients per caseworker. The current caseload per WP adviser is 120-180 jobseekers (Work and Pensions Committee, 2013). This is far too high to deliver effective and personalised support for those with complex barriers. Comparisons with the previous contracted-out UK programme such as the Employment Zones and the Australian model of contracted out employment provision suggest that Work Programme providers have lower levels of funding available per client or might need to secure much longer periods of employment to obtain similar levels of funding per participant (OECD, 2014). The up-front attachment fees will also be phased out (in the fourth year of the WP) raising further concerns on the adequacy of services for the most disadvantaged clients. Overall, support for ESA clients is likely to be squeezed despite their poor employment outcomes. Meanwhile, as a result of the comprehensive reforms, the share of ESA clients in all WP clients continues to increase including a fast increase in ex-IB claimants now

categorised in WRAG as a result of the reassessment process. Tailored support will be critical for this group, as many of them have been out of work for a long period with limited contact with JCP during their benefit claims.

Figure 2.5. **Spending on active labour market policies is low in the United Kingdom**

Disability recipiency rate (caseload over the population) and spending on active labour market programmes (as a percentage of GDP), 2010[a]



Note: Active Labour Market Programmes (ALMPs) include 1. Public Employment Service and administration; 2. Training; 4. Employment incentives; 5. Supported employment and rehabilitation; 6. Direct job creation and 7. Start-up incentives; see the sources for further definitional information.

a. Data for expenditures refer to Categories 1 to 7 in the OECD/Eurostat Labour Market Programme Database, with the exception of Norway for which they refer to the sum of Categories 1.1 and 2 to 7. For Australia, the United Kingdom and the United States, data refer to FY 2009/10. For Switzerland, data for Category 5 (Supported employment and rehabilitation) have been extrapolated because data related to the sub-category 5.1 (Supported employment) were not provided by the Swiss labour market authorities.

b. Data refer to 2007 for France; to 2008 for Austria and Australia and to 2009 for Germany, the Netherlands, the United Kingdom and the United States.

Source: *OECD/Eurostat Labour Market Programme Database*, www.oecd.org/employment/database.

StatLink *http://dx.doi.org/10.1787/888932978721*

Low levels of funding for the WP can be seen in the context of limited resources devoted to active labour market programmes in the United Kingdom more broadly. Figure 2.5 illustrates, for selected OECD countries, the relationship between spending in Active Labour Market Policies (ALMPs) and the disability recipiency rate. The United Kingdom stands among a set of countries with very low spending, despite a high disability benefit recipiency rate.[8] Spending is substantially lower than in, for example, Denmark, Netherlands and Belgium that have disability

beneficiary rates similar to the United Kingdom. The low spending in the United Kingdom can be seen in the context of very limited activation requirements for beneficiaries of disability benefit in the past. With increasing obligations to participate in work-related activities, spending on ALMPs needs to be pushed up.

Are the incentives right?

The extent to which WP providers work with the most disadvantaged clients is directly related to the structure of the differential payment system. The low job outcomes achieved so far for ESA clients suggest that the current differential payment model does not ensure that customers with complex barriers receive support adequate for their needs. Arguably, the incentives must be altered to take into account a range of factors relating to labour market disadvantage.

Any customer categorisation system will only succeed if it is based on a robust assessment of a customer's needs and labour market distance and potential (e.g. age, labour market history, education, health status, etc.). Currently, in the United Kingdom some categorisation of claimants exists, as customers are referred to the Work Programme at three, six, or twelve months into their claim or at the start of their claim. The point of referral largely is based on the type of benefit claimed, age and some personal characteristics. However, this is a rather simplistic approach which is unavoidably leading to considerable "parking" of the least employable within the given categories, and also across categories to the extent that payment differences are too low to reflect differences in needs of the average client of each group. According to a qualitative evaluation of the Work Programme by Lane et al. (2013), providers find the broad benefit type categories quite a poor way of segmenting client needs and some primes suggested that the payment differences were not large enough to influence their behaviour.

Other countries have chosen other ways of tackling this problem, though facing the same challenges. Australia uses a profiling approach to assign clients to risk groups with different levels of support needs. However, the number of groups is small and within-group differences in needs therefore very large – in turn leading to a high occurrence of parking the more difficult clients in every group. There is also ongoing discussion about the adequacy and reliability of the profiling tool (OECD, 2014).

Like other countries, the United Kingdom, struggles with a high prevalence of (mental) health issues in their clientele for which the payment schedule provides little resources. A labour market distance factor (e.g. outcome payments increasing with the duration a client has been out of work at the point of referral) could be added easily as it is done in Australia.

Ideally a system would be based on a combination of benefit status, labour market distance and health needs – determined through a robust profiling tool – with sufficient differentiation between clients. In addition, however, it will be important to minimise the risk of parking within client groups – for example, by increasing outcome payments with the proportion of clients helped into sustained employment *within* each payment group (in the literature frequently referred to as "accelerator factor").

An alternative way to boost resources and ensure that funding is available for personalised employment support for ESA claimants and those with mental health problems more generally, is to ring-fence additional funds which are then used exclusively to meet the needs of this group. In Australia, providers are given a Job Seeker Account which is quarantined for expenditure on training, wage subsidies and other assistance to tackle barriers to employment (OECD, 2013c). The introduction of such discretionary resources can give incentives to case managers to invest in disadvantaged jobseekers and lower incentives to park ESA clients.

Follow-up support should be enhanced

One innovative and potentially positive feature of the Work Programme is that providers can claim greater financial rewards for finding sustained employment for ESA claimants and other disadvantaged groups including lone parents. This provides incentives for ongoing and in-work support for clients returning back to work. Such an approach is especially valuable for persons with mental health problems as they have a higher likelihood of leaving their jobs due to the nature of their illness. Such post-placement incentives to follow-up jobseekers are missing in other countries whether employment service is provided by a public employment service or contracted-out to private providers such as in Australia and the Netherlands.[9] Embedded payments for sustained outcomes also provide incentives for better matching of jobseekers' skills with appropriate jobs. Again, retention rates among those with mental health conditions could be improved if they can be placed in the "right" job. Indeed, the results of the initial evaluation demonstrate that for many providers job sustainability has meant an increased reliance "on the quality of the match between the participant and the job in the first place" (Newton et al., 2012).

In reality, however, the extent and nature of in-work support offered by providers could be very limited for the harder-to help clients. So far, this has mostly taken the form of telephone follow-up with claimants to identify problems and "offer reassurance". Though this "light" support might be adequate for JSA claimants, it is likely to not be enough for ESA clients that have face greater challenges at the workplace. Providers reported higher than expected caseloads from other categories as one key obstacle to

providing systematic follow-up support. This is yet another symptom of the lack of resources invested in the WP whereby providers are having to compromise on the quality of services as discussed above. More can be done to ensure that people can retain their jobs once they move off benefits. For example, further improvements are needed to raise awareness of programmes such as the Access to Work scheme offered by Jobcentre Plus (JCP). This scheme provides support to claimants with disability to settle in and retain a job and has been recently adapted to cater for persons with mental health and fluctuating conditions (see Chapter 3 for more details).

Building a strong relationship with employers should also be central in the follow-up process. Research from other OECD countries and the United Kingdom suggest that stigma related to mental health problems is one of the biggest barriers to employment. According to research conducted by one of the largest private providers, about 40% of employers view employees with mental health problems as a "significant risk" and fewer than four in ten employers would knowingly employ someone with a mental health problem (Shaw Trust, 2010). Support to employers could include raising awareness and understanding of mental health conditions, and working with employers and claimants to arrange flexible working arrangements and support.

Building mental health knowledge and integrating health focused measures into the delivery of employment services

What key factors determine return to work for those on disability benefits? This is a pertinent question for both policy makers and the private sector which now has a greater role in designing employment programmes. Among other factors, a number of studies show health as a major explanatory factor for re-employment of disability claimants. A longitudinal study of IB claimants highlights that around 80% of respondents who were working when followed-up said that improvements in their health had been important in helping them get back to work (Kemp and Davidson, 2010). Health is also found to be the dominant reason for job loss among claimants as well as a major obstacle to their re-employment (Beatty et al., 2010; and Lindsay and Dutton, 2010). Given these findings, health interventions should clearly be part of the overall employment support package in helping people towards work.

At present, tailored services for clients with mild and moderate mental health problems are delivered on an ad-hoc basis and remain under-developed. One indication of insufficient health interventions is the use of specialist providers in the WP.[10] Individual contracts between DWP and the 18 primary contractors set out the types of services specialist subcontractors would be expected to provide, for example debt counselling, health and disability advice and working with offenders, or for specific routes into the labour market, such

as vocational training or self-employment. Early evidence has highlighted that the primary contractors have failed to sub-contract with suppliers of more specialist services, who in theory would have provided tailored support to participants with more complex barriers (Work and Pensions Committee, 2013).

Providers may also have limited commitment to financing health-focused services as there is no guidance or minimum standard stipulated for persons with health conditions in the current contracts. This is a striking departure from previous employment programmes, such as the provider-led Pathways to Work scheme, where contracts specified that providers must offer some claimants a Condition Management Programme (CMP).[11] The introduction of CMP was the first major attempt to combine health interventions, developed in partnership with the National Health Service (NHS), in an employment-oriented programme, acknowledging that many beneficiaries of disability benefit are disadvantaged in terms of both employability and health. With the new "black-box" approach, providers are free to choose the type of health interventions they use, but there is scope for drawing lessons from the delivery of the CMP. These can provide a good starting point for the development of future health-oriented interventions. This is especially important in the current context of the United Kingdom in which the health sector is rapidly building a market to increase availability of health interventions (see Chapter 4) and thus creating opportunities to collaborate further with the WP providers. The following lessons emerge from several evaluations of the CMP:

- *Health intervention such as CMP can improve people's psychological well-being and readiness for work*, notably through building confidence and motivation, and equipping people to self-manage their health conditions (Ford and Plowright, 2009).
- *Ensuring high take-up of health interventions is difficult*. CMP was highly under-used. Of the 1.8 million people starting the *Pathways to Work* programme up to March 2011, for example, only 123 880 (around 7%) engaged with the CMP (DWP, 2011b). The low take-up is to a certain degree related to the voluntary nature of the programme.
- *Working in partnership with the health services is beneficial*. It is argued that the diminishing role of the NHS in the delivery of the programme as *Pathways to Work* was rolled-out and the growing role of private sector contractors who lacked the same professional expertise, resources and credibility reduced the effectiveness of CMP (Lindsay and Dutton, 2013).

There is now growing evidence that psychological therapies such as the Cognitive Behavioural Therapy (CBT) are cost-effective in treating mental disorders which can be an obstacle to return to work (see Chapter 4 for more details). There is also growing evidence that where the CBT has an employment focus, with employment advisors enabling service users to look ahead to manage work performance, a markedly quicker return to work for those (out of work) on sick leave can be (Blonk et al., 2006, Lagervald et al., 2012).[12] However access to such therapies in England is still problematic, albeit improving and access to appropriate employment advice needs to be developed. Furthermore, the provision of integrated services such as Improving Access to Psychological Therapies (IAPT) which aim to deliver employment and health support to individuals with mild and moderate mental disorders is being enhanced but capacity is below the needs of large number of ESA clients.

In response to the growing recognition of mental health problems among benefit claimants, DWP recently launched a toolkit to improve the ability of employment advisors to work with jobseekers with health conditions. The toolkit's particular focus is to help advisers identify when a jobseeker may benefit from a more specialist employment or mental health intervention, and to know what specialist support is available, how to find it and how it can help the jobseeker to obtain their job goal. Development of such tools to empower caseworkers is an important step. Accurate and timely, identification of mental health problems are likely to remain challenging for non-experts due to the nature of the illness and the reluctance of jobseekers to disclose mental health issues.

Delivering health-focused interventions also implies working closer with health services and building better linkages with specialist suppliers at the local level. DWP introduced a Mental Health and Well-being Partnership role in all Jobcentre Plus districts from October 2009. The function exists to improve and facilitate links between local mental health and employment services. They identify the availability of local support (both internal and external) that advisers may signpost customers to and provide a support role to advisers who are working with customers with mental health conditions. Just like JCP, the WP providers could also appoint co-ordinators to strengthen partnerships with local mental health services, as well as possibly integrate health specialists (psychologists, psychiatrists) in their employment delivery teams. This could improve the quality of advice to employment advisors on mental health aspects and improve referrals to specialist organisations.

DWP has pilot schemes from November 2013 to address the health needs of ESA clients by requiring meetings with healthcare professionals to address barriers to work. Clients on ESA-WRAG who are expected to be able to return to work in 18 months will have to have regular meetings with

doctors, occupational health nurses and therapists which will replace the WFIs at JCP as a condition of receiving their benefit. The length and frequency of the meetings will be flexible, depending on needs but there is no obligation to seek treatment. These pilots will run until August 2016.

Finally, DWP could also consider researching different employment focused approaches for individuals with mild and moderate mental health problems who are out of work following the principles of the Individual Placement and Support Model (IPS) (Box 2.1). The IPS model was designed specifically to help people with severe mental health problems obtain employment and it has to date demonstrated evidence for this but has not been trialed for people with milder mental health problems. A study by the Centre for Mental Health shows that the cost of an IPS employment specialist compares favourably with the level of payments made to Work Programme providers (Centre for Mental Health, 2013). An IPS-type pilot could be jointly commissioned with Public Health England and NHS England, since they now also have employment outcomes as part of their outcomes framework.

Box 2.1. **Individual Placement and Support model: Can it work for those with mild and moderate mental health problems?**

The Individual Placement and Support model is an approach to help people with severe mental illness to get back into employment. IPS is currently largely offered in secondary mental health care settings rather than by the employment system. This is partly due to the target group of the model which is comprised of individuals with very severe mental health conditions.

However, there is overwhelming evidence on the success of the model to get people back into the open labour market. The key principles of the model include: i) Competitive employment; ii) Eligibility is based on individual choice – no exclusions; iii) Job search is individualised; iv) Job search is rapid; within four weeks; v) Employment specialists and clinical teams work and are located together; vi) Continuous in-work support; vii) Employers are approached with individual's needs in mind; and viii) Supports through the transition from benefits to work.

There is strong evidence that IPS produces better outcomes than alternative vocational services at lower cost overall to the health and social care systems and would be viewed as more cost-effective than standard vocational services (Knapp et al., 2013). The study (a multisite randomized trial of IPS in six European countries) showed that 55% of the individuals assigned to IPS worked for at least one day during the 18-month follow-up period compared with 28% of individuals assigned to vocational services. Individuals assigned to vocational services were significantly more likely to drop out of the service (45%) and to be readmitted to hospital (31%) than people in the IPS arm of the trial (13% and 20%, respectively). Randomised controlled trials across the Unites States, Canada and Australia have also shown that IPS participants have much better employment outcomes than groups taking other approaches (i.e. services based on more traditional approaches of "train and place", which provide vocational training and job preparation before looking for competitive employment (Bond et al., 2008).

Investment in skill upgrading and re-training

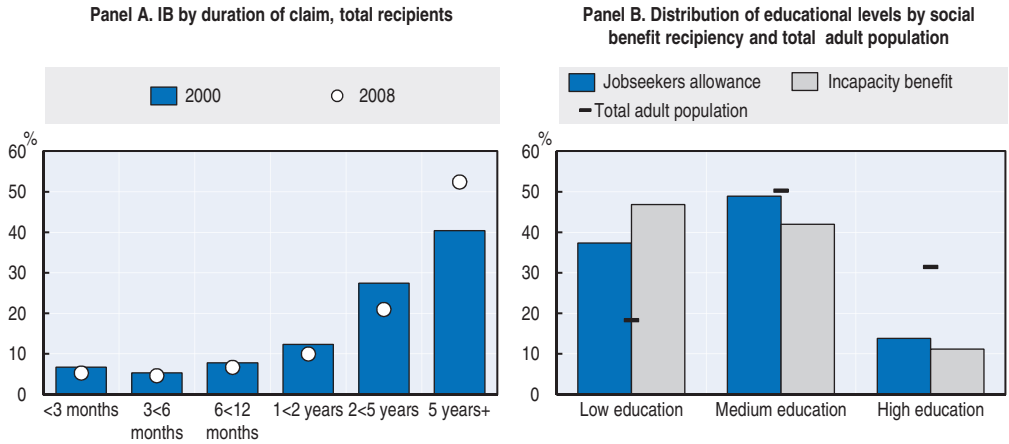
Many ex-Incapacity Benefit (IB) claimants now on Jobseeker's Allowance (JSA) and ESA (WRAG) will have serious deficiencies in skills and relevant qualifications to compete in today's labour market. In 2000s, the average duration of IB claims increased. By 2008 over 50% of claimants had been on IB for five or more years; clearly current ex-IB claimants must often have a long history on benefits (Figure 2.6, Panel A). Survey data confirm that IB claimants are overrepresented among the lower-qualified: qualification levels are lower than those of JSA recipients in general and the share with low qualification is more than double than for the total population (Figure 2.6, Panel B). At the same time, IB claimants are also more likely to have worked in manual occupations as many of them were "shifted" onto disability benefit as a result of deindustrialisation in the 1980s and 1990s. These factors together highlight the need to identify the skills gap and offer corresponding labour market programmes which will be critical to increase the employability of these groups.

Providing adequate training will be one way to raise skills of those who have been out of work for many years. However, reported expenditure on training measures as a percentage of GDP in the United Kingdom is among the lowest of all OECD countries (Figure 2.7), as is active labour market programme spending more generally. This reflects the dominant work-first ideology in the United Kingdom that advocates moving people into employment as quickly as possible. While the work-first approach has generally been more effective in reducing unemployment duration and moving people off-benefits, one challenge for the government is to ensure that active labour market policies promote an appropriate balance of activities. In other words, greater access to skills and training as well as job-brokerage and job-search counselling, particularly in the context of weak labour market conditions where prospects of finding a job for the most disadvantaged are particularly bleak. Further investment in training of the unemployed more generally will be necessary given the rising number of disadvantaged people on JSA (see below). At the same time, it is important to evaluate of the effectiveness of this training against the mixed evaluation outcomes of training programmes more broadly.

Efforts to increase training provisions have been intensified lately. In 2011, the government launched a new initiative which invited providers in the further education and skills sector to prioritise labour market-focused training for benefit recipients.[13] As a result, claimants of JSA and ESA-WRAG (and partners where the claim is joint and both are subject to full work-search conditionality) are eligible for fully funded training to help them into work, provided this is accredited and on the Qualification and Credits Framework (QCF). Training providers can provide short courses

leading to credits on the QCF, or full qualifications, or basic skills. Courses on offer to JSA and ESA-WRAG claimants are generally short (around two to eight weeks), part-time and delivered in small groups. Colleges and training providers are free to negotiate with prime or sub-contractors to meet the needs of Work Programme clients.

Figure 2.6. **Many ex-IB claimants lack skills and labour market experience**



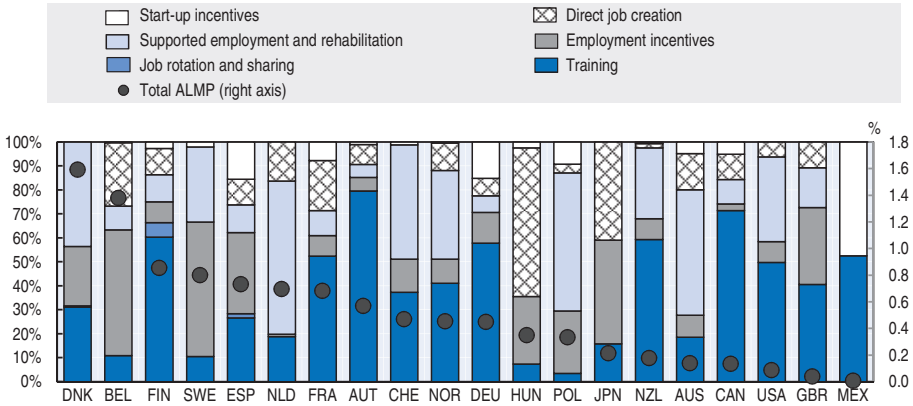
Source: OECD Secretariat calculations: Panel A from the Department for Work and Pensions and Panel B based on the Adult Psychiatric Morbidity Survey 2007.

StatLink http://dx.doi.org/10.1787/888932978740

The prioritisation of JSA and ESA-WRAG claimants in training is in the right direction, ideally targeted to the most disadvantaged. As with WP providers, training providers would also need to take into account health, confidence and motivational barriers of their clients. For instance, in a recent evaluation training providers highlight low motivation, alcohol dependency and drug use as a factor for poor training attendance (BIS, 2012). These outcomes are strongly correlated with mental ill-health and thus likely to be persistent among WRAG, long-term unemployed and ex-IB claimants. The significant shift towards outcome-based funding built into the employment services, the training sector and the health sector (see Chapter 4 for the latter) substantially opens the door for collaborating and integrating different services to provide holistic approaches to helping those with mental ill-health back into employment.

Figure 2.7. **Spending on training measures is almost negligible in the United Kingdom**

Shares of spending by ALMP category and total ALMP spending (in % of GDP), 2011[a]



a. Data for the United Kingdom refer to 2009.

Source: OECD/Eurostat Labour Market Programme Database, www.oecd.org/employment/database.

StatLink http://dx.doi.org/10.1787/888932978759

Balancing obligations and supports

The more financial resources are invested in measures for employment integration of persons with health problems, the more reasonable it becomes to expect people with partial work capacity to make use of them. However, making payment of disability benefits conditional upon availability for work, active job-search and requirements to participate in active labour market programmes remains one of the biggest challenges in disability policy across OECD countries.

Requirements were strengthened but remain modest

The UK Government has made systematic effort to increase obligations for those receiving disability benefits over the past decade. The introduction of mandatory work-focused interviews (WFI) under the Pathways to Work scheme was the first step towards "activating" disability benefit recipients. Under Pathways, the initial WFI normally took place during the 8th week of an ESA claim and individuals thereafter were required to take part in a series of up to six WFIs at intervals of about one month. Failure to attend these interviews could lead to benefit reductions. Under current regulations, claimants in the ESA-WRAG will continue to have mandatory WFIs with Personal Advisers (PA) at the JCP and carry out "work-related" activity, if appropriate to their circumstances. Work related activity and flexible WFIs are tailored to the individual at the discretion of the Jobcentre Adviser. This flexibility is a new

feature of the "Jobcentre Plus Offer" and differs from the previous interventions regime with pre-determined interviews. Claimants in the WRAG receive an initial diagnostic work-focused interview to help identify barriers to work, such as skills gaps or support requirements. The adviser will then draw up an "action plan", which will outline the activities that claimants could undertake to help them prepare for a future move into work. Referrals to WP providers are compulsory for ESA-WRAG claimants (income- related only) with a prognosis of 3, 6 and 12 months. PAs can mandate participants to take part in activities that support a move into employment but cannot ask claimants to i) apply for jobs, ii) take-up medical treatment or iii) take-up work.

Despite substantial progress in regard to engaging persons with partial capacity, these reforms arguably have not been far-reaching enough. ESA-WRAG clients, who in theory should be able to return to work when their health improves, are only required to engage in activity to prepare for paid employment, such as training or rehabilitation but are not required to look for work. In addition, ESA claimants are not required to engage until the outcome of the WCA is known, although this will be changing under Universal Credit where claimants in the WRAG category will be required to engage from day one. In other OECD countries clients with partial work capacity comparable to ESA-WRAG would be placed in the unemployment benefit system with a similar conditionality regime as for the regular unemployed, with corresponding part-time work requirements. Australia has moved in this direction a few years ago, and a similar arrangement has been put in place more recently in New Zealand – in both countries the threshold being the ability to work at least 15 hours per week. Other OECD countries like Austria, Denmark, Germany and Switzerland, use a "rehabilitation-before-benefit" principle as a way of defining responsibilities of claimants; participation in medical and vocational rehabilitation measures is mandatory before a disability benefit can be considered. On this account the UK system is inherently inconsistent: ESA-WRAG clients are not required to look for a job but WP providers are meant to find them jobs. This incoherence jeopardises the success of the regulation. Lessons from other countries – for example single parents in Australia receiving a lone-parent benefit – are pretty clear: the introduction of job-search obligations makes the move off benefits more likely, the offer of job-search support by itself, on a voluntary basis, is not enough (Fok and McVicar, 2013).

Despite the controversy around individual obligations, research suggests mandatory back-to-work support can be effective in facilitating a return to work. A meta-analysis of the various return-to-work programmes in the United Kingdom concluded that the obligatory WFIs and early medical assessment were the key aspects of the Pathways to Work scheme that moved people off benefits and into work, whilst the voluntary components had no

additional employment impact (Clayton et al., 2011, NAO, 2010). These findings are also relevant in the context of the new Jobcentre Plus offer (as mentioned above) under which greater flexibility may threaten systematic intervention for ESA clients. While obligatory WFIs can have an impact on moving claimants off benefits and into work quickly, their quality also matters. For instance, evidence on the new flexible approach shows mixed results with ESA claimants being less positive (see below). In many OECD countries, lack of obligations to participate in work-related activities in part explains low take-up of employment programmes targeted at persons with disabilities. The take-up of these services among those with mental health problems is even lower (OECD, 2010).

Sanctions have escalated and may go too far

Sanctions under the new regime have become stricter for all claimant groups including ESA-WRAG. Failure to attend a WFI or to take part in a work-related activity can lead to a 100% reduction in benefit until the client has satisfied his or her obligations. Thereafter, the sanction continues for an additional week; or even two to four weeks in the case of repeat violations.[14] Similarly, ESA claimants will experience a strict sanctions regime under the new Universal Credit (UC). Though the conditionality regime seems to be similar to current ESA rules, there will be a very strict sanction regime under the UC, with sanctions going far beyond those seen in other OECD countries and much higher than under current ESA regulations (see Box 2.2 for details).

Available data reveal that sanctions are used slightly more frequently for those with mental health problems. In the year 2011/12, 2.8% of all ESA-WRAG claimants with a mental disorder were sanctioned compared to the overall rate of 2.7%; this is equivalent to 67 000 disability beneficiaries (Table 2.6). Data on sanctions under Pathways to Work are unavailable and therefore it is difficult to say whether sanctions are now more frequent. Likewise, international comparisons on the use of sanctions for disability beneficiaries are difficult due to a lack of data.

Under UC, personal circumstances will be taken into consideration before a sanction is applied e.g. if the person has a mental disorder. This is potentially problematic; sanctions can be harsh for those with a mental illness but they can also become too loosely applied for this group if their health problem is “taken into consideration” too generously. It is too early to tell what impact this change could have on those suffering from a mental disorder and whether a right balance will be found.

Box 2.2. **Conditionality and sanctions under Universal Credit**

The "claimant commitment" is at the heart of the new conditionality regime. It is basically a record of a claimant's individual responsibilities in relation to an award of Universal Credit (UC). It includes the "work-related requirements" the claimant has to undertake; the amount and duration of benefit sanctions if the requirements are not met without good reason, together with notice of the right to appeal against a sanction; and the duty to notify changes of circumstances and correct information to avoid recoverable overpayments and prosecution.

Work-related requirements

- *No requirements*: claimants who cannot reasonably be expected to work or prepare for work over a sustained period, or who are already earning all that could reasonably be expected above their conditionality threshold.
- *Work-focused interviews only*: claimants who are only expected to stay in touch with the labour market and begin thinking about a move into work, more work, or better paid work.
- *Work preparation*: claimants expected to prepare for a move into work, more work or better paid work by, for example, participating in the Work Programme, but not expected to look for work yet.
- *All work-related requirements*: claimants expected to move into work, more work or better paid work.

Benefit sanctions

There will be higher, medium and lower level of sanctions. These are applied if a trained decision maker decides a claimant failed without good reason to meet a requirement properly notified to them:

- *Low*: for failure to undertake specific action required by a JCP adviser. Universal Credit payment reduced for every day until the claimant takes the specific action, followed by a further reduction for 7, 14 or 28 days (depending on how many times a claimant has failed).
- *Medium*: for failures to actively seek and be available for work. Universal Credit payment reduced for 28 days or 91 days for second and subsequent failures within a year.
- *High*: for failures to comply with the important job-seeking requirements, including refusing a reasonable job offer or leaving employment voluntarily without good reason. The sanction is withdrawal of benefit of 91 days, 182 days, and 1095 days depending on the number of failures.

In-work conditionality

For the first time, UC will extend conditionality within the benefit system to claimants already in work. Working claimants will be expected to meet a new, "higher" conditionality earnings threshold equivalent to a 35-hour week at national minimum wage rates through a combination of additional employment, higher hourly wages or increased hours.

Table 2.6. **Each year, 3% of all disability beneficiaries face a benefit sanction**

Number and proportion of conditionality sanctions imposed on ESA-WRAG claimants, between 1 June 2011 and 31 May 2012, by main disabling condition

Main Disabling Condition	Number of sanctions (total)	Proportion of claims sanctioned[a]
Mental and behavioural disorders	5 140	2.8%
Diseases of the nervous system	360	1.9%
Diseases of the circulatory or respiratory system	580	2.2%
Diseases of the musculoskeletal system and connective tissue	1 890	3.0%
Injury, poisoning and other consequences of external causes	820	2.9%
Other	2 330	2.5%
Total	11 130	2.7%

a. One sanction per eligible ESA-WRAG claim expressed as a proportion of all eligible claims.

Source: ESA Sanctions Official Statistics, August 2012, Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979158

Finding the right balance

In sum, conditionality has gradually become stricter for persons with reduced work-capacity and it is possible that the sanctions regime may be becoming too harsh. A rigorous activation routine can – mainly through the threat effect – be effective in reducing unemployment duration and related expenditure. However, it is important that increased conditionality translates into effective job-search i.e. finding suitable jobs that lead to better-quality and sustainable job outcomes. Evidence from other OECD countries is mixed and illustrates that benefit sanctions can lower the quality of post-unemployment jobs in terms of both job duration and earnings (Arni et al., 2009). Sanctions have many effects, potentially including family hardship, poorer health, damaged relationships and a higher risk of homelessness (Peters and Joyce, 2006; Vincent, 1998; Dorsett et al., 2011). Persons with mental health problems are likely to be disproportionately affected by some of these effects given that all these factors are strongly correlated with mental ill-health. Evidence also suggests that warnings alone can be sufficient to prevent moral hazard. For Switzerland, Lalive et al. (2005) found that warnings before sanctions occur together with rigorous monitoring of job-search are effective in influencing exit from unemployment. In light of this evidence, sanctions will have to be used with care – also in view of the high poverty rates of the group of people in question (Chapter 1); a too severe sanctioning regime may produce more

losses in terms of well-being of the individual and their families than gains in terms of getting unemployed people into sustainable good-quality jobs.

At the same time, individual obligations and conditionality may not go far enough, certainly for particular ESA claimant groups. ESA-WRAG clients in the first year of their contributory disability benefit payment have no obligations to register with a WP provider (if they choose to join the Work Programme their participation becomes mandatory) but are required to attend WFIs at the discretion of advisers. After this year, if they are not entitled to the income-related ESA follow-on benefit (and only qualify for credits), they face no obligations either nor will they be referred to a WP provider. They can seek support on a voluntary basis. For this group, more obligations (and corresponding sanctions) are indicated in exchange for an obligation for the state to provide adequate services. This occurs both in the first year when this group receives a contributory payment and in the second year when they stay on the ESA records as credit-only cases. For the latter group which does not receive actual benefit payments, sanctions could take the form of a loss of the credit.

These concerns are also particular relevant for the Support Group which is exempt from requirements and work-related activities altogether and, accordingly, will receive very little active help to find employment or improve employability. In this context, participants' particular with severe mental health conditions could be offered employment support through the Individual Placement and Support model (IPS) as discussed above.

Addressing the "flaws" in the Work Capability Assessment

The number of appeals is gradually reaching an acceptable level

The Work Capability Assessment (WCA) lies at the core of the disability reform. The biggest objective of the assessment was to move from assessing the person's incapacity to assessing his or her capacity. The assessment looks at an individual's physical and mental capabilities and concentrates on the functional effects of an individual's condition rather than the condition itself. A DWP decision maker uses the WCA along with all other available evidence (including any medical evidence provided by the individual's GP or specialist) to determine an individual's capability for work and the appropriate work-related activity.

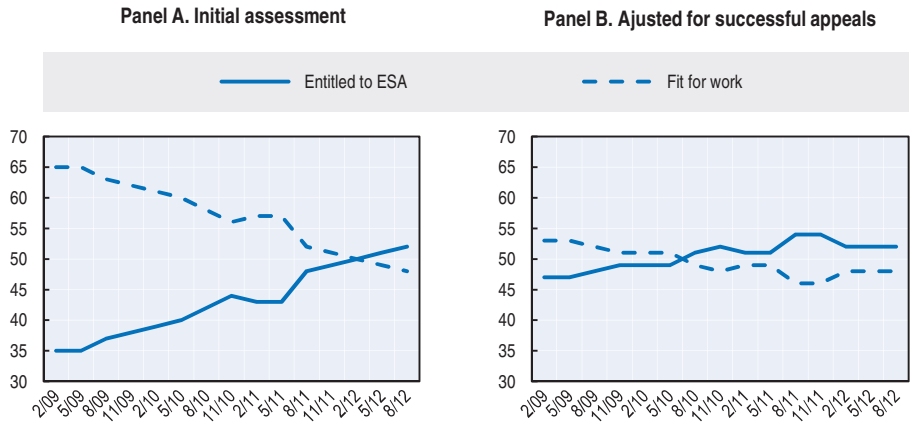
WCAs are delivered by a private company (Atos Healthcare) which employs healthcare professionals to carry out the assessments. This includes a mix of GPs, physiotherapists and nurses. The design and implementation of the WCA have been under scrutiny for some time most notably due to

many claimants being "wrongly" assessed. The appeal rate and the corresponding rate of successful appeals have been very high. The government has attempted to change and improve procedures based on a series of independent reviews of the WCA but a recent parliamentary enquiry into the WCA concludes that WP providers continue to receive claimants who are unfit for work (Work and Pensions Committee, 2013).

Available data suggest that the WCA reforms are slowly bearing fruit. In its first years, the difference between initial and post-appeal assessment outcomes was very large but the gap was gradually closed by late 2012 (compare Panels A and B in Figure 2.8). The ultimate assessment outcome was rather stable over time, with around 50% each either found fit for work or entitled to ESA. Today this outcome is largely achieved through the initial assessment whereas previously wrong assessments were "corrected" by the high appeals rate.

Figure 2.8. **The quality of work capability assessments has improved**

Outcome of functional assessment for those entitled to ESA by date of claim start: initial outcomes (Panel A) and outcomes adjusted for successful appeals (Panel B), 2009-12



Note: The x-axis refers to the three-month period ending in the month indicated and data refer to new claims made for Employment and Support Allowance only.

Source: Employment and Support Allowance: Outcomes of Work Capability Assessments, Great Britain; DWP: *Quarterly Official Statistics Bulletin*, No. 30, April 2013.

StatLink *http://dx.doi.org/10.1787/888932978778*

Involvement of mental health experts remains inadequate

Among the many challenges identified in the independent reviews of the WCA, the most important was how it takes account of mental health problems and fluctuating conditions (Harrington, 2010). This is a pressing issue in many OECD countries as assessment procedures continue to focus on physical health conditions and are often delivered by generalist medical professionals who may have only a limited insight into mental health conditions. Following the Harrington review, "Mental Health Champions" (MHC) were introduced in the WCA process with the primary aim to provide advice and coaching to healthcare professionals at any stage in a case the claimant has a mental illness. The recruitment of mental health experts has obvious advantages, but subsequent evidence suggested "they have little or no impact on the quality of mental function assessments" (Harrington, 2012). Some representative groups claim that the awareness of MHCs is low and not all are qualified psychologists or psychiatrists. One drawback currently is that much of the MHC advice is delivered through a telephone service. This may affect the quality of the collaboration between health professionals as well as its frequency. In other words, systematic intervention by mental health experts is lacking and their involvement is largely at the discretion of the Atos assessor who in turn may not be able to judge when to involve a MHC. Moreover, there are only 60 MHCs across the country which may not be sufficient for a systematic involvement in all cases.

The restricted sharing of assessment results creates problems

One major problem with the current WCA procedures is that the results from the assessments are not always shared with those charged with responsibility of helping people back into work i.e. JCP and WP providers. This is not surprising as anecdotal evidence suggests that only very limited work-relevant information is generated through the WCA. DWP has started pilots to examine possible approaches to improve co-operation between WCA decision makers and personal advisers of JCP. New methods trialled in these pilots were more successful for individuals found not to have Limited Capability for Work or Limited Capability for Work Related Activity after undergoing a Work Capability Assessment (who would then usually apply for JSA) than those individuals who were found to have Limited Capability for Work or Limited Capability for Work Related Activity. As a result, a new WCA outcome template for disallowed cases will be implemented nationally as of the end of 2013. However, further improvements are still needed to generate better information on clients' work-readiness and other factors that may help claimants in their job search for those eligible for ESA.[15] A separate component of the assessment for ESA was the Work-Focused

Health-Related Assessment (WFHRA) which focused on health-related workplace barriers, was suspended before the start of the WP.[16] The WFHRA looked at what work the claimant might be capable of doing and how their condition can be managed to help them find and stay in work. Though the WFHRA had the right goals, there were a number of weaknesses in the process. First, the objective of WFHRA was not clear for many claimants in the assessment phase; it was often misunderstood as a "second medical assessment" (Barnes et al., 2010). Second, the assessment was delivered through Atos medical staff without the competence to discuss work-related issues and little understanding of the type of work-related supports available to claimants through JCP. Third, there was no systematic procedure on the number and type of questions asked in the WFHRA process.

The WFHRA could be improved along the lines of the new workability assessment tool currently developed in Denmark (OECD, 2013d). Similar to the WFHRA, the workability tool intends to identify tasks the persons can do, their work motivation and workplace barriers. The assessment is delivered by a multidisciplinary team involving municipal caseworkers, occupational therapists, psychologists and psychiatrists. A preliminary evaluation concluded that the new approach can result in positive effects on sickness absence duration and return-to-work, provided assessments are done and action is taken early, in a multidisciplinary and co-ordinated way and directed towards the workplace. Sickness absence in trial sites was shown to have fallen by 2.6 weeks on average (NRCWE, 2012). Elements of this approach could be adopted by either JCP, or alternatively, by WP providers who may significantly benefit from additional information that helps them to understand barriers of hard-to-help clients e.g. the type of support or adjustment in workplaces suitable for clients with mental health problems.

Long assessment and appeals procedures delay necessary intervention

The operational problems in the WCA in turn are delaying intervention for beneficiaries to help them back to work. For the three-month period to February 2013, almost 496 000 claimants (equivalent to around 34% of the ESA caseload) were either waiting for their WCA to be completed or an appeal decision on their claim to be taken (Table 2.7). Over 200 000 persons were waiting for at least six months, and some even more than two years. This is in sharp contradiction to the original objective of the WCA which aimed to have an assessment completed within 13 weeks of the initial claim. Claimants with a mental disorder or a disorder of the nervous system dominate this claimant group, presumably reflecting the complexity in assessing the work capacity for these cases.

Table 2.7. **Waiting times for ultimate assessment decisions are very long**

Number of beneficiaries in assessment phase by duration and health condition, February 2013

	Up to 3 months	3 months up to 6 months	6 months up to 1 year	1 year and up to 2 years	2 years and up to 5 years	Total
Total	166 020	113 800	108 490	71 180	36 890	496 380
Mental disorders	39 180	24 890	22 370	14 680	8 150	109 270
Nervous system	69 120	50 250	47 900	31 220	15 610	214 100
Circulatory or respiratory system	4 790	3 550	3 250	2 100	1 060	14 750
Musculoskeletal system	9 460	6 120	5 930	3 990	2 130	27 630
Injury, poisoning	24 520	19 040	20 900	13 950	7 400	85 810
Other	18 940	9 960	8 150	5 230	2 540	44 820

Source: Department for Work and Pensions.

StatLink http://dx.doi.org/10.1787/888932979177

The long waiting period until a decision is taken as to whether a claimant is entitled to an ESA payment and with what participation requirements means that necessary intervention is delayed and early intervention is often impossible. Participating in work-related activities might be considered unfair before a decision has been made on whether a person qualifies for WRAG or SG (or maybe no benefit at all). However, it will be important to engage this group early on, for example in the form of interviews with PAs from the JCP, to discuss and if necessary address health and work-related barriers earlier.

The recent initiative by DWP to raise capacity by bringing in new assessment providers while also improving the quality of assessments through a strengthened quality assurance process is welcome.[17]

Recognising and addressing mental health needs of all benefit recipients

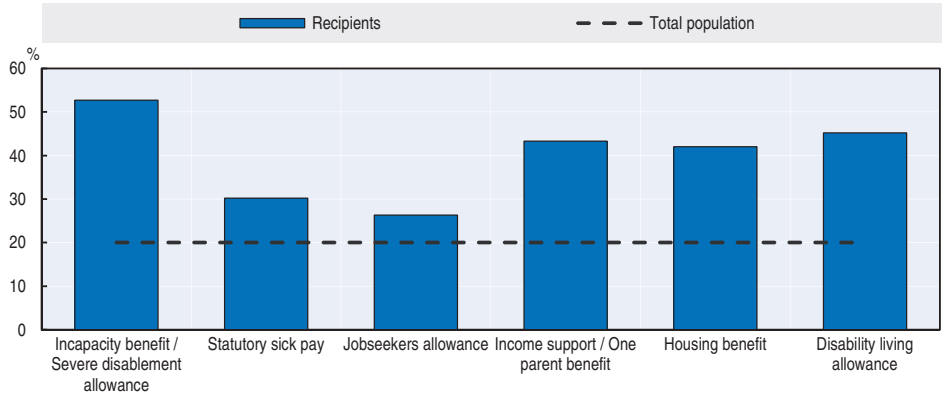
Mental health issues are not only of concern for the disability benefit system alone. Given their weak attachment to the labour market, people with mental ill-health frequently move in and out of work and shift between different benefits, primarily between unemployment and sickness and disability benefits.[18] The need to tackle health-related work barriers of recipients of various working-age benefits has further intensified with the ongoing reforms where the borders between sickness and disability and unemployment schemes are fading away.

Mental health problems are widespread among inactives and unemployed

Population survey data suggest that especially among people receiving income support, one-parent benefit, housing benefit or the Disability Living Allowance, the share with a mental disorder, at over 40%, is very high – close to the share found for those receiving a disability benefit (Figure 2.9). Also among recipients of Statutory Sick Pay or JSA, the share is higher than in the population not receiving a benefit. Often this will be a common rather than a severe mental disorder and often a problem not diagnosed or treated (because the data are based on self-assessment). But the claimant's mental health problem will often be a key barrier to move off benefit and return to work.

Figure 2.9. **Mental ill-health is very widespread among social benefit recipients**

Of all people receiving selected social benefits, the percentage of those who have a mental disorder, 2007



Source: OECD Secretariat calculations based on the Adult Psychiatric Morbidity Survey 2007.

StatLink http://dx.doi.org/10.1787/888932978797

The international evidence on mental health conditions among the unemployed and their impact on job-search behaviour and outcomes is limited. However, the first national longitudinal study in the United Kingdom dedicated to examining the psychological health and well-being of JSA claimants (McManus et al., 2012) has generated urgently needed evidence for better policy making for this group. A number of important findings emerge:

- *New JSA claimants started a claim with worse mental health than that of the rest of the population*. In the four months that followed, one-third of them experienced a recovery or improvement in their

mental health, one-third experienced little or no change and one-third experienced a deterioration.[19]

- *Job-search activity varies with mental health*. Overall, people with mental ill-health had less confidence in their job-search abilities and sent out fewer job applications.
- *JSA claimants with mental health problems were less likely to enter a job.* One-third of JSA claimants without a mental disorder had found work four months later (by the time of the second interview). This compared with one-fifth of people with a common mood or depressive disorder, and about one-sixth of those with a severe mental disorder.
- *Finding a job is associated with recovery of mental health* while a higher risk of deterioration of mental health is associated with factors like having a longstanding health problem or an anxiety disorder, living in an urban area, and continuing to experience adverse events while unemployed.

These findings show that mental ill-health is a significant barrier in finding jobs for JSA claimants. This highlights the need for further developing policies to address mental health problems of this group.

Mental ill-health is rarely addressed in the early phase of an unemployment spell

In view of the large and growing number of people with milder mental health problems on the JSA and ESA caseloads, the initial period JSA and ESA customers stay with JCP – before being transferred to a WP provider – is critical. The delivery of appropriate services during this period is tightly linked with timely and accurate identification of vulnerable groups. Currently, there are no formal, system-wide profiling tools used by JCP. Identification of need and early referral to targeted support is partly dependent on which benefit the customer is claiming. A Customer Assessment Tool is available to personal advisors to help them identify their customers' main barriers to work. The tool is largely based upon a set of responses to ten "statements" which look at jobseekers' skills, confidence, willingness to carry out job-search and so on but has no way of identifying mental health issues. In addition, the use of the assessment tool is varied with relatively more experienced advisers using it as a confirmation tool rather than a diagnostic tool and less experienced advisers using it as a tool to provide structure and guide their interviews with a customer (European Commission, 2010).

One particular concern with using the type of benefit to identify needs is that people with "invisible" disabilities, such as mental health conditions, claiming unemployment benefit may not be identified as vulnerable when they should be. As a result, effective support (including treatment) can be delayed for several months or possibly years which in turn can starkly impact the transition into work and the ability to search for jobs effectively (as discussed above). Distinguishing by benefit will also become increasingly inadequate in light of the recent reforms whereby people on sickness and disability benefit are increasingly moving to unemployment benefit.

The poor identification of those with mild and moderate mental disorders particularly raises concerns for ESA contributory claimants, for two reasons. First, they are not mandated to join the WP and, thus, do not qualify for the intensive support albeit having similar health barriers to those that are mandated. Second, lack of early identification and intervention is a missed opportunity given their close proximity to the labour market. ESA claimants with a longer duration prognosis placed in WRAG (i.e. those with prognosis of more than 12 months) would also be affected as they will spend at least one year with JCP before being referred to a WP provider.

Mechanisms to recognise the needs of unemployed persons with mental health problems are still under-developed across OECD countries but a change is occurring in a few. For example, in Belgium the public employment service addresses health problems routinely because persons with health-related needs are typically kept in the unemployment system (rather than shifted onto the disability scheme). Jobseekers in Flanders are systematically assessed for mental health problems. Cases with more severe barriers are sent for a diagnosis to an in-house psychologist or an external research centre specialised in in-depth multidisciplinary screening (OECD, 2013e).

Raising mental health awareness among personal advisers is critical

For many JSA recipients an interview with a PA is the only opportunity to raise their health concerns. But advisers do not have the right competences and training to address mental health problems. According to the above-cited recent study among JSA claimants, discussions on strategies for finding work are common during these interviews, while only a few claimants felt that their health or well-being was discussed, and where it was, the focus was on physical rather than mental health conditions. Survey findings from DWP also show that JSA claimants tended to be wary of raising health issues "in case it cast doubt on their availability for work". This raises the need for health issues to be addressed more proactively by

JCP advisers, so that a combination of employment and health support can be provided to customers with work-limiting health conditions.

PAs have a central role in both recognising mental health problems and referring individuals to corresponding health and employment support especially in absence of a robust profiling tool which is currently the case in Jobcentre plus offices. The recently built mental health toolkit (as mentioned above) which is also available to advisers in JCP is the right way forward in empowering JCP caseworkers in providing better support to claimants with mental health problems. Establishing good communication and sustainable relationships with their clients can also help to change their attitudes about work and taking up employment opportunities and training. Survey findings among JSA claimants suggest that claimants who felt that they were supported and encouraged were more likely to see their mental health improve in the months that followed (McManus et al., 2012). The quality of interactions with jobseekers and their success in job placements for people with common mental disorders can be further improved by psychologically trained caseworkers as shown in the case of Denmark (OECD, 2013d).

There, the psychologists talk to clients as life coaches, not therapists. The focus of the counsellor who has weekly one-to-one meetings with the client is on training and employment, not the client's personality; talking about returning to work, psychological counselling and helping to *access* mental health treatment are key aspects during these meetings.

Rapidly changing profiles of JSA claimants and WP customers

In many ways, recent policy changes in the United Kingdom seek to correct for past policy mistakes whereby unemployed persons were shifted to sickness and disability benefits in order to reduce unemployment (OECD, 2010 and OECD, 2007). This diversion between unemployment and health benefits in the United Kingdom has been documented extensively. For instance, Beatty and Fothergill (2005) estimated that up to 900 000 unemployed had been diverted onto disability benefits in response to deindustrialisation in the 1980s and 1990s and in areas with insufficient aggregate labour demand. The latest reforms will lead to the reverse development: it is estimated that 78% of the WP caseload by 2014 will have some current or previous connection to ESA or IB, either having being transferred to JSA from IB; new ESA claimants being assessed into JSA, or ESA-WRAG claimants – i.e. the WP is dealing mainly with hard-to-place groups (Heap, 2012).

Both the reassessment of the existing disability benefit caseload and stricter eligibility criteria set an example for other OECD countries that are struggling to realign the disability and unemployment benefit systems.

However, many people on IB are likely to have picked up mental health problems in the course of their lives. Therefore improving work-related issues alone will not bring them to the front of the queue for jobs. The new tougher threshold for ESA excludes some people with ongoing but still work-limiting health issues. Similarly, some ESA contributory claimants whose claim automatically comes to an end after 365 days who typically move on to JSA will also still have health-related issues. More recognition of health issues including mental health issues within the JSA regime is needed in order to bring people back into employment.

One major issue is that with the change in benefit status, from disability to unemployment, there is a risk that beneficiaries receive less intensive and less individualised support during the WFIs with their JCP adviser (compared with the support they would have had otherwise under the ESA/IB status). A follow-up study of those who claimed JSA immediately after their ESA claim ended confirms this. JCP staff gave little individualised support addressing claimants' health problems but also little focus on improving job-search techniques. The latter may show preconceived attitudes of caseworkers who believe that previous ESA claimants with partial work-capacity cannot work. Moreover, staff in the JCP office changed from interview to the next which meant that claimants could not develop a relationship with the person they were seeing (Barnes et al., 2011). This must be seen against evidence suggesting that the probability of these JSA claimants to move into work is only half of that for JSA recipients with no sickness or disability benefit history (McManus et al., 2012).

Since 2011, PAs have been given more flexibility to tailor support for clients, known as the "JCP offer". Results show that support for ESA claimants continues to be sub-optimal: ESA claimants "do not seem to discuss or receive support to the same extent as JSA claimants" (Coulter et al., 2012). This was a particular concern for ESA claimants that were looking for work (around 16% of all ESA claimants surveyed). Determination of claimant needs was fairly unstructured, with advisers using their intuition, experience and knowledge as their main diagnostic approach rather than formal diagnostic tools. According to the final evaluation of the new procedures, JSA claimants like ESA claimants with specific constraints and particular challenges, including those with a disability (particularly a mental health condition), looking for work do not always seem to discuss or receive the level of support they require and have less positive perceptions of the offer (Bloch et al., 2013). The evaluation recommends that support should be enhanced to meet the needs of ESA claimants looking for work; to ensure they are being signposted and referred to appropriate support to help

them into employment; and it would be beneficial to implement specific monitoring to identify advisers who are struggling in this area.

The role of Job Centre Plus and its competencies in dealing with hard-to-help clients will also become increasingly important as claimants return to JCP after having participated in the Work Programme for two years. Important findings emerge from pilots which tested different strands of employment support for those completing the WP. These pilots ran from November 2011 to July 2012 to support the very long-term unemployed who remained on JSA having completed their time in employment programmes but did not find a job. According to the evaluation, the very long-term unemployed tended to have complex needs and a range of different challenging barriers. These included very low motivation, low confidence, ill-health and disability (including mental health problems and learning disabilities), and drug and alcohol dependency. The impact analysis showed that those being assigned to the Community Action Programme and Ongoing Case Management spent significantly less time on benefits and more time in employment in comparison to the control group in which participants were offered the standard JCP interventions. Subgroup analysis suggests that Ongoing Case Management is effective across age categories, in particular those aged 50 years and over. It is also effective for participants that self-identify as having a long-term illness or disability. In other words intensive and continuous support including frequent contact with the same adviser seems to be effective (Rahim et al., 2012; McAuley, 2013).

The move towards Universal Credit is welcome but does not automatically secure better employment outcomes

October 2013 will see the launch of the Universal Credit (UC), probably the biggest ever move across the OECD towards a single working-age benefit. It will entirely replace the system of means-tested benefits and tax credits for working-age adults, including Income Support, income-related JSA and ESA, Working Tax Credit, Child Tax Credit and Housing Benefit. A simplified benefit system and one that makes work pay by improving incentives to work are a core rationale underpinning this new benefit.

The move to UC is welcome as it will reduce the difference between disability benefits and other working-age benefits; in particular in terms of benefit generosity and conditionality which in the past has resulted in people i) moving from unemployment to disability benefit and ii) being shifted around between different benefits and agencies and not supported in the best possible way.

Some of the planned changes coming with UC, primarily the increased flexibility in the benefit system, will be especially helpful for clients with a

mental disorder who often suffer from fluctuating conditions and as a result are more likely to move in and out of work. In other words, UC could act as a temporary benefit and remove any risk associated with transitions into work and, by reducing administrative burden, smooth these transitions.

In spite of this positive development, there is a risk that attention to health, particularly mental health issues will be limited. The impact evaluation of the UC estimates that it could lead to 300 000 additional people working (DWP, 2012). However, a significant proportion of the population on UC will be suffering from mild and moderate mental health problems. In addition, the share of this group with health-related needs is likely to grow further as claimants on contribution-based ESA exhaust their maximum payment duration of one year and consequently apply for income-based ESA.[20] A "one size fits all" customer focus will fail to identify all vulnerable UC claimants.

Conclusions

The welfare system in the United Kingdom has gone through comprehensive reform in the past ten years or so, including a series of disability reforms and culminating in a move towards a single working-age payment, the Universal Credit. The aim of the disability reforms was to reduce the huge disability benefit caseload by both lowering the number of new claims (through stricter assessment and eligibility) and moving large numbers off benefit (through reassessment and recently means-testing and time-limiting of payments). This will not mean, however, that those with very real health problems in areas with limited employment opportunities will be more able to compete in the workforce. Some people will be moved onto unemployment benefits and others will be excluded from benefits, but this will not translate into higher employment rates for some individuals unless their health-related employment barriers are also being addressed as part of the activation agenda.

In parallel to the welfare reform, employment support has 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, the free choice of service for WP providers implies that little is known about what is being done (services offered are a black box) and service funding still provides significant incentives for "parking" implying that clients facing greater hurdles to finding employment, including those with mental health conditions, are frequently underserved.

Despite far-reaching reforms, the right balance between responsibilities, sanctions and supports is still to be found. The move towards stronger

obligations also for ESA claimants is evolving but more can be done; some claimants have to participate in the WP but there is no requirement to look for work; and for others interventions remain entirely voluntary. Sanctions for non-fulfilment of obligations, on the other hand, are possibly too harsh when the same effect can probably be achieved with a less strict regime.

Finally, despite improvements, the lack of early intervention especially in the sickness and disability schemes – a key problem in the UK system for a long time – continues to be an obstacle for a swift return to work. People with work barriers and health conditions could still find themselves in the welfare system for a long while before their employment barriers are being addressed.

Overall, the shift in the United Kingdom towards a single working-age payment and one Work Programme that serves all jobseekers (or most of them because some special disability employment services remain outside) seems incomplete. There is widespread awareness that WP providers will have a more difficult clientele in the future with a high prevalence of (mental) health conditions, but little is done to identify those people and to assure they get the right health and employment services quickly. People on JSA in particular are unlikely to see their health problems addressed.

In this context, the following recommendations are put forward to increase the effective employment support provided to jobless people with a mental disorder:

Increase attention to mental health in all benefit programmes

- *Identify mental health problems systematically in all benefit schemes, especially also in UC*. Some mental health conditions can be detected by enhancing knowledge of caseworkers on such conditions while others will require the use of a validated instrument to screen for existing or potential mental disorders that pose a labour market barrier and require treatment. These instruments are readily available and can be used when a problem is suspected. Such tool should be used across the range of beneficiaries and clear guidelines be developed on how and where to refer customers at risk; the challenge is to avoid wasting resources on conditions that will improve while enabling specialist support quicker for those who need it.
- *Put more focus on integrated employment and health measures*. Job Centre Plus and WP providers can involve external expertise and outside psychologists and recommend the use of proven therapies. However this may result in delay of treatment of milder disorders in

view of the shortage of psychological therapies more generally. To tackle this, JCP and WP providers could either i) increase specialist in-house provisions by integrating mental health experts in employment service delivery teams or ii) improve the co-operation with the health sector and jointly commission psychological therapies. For the latter, it will be important to ensure that employment measures are on a par with health advice and treatment. *Automatically enrol ESA (WRAG) both contributory and Income-related and JSA clients with mild and moderate mental health disorders to IAPT*. This will ensure these clients with a mental disorder have quick and secure access to psychological services which can treat individuals quickly. This could be done when the client first goes to the Jobcentre after the award of ESA.

- *Begin pilots using the approach of evidence-based models such as the IPS for those with common mental disorders.* The IPS model has been successful in moving individuals with severe mental illnesses into employment. How to translate this success for individuals with mild and moderate disorders should be considered.

Strengthen early intervention in the welfare system

- *Raise efforts to help early on*. Make sure to reach people at risk earlier by shortening periods in which additional barriers could remain unrevealed. Any mental health screening, for example, should be applied at an early stage – for instance by using pre-screening tools during the WFIs.
- *JCP role in first year is critical*. More support by JCP during the first year is important in view of return-to-work probabilities which decline very rapidly over time. Such early support would be particularly important for some JSA and ESA contributory clients who are not mandated to join the Work Programme but likely to have additional health-related work barriers which are often discovered only after the first year of unemployment.
- *Improve work-relevant information generated by the WCA*. The adequacy of the WCA for clients is critical for early intervention; for example, timely more work-relevant information in the WCA would be needed and shared accordingly between JCP advisers and WP providers to offer right employment support early on. Reintroducing a strengthened, multidisciplinary Work Focused Health Related Assessment (WFHRA) in addition to the WCA would help the discussions with the JCP adviser as well as the WP caseworker should be considered.

- *Refer reassessed ex-IB claimants to the WP in a timely way*. All those losing their IB or ESA entitlement after a reassessment should be referred to a WP provider quickly to assure a swift return to the labour market for those people.
- *Carefully monitor destinations*. People who are found fit for work (be it through a first assessment or a reassessment) should be followed-up and their destinations tracked over specified periods – as a means to evaluate and understand the impact of the new regulations and to be able to offer support quickly if people fail to return to work.

Improve the effectiveness of the Work Programme

- *Getting provider incentives right*. Extend the WP pricing model to address the current focus of providers on those most job-ready. The pricing could relate to a combination of three factors: labour market distance, benefit status and health needs. This in turn will require for DWP to develop a robust profiling instrument which can be used to identify different groups and corresponding outcomes payments. In addition, consider to increase outcome payments with the proportion of clients helped into sustained employment within each payment group ("accelerator factor").
- *Increase resources for those with mental ill-health*. More resources are required for providers to address health needs and mental health needs in particular. This could be achieved by ring-fenced extra funding, which should be tied with addressing needs identified in the WCA.
- *Increase resources in the Work Programme generally*. More generally, labour market policy and WP spending is low in the United Kingdom compared with other OECD countries. Caseloads of 120-180 clients per caseworker are far too high for any targeted casework.
- *Pay attention to skills of (ex-IB) claimants*. Skills development of WP customers is another aspect requiring more focus and funding. This is especially true for former disability beneficiaries displaced from old industries many years ago and now required to move back into the labour market. Many of those people face both (mental) health and skills barriers.

Find a better balance between rights and responsibilities

- *Tighten and extend job and training obligations for ESA (WRAG) group*. For many jobseekers obligations remain weak and partial. Work-search requirements should be increased for ESA clients in WRAG group in line with other OECD countries where claimants with partial work-capacity are placed on unemployment benefits. Such work-search requirements should be combined with treatment, rehabilitation, and training fully in line with their health and skills needs and adjusted in line with changes in, for example, work ability.
- *Consider lowering sanctions*. On the contrary, sanctions for not fulfilling existing obligations can be fierce – putting more pressure than necessary on the client and his or her family but also on the JCP adviser taking the benefit sanction decision. This issue is also critical in view of very high poverty rates in the United Kingdom for people with a mental disorder.

Notes

1. Estimates suggest up to nine in ten workless people with a mental health condition want to work.
2. The aim of the previous government was to reduce the number of disability benefit recipients from 2.5 to 1.5 million. This aim was part of a broader strategy to aspire towards reaching an employment rate of 80% in the United Kingdom.
3. For a short description of the benefit system and the distinction between contributory and income-based payments, see Chapter 1.
4. The disability benefit caseload includes people receiving Incapacity Benefit, Income Support with a disability, or Severe Disablement Allowance.
5. Looking at trends over time is, at this stage, only partially meaningful given the number of measures that are being phased-in or phased-out; it will take a few more years for the entire system to reach maturity.
6. Table 2.2 also shows much higher outflow rates for those still in the assessment phase; many of those people will never make it onto ESA which is why these numbers cannot be interpreted as outflow from ESA, but instead should be seen as a prevention of new ESA claims.

7 . DWP and others have argued that the One-Year Job Outcome Measure better captures performance than the MPL indicator (SMF, 2012; and CESI, 2013). One weakness of the MPL indicator is that the denominator includes referrals for some claimants who had not been in the programme long enough to achieve six months, i.e. the time at which providers receive their job outcome payments, thus pushing down the performance rate. In addition, the annual MPL figure is very sensitive to the level of referrals; declining referrals will make performance appear better while increasing referrals will make performance appear worse.

8. Spending on activation requirements (including job-brokerage and job-search monitoring) which are implemented largely captured by Category 1 is relatively high in the United Kingdom. However, spending on other labour market programmes such as training and skill development, work experience and subsidised employment is exceptionally low.

9. In both Australia and the Netherlands there is no payment to the provider beyond the 13-weeks employment target.

10. Prime providers partly deliver their services through subcontractors and have configured their supply chains in diverse ways. Two of the largest primes, Serco and G4S, subcontract all service delivery. All other primes subcontract to some extent, either to "Tier 1" subcontractors, who generally deliver the end-to-end process and/or to "Tier2" subcontractors who deliver specialist interventions for particular types of clients, often with more complex barriers to employment.

11. CMP services delivered a range of interventions including pain management, exercise planning, and stress management, techniques to improve sleep, relaxation therapies, and anxiety management. At the centre of the CMP model was a commitment to the principles of cognitive behavioural therapy (CBT) techniques as a means of helping clients to manage health conditions.

12. Lagerveld et al. (2012) compared the effectiveness of two individual-level psychotherapy interventions including i) cognitive-behavioural therapy (CBT) and ii) work-focused CBT that integrated work aspects early into the treatment based on a quasi-experimental design. Both interventions were carried out by psychotherapists with employees on sick leave because of common mental disorders (depression and anxiety disorders). A full RTW occurred 65 days earlier; partial RTW occurred 12 days earlier and a significant decrease in mental health problems was equally present in both conditions. Earlier study confirmed these findings (Blonk et al., 2006).

13. In England, the Department for Business, Innovation and Skills (BIS) holds the budget for training, which is contracted out to colleges and independent training providers through the Skills Funding Agency (an agency within BIS).

14. Previously, non-compliance would lead to a benefit reduction of GBP 14.07 a week, rising to GBP 28.15 a week after four weeks, until claimants met conditions.

15. Evaluation of the templates identified that the quality of the Personalised Summary Statement information was poor in comparison to those provided by Atos HCPs in other regions. The Project observed that the majority of statements in the Pilot were too generic and standardised and not personalised to the claimants circumstances.

16. The WFHRA was originally carried out immediately after the face-to-face WCA, meaning that all ESA claimants, regardless of their eventual claim outcome, were required to attend a WFHRA. The two assessments were subsequently decoupled and only those in the WRAG were required to attend a second appointment for a WFHRA, at a later date.

17. In July 2013, DWP contracted an independent institute to provide advice on how to strengthen quality assurance in its health and disability assessments and also requested Atos to put in place a performance improvement plan.

18. For instance, evidence on destinations of ESA leavers shows that around 41% of benefit recipients immediately claim for another out-of-work benefit. Among this group, almost four in five had started claiming JSA (Adams et al., 2012).

19. This is based on three measures: how satisfied people are with their life overall; positive (feeling happy) and negative (feeling anxious) feelings related to how they felt yesterday; and how worthwhile people feel are the things that they do.

20. According to DWP's impact assessment, up to 60% of ESA claimants will be eligible for income-related ESA follow-on payments when the one-year time limit is reached (DWP, 2011a).

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Chapter 3

Sick on the job: The role of employers in the United Kingdom

Employers are ideally placed to help people in the workforce to deal with mental health problems and retain their jobs. This chapter first describes the link between mental ill-health and working conditions, reduced productivity and sick leave. It then discusses prevention strategies to address psychosocial risks at work as well as strategies of UK employers to deal with mental health problems at work and their role towards managing sickness absence. The chapter ends with a focus on new reforms in the United Kingdom to address sickness absence and improve early intervention in the sickness period and related implementation challenges.

Introduction

Common mental health problems are widespread at the workplace. This is because contrary to expectations, a significant number of people with mental health problems are in employment, and the intricate relationship between work and mental-ill health implies that despite work being beneficial, poor-quality jobs and work-related stress can exacerbate or even trigger mental illness. Poor mental health at the workplace carries enormous costs for employers through sickness absence and reduced productivity while at work. It also generates high welfare costs as the lack of intervention at the workplace leads many people to leaving the labour market altogether and resorting to long-term sickness and disability benefits. This is why tackling mental health problems at the workplace should be a top priority and employers are in the best position to do so. Employers in the United Kingdom are increasingly becoming aware of the adverse consequences of mental ill-health. At the same time, the policy field in regards to fostering an early return to work after a period of sickness absence is evolving. However, there are concerns whether the right balance between employer obligations and employer incentives is being achieved for new policies to work effectively and for employers to do the utmost to prevent mental health problems arising at the workplace.

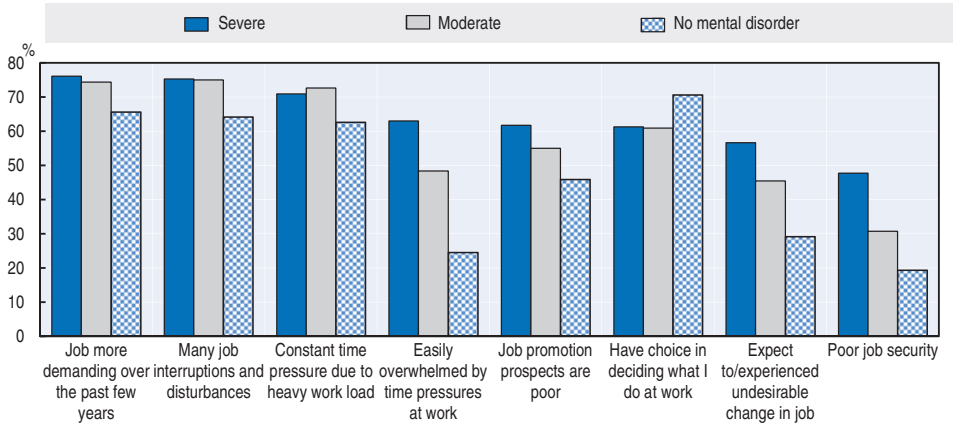
Mental health is closely associated with workplace factors

OECD (2012) concluded that: workers with a mental disorder tend to work in jobs of poorer quality; job strain can have a significant negative impact on the worker's mental health; over time, self-reported job strain has increased in most occupations; and good management is one of the key factors in assuring quality employment and mitigating workplace mental health risks.

Data from the Adult Psychiatric Morbidity Survey of 2007 corroborate these findings. People with a severe or moderate mental disorder on average report having: less autonomy in their work; higher job insecurity; and poorer job promotion prospects (Figure 3.1). They are also more likely to report that jobs have become more demanding over the past few years. Moreover, workers with a mental disorder more often report: being overwhelmed by time pressures at work; having many job interruptions and disturbances; facing constant time pressures due to high workload; and experiencing undesirable changes in their jobs.

Figure 3.1. **Workplace factors are highly correlated with mental health**

The share of those who "agreed" with the statement, 2007



Source: OECD calculations based on Adult Psychiatric Morbidity Survey, 2007.

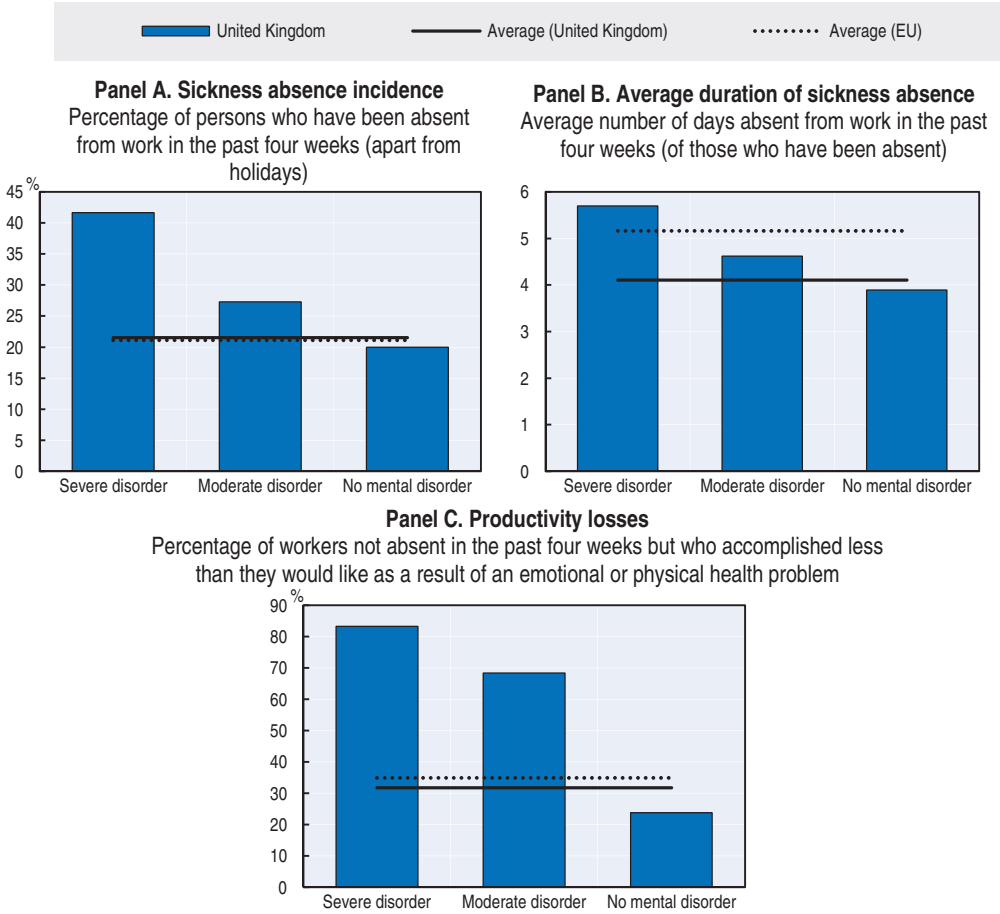
StatLink http://dx.doi.org/10.1787/888932978816

Simple associations between working conditions and the mental health status, however, do not proof causality. They could instead illustrate that workers with poor mental health are less likely to find high-quality jobs or perceive their working conditions of poorer quality. Nevertheless, extensive academic literature on this topic has proven the causal effects of various work stressors such as workload, job insecurity and job-strain on depression and anxiety disorders.[1]

In turn, mental ill-health has a number of repercussions on workers' productivity. Data from the Eurobarometer illustrate that workers with a severe mental disorder take more sick leave than people without mental health problems: in a period of four weeks, their chances of sick leave is higher, 40% compared to less than 20% for those without a mental disorder (Figure 3.2, Panel A); and their sick leaves are longer on average, six days compared to four days (Figure 3.2, Panel B). The difference between employees with moderate mental disorders and those without is relatively small but productivity levels while at work are strongly impacted also for those with a moderate mental disorder: seven out of ten of those workers report productivity reductions (Figure 3.2, Panel C). Costs associated with sickness absence and performance reductions because of mental health problems are very large. Studies in the United Kingdom estimate the cost of sickness absence to be as high as GBP 8.4 billion and almost twice as much for productivity losses (Sainsbury Centre for Mental Health, 2007).

Figure 3.2. **Impact of poor mental health on absence and performance is large**

Incidence of sickness absence and reduced productivity (in per cent of all workers) and average sickness absence duration (in days), by mental health status, 2010



Source: OECD calculations based on Eurobarometer, 2010.

StatLink http://dx.doi.org/10.1787/888932978835

Workplace policies to retain performance and productivity

Addressing psychosocial risks at work

There is no explicit legislation in place in the United Kingdom specifically on work-related stress. However, under the Health and Safety at Work Act 1974, employers have a legal duty to secure the physical and

psychological health, safety and welfare of their employees whilst at work. In addition, under the Management of Health and Safety at Work Regulations 1999, UK employers are required to carry out a suitable and sufficient assessment of significant health and safety risks, including the risk of stress-related ill-health arising from work activities, and take measures to control that risk.

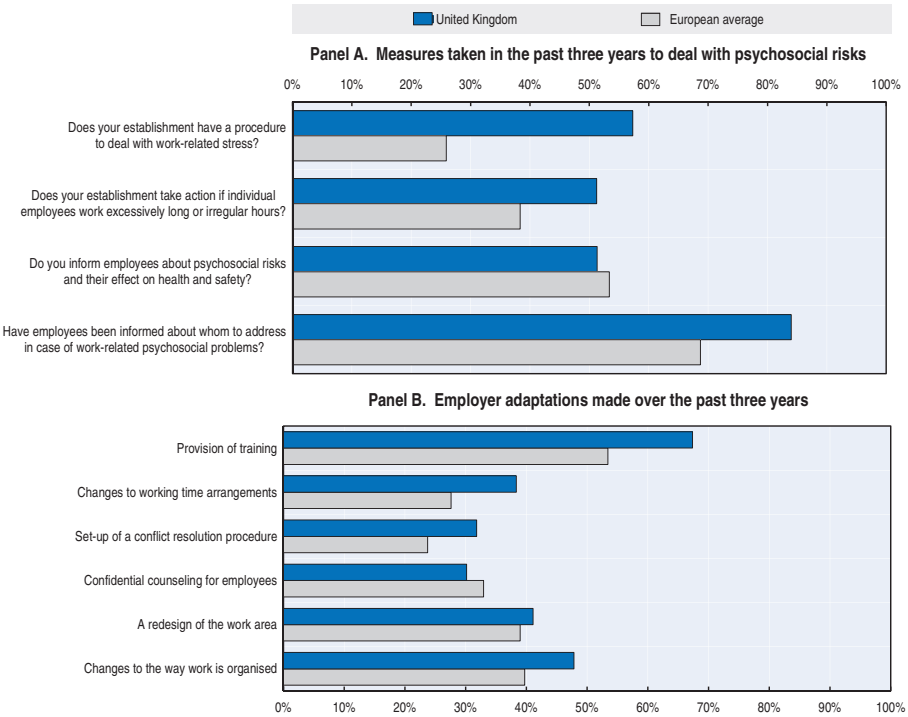
So far, the predominant approach to work-related stress has relied on trying to influence employers by establishing a set of Management Standards under the aegis of the Health and Safety Executive (HSE). The Management Standards for work-related stress identify six key areas of work design which, if not properly managed, are associated with poor health and well-being, lower productivity and increased sickness absence. The six main causes of stress are: the demands made on employees; the level of control on their work; the support available; the nature of relationships; their role within the organisation; and the way organisational change is managed and communicated in the organisation. To determine stress levels in a range of areas, employers can use a free online tool known as the Indicator Tool, a 35-item survey containing seven sub-scales, created to capture an organisation's performance against the six standards outlined above. The outcomes from the evaluation can then help employers to develop specific and practicable solutions to minimise these risks. Employers can also use other data and mechanisms to assess the level of stress within their organisation, for instance, sickness absence data, staff turnover rates and the number of referrals to their occupational health service.

The Chartered Institute of Personnel and Development (CIPD) survey of 573 employers in 2010 revealed that only one-third of respondents are using the HSE Management Standards. Furthermore, studies have shown that since the Standards came into effect in 2004, there has been little decline in work stressors (Chandola, 2010). The latter is presumably related to the enforcement of the Standards which remains largely voluntary. Related to this is also the changing role of HSE, which in recent years has shifted towards issuing practical guidelines and tools to manage work-related stress and working with and through others to promote the use of the stress management standards when appropriate[2] rather than undertaking proactive inspections (albeit action will be taken if the authority receives information on poor performance or non-compliance). Though HSE has become an active contributor in the area of work-related stress, a greater focus on inspection based activities in order to increase the utilisation of such tools and in turn providing support to employers who find it difficult to implement such standards.

In a survey conducted by the European Agency for Safety and Health at Work (2010) on how European countries manage psychosocial risks at work,

the United Kingdom appears to perform better than average. UK employers are: more likely to establish procedures to deal with work-related stress; take action if workers work excessively long hours; and signpost their employees to seek help. Even so, there is room for improvement. Among employers covered in the survey, 50% do not tackle long working hours and one-third has no procedure in place to deal with work-related stress. UK employers are slightly better in educating their employees about the effects of psychosocial risks on their health (Figure 3.3, Panel A). UK employers also have used specific measures to deal with psychosocial workplace risks slightly more often than the European average – ranging from confidential counselling and conflict resolution procedures put in place by about 30% of all employers to work design and working time arrangements (around 40%) and to the provision of training for their staff (about two-thirds) (Figure 3.3, Panel B.).

Figure 3.3. **UK employers do comparatively well in addressing work-related stress but nevertheless more could be done**



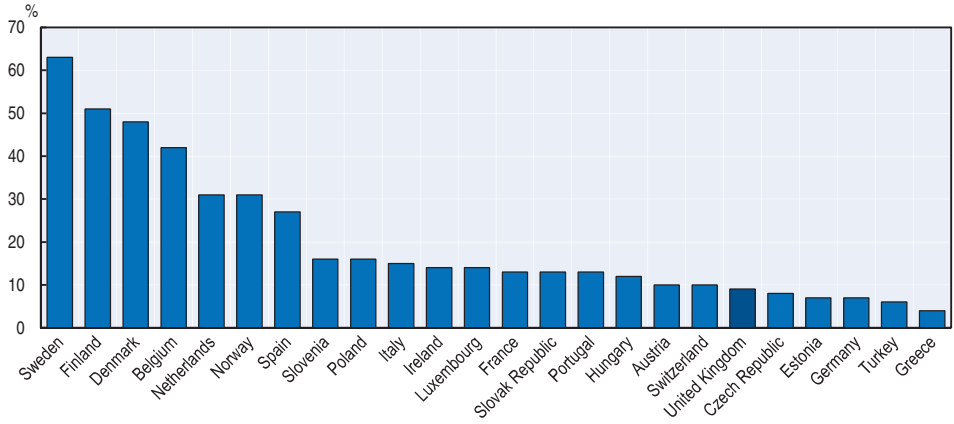
Source: OECD calculations based on the 2009 European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

StatLink http://dx.doi.org/10.1787/888932978854

The ability to carry out risk assessments and design suitable actions also depends on the availability of appropriate expertise, advice and information. The same survey also reveals that on average the use of more specialist expertise such as psychologists (rather than general health and safety experts and occupational health service doctors) is rare in the United Kingdom: only one in ten UK employers can draw on such expertise, compared with 50-60% of all employers, for example, in Sweden, Finland and Denmark (Figure 3.4). The infrequent availability of occupational psychologists in the United Kingdom reflects a situation in which most Occupational Health Services (OHS) still tend to give attention mainly to more traditional physical rather than psychosocial risks despite the very high prevalence of the latter.

Figure 3.4. **Very few UK employers have access to psychological expertise**

Share of establishments which can draw on expertise by psychologists, by country



Source: OECD calculations based on the 2009 European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

StatLink http://dx.doi.org/10.1787/888932978873

What support for those struggling at work?

Figure 3.2 above illustrated that reduced productivity because of health problems is very widespread among workers with a mental disorder, suggesting that many of them are struggling at work and facing problems that reduce performance and output but which do not necessarily lead to these workers being off sick. Mental health at the workplace can affect workers in various ways. According to a survey conducted by CIPD among 2000 employees, up to 80% reported to find it difficult to concentrate as a

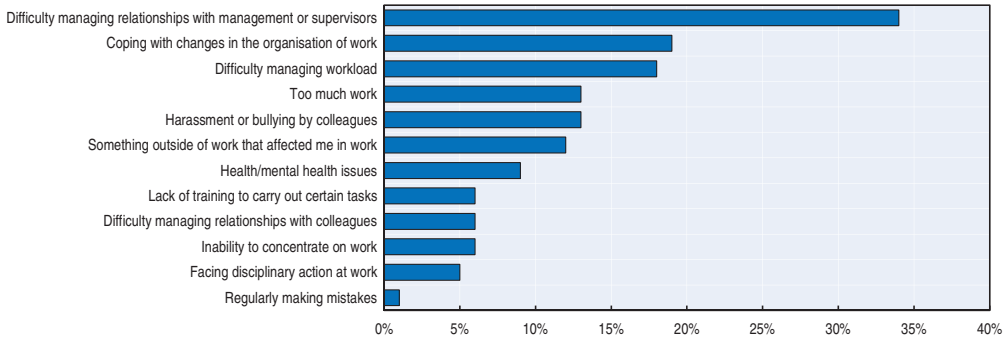
result of going into work with poor mental health; 60% thought poor mental health interferes with their ability to make decisions; 37% believed they are likely to get into conflict with colleagues; and 33% said they find it difficult to learn new tasks (CIPD, 2011).

In turn this implies that helping workers with mental health problems who are not necessarily taking sick leave is critical. This is especially important for small and medium-sized enterprises (SMEs) in view of evidence suggesting that a disproportionate number of people come from SMEs onto ESA without first going onto sick pay, in part explained by less generous sickness benefit entitlements (Black and Frost, 2011).

Addressing conflicts at work, either with colleagues or with managers, is a big challenge to tackle at the workplace. Employment services provided under the Improving Access to Psychological Therapies (IAPT) initiative – which is discussed in detail in the subsequent health chapter – were in part put in place with a view to managing conflict situations. Data on the reasons underlying the use of IAPT employment services suggest that difficulties in handling the relationships with supervisors are dominant (Figure 3.5).

Figure 3.5. **Conflicts with managers are a main reason for workers to seek help**

Proportion of individuals seeing an IAPT employment advisor, by reason



IAPT: Improving Access to Psychological Therapies.

Source: Hogarth, T., C. Hasluck, L. Gambin, H. Behle, Y. Li and C. Lyonette (2013), "Evaluation of Employment Advisers in the Improving Access to Psychological Therapies programme", *DWP Research Report,* No. 826, London.

StatLink *http://dx.doi.org/10.1787/888932978892*

To what extent are British companies addressing these workplace challenges? A survey in 2011 among 2 000 British employees sheds some insight into the type of services their employers provide to improve general well-being at work. Broadly speaking, it confirms the findings from the

employer survey. Health and safety training to workers was the most commonly cited measure. Only 13% of employers provided OHS and 16% access to counselling and other Employment Assistance Programmes designed to support employees struggling at work and typically addressing bullying and harassment issues (Young and Bhaumik, 2011). However, these provisions vary immensely with the size of the organisation. Larger firms with more than 250 employees are more likely to provide such services than medium (50-249 employees) and small firms (with 2-49 employees). For instance, 79% of large organisations provide OHS compared with 46% and 11% of medium and small-sized firms, respectively. Moreover, the public sector provides these services more often than the private sector.

The extent to which any of the services are tailored for those with mental health issues is not known. One major difficulty in providing targeted service to this group is the lack of disclosure, in addition to the general difficulty for employers to detect mental disorders. In relation to addressing and identifying problems of anxiety, depression and stress among those who have not yet gone on sick leave, workplace-based screening could be carried out. There are a number of studies illustrating that screening for depression followed by access to specialist advice and treatment can be cost-effective for employers. Wang et al. (2007) assessed the five-year potential cost effectiveness of a programme which consisted of a one-time workplace-based depression screening for all employees and telephone based care management by trained clinicians for those with positive results. Findings showed that the intervention costs to employers were much lower than the costs of sickness absences, productivity losses and employee turnovers avoided through the intervention. Furthermore, according to a randomised controlled follow-up study of the same intervention, the authors concluded the financial benefits to employers in terms of recovered hiring, training and salary costs suggest that many employers would experience a positive return on investment from outreach and enhanced treatment of depressed workers. Studies from the United Kingdom have shown similar results. Knapp et al. (2009) assessed the cost-effectiveness of a workplace-based intervention for depression and anxiety disorders, and whether it reduced sickness, absenteeism and presenteeism, compared with no intervention.[3] The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees.

Encourage take-up of "Access to Work" support

In the United Kingdom, very few structures and polices are in place to deal with problems at the workplace and help employers and employees

address issues. One such new support tool is the employment advice accessible through the IAPT initiative (see Chapter 4). Another tool that has existed for a long time, but which has helped only very few people due to very low take-up is the *Access to Work* scheme. The government-run scheme is targeted at workers and the self-employed[4] with a disability or a health condition that will last for 12 months or more and provides flexible grants to workers and their employers for practical work support, typically for specialist equipment or transport to work.

As of 2011, in response to a comprehensive review of the entire disability employment support,[5] Access to Work has been redesigned to also support those experiencing depression, anxiety, stress and other mental health issues affecting their work. The support offered can include: i) assessment of individual needs to identify suitable coping strategies; ii) work-focused mental health support for six months, tailored to the identified needs; iii) a personalised support plan, detailing the steps needed to remain in, or return to, work; iv) suggestions for adjustments in the workplace, or in working practices, that could help individuals to fulfil their role; and v) advice and guidance for employers on how they can support employees who have a mental health condition. These modifications mark a significant step in recognising and responding to specific needs of individuals with mental health problems.

The take-up of the scheme by people with mental health conditions is a major concern. In 2012, only 3% of participants in the programme cited mental health conditions as their primary disability (Gifford, 2013). Another criticism of the programme is its low awareness among employers, some even claiming that "it is the best kept secret in DWP" (Work and Pensions Committee, 2009). To address these issues, the government announced an extra GBP 15 million for the programme and has launched a 12-month targeted marketing campaign to raise awareness of the scheme amongst under-represented groups and employers. These measures are welcome as this could be a major step to support those struggling with mental health problems at the workplace. However, it will be important to monitor the impact of these measures on the take-up and further invest in the scheme if individuals with mental health conditions continue to be under-represented.

Enhancing the role of managers

Attitudes and perceptions of managers towards mental health, their knowledge and ability to spot work-related problems are naturally a very important aspect of: preventing mental health problems at work; stopping work-related stress from affecting the health and performance of their team members; and supporting workers on sick leave in their return to work. Besides, line managers take prime responsibility for managing short-term

absences in 70% of organisations overall, rising to 87% in the public sector, demonstrating the critically important position of line managers in absence management and employee retention (CIPD, 2012). However, a 2010 survey found that 72% of workplaces still had no formal mental health policy, and 23% of managers were unable to name a single mental health condition (Shaw Trust, 2010).

Providing managers with training and skills to identify and respond to depression and anxiety is critical especially as they are particularly frequent but complex and difficult conditions to detect. There is evidence suggesting that reporting of stress and other mental health problems are often confused. When employees report that they are suffering from stress and attend employee assistance programmes, a significant proportion (up to 86%) are found to be actually suffering from serious mental health conditions (Arthur, 2002).

Employers are not obliged to provide training for their managers on how to manage colleagues with mental health problems. Nevertheless, a variety of organisations offer mental health training for managers. For example, HSE worked alongside CIPD and Investors in People to identify competencies required by managers to successfully identify and prevent stress in their employees. This has led to the development of advice and a toolkit available on the HSE website, which also allows managers to identify their mental health knowledge gaps.[6] There are also a range of training programmes on managing employees with mental health conditions run by NGOs and charities. Manager training focuses on improving competency and recognising common mental health problems, including stress. However, information on the take-up of such training is lacking and little is known about their effectiveness.

Some information is available on the effectiveness of a training tool known as the Mental Health First Aid. The two day course is designed to recognise the signs and symptoms of common mental disorders and aims to increase the mental health literacy of the whole population.[7] A number of evaluations of the programme indicate an increase in knowledge and confidence in helping employees with mental health problems (Borril, 2011). Currently, most companies have an employee trained in "first aid" (typically dealing with physical problems) but more companies could offer training in mental health to their managers and employees.

Some good practices exist in UK companies

UK employers have not been complacent about the rising costs created by work stress and their workers mental ill-health. In many bigger companies interesting approaches can be found which are seen as the

benchmark for firms in other countries (see Box 3.1). Better information about the actual impact of these programmes and hard evidence on outcomes such as sickness absence, worker turnover and productivity would help greatly in establishing the business case.

Box 3.1. **Some examples of good practice in UK companies**

British Telecom: a three-pronged approach

British Telecom takes a strategic approach to Health, Safety and Well-being and has developed a three-tiered mental health framework as part of this. Level one focuses on promoting employee well-being and preventing mental distress, for example through tips on the intranet and management training around softer skills. Level two is an initiative to identify distress and intervene early to prevent it from escalating, through an online stress risk assessment for employees and companion training for line managers about how to respond to people's results. Level three includes a range of support and treatments for people experiencing mental health problems. Employees are encouraged to work with their line manager to produce an "advance directive", to identify early warning signs and establish a plan of action for if they become distressed.

A new development has been the launch of a Cognitive Behavioural Therapy (CBT) service for staff experiencing mild-to-moderate mental health problems that do not need have to be diagnosed by a doctor. Line managers can refer employees to occupational health, who can then decide whether CBT would be appropriate and, if so, what type. This has been used by around 200 people and satisfaction rates have been very high. British Telecom has reported that its mental well-being strategy has led to a reduction of 30% in mental health-related sickness absence, and a return to work rate of 75% for people absent for more than six months.

Deloitte: mental health champions

Deloitte has nine mental health champions who can be approached confidentially by all employees, outside of line management structures, if they have a mental health problem or concern. All champions have had awareness training to give them a basic understanding of mental health, as well as knowledge about the support that is available through the firm. The champions are also available to give advice to managers about facilitating conversations with staff who they suspect are experiencing mental ill-health.

EDF Energy: supporting staff

A workplace audit showed that the company was losing around GBP 1.4 million in productivity each year as a result of mental ill-health among its employees. As part of its employee support programme, the company offered psychological support (CBT) to employees and trained over 2 000 managers to recognise psychological ill-health among staff and to minimise its effects. This resulted in an improvement in productivity which saved the organisation approximately GBP 228 000 per year. Job satisfaction rose from 36% to 68%.

Among good practice initiatives reaching larger and smaller companies are two employer award schemes operated in Wales. One scheme, the "Corporate Health Standards", follows a strict structured process whereby organisations are reassessed every three years; it targets larger companies, which need to have in place a mental health policy and corresponding training for managers, among other things. The other scheme, the "small workplace health award", targets smaller companies; it is more flexible and modular and can but does not have to include mental health explicitly. Importantly, both award schemes have a revalidation process to monitor continued engagement.

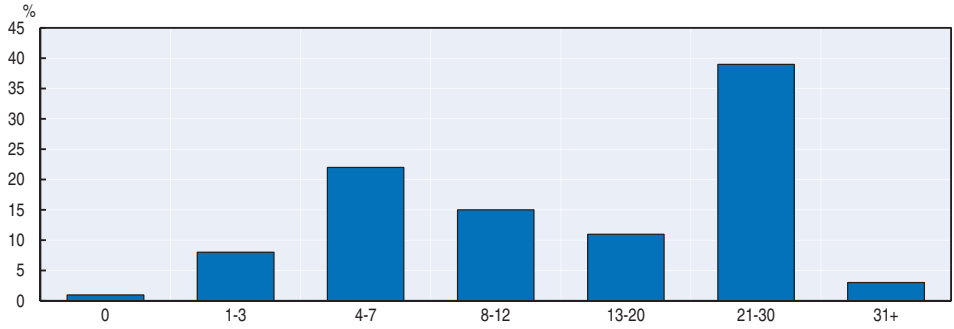
Managing sickness absence at the workplace

Employer responsibility to provide sick pay

Employers in the United Kingdom have to cover statutory sick pay (SSP) for their employees for a period of six months. Though it is administered and paid by employers, SSP is a statutory entitlement and is quite separate from any occupational sick pay entitlement an employee may have. Since SSP is less generous in comparison with sickness benefits in other OECD countries, the vast majority of employers (81%) top this up by Occupational Sick Pay (OSP). A further 10% provide OSP to some of their employees depending on their level in the organisation or the nature of their role. Only a minority of 3% do not provide OSP (CIPD, 2012).

Figure 3.6. **Occupational sick pay varies considerably across firms**

Proportion of employers providing occupational sick pay to long-term sick employee with at least one year of service, by number of weeks of the payment



Source: CIPD Absence Management Survey 2012.

StatLink http://dx.doi.org/10.1787/888932978911

Where occupational sick pay is provided, it usually fully covers the first three days of absence, particularly in public sector and non-profit organisations. The majority of sick-pay schemes across all sectors provide payment at the level of the employees' full wage for a longer period. There is considerable variation in how long organisations provide occupational sick pay to long-term sick employees with at least one year's service (Figure 3.6). About four in ten employers pay OSP for up to 21-30 weeks. However, the average OSP payment duration is strongly influenced by public sector employers who are by far the most generous in granting OSP for such a long period, 74% compared to 24% in the private sector.

While OSP appears to be generous, provision for dismissals of those who are absent due to health reasons seems to be rather lax. There is no legislation giving an employee the right to return to work after a period of sickness absence, nor is there any specific statutory provision to disallow terminating an employment contract of an employee who is absent from work for a long period of time due to health reasons. ACAS, a non-government body,[8] provides guidelines on managing sickness absence but they are not legally binding. According to the guidelines, employers should only dismiss employees on long-term absence as a "last resort" when all other options have been exhausted such as reasonable adjustment, a phased return to work, flexible hours and job design etc. However, since there is no specific statutory provision covering sickness-related dismissals, an employee can only lodge a complaint for unfair dismissal to an employment tribunal.

In addition, long-term sickness absence may on its own bring an employment contract to an end by "frustration" of the contract. The latter would constitute a dismissal and therefore there is no possibility for an employee to bring the case to the tribunal. Administrative data on dismissals during sickness absence on the grounds of ill-health are unavailable. However, survey data from the United Kingdom show that generally employers do not shy away from their use. Around seven out of ten employers report having taken formal disciplinary actions up to and including dismissals due to poor attendance against at least some employees (CBI, 2011). Though employers are more likely to use disciplinary action where absence is non-genuine, their frequent use is likely to put those with mental health problems under a higher risk of being dismissed since employers can easily misinterpret behaviour caused by mental illness as non-genuine.

Overall, there are some concerns whether the balance between obligations or responsibilities and financial incentives for employers in the United Kingdom is at the optimal level. The fact that many employers top-up SSP with OSP is often argued to be giving employers sufficient

incentives to look after the health of their employees. In reality, however, this is unlikely to be the case – particularly among medium and small-sized firms (as discussed above). Added to this are vague regulations to keep workers in work. Bearing this in mind, the recent announcement to abolish the Percentage Threshold Scheme offering a rebate to employers experiencing higher-than-average levels of sickness absence is welcome.[9] The scheme mainly used by small businesses costs the State around GBP 50 million each year and provided no incentive for employers to reduce the level of sickness absence in their company. Smaller firms face particular pressures, but much greater focus on tackling absence is needed, rather than the State simply reimbursing some of the cost.

Early intervention during sickness absence has been poor until recently

The most recent available data (for 2007) show that one-third of the people moving onto long-term disability benefit initially goes through a period of sick pay and, in addition, one-quarter is still employed at the time of the claim (Table 3.1). These shares refer to the status immediately before the claim; many of those claiming a disability benefit from unemployment or income support will also have had interim periods of sickness absence beforehand. Besides, persons who migrate to disability benefit straight from work or sick leave are significantly more likely to be working while receiving a disability benefit than those who come from a longer-lasting non-work route. Disability benefit claimants also become markedly more pessimistic about their chances of getting a job one year after their claim, illustrating that perceived barriers to work increase with duration out of work (Kemp and Davidson, 2010). These are major reasons why it is necessary to tackle sickness absence early on to prevent long-term labour market detachment.

One major weakness of the UK benefit system is the lack of focus on early intervention, which could prevent more people from needlessly moving into benefits and instead support a quick return to work. At present, support for return to work would typically only come after nine to twelve months on sick leave. Earlier intervention and action to maintain people in work would be more cost effective. A review in 2008, "Working for a Healthier Tomorrow" (Black, 2008), provided a major catalyst to change policies on this front. Two initiatives from that review which were designed to test the demand and boost the supply of OHS, were the Occupational health Advise Services and the Fit for Work Service pilots. Both initiatives were explicitly targeted at SMEs based on the evidence that companies with fewer than 250 employees generally have little or no access to occupational health support or other tools to help them deal with employee sickness absence or to tackle mental health issues at work.

Table 3.1. **Sickness is a major precursor to disability benefit receipt**

Share of all recent IB claimants

	2002	2007
Working	40	23
Off sick from work	17	33
Not in work, but getting IS or JSA	26	28
Not in work, but not getting IS or JSA	17	16
Total	*100*	*100*

Note: Refers to the 90-day period before starting a claim in case of previous IS or JSA receipt.

Source: Department for Work and Pensions, Routes onto Incapacity Benefit Survey.

StatLink http://dx.doi.org/10.1787/888932979196

The Occupational Health Advice Service pilots in England, Scotland and Wales were established in late 2009 to provide small and medium sized enterprises with early and easy access to high quality, professional advice in response to individual employee health issues. After the launch of the fit note in April 2010, the service was also made available to GPs to assist with any professional queries they had about the fit note or any other occupational health issues related to patients. The service provider in England launched a multi-channel service in November 2011. The published evaluation which looked at the period between December 2009 to March 2011 found that the service was considered extremely useful by those using it (mostly employers with questions referring to sickness absence, attendance management and difficult issues such as mental health), particularly the access to "instant" advise and the one-stop-shop nature of the service but that the take-up was below expectations at that time (Sinclair et al., 2012). Management information, required from the providers at regular intervals for performance management by DWP, shows that take up has improved considerably since March 2011.

The Fit for Work Service (FFWS) was piloted in several regions in England, Wales and throughout Scotland from April 2010 to March 2013.These services provided employees in the early stage of sickness absence (normally 4-12 weeks of absence) with case-managed multidisciplinary support with the aim of facilitating a faster return to work than would otherwise be the case – so keeping them in employment. The service was based on the bio-psychosocial model and aimed to provide early intervention services to help individuals by making access to health–related support more widely available. Each pilot had its own way of operating. The interim evaluation report of the first year described that, for instance, a

"standard" service was offered in some cases where case managers assessed clients and provided a range of non-clinical supports; and an "enhanced" service offered access to a wider range of supports including from subcontracted external providers. Access to FFWS was via either self-referral or referral by the GP. Most service users had a mental health condition or a musculoskeletal disorder and most clients had more than one health disorder.

Over the first year, the volume of clients was not in line with expectations of the pilots when they formed their original plans, with take-up significantly lower than expected. In addition, the pilots did not stick to the target group of people in the early stages of sickness absence and the majority of the clients were "presentees" i.e. those who were attending work but at risk of sickness absence. All services had difficulties securing the volume of referrals expected from GPs on the one hand and also experienced the difficulty of promoting a service to small businesses that is needed only when an employee has been on sick leave for over four weeks.[10] The higher use of such services by employees working in larger companies (services which are all free of charge) could either suggests that there is a far more general demand for services bridging the workplace and the benefit system and preventing premature labour market exit or reflect employees preferences in seeing services offered by external providers rather than those provided by their own companies due to fear of dismissals or stigma.

The interim report suggested that up to 74% of absentees who joined one of the pilots in the first year and who were discharged before the end of March 2011 were back at work by the time they left. Around 18% were still off work on sick leave and 8% were unemployed. Just over 10% of those who were initially assessed subsequently failed to engage. The average length of time people stayed with the service appears to be around four months, although some sickness absentees may have returned to work before they were formally discharged. Most respondents said that they would not have received the interventions they had without the support of the FFWS (Hillage et al., 2012).

Evidence from service providers and clients suggested that a number of factors can be attributed to the successful results so far including: a quick access to a holistic initial assessment; ongoing case management to identify latent concerns (often non-medical) and maintain momentum towards a return-to-work goal; fast access to physiotherapy or psychotherapy if required; facilitated communication between employee and employer and advice for return-to-work options; and advice to improve and manage longer-term health conditions (Hillage et al., 2012).

For the second and third years the pilots were asked to increase their efforts to recruit employees on a period of sickness absence from work

particularly those working in SMEs in order to test the policy proposition and to work towards more realistic volumes.

Recent policies for improving sickness absence are a step in the right direction but will they be successful in the absence of incentives?

The Sickness Absence Review (Black and Frost, 2011) rightly identified additional reform needs in the UK system to move to an effective early intervention approach. Among its recommendations are the introduction of an independent assessment service; a new brokering service accessible at an early stage aimed at helping people to change a "wrong" job; as well as changes affecting employer incentives (tax relief for vocational rehabilitation costs of employers) and abolition of the reimbursement of excessively high sickness absence costs.

The government in its response to the review has announced it will set up an independent service known as the Health and Work Service (HWS), expected to begin in 2014 (DWP, 2013). This is a welcome initiative as the service will fill the gap in occupational health support without which many individuals struggle to get back into work. Specifically, the new service will provide a work-focused bio-psychosocial assessment to employees earlier in the sickness spell (from around four weeks) (see Box 3.2 for more details). This timing will be, in contrast to the current situation where an employee can be on sick leave and on sickness benefits for at least nine months or up to a year based on a GP sick note plus 13 weeks on ESA before the WCA is conducted. The service will also offer advice to employers and employees on needs for rehabilitation and supports for return to work for both workers on sick leave and those still at work thus keeping the role played by Occupational Health Advice Services (as mentioned above).

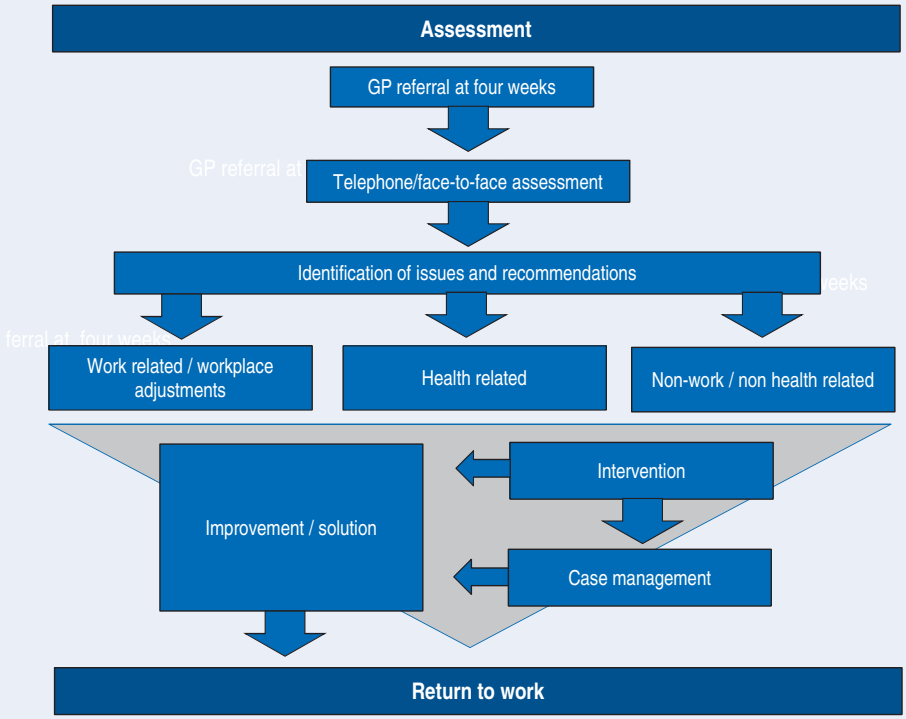
Box 3.2. **A major initiative to expand the UK occupational health service**

The *Health and Work Service* will be the beginning of a real national service providing an in-depth assessment of how an employee's health is affecting their ability to work and advice on how people on sick leave can be supported back to work.

Assessments will be provided after an employee has been off work for around four weeks, supported by a case managed approach and followed by signposting to interventions. GPs have the prime responsibility to refer individuals to HWS at the four-week point, though individuals can be sent earlier if they consider them suitable for early intervention. Employers will be able to refer subsequently. Once a referral is made, an occupational health advisor will assess the individual. After the assessment, a Return to Work Plan will be shared with the employee, the employer and the GP outlining the obstacles preventing a return to work, interventions that would facilitate the return to work, and, a timetable for return to work.

Box 3.2. **A major initiative to expand the UK occupational health service** *(cont.)*

An illustration of the new HWS process



Source: Government response to the Sickness Absence Review, DWP, January 2013.

The establishment of the new HWS has considerable potential to tackle sickness absence by providing services at very early stages and by bringing occupational health care closer to employment issues. At present, the precise details of the HWS remain vague about the delivery of the necessary interventions. Moreover, there are various implementation issues that need to be considered for the service to be fully effective.

First, there are concerns over the co-operation between employers, GPs and advisors at the health services. Evidence from other countries suggests that soft co-operation without strict obligations and their enforcement has very small impact, if any, in reducing sickness absence. For example, the long-running tripartite agreement on sickness absence in Norway that involves the sick employee, the employer and the doctor to support

employees at an early phase of sickness absence had minimal impact on reducing sickness absence and preventing people from moving onto disability benefits (OECD, 2010). Although much has been achieved in changing employer attitudes towards adapting workplaces for people with physical health conditions, evidence for making similar adjustments for those with mental health conditions suggests the contrary. Incentives for employers to co-operate are being strengthened in the United Kingdom by offering tax exemptions on employer spending on medical treatment (see below). Nevertheless, there are no legal requirements on employers to implement the recommendations given by HWS where possible nor are there any sanctions for non-compliance. Without strong enforcement procedures, there is a risk that employers' incentives to retain workers (especially those with mental health problems) remain weak. This is worrisome in the context where "firing" individuals with mental health problems is persistent. A 2011 Populus poll of 2 000 adults in employment found that of those who disclosed a mental health problem, 22% were sacked or forced out of their jobs.[11]

Second, it will be important to tailor services for those with mental health problems. Given the high proportion of workers going on sick leave due to work-related stress and mental health conditions, it is critical to have capacity in the service to identify psychological problems through adequate screening tools and provision of integrated work-related and psychological services. The government's intention to use a bio-psychosocial assessment approach will help capture those with mental health issues is welcome. Better identification of mental health problems will in turn increase higher demand for psychological support. How to improve access to psychological intervention should be carefully considered. Latest data show that waiting times to psychological therapy are still long (Chapter 4). A delay in access to therapy in turn can undermine the effectiveness of services. In light of this either making psychological therapy available in-house should be considered or further co-ordination is needed with the health sector to boost psychological therapies more generally.

Third, building appropriate capacity, in other words the workforce necessary will be a challenge until a sufficient number of personnel are trained. It will be important that the new service can find the workforce it needs without detriment to other, existing occupational health provisions. In parallel with this, the quality and standards of the service must be monitored to ensure it is delivering the necessary benefits.

Fourth, substantial efforts need to be made to raise awareness of the services. Evidence from FFWS pilots suggests that only 40% of the number expected had taken up services. Most pilots spent considerable efforts trying to secure referrals from GPs and found it much more difficult than expected

to get access to GPs to explain the advantages of the service and sustain their interest.

Fifth, it is important that sufficient and sustainable funding is provided to run the new service effectively, also if a high take-up is achieved. The structure of funding will also make a difference to the success of the new service. An employer co-payment if well designed would increase their incentives to use the service and co-operate with doctors.

In addition to the announcements of the new service, employers who support their employees to return to work after a period of sickness absence will be entitled to a tax exemption on employer spending on medical treatment. Where an employer funds such interventions, the expenditure, up to a cap of GBP 500, will be exempt from income tax and national insurance contributions.[12] It will be valid for more than one intervention and limited to medical treatment recommended by either the new service or employer-arranged occupational health services. Employers can: pay a third party provider directly for treatment arranged by an employee; arrange and pay for treatment on behalf of an employee; or reimburse an employee.

The Sickness Absence Review also recommended establishing a separate job-brokering service for those employees for whom returning back to the same employer is not possible. Indeed, many individuals are likely to be in the "wrong" job and moving into a new job may be a preferable option. The government however has instead proposed to "signpost" individuals to the Universal Job Match, an online job-search tool for service for those employees who are able to work, but unlikely to return to their current employer. Referring individuals struggling at work, with common mental health problems or with low motivation, to online job-matching services may not help fostering their mobility. Disadvantaged employees will also need early and intensive support from existing services such as Job Centre Plus.

Conclusions

A significant weakness of the interaction between employer-provided sick pay and the UK benefit system is the point of state intervention, which often comes after people have lost their job. The experimentation via FFWS and the Occupational Health Advise line has generated considerable evidence and has led to the development of the Health and Work Service. The new service has the potential and provides opportunities to render a holistic approach by bringing GPs, employers, employees and occupational health professionals together to limit the number of people drifting into labour market exclusion and improve individuals' health so they can lead healthy and productive working lives.

One shortcoming of recent policy changes is, however, 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. Overall, HSE has a well-developed framework relating to awareness of stress and actions to try to prevent and reduce it but only few employers appear to be making use of this advice.

Employer obligations and incentives are critical to tackle both of the above challenges. While the government has introduced a range of new policy initiatives, 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 that mental ill-health has on productivity – assuming the business case is strong enough. A few bigger companies seem to be doing more than other OECD countries, but these are still the exceptions rather than the rule.

The following recommendations are therefore put forward to both better manage sickness absence and tackle productivity losses arising from poor mental health:

Tackle productivity losses at work due to stress and mental ill-health

- *Make better use of management tools and guidelines*. The HSE and others have developed a range of tools for managers to address the psycho-social work environment, including the Management Standards and an Indicator Tool. HSE should take proactive role in terms of monitoring to increase the use of these instruments in UK companies to assure that all workplaces have procedures in place to deal with work-related stress and arising mental health issues.
- *Strengthen the capacity of Occupational Health Services to deal with mental health*. Many employers use OHS but with a traditional focus on physical health. A service with a sufficient number of occupational psychologists (who increasingly get involved in other countries) could help companies to address the psycho-social work environment and react to stress symptoms and mental health problems among their workers.
- *Help SMEs in addressing mental health problems*. Currently, few small companies use OHS – only 10%, compared with 80% of large

companies. The occupational health advice telephone line was a promising step but take-up of such services now offered through the HWS will need to be boosted to assure that small companies get access to OHS support and to achieve a real change on the work floor.

- *Make the Access to Work scheme widely available to support workers with mental health problems*. Access to Work is a potentially powerful and very flexible instrument to help employees who still have a job but it is so far not used at all by people with mental conditions. The current plan to expand the system to reach this group is welcome but it will be important monitor the impact of these measures on the take-up and further invest in the scheme if individuals with mental health conditions continue to be under-represented.

Make sickness absence management a top priority

- *Learn from Fit for Work Service pilots.* FFWS were successful for a number of reasons including high investments (allowing low caseloads) and an effective mix of interventions bridging the gap between the workplace and the benefit system (quick access to a holistic initial assessment; ongoing case management; fast access to physiotherapy or psychotherapy; and good employer-employee communication). The cost per client was low vis-à-vis the potential savings for the benefit system. It will be critical that such service remains during the transition to HWS.
- *Rigorously implement the new Health and Work Service.* The HWS is expected to address the issues raised in the Sickness Absence Review and build upon the successful FFWS pilots. This will only be the case if the FFWS pilot success factors are maintained; the new service is sufficiently resourced; and a number of remaining issues are being addressed. The latter include:
  - The need for good co-operation between the main actors, especially doctors, workers and employers.
  - A strong mental-health focus of the new service, including the capacity to identify mental health issues quickly and to provide integrated health and work or workplace services as needed.
  - Sufficient qualified staff in the new service (with skills and expertise that include an understanding of work-related issues with specific focus on mental health problems), without

similar staff resources being taken away from existing Occupational Health Services.

  - Sustainable funding of the new service which also provides good incentives to the key actors (especially employers) for a high use of the service.

- *Consider opening HWS for those struggling at work.* Currently, only the "advice" element can be offered to employees but the high cost of productivity loss while at work suggests that a full assessment, case management and follow-up offered to those on sick-leave should be extended to those struggling at work.

- *Facilitate information sharing between HWS and JCP.* Information gathered on clients during their sickness spell should be shared with JCP for those who end up on ESA or JSA later on. This will improve knowledge on clients' barriers and work-readiness which will be useful for caseworkers in JCP.

- *Enable quick and early access to employment services for those on sick leave.* The Sickness Absence Review rightly concluded that many people on sick leave are in the wrong job, needing help to change their job. The Review suggested putting a new brokering service in place for this purpose. With the same idea in mind, a cheaper solution would be to give people on sick leave access to JCP and refer them to a WP provider quickly should they need help in making a job change possible. This in turn would require a holistic assessment to determine whether people are struggling at work and placed in "wrong" jobs so that an appropriate referral can be made.

Monitor employer roles, obligations and incentives

- *Monitor employer behaviour.* The new services and the above-listed changes have considerable potential but hinge on employer involvement. Employer reaction and involvement should be monitored continuously. Tighter obligations and stronger financial incentives for employers should be considered if service use and outcomes fall short of their potential.

- *Dissemination of good practice.* Some UK firms have very interesting practices in place. Employer organisations and unions could do more to share and disseminate good practices among other employers. Employers are most likely to learn from other employers, especially if confronted with a clear business case for action and intervention.

- *Paying for health services pays off.* Studies have shown that it will pay off for an employer to screen the workforce for stress and mental ill-health symptoms and to signpost them to, and even pay for, short-term mental health services. Such action could be promoted among employers, in addition to or as part of the on-going reforms.
- *Activate Occupational Sick Pay.* OSP, provided by most employers to top up the relatively low SSP, is a pure payment scheme – thereby if anything making sick leave more attractive. OSP spending and sickness absence durations could be reduced if the OSP scheme also included absence monitoring and return-to-work components.

Notes

1. See for example the meta-analysis by Stansfeld and Candy (2006).
2. A good example of this is their membership of the Responsibility Deal Health and Work Network run by the Department of Health. This network has recently developed a specific pledge on mental health which companies and organisations can sign up to voluntarily.
3. The target population is a hypothetical cohort of working-age individuals in a white collar enterprise with 500 fulltime equivalent employees, all of whom are screened.
4. The scheme is also available to individuals with a health condition that are i) in need of help at a job interview with an employer, ii) about to start employment and iii) about to start a JCP agreed work-trial.
5. This reform is part of the government's response to the Sayce Review (Sayce, 2011) which concluded that disability employment funding is in need of a major shift – with a stronger focus on effective programmes (especially Access to Work) and on providing choice to the people concerned, and away from traditional funding of sheltered workplaces in highly inefficient companies.
6. www.hse.gov.uk/stress/mcit.htm.
7. The programme currently aspires to train one in every ten adults in England.
8. ACAS is predominantly funded by the Department of Business, Innovation and Skills but it is governed by an independent council.

9. The scheme covered part of the cost for smaller firms with exceptionally high sickness rates. Employers find the current PTS scheme cumbersome and complex and leading to very high administrative costs.

10. Most FFWS users (around two-thirds) in pilots in England and Wales worked in larger organisations while most clients in the Scottish pilot worked in SMEs (Hillage et al., 2012).

11. www.mind.org.uk/news/5053_workers_face_the_sack_for_admitting_they feel_stressed.

12. Technically employers funding recommended medical treatment are entitled to an employer National Insurance Contributions (NICs) disregard and employees receiving the treatment are entitled to an income tax exemption and, where applicable, an employee NICs disregard. In reality many employers will cover employees' tax and NICs liabilities resulting from employer-funded treatments. Indirectly, therefore, employers who fund medical treatments are the main beneficiaries of the tax exemption.

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Chapter 4

The new role of the health sector in the United Kingdom: How can it support work and well-being?

This chapter looks at the role of the (mental) health system which has a growing responsibility in supporting return to work of those who are out of work due to mental ill-health. It first assesses the effectiveness of the mental health care system in providing adequate treatment to persons with mental disorders. Particular attention is given to new initiatives put in place to increase psychological therapies to individuals' with mild and moderate disorders. It then reviews the role and challenges of GPs in providing treatment and managing sickness absence and work-related matters. Finally, it looks at various innovative and promising new policies integrating employment with health outcomes.

Introduction

The previous chapters highlight mental health problems as a major driver for labour market exclusion and inactivity. Mental illness is widespread among those receiving income replacement benefits and a major cause of sickness absence in the workforce. The health system has a big role in turning around these adverse outcomes as most mild to moderate mental illnesses have a good potential of improvement over time, if treated quickly and effectively. Unlike in many other OECD countries, the health system in the United Kingdom has reacted quickly to these challenges in recognition of the wider social and economic benefits. Two major responses have included improving access to psychological therapies and the beginning of integrated employment and health service delivery for common mental health problems. Notwithstanding this promising start, there is still a long way towards fully tackling these challenges given the large burden of mental health problems in the country.

The mental health treatment gap

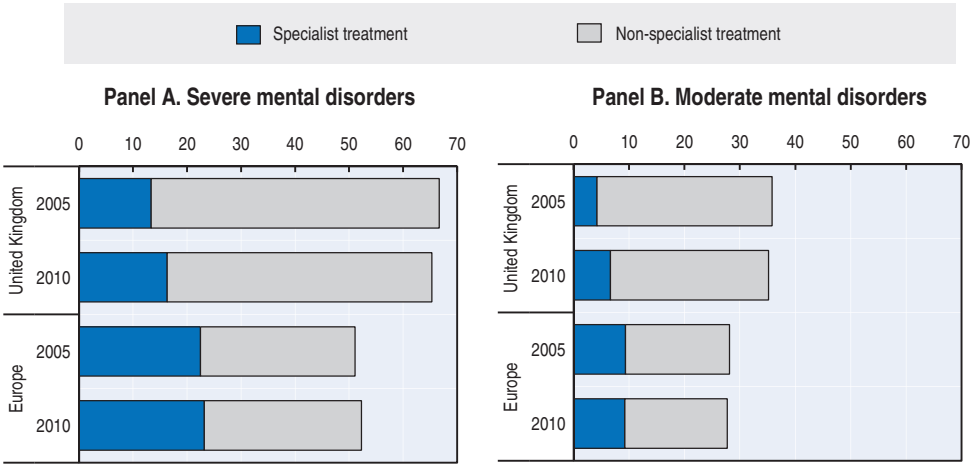
Given the considerable number of people affected by mental disorders, it is only reasonable to expect adequate provision of treatment to alleviate individual suffering as well as restoring functionality to enable people stay close to the labour market. However this is still far from being the case in practice. Like in other OECD countries, there is a huge gap between the need of mental health treatment and the actual treatment received in the United Kingdom. Evidence on the share of people with a mental health disorder who sought treatment for their illness, based on data from the Eurobarometer, suggest that only a third of those with mild to moderate mental disorders were in treatment in the past twelve months, and around half of those with a severe mental disorder (Figure 4.1). This reflects many factors including: i) stigma and fear; ii) misdiagnosis; iii) refusal of treatment; and iv) the scale of availability of treatment. Nevertheless, treatment rates are higher in the United Kingdom than on average for a number of OECD countries, for both moderate and severe mental disorders, possibly reflecting a lower degree of stigmatisation in the United Kingdom.

But importantly, even those who are treated, get a very limited amount of specialist care, albeit this has improved recently. In the United Kingdom, more than in other countries, treatment is predominantly provided by primary care services i.e. general practitioners (GPs) while treatment by a specialist such as a psychologist or psychotherapist is less frequent. Presumably related to this, more than elsewhere treatment is predominantly through medication whereas the use of psychological therapies is rare. Of those who are treated, be it for a severe or moderate mental health disorder,

over 70% received anti-depressants only, 19% received therapy and anti-depressants and 10% received therapy but no medication (Figure 4.2, Panel A). Medication and the use of anti-depressants are also very frequent among people without a clinical mental disorder (Figure 4.2, Panel B).

Figure 4.1. **Most mild to moderate mental disorders remain untreated, also in the United Kingdom**

Share of people who sought treatment for their mental illness in the past twelve months, by severity of the illness and type of treatment, United Kingdom versus EU-21[a], 2005 and 2010



Note: "Specialist" treatment includes treatment by a psychiatrist, psychologist, psychotherapist or psychoanalyst. "No specialist" treatment includes treatment by a general practitioner, a pharmacist, a nurse, a social worker or "someone else".

a. Europe is an unweighted average of 21 European OECD member countries.

Source: OECD calculations based on Eurobarometer 2005 and 2010.

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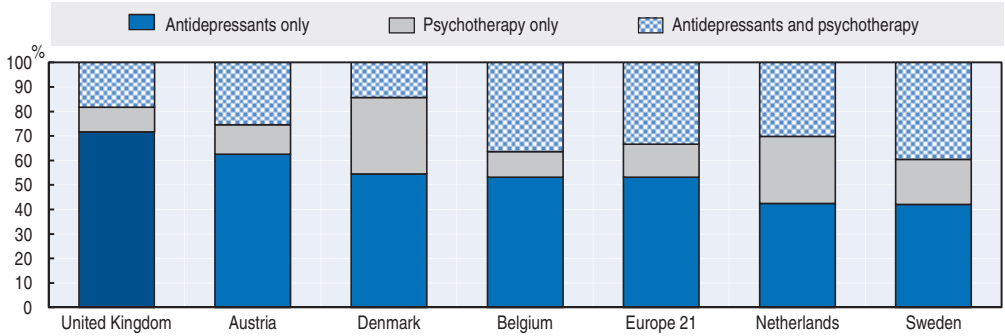
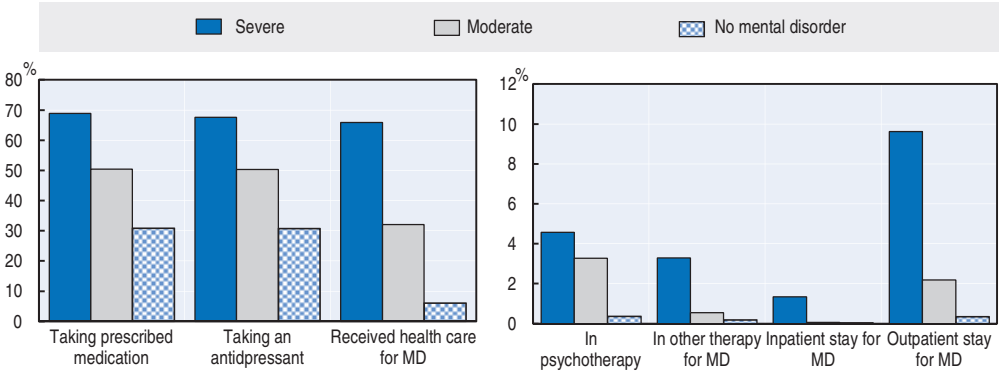
Overall, treatment seems to be more frequent in the United Kingdom at the risk of being less adequate. In other words, there is lack of psychological therapy which in fact has shown to be highly effective in treating common mental disorders. Ample evidence demonstrates that effective psychological treatments such as Cognitive Behavioural Therapy[1] (CBT) can ameliorate symptoms of common mental disorders with recovery rates of over 50% for anxiety disorders and significantly reduce the likelihood of relapse (Layard, 2013; Roth and Fonogy, 2005). Besides, recent evidence has demonstrated that cost-effective therapy in turn can generate savings to the health care system and the economy (Layard et al., 2007).[2]

Figure 4.2. **Most UK patients consume antidepressants only, with severe mental conditions receiving the most treatment**

Panel A. People with a moderate or severe mental illness in treatment[a], by nature of their treatment, 2005



Panel B. Share of people receiving different types of treatment for a mental disorder in the United Kingdom, by severity, 2007



MD: Mental disorder.

Note: Europe is an unweighted average of 21 European OECD member countries.

a. Professional treatment for a psychological or emotional problem in the last 12 months.

Source: OECD calculations based on Eurobarometer 2005 for Panel A and the Adult Psychiatric Morbidity Survey 2007 for Panel B.

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Building up mental health services

Psychological therapies are growing and their provision must continue

The United Kingdom has not been idle in addressing the mental health treatment gap. To alleviate the distress and costs associated with depression and anxiety disorders, the UK Department of Health (DH) announced an unprecedented increase in funding for the provision of psychological therapies in the National Health Services (NHS) in 2007 (DH, 2007). This marked a major shift in mental health policy in recognition of the high prevalence of mental disorders in the population and the high economic costs incurred to society (see Box 4.1 for more details).

Box 4.1. **Political will and economic rationale were major drivers for the Improving Access to Psychological Therapy initiative**

The IAPT programme stemmed from a wide range of clinical and policy developments. However, two developments are particularly worth highlighting. First, starting in 2004, the National Institute for Health and Care Excellence (NICE) systematically reviewed the evidence for the effectiveness of a variety of interventions for depression and anxiety disorders. These reviews led to the publication of a series of clinical guidelines that strongly support the use of certain psychological therapies.*

In the second phase, economists and clinical researchers joined forces to argue that an increase in access to psychological therapies would largely pay for itself by both reducing other depression and anxiety-related public costs (in terms of welfare benefits and medical costs) and increasing revenues (through taxes from return to work, increased productivity, etc.). This argument was advanced in academic articles (e.g. Layard et al., 2007), but also in the more populist pamphlets such as The Depression Report (Layard et al., 2006) and We Need to Talk (Mind, 2010)

A general political commitment to increase the availability of evidence-based psychological treatments was secured in 2005 and two pilot projects (Doncaster and Newham) were funded in the following year. Evaluation of both demonstration sites indicated that at least 55% of patients who attended at least two sessions (including an assessment interview) recovered and 5% transitioned from unemployment into part-time or full-time employment (Clark et al., 2009). Overall, this study demonstrated that the talking therapies model can be effective in the treatment of depression and anxiety.

* See Department of Health (2012), "Talking Therapies: A Four-year Plan of Action", for a summary of NICE's recommendations for the psychological treatment of depression and anxiety disorders.

The "Improving Access to Psychological Therapies" (IAPT) initiative aims to provide faster access to evidence-based psychological therapies, especially through CBT. IAPT services were initially targeted at people of

working age, but in 2010, it was opened to adults of all ages. Access to IAPT services is by self-referral or referral from the GP. Therapies are short-term (with a maximum of 20 sessions); delivered by service teams typically made up of psychologists, psychotherapists, therapists, graduate primary care workers and administrative staff; and targeted at those with a common mental disorder. The IAPT programme will be fully rolled-out in England by the end of 2015.

An evaluation of the first three years of the programme shows that around 1.1 million people have entered into the first phase of the programme and that the numbers of people accessing the programme has increased steadily. Recovery rates have now reached 45% and are on track to meet the target recovery rates of at least 50% (DH, 2012a).

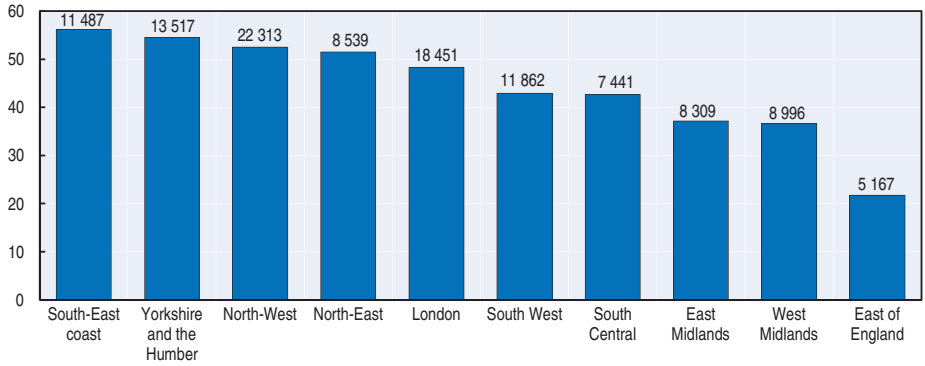
Through IAPT, the capacity of psychological therapy services has been improved very significantly, but provision of services throughout England is patchy and there is potential for further improvement, especially in the following three areas. First, there are indications of inequality in service access with individuals facing longer waiting times in some parts of the country than others. Administrative data for the third quarter of 2012/13 reveal that waiting times still vary hugely across the country. Up to 50% of those being referred to IAPT during that quarter had been waiting for more than 28 days in the North-East and the North-West, with the fewest people waiting more than 28 days in the East of England, East Midland and West Midlands (Figure 4.3). Of those who are unable to get access before 28 days, some individuals face very long waiting times. According to a survey among people who attempted to access psychological therapies of the NHS in England between 2008 and 2010, one in five had been waiting over a year to receive treatment while one in ten had even been waiting over two years (Mind, 2010). The delay in treatment not only exacerbates individual suffering but also reduces their chances to return to work. Reducing waiting times will be pertinent in the broader policy context of prevention and tackling long-term sickness absence. One way to improve access is to adopt a national waiting time target in psychological therapy following the so-called HEAT targets in the Scottish National Health Service which guarantee on-time evidence-based psychological treatments.[3]

Second, access to and use of services still remains insufficient given the scale of common mental health problems, albeit improving slowly. The government is currently working towards a target whereby at least 15% of adults with common mental disorders (equivalent to 6 million people) in need of psychological therapy will have timely access to services, with a recovery rate of 50% by 2015 in England. This commitment to increase access to services is welcome but the set target is not ambitious enough against the high prevalence of mental illness. Access can be increased only

by securing further funding for such services. According to DH programme budget data, overall investment in psychological therapy services has increased more than for several other services, from GBP 52 million in 2002 to GBP 386 million in 2011/12, reflecting the growing importance of psychological therapies. However, spending on psychological therapies still accounts for no more than 7% of the total direct spending on mental health services (Figure 4.4).

Figure 4.3. W**aiting times to psychological therapy vary considerably across regions**

Proportion of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session, by region, third quarter 2012/13



Source: Health and Social Care Information Centre.

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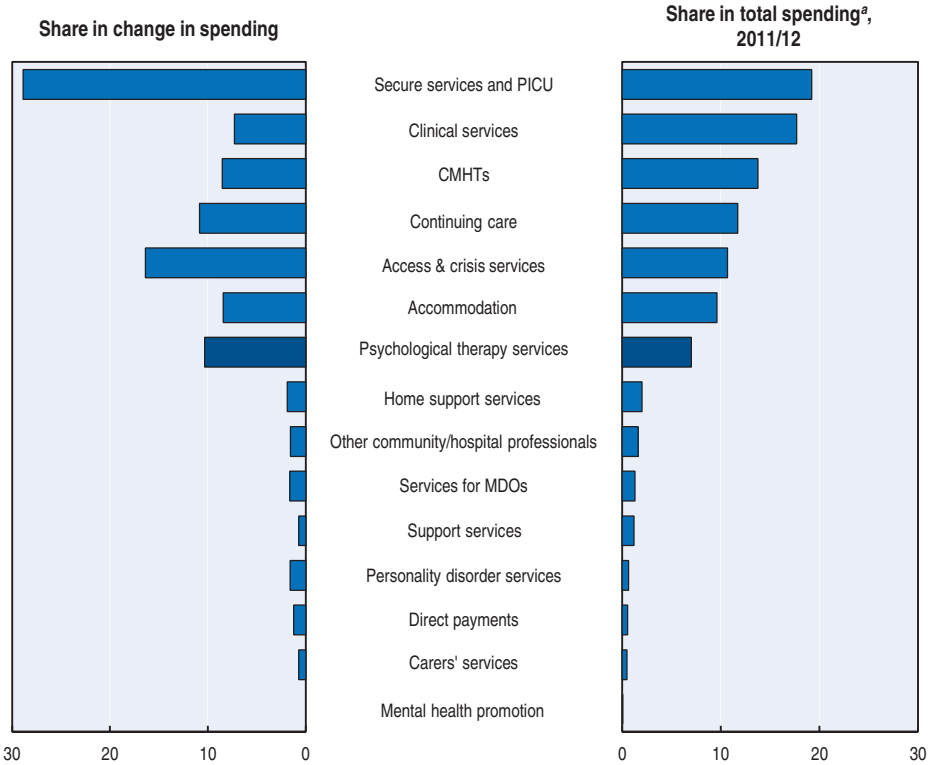
Finally, there are some concerns over stability and continuity of the national IAPT programme within the restructured NHS which has moved away from centrally led, centrally funded programmes towards local determination of priorities.[4] A new four-year action plan on "Talking Therapies" as part of the Mental Health Strategy allocated an additional GBP 400 million to complete and extend the programme over the period 2011-15 (DH, 2012b). However, continued long-term funding will require local decisions as a consequence of health care reform. Even if it does continue, the delivery of services could be varied and risks losing fidelity to the original model. Furthermore, the extent to which GPs prioritise and commission will vary with some being well placed to commission mental health services more generally, and others not due to a lack of knowledge of local and social mental health services and treatment approaches. One channel by which mental health is hoped to get sufficient attention is through the "Mandate to the NHS England" which sets out key goals and improvement areas for NHS England and states that mental health must be treated as seriously as physical health. It will be important to take this into account in judging the performance of the local health service commissioners.

Figure 4.4. **Spending on psychological therapies is growing but remains small compared with the costs for other mental health services**

Share of different spending items in total mental health spending in 2011/12 and share in total spending increase since 2002



MDO: Mentally Disordered Offender; PICU: Psychiatric Intensive Care Unit.

a. Excludes spending on employment/day/resource centres which accounted for 5.3% of total spending in 2002/03 and 2.4% in 2011/12.

Source: Mental Health Strategies (2012), National Survey of Investment in Adult Mental Health Services 2011/12, Report prepared for the Department of Health, August 2012.

StatLink *http://dx.doi.org/10.1787/888932978987*

Improve the ability of GPs to deal with common mental disorders

GPs act as a first point of contact for a significant proportion of people with common mental disorders.[5] Consequently, the ability of GPs to manage illnesses, treat or refer individuals to more specialist services becomes critical. However, primary care still remains under-skilled in its treatment of mental illness, with many GPs acknowledging a lack of expertise in the area

and many people failing to get adequate care. Typically, GPs are likely to treat common mental health problems with anti-depressants only (as shown above) instead of evidence-based treatments that have shown to support individuals to remain in or return to work. Nonetheless, they can refer a patient to a NHS counselling service or an IAPT service but this remains problematic too, given the large waiting times for psychological therapies. Providing mental health training to GPs, to boost their confidence in treating psychological health issues by appropriate prescribing of medication as well as building capacity within primary care to provide therapy in the long-run will be critical to better manage future challenges.

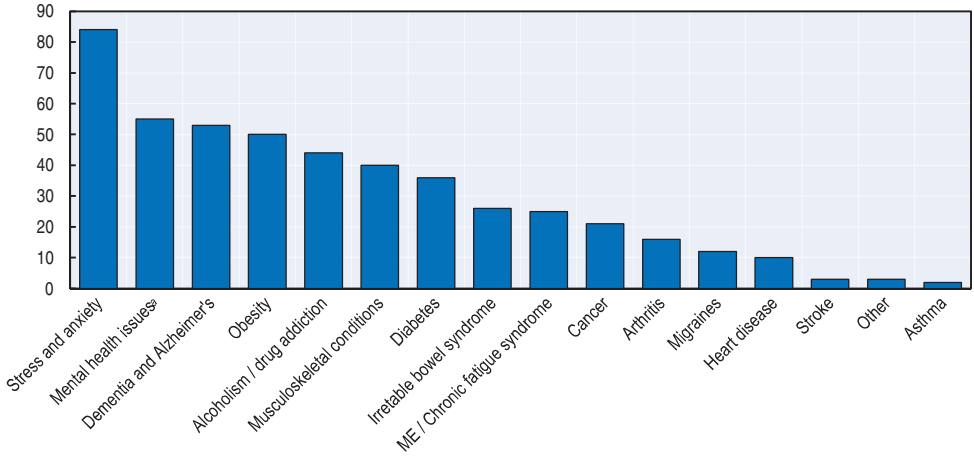
Some positive changes in supporting GPs to provide therapy are already taking place by allowing them to prescribe computer-based counselling courses to their patients with mild to moderate mental illnesses. For instance, GPs can now prescribe access to courses such as "Beating the Blues" and "FearFighter" which are approved by NICE as effective evidence-based treatments. Living Life to the Full Interactive is another computerised CBT course for mild-to-moderate depression and anxiety, and is supervised by a GP or qualified therapist. In Scotland, Living Life to the Full Interactive is also accessible through Action on Depression, Scotland's national charity for depression, which is delivering the programme with funding support from the Scottish Government. Entitlement to the treatment course – free of charge – is for all Scottish citizens who score a set "mood score" on a standardised test. Initial contact can be through the internet, via email, and individuals can download a self-assessment mood scale, after which they are contacted for further discussion and decisions over next treatment steps.

The above initiatives are welcome. Going forward, further fundamental changes will be important to respond to the challenges. At present, postgraduate GP training lasts three years, involving rotations in many different specialties, but the majority of GPs do no rotation in mental illness (Centre for Economic Performance, 2012). The Royal College of General Practitioners (RCGP) is currently bidding for an enhanced and extended GP training of four years across the United Kingdom, including Scotland.[6] Mental health is a key priority when enhancing and extending GP training. Specifically, it is envisaged that the first two years will include placements that provide all GP trainees with adequately supervised exposure to psychiatric problems, including common mental health conditions, psychosis and suicide risk assessment (RCGP, 2012). The framework also endeavours to increase GPs knowledge to help people of working age to remain in or return to work and include specific training about the epidemiology of local population needs as well as sickness certification in primary care to support patients to return back-to-work journey.

As yet, no final decision has been made to implement the above changes including the extension of GP curriculum from three to four years. Further delays in implementing these changes will exacerbate problems as the number of people visiting GPs with concerns related to stress and anxiety is only growing. According to a survey by Aviva, a private health insurance company in the United Kingdom, an alarmingly high proportion of GPs (84%) identified stress and anxiety issues as being the biggest upward trend in their practices over the past year (Figure 4.5). In addition, over three-quarters of GPs (77%) reported that mental health issues will continue to be the single biggest issue they will treat over the next year (Aviva, 2013).

Figure 4.5. **General practitioners see more patients than ever before who suffer from stress and anxiety**

Proportion of GPs noticed an increase in patient numbers over the past year, by health condition



a. Excludes stress and anxiety.

Source: *Aviva Health of the Nation Index Report*, 2013.

StatLink *http://dx.doi.org/10.1787/888932979006*

It is important to bear in mind that any changes to the curriculum will affect the future workforce, therefore gains will manifest only in the long-run and slowly. How policies can target the current workforce is a big challenge. Some short-term measures have been put in place, albeit on a relatively small scale. For instance, an online training tool was set up so that GPs and primary care staff could continue learning in their own time. In addition, as part of the national anti-stigma campaign – "Time to Change" – primary care staff received a ten minute face-to-face conversation with a trainer, in which the trainer shared their experiences of primary care and also stories of the stigma or discrimination they faced in primary care.

The health system understands its employment responsibility but more can be done

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 stability has reached a very high level in the United Kingdom, and it has reached people in all agencies and institutions. The Department of Health has adopted the government's thinking on health, work and well-being and aims to develop the health and mental health system along with this evidence. The new Mental Health Strategy for England ("No health without mental health") aims for good mental health for all people and to improve social outcomes for people with mental health problems, including better employment rates.[7] This is reflected in policy in two main ways:

- The NHS Outcomes Framework for England for 2012/13 which the government will use to hold NHS England to account for includes two sub-indicators on employment of people with long-term health conditions and those with mental illness.
- The Public Health Outcomes Framework includes these same two indicators and on the sickness absence rate.[8]

The inclusion of employment indicators in the overall outcomes framework of the health system is highly welcome as a step forward in aligning health and employment outcomes and polices. Nevertheless, it remains unclear how much weighting will be given in practice to improvements in employment as it is just one of many other sub-indicators under the over-arching domain of "Enhancing quality of life for people with long-term conditions". Importantly, despite the general shift towards making employment a priority of the health system, there are yet no corresponding indicators around employment in the "Clinical Commissioning Group Outcome Indicator Set" (CCGOIS) which acts as a yardstick against which Clinical Commissioning Groups are judged for their contribution to improving outcomes and the quality of commissioning. This means that CCGs are less likely to include employment for people with mental illness in their commissioning arrangements and thus fail to support the continued labour market participation of their patients. The lack of attention on employment-oriented measures also indicate that primary care is not formally required or incentivised to consider the labour market status or aspirations of patients of working age. Nor are they required to refer patients to secondary care services which might support return to work. NHS England is working with the Health and Social Care Information Centre to develop a Clinical Commissioning Group Outcomes Indicator for the employment of people with mental health conditions. It is important that

these changes are materialised quickly to align incentives of different authorities within the health sector during the early stages of the reform process.

Linking health intervention and employment service

The wider impact of this new strategic orientation remains to be seen, but new employment service knowledge and capacity is being developed by the NHS. In 2009, two years after IAPT was established, an Employment Adviser (EA) pilot programme was introduced whereby IAPT therapists referred their clients to the EA service if they were in employment or on sick leave and facing employment issues.[9] The pilot, first of its kind targeting those with mild and moderate mental disorders, represents substantial progress and potential for integrating psychological therapies and employment support. The main aim of the pilots was to test the proposition that provision of an integrated health and employment advice service would: i) reduce the incidence of health-related job loss; ii) increase the likelihood of an earlier return to work following a health-related absence; and iii) reduce the number of people accessing out-of-work benefits.

EAs who where they exist are sometimes but not always co-located with the IAPT service, offer individually tailored practical and motivational support and work closely with the person's employer, but are not involved in job brokering. Notably, employment services can also be used by someone not needing any psychological therapy. Recent evaluation of the pilot showed that EAs "add value" to the IAPT service both in terms of facilitating a quicker return to work from sick leave and increasing the likelihood to remain in employment. Of those who were on sick leave when they started seeing the EA, 63% were attending work when they stopped seeing their adviser; 9% were still in employment but remained off sick; and the remaining 29% had left employment and were unemployed, permanently sick/disabled, retired or otherwise economically inactive. Of those who were attending work when they first saw an EA, 84% were still attending work when they stopped seeing their EA (Hogarth et al., 2013). The evaluation also points out that when people have employment as well as health problems they highly value co-ordinated help from both employment and health services.

Overall, the report drew some encouraging conclusions but an analysis of the employment outcomes of those in IAPT who saw an EA with those who did not proved inconclusive. This can be partly explained by selection effects with people seeing an EA having poorer mental health and more significant work problems. Furthermore, evidence suggests that employment support was not fully "integrated" with health support. For example, some IAPT patients were not referred to an employment advisor until their therapy session ended, in which case employment support take place several

weeks or months after an individual first reported their health problems. Some lessons from the Individual Placement and Support model which has a well-established evidence base could be integrated into existing support to improve the impact of integrated services on employment outcomes. For instance, integration of employment and health support means employment advisors should i) actively take part in assessment meetings and ii) influence referrals and share the decision-making process. This may present a challenge to services that are more used to working "in a series", rather than "in parallel". Employment specialists must be central and equal members of the service team, not peripheral "add-ons" (Sainsbury Centre for Mental Health, 2009).

The evaluation adds to the evidence base for early intervention to reduce the risk of health-related job loss and flows onto benefits, but the future of IAPT and of the integration of employment and health services it has created remains to be seen in the new health care landscape. The four-year action plan on Talking Therapies states that in the future all IAPT services will deliver employment support and that funding to support one employment support worker for every eight therapists will be available by the end of 2013/14. However, the extent to which funding is used for employment-related activities remains at the discretion of clinical commissioning groups. Moreover, it is questionable whether one employment advisor for every eight therapists will be sufficient to deliver good-quality services and reap the potential employment gains. Evidence from an IAPT service from one local authority in London, in Wandsworth, demonstrates that 84% of all clients moved back to employment between 2010 and 2011, partly due to the low caseload of the EA (30-35 clients). Overall, commissioning employment advice alongside therapy for working-age users of mental health services should be a priority for local commissioning bodies as this would contribute towards employment and sickness absence targets set out in the Public Health Outcomes Framework. Ongoing political commitment will also be a pre-requisite for securing integrated services in recognition of economic gains arising from it. A recent assessment of the economic impact of IAPT employment support services in London concludes that every 1 GBP spent generates 2-3 GBP in benefits of which 30% benefits the individual and 70% the state (Office for Public Management, 2011).

IAPT is not the only initiative in the United Kingdom through which a better link is being sought between the health and the employment situation of an individual. An interesting initiative targeting mental health of GPs is being piloted (see Box 4.2). There is no evaluation yet and take-up is still very low, at about 2% of all potential customers every year. This is a well-resourced service that would also be valuable for others, for example teachers and managers.

Box 4.2. **An accessible mental health service for doctors in London**

An interesting good-practice pilot in London reflecting the new employment responsibility of the health system is a NHS-funded job-oriented mental health service for health professionals – who are affected by mental ill-health more than others but least likely to disclose their problems because of the widespread "superman phenomenon". The service is free, confidential (even anonymously if preferred) and very easy to access and it provides very fast intervention (e.g. therapy within a week). Success factors include the involvement of a multidisciplinary team; a very low caseload; and a focus on graded return to work where this is possible (with the involvement of the employer).

From sick notes to fit notes

Like employers, GPs are key actors in preventing labour market exclusion being gate-keepers to sickness and disability benefits, and they are critical for motivating a quick return to work of those who are ill. Thanks to the well-being and work movement, change is also now visible among GPs who too often dismiss the option of work in the recovery process. According to recent surveys, up to 99% of GPs consider work being beneficial for health and a vast majority of them agreed that being actively involved in helping their patients return to work was important (Hann and Sibbald, 2011, 2013).This shift in attitudes is relevant in the context of a recent radical change to certifying sickness absence by GPs. As of 2010, GPs have to provide the Statement of Fitness for Work (known as "fit note" and replacing the previous "sick note") across England, Wales and Scotland.[10] GPs are now not only requested to assess whether their patient (the sick employee) is able to work but also suggest basic changes to the work environment or job role or other steps to help the employee return to work earlier. For instance, if a patient is classified in the "maybe fit for work" category, the doctor is required to specify at least one of four options outlining common return-to-work approaches including a phased return to work; amended duties; altered hours; and workplace adaptations. They are also now required to assess a patient's fitness for (any) work (rather than fitness for a specific job). The changes also meant a move towards an electronic fit note which in theory should generate new and standardised data (including on the causes of absence) and provide transparency to a hitherto rather undisclosed process.

Qualitative evaluations suggest that the fit note is being used by GPs to initiate discussions about work with their patients and that it has also improved the information flow between employers and employees (Chenary, 2013).[11] Although fit notes have facilitated a dialogue between the different parties involved in sickness absence, there is a long way to go to make the most from the new approach. One particular challenge for better

use of the fit note is the lack of workplace knowledge among GPs more generally. GPs are not equally confident in using all the return to work options on the fit note and differentiating between the return-to-work options. The new independent, state-funded Health and Work Assessment and Advisory Service (as discussed in Chapter 3) in many ways will have an important role to play in addressing some of these challenges and in turn supporting GPs to fulfil their roles. In 2011, DWP initiated the National Education Programme for GPs with the RCGP which trains doctors on health and work issues, including the fit note and mental health issues. The RCGP has taken this forward and now delivers a half-day workshop designed to increase knowledge and skills and boost confidence in dealing with clinical issues relating to work and health. In addition, an on-line tool is available especially for GPs and other healthcare professionals providing access to information, guidance and training on the management of health and work. GPs also have free access to professional and confidential occupational health advice in relation to individual patient issues as well as general occupational health queries. All these measures go in the right direction but do not guarantee a systematic change as the use of these services is largely at the discretion of GPs. More can be done to ensure that training is delivered in a comprehensive and systematic way. This can only be built through ongoing training requirements and changes in the curriculum of medical schools.

Challenges also remain in issuing fit notes for those with mental health problems. There is some evidence suggesting that GPs due to poor knowledge of mental health problems and their interaction with work may have a greater tendency to write these patients off sick for longer. For instance, the latest evidence available suggests that "fit notes" for mild-to-moderate mental health disorders were ten times more likely than those for respiratory illnesses to be for longer than four weeks (Shiels et al., 2013). At the same time, GPs are much less likely to place those with common mental health problems in the "may be fit for work" category than for other diagnoses. Excessively long sick leave is detrimental for some health conditions including Generalised Anxiety Disorders, resulting in deterioration in work confidence and readiness. To minimise the awarding of inappropriately long sick leave and to make the medical decision-making process for granting sick leave more homogenous and transparent, developing sick-leave guidelines should be considered as in Sweden.[12] Such guidelines can also facilitate a timely referral to the HWS for those who pass the four-week limit.

New opportunities for improving health and employment outcomes

Along with a general overhaul of the health system, reforms also marked a major shift in the commissioning of adult mental health services, by mandating the use of the "Payment by Result" (PbR) model for mental health

services for working-age adults and older people from April 2012. PbR is a mechanism by which providers are paid a standard set price (tariff) for the treatment of people sharing similar healthcare needs (clusters). Each cluster in turn is linked to a care package (the currency) for which providers are paid (see Box 4.3 for more details). The introduction of the currencies marked the first move to providers being paid according to their active caseload rather than on the basis of their historic block contracts with commissioners. The currency model also applies to independent or voluntary sector providers who are providing services to NHS patients. An intrinsic element of the currency model for mental health is capturing and monitoring quality and outcome metrics, including employment status. This data flows routinely to the centrally held Mental Health Minimum Data Set. In the longer term this can be used to move from process-driven to outcome-based funding of mental health care with the aim to improve service delivery and efficiency. The new system will also place a renewed emphasis on accurate assessment and diagnosis, and standardisation of clinical care with all practitioners using the same assessment tools and risk assessments.

Unlike the mental health clustering model which seeks to make payments for defined packages of care, giving differential pricing for a range of needs (payment by activity), IAPT services has begun to experiment with the recently enhanced dataset to incentivise improved outcomes rather than simply activity. In 2012, PbR was piloted across 22 sites in England by designing and developing an outcome-based currency system in IAPT. PbR currencies were based on performance across five areas of outcome along with different weighting each of those attracts. These include: access outcomes (15%); clinical outcomes (50%); work and social adjustment outcomes (10%); employment outcomes (10%); and patient satisfaction and choice outcomes (15%). The most significant weighting is still given to clinical outcomes. The aim of the pilot was to test the practicality and robustness and the financial and quality appropriateness. Early results were inconclusive due to insufficient data and further testing was recommended to generate local prices with any "credence" (NHS, 2013).

The move towards introducing an outcome-based approach in IAPT services is welcome. This can potentially bring a number of benefits including rewarding high quality providers and promoting the use of evidence-based treatments across the board. However, there are concerns whether IAPT services can truly operate as a full outcome-based funding model at this stage. On one hand, IAPT has collected a rich dataset on outcomes; it has a reasonably defined target group and a set of evidence-based interventions that work. On the other hand, an outcome-based model requires sufficient number of qualified providers, which are too few at this stage, to operate on a competitive basis. On top,

most of the IAPT services are provided by small charities and small business that do not have the financial capital to warrant fully outcomes-based contracts. Large employers sometimes use Employment Assistance Programmes but they too have not entered the market. Therefore, a hybrid model of funding should be considered whereby the DH pays the majority of the payments for core services (a service fee) combined with an outcome-based element until a well-developed market exists. The introduction of payment by outcome could also facilitate a better connection between the health and the employment sector given that the latter also functions as an outcome-funded market. For example, the outcome-based funding in IAPT opens up scope for purchasing units of mental health care for example by Work Programme providers or Job Centre Plus. Opportunities should also be sought with prime WP providers to commission new provision of IAPT services.

Box 4.3. **Payment by result in the mental health sector: How does it work?**

The Payment by Result (PbR) model was introduced in the English NHS almost a decade ago for the majority of services provided in acute hospitals. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are defined as the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long-term condition. Tariffs are the set prices paid for each currency.

The approach being taken to introduce PbR in mental health care is to cluster people into groups according to their needs and clinical description. A mental health clustering tool has been developed for use by clinicians to help them decide how to allocate someone to a care cluster. The clusters are based on descriptions of characteristics of people that is assumed will have similar mental health support needs. There are 21 different clusters under three main groupings: non-psychotic including common mental health problems; psychotic; and organic. Within these, a 1-4 scale indicates the seriousness of the condition, and clusters are pegged to various maximum review periods ranging from four weeks to annual. Each cluster is linked to a care package (the currency) for which providers are paid. At the moment care packages and tariffs are set locally.

In the long-run, further changes should be considered in order to better incentivise IAPT providers to focus on employment outcomes. Greater weighting should be given to employment outcomes. Also, a more refined payment system, taking into account the employment status and the distance from the labour market at the initial stage could be considered.[13] For instance, those who are attached to an employer but on sick leave have a higher likelihood of return than those claiming ESA and out of work for longer. This approach will also better align the incentive structure embedded in the WP that differentiates payment by benefit type (using the latter as a

proxy for distance from labour market). More detailed data collected on employment status since 2011 (as discussed above) should facilitate experimenting with differential IAPT payment systems within this indicator.

Conclusions

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 very high level in the health sector in the United Kingdom compared with many other OECD countries facing similar problems and challenges. However, the scale of the policy responses 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 considerably but remains problematic in some parts of England. More generally, there are concerns around the continuity and quality of IAPT in the new devolved policy context in which priorities are set on a local level. Similarly, there are questions whether the new employment service knowledge and service capacity currently built in the NHS will be sustained and grow in the long run. Further innovation is taking place with the hope that outcome-based contracts in IAPT will facilitate greater efficiency and choice in mental health services. Despite its potential attractiveness, a fully outcome-based model may not be appropriate for IAPT services until a greater number of providers with a sound financial base enter the market.

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 (that bring together other local partners, such as Local Authorities), and overseen by NHS England (as NHS England determine allocation of funds to CCGs, and commission Primary Care services). This will add to the other key roles of GPs as first contacts to detect mental health problems early and refer patients to more specialist services when necessary, and as gate-keepers to the sickness and disability schemes. The challenge will be to support and empower the current as well as the 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 welfare reform, the need for integrated services will become equally evident in the employment policy field. The main issue is not the question which sector is taking more

initiative, nor is there a major problem with service duplication because 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 significant proportion of people on sickness and disability benefits. A big challenge for the United Kingdom, however, will be to turn the many promising initiatives and pilots into a systematic structure to assure take-up of the new hitherto lacking services reaches the desired level. Such structures can include new service hubs (like the HWS), systematic referrals across services provided in different sectors, and cross-funding of services (like DWP co-commissioning for IAPT services run under DH responsibility.

In order to tackle these challenges, the following recommendations are put forward:

Empowering general practitioners, the main actor in the health system

- *Improve mental health knowledge*. General practitioners are the first contact for most people seeking mental health treatment or accessing sick pay with a mental illness. Nonetheless, mental health knowledge of GPs is insufficient as reflected in the very high prescription of medication for common mental illness. For the current primary care workforce, the provision of, and the mandatory participation in, mental health training modules will be critical. For the future health workforce, the current plan to expand initial GP training by one year with significant exposure to mental health problems and treatments should be followed without delay.
- *Issue sick-listing guidelines*. Several countries have good experiences with illness-specific sick-listing guidelines, developed by doctors for doctors. Such guidelines – including standards on referral to specialist health care and the typical and "optimal" duration of absence for different illnesses – should also be developed for the United Kingdom, and training about sick-listing aspects provided for both the current and future health workforce.
- *Develop workplace and work capacity knowledge*. In line with the recent shift from providing a sick note to providing a fit note, GPs also need much better knowledge about the demands of workplaces, the impact on health of differing working conditions and the most suitable adjustments in the workplace and in working conditions for people who are sick and trying to return to work, especially those with a mental illness.

Narrowing the mental health treatment gap

- *Assure quick referral to adequate treatment*. Quick and easy access to adequate mental health treatment offers the best chances for a quick recovery and return to work. This is not secured in the United Kingdom where the likelihood of such treatment depends on the region in which a person lives and on the ability of the GP to deal with mental illness.
- *Further reduce waiting times for therapies*. In particular, despite laudable recent efforts to increase access to evidence-based psychological therapies (especially Cognitive Behavioural Therapy – CBT), waiting times to access therapy are long. Significantly more funding will have to be shifted towards this element of treatment for mental health which still accounts for less than 10% of total mental health spending.
- *Improve links between primary and specialist health care*. With GPs being gate-keepers to specialist health care, access to psychiatry is not always secured when it is needed and often coming too late. Faster referral can be useful, provided psychiatrists are also trained sufficiently in the key role of work for recovery, and resulting workplace and work capacity aspects.

Enhancing employment focus in the health system

- *Sustain funding for employment advisers*. Employment advisers being brought into the pilots to improve access to psychological therapy (IAPT) seem to have significant potential in helping people stay in, or quickly return to, their job. Evaluation of the programme should however be continued using control trials as done in other countries (e.g. Netherlands) to accurately assess the impact of such services. Funding of programmes should continue until then (through funding from DH, DWP or both) and altered depending on further evaluation results.
- *Expand good practices available in pockets of the country*. Doctors themselves are key actors who suffer from mental ill-health more than other people, which is why having a dedicated service combining all that is known about good service (with free, confidential, accessible, and fast intervention) – as currently available in London – is laudable. This service should be copied in other regions and similar services could be considered for other key professions such as teachers and managers.

- *Greater focus towards employment outcomes*. The inclusion of employment outcomes in the outcomes framework of the health system in England should be refined, with increasing weight to employment and decreasing weight to clinical outcomes in reimbursing health services.

Making the most of ongoing health care reforms

- *Provide guidance in mental health service commissioning*. The shift of power to the local level comes with significant potential. However, guidance should be provided to local actors to assure coherence across the country and appropriate commissioning of mental health services which could otherwise easily remain under-resourced.
- *Include employment targets in the outcomes frameworks of the CCGs.* This is in line with employment now being an expected outcome in the NHS and for public health and will be critical to ensure that CCGs include employment in their commissioning arrangements.
- *Monitor mental health policy outcomes at the local level*. Outcomes will subsequently have to be monitored very closely at the local level, with sufficient focus on non-clinical outcomes, and corrections be made if developments fall short of the expectations in all or some regions. This is also true for the ongoing shift to payment-by-results which has yet to be harmonised across the country.
- *Match IAPT funding with shift to payment-by-results*. The shift in funding should also affect the IAPT services which are ideally placed for outcome measurement through its strong employment component. In view of the underdeveloped market in this field, initially a hybrid funding model (a mix of outcome and service fee) may be most appropriate.

Notes

1. Cognitive Behavioural Therapy (CBT) helps people to reorder their thoughts, manage their feelings and behaviour.
2. In a ground breaking study in 2007, Layard et al. estimate that the extra GDP produced over the two years after treatment has ended is likely to be around GBP 1100, and society will also gain from NHS savings of perhaps GBP 300 and reduced suffering valued (on NICE criteria) at around GBP 3300. These gains far exceed the cost of GBP 750 per person for ten sessions of CBT.

3. Faster access to mental health services by delivering an 18 weeks referral to treatment for psychological therapies from December 2014 was approved by the Scottish Government in November 2010.

4. As mentioned in Chapter 1, the health system of England is currently undergoing a radical change, with regard to its governance, funding distribution and service provision. Delivery responsibility is shifted from Primary Care Trusts – a more centrally controlled provision of services, previously controlling 80% of NHS funds – into the hands of local clinicians (GPs) who sit on the so-called Clinical Commissioning Groups to organise and manage health services.

5. Around 90% of all mental health care is undertaken in primary care (Gask et al., 2009).

6. In Scotland, a large proportion GP trainees already undertake four years training but the RCGP would like all four-year training programmes to follow its enhanced educational model to ensure equity across the United Kingdom.

7. Scotland, Wales and Northern Ireland are not going through the same health care reform process as England. Employment indicators are included in the Public Health Outcomes framework for Wales– for instance, the indicator for improving health and work includes the gap between employment rates for those with a limiting long-term health condition and the overall employment rate.

8. Public Health England is the new executive agency of the DH and holds responsibility in preventing ill-health more generally, improving the health and well-being of the population, and reducing inequalities in health and well-being.

9. Pilots were initially introduced in 11 areas of England and later also in Scotland and Wales.

10. People can self-certify their absence for up to seven days in a row, but from the eighth day, they need to request a fit note from their GP or another doctor.

11. A survey among employees on sickness absence showed that around two-thirds of respondents agreed that the fit note and discussions with their GP have helped them to discuss changes with their employer (Chenery, 2013).

12. These guidelines provide information on treatment, prognoses and recovery times for common mental conditions, as well as recommendations for the duration of sick-leave (see OECD, 2009 and 2013 for more details).

13. Further sub-indicators can be introduced in the Employment Outcome indicator as currently experimented in the Access Outcomes indicator which are broken down into six measures (see NHS, 2013 for more details).

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Further reading

Sick on the Job? Myths and Realities about Mental Health and Work (2012)

Mental Health and Work: Belgium (2013)

Mental Health and Work: Denmark (2013)

Mental Health and Work: Sweden (2013)

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