



The Sainsbury Centre

for Mental Health

BRIEFING 34

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BRIEFING 34

The Sainsbury Centre for Mental Health works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services. We now focus on criminal justice and employment, with supporting work on broader mental health and public policy.

The Sainsbury Centre was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding.

Photograph by F. R.A. Taylor

Work and wellbeing: Developing primary mental health care services

Executive summary

For adults of working age with common mental health problems, such as depression and anxiety, the journey towards long-term unemployment and disability often begins in the GP's surgery with the signing of a sickness certificate. This is a matter of concern for government, commissioners and clinicians alike. This briefing paper looks at the reasons why this issue has become so important and at positive ways to address it.

In an average general practice, at any time, 1,200 in every 10,000 registered adults of working age (16-64 years) will have a common mental health problem (ONS, 2000).

Two-fifths of sickness absence in the UK is caused by anxiety and depression, while about one million people live on incapacity benefits due to a mental health problem (Oxford Economics, 2007).

Unemployment damages people's health and wellbeing (Waddell & Burton, 2006). It is as serious a public health problem as smoking or obesity. Getting work can, however, reverse the ill effects of unemployment.

GPs can offer patients effective support to get back to work following the issuing of a medical certificate. The best approach requires a combination of:

1. Appropriate therapy (e.g. cognitive behavioural therapy [CBT]).
2. An assessment of fitness to work.
3. Communication with employers and JobCentre Plus.
4. A back-to-work plan.

During the process of issuing a prescription, GPs generally accept responsibility for the possible side effects of the medication. Similarly, the process of sickness certification should include a consideration of the potential adverse consequences. Issuing a medical certificate should be viewed in a similar way to issuing a prescription for medication. It is a therapeutic intervention that has both beneficial effects and potential unplanned effects.

The education and training offered to GPs is already changing to reflect the importance of employment to people’s health. Changes are also needed in the way health services are commissioned; in the incentive structure of the GP contract; in the culture of general practice and in the IT systems available to primary care staff.

We recommend:

1. The development of local area agreement (LAA) arrangements that allow other statutory stakeholders to be involved in the commissioning of services at the practice-based commissioning group (cluster) level – a mini LAA.
2. That the GP contract includes a requirement to deliver a system of care for people whose employment is at risk because of their mental health.
3. That the National Primary Care Mental Health Collaborative Programme (See Box 3), or a similar quality improvement programme, is made available to all practices in England, so that the cultural shift which is so necessary can be achieved.
4. That changes are made to the system requirements of all software providers of practice computing systems to make it easier to support patients issued with medical certificates.

Introduction

Mental health problems are common. The World Health Organisation (WHO, 2007) believes that, by 2020, depression will be the most common long-term disability worldwide, after cardiovascular disease.

Table 1: Prevalence of mental health problems per 1,000 adults aged 16-64 years (ONS, 2000)

Psychotic illness.....	4
Mixed anxiety and depression.....	92
Generalised anxiety.....	47
Depressive episode.....	28
All phobias.....	19
Obsessive compulsive disorder.....	12
Panic disorder.....	7
All neuroses.....	173
Drug dependence.....	42
Alcohol dependence.....	81

Table 1 shows the likely number of people with mental health problems in the community (ONS, 2000). In an average practice of 10,000 adults (aged 16-64 years), these figures would translate to around 1,200 people with a common mental health problem and a further 25 people with a psychosis.

It is not surprising therefore to learn that some 30% of the 280 million consultations undertaken by GPs each year have a mental health component (RCGP, 2006), and that about 90% of all mental health conditions (DH, 1999) are managed entirely in primary care.

Mental ill health does not only have an effect on the wellbeing of the individual, it also has an effect on their ability to work and this in turn has an impact on the national economy.

According to the Treasury, there are some 160 million working days lost each year due to sickness absence: 28 million are work related illnesses and 12.8 million of these (or two in five) are due to anxiety and depression. Forty per cent of new claimants of incapacity benefit have a mental health problem (Oxford Economics, 2007).

Each week one million people report sick. Of that one million, 3,000 remain off work six months later, and 80% of these will still be off work five years later. The expectation of people taking sick leave is that they will return to work. The evidence, however, shows that if an individual is off work for 12 months, they are unlikely to return to work for another seven years. If they have been off work for two years, the chances of returning to work decline even further, so that they are more likely to retire rather than ever return to work (Waddell & Burton, 2006).

Worklessness and mental ill health

Given the potentially disastrous consequences for people if they lose their jobs and become long-term

unemployed, it is very important that everyone involved makes the right decisions at the right time. Recent studies have found:

- **Unemployment**

Strong evidence exists that unemployment is harmful to health. The unemployed have higher mortality, poorer general health, poorer mental health and higher medical consultation, medication consumption, and hospital admission rates (Waddell & Burton, 2006).

- **Re-employment**

There is strong evidence that re-employment leads to improved self-esteem, and improved physical and mental health (Waddell & Burton, 2006). The magnitude of this improvement is more or less comparable to the effects of job loss. Thus the harmful effects of unemployment can be reversed by re-employment. People who move off benefits and (re)-enter work generally experience improvements in income, socio-economic status, mental and general health. Those who move off benefits but do not enter work are more likely to report deterioration in health and wellbeing.

The role of the GP

The first people, apart from the individual and their family, likely to have to decide how to manage the onset of mental ill health are the employer and the general practitioner (GP). The GP has a number of responsibilities, both clinical and administrative, in advising an individual about how their illness affects their capacity to work. This is “an every day part of the management of clinical problems” (DWP, 2004). To do this effectively, the GP should have an understanding of clinical research relating to an individual’s condition and of how worklessness can affect someone’s health and wellbeing.

Current regulations (BMA, 2004) stipulate that only medical practitioners can issue medical certificates (sick notes). The difficulty encountered by many GPs is that there appears to be a tension between acting as an advocate on behalf of the patient, and providing the most appropriate advice on capacity to work. This is made more complex by the fact that issuing a medical certificate is a therapeutic intervention and in many ways similar to issuing a prescription for a drug. Drugs have both beneficial effects, and unplanned and unwanted side effects. In the same way, issuing a medical certificate can also have both beneficial effects and unplanned side effects. Some of the unplanned and unwanted effects of worklessness are that it is associated with a range of negative consequences

for the individual, their family, and society with the duration of worklessness being particularly significant. A sick note can become very ‘addictive’.

During the process of issuing a prescription, GPs generally accept responsibility for the possible side effects of the medication. Similarly, the process of sickness certification should include a consideration of the potential adverse consequences.

How should GPs support people who need time off work?

Most people recover and go back to work with, or sometimes without, a short course of treatment. However, for people who are not recovering and returning to work as expected, there needs to be a more focused approach to fitness for work in primary care than has hitherto been the case. Research suggests that it is possible to identify those who are going to need extra support within three to four weeks (Seymour & Grove, 2005). What prevents people from working are the symptoms they experience and how they cope with them (especially in social relationships), rather than the illness itself (Wanberg, 1997).

Anxiety and depression are the key conditions with which GPs can help people to return to work. They are much more common than psychotic symptoms, which generally require specialist help before return to work can be considered. Anxiety in itself has no direct relationship with sickness absence, as it may have confounding effects. For example, a person may return quickly from sickness absence due to increased problem-solving activity triggered by anxiety, or may be delayed by the depression which is frequently associated with clinical anxiety (Shiels *et al.*, 2004).

Depression is the most common barrier to return to work, due to loss of confidence, low self-esteem, poor memory and concentration, and sleep disturbance, all of which are associated symptoms. Depressive disorders and ordinary distress associated with life events can have a major effect on a person’s ability to go to work. The number of symptoms of depression that a person is experiencing directly affects their ability to return to work, regardless of the initial ‘diagnosis’ or the original reason for taking sick leave.

Box 1 shows how GPs should help people with mental health problems to return to work.

Box 1: Mental health and work: the GP's role

GPs can help people with mental health problems to return to work by providing a combination of the following:

1. Appropriate therapy

- Cognitive behavioural therapy, including computerised options recently recommended by the National Institute for Health and Clinical Excellence (NICE);
- Anti-depressant medication for clinically appropriate conditions with patient's co-operation;
- Graded activity: physical, social and work-related activity.

2. Assessment of fitness to work

This should include the following considerations:

- The relationship between illness and work.
- What the work involves (job description).
- Is work affecting the person's symptoms?
- Negative: problems/stress at work.
- Positive: distraction/escape from problems at home.
- Is the illness affecting work?
- Capability/suitability for certain types of tasks.
- Risk assessment.
- Is specialist referral necessary to answer these questions?

The consultation process should also include an understanding of:

- The interaction between the person's work and their presenting problem.
- The demands of the job and the possibility of suitable alternative tasks.
- The availability of occupational health support in the workplace.
- The motivation of the individual to return to work.

3. Communication

A clear idea of the cause and likely duration of symptoms (if possible) should be given to the employer and/or Jobcentre Plus on the person's sick note (in the diagnosis and remarks sections). This can be supplemented by written or telephone communication, as appropriate, (by agreement with the patient) with their line manager, human resources and occupational health departments, and Jobcentre Plus advisers.

4. Back-to-work plan

For those who have been off work through mental ill health, a return to work plan, agreed by the patient, employer and GP, is often very helpful. The act of constructing a plan means that the likely difficulties, including unhelpful behaviour and attitudes from managers and colleagues, are foreseen and to some extent prepared for. The plan does not have to be made by the GP but the GP should make an input. A specialist employment adviser or case manager is probably the best intermediary. Such advisers are increasingly being employed by local employment service providers, some employers and trades unions. The components of a plan should include a discussion of issues such as:

- Does the decision regarding (relative) fitness for work require a specialist opinion?
- When is the person likely to be ready to return to work?
- Would staying at home exacerbate their problems?
- What limitations does the individual currently have?
- Would they benefit from:
 - o Adjustments to hours of work (reduced hours/phased return)
 - o Changes to job/role (e.g. are they unfit for specified tasks)
 - o Changes to the environment?
- Do these changes constitute 'reasonable adjustments' with respect to the Disability Discrimination Act (DDA)?
- What to say to colleagues about the mental ill health.

Return to work is also dependent on a person's preferred coping styles (Ford, 2006), of which the most successful has been shown to be a combination of acceptance of limitations, positive reframing and planning for the future. These strategies can be encouraged by a health professional skilled in behaviour change methods such as motivational interviewing (Prochaska & Di Clemente, 1982).

Education and training

Changing the way mental ill health is managed for working age adults will require both education – about the relationship between work and health – and training for health professionals in how to manage the fitness for work consultation in a therapeutic manner.

It is now accepted that general practitioners have a key role in the management of fitness for work and sickness certification. However, if change in practice is to occur, training about common health complaints and their management must move beyond the GP to all health professionals. GPs working alongside hospital consultants, nurse practitioners and other allied health professionals must provide consistent messages about work and health.

Undergraduate education

A new competency framework in occupational medicine at undergraduate level has been developed by the Faculty of Occupational Medicine at the Royal College of Physicians and the Department for Work and Pensions. This was completed in May 2007 and is available on the Faculty of Occupational Medicine's website (www.facocmed.ac.uk/edtrain/ugresrce/r_compf.jsp).

Postgraduate education

Postgraduate training for general practitioners, as for all medical specialties, now requires that there is a specific curriculum that is approved and implemented. For the first time there is a nationally recognised and approved curriculum for general practice.

The curriculum for mental health covers all aspects of care, including the importance of work and meaningful day time activity. Details of the curriculum can be found on the Royal College of GPs website at www.rcgp.org.uk. It is anticipated that new research on the therapeutic value of

employment will be included in regular updates to the curriculum. It should be noted that work is important to many other clinical areas, not just mental health.

Box 2 outlines a programme being developed by the Royal College of GPs to enhance professional standards in health and work.

Box 2: National educational programme for health and work

The Royal College of General Practitioners is developing a national educational programme for enhancing professional standards in the area of health and work. The purpose of the training is to increase the knowledge, skills and confidence of GPs in dealing with clinical issues relating to work and health. It aims to increase GPs awareness of their responsibilities in this area and to increase the confidence of GPs and primary care teams in providing evidence-based best practice for patients around work and health.

The content of the programme has been constructed so that it offers GPs the opportunity to reflect on everyday issues in managing a consultation about health and work. This provides a sounding board for discussion and the opportunity for participants to practise new skills.

The educational programme, in its pilot stage at the time of writing, will deliver six face-to-face workshops around the UK which will be independently evaluated. Following evaluation of the pilot, a revised programme will be rolled out across the UK.

Policy implications

To achieve the necessary changes to the way GPs support people to find or retain work, reforms are needed to create the 'levers' for local action. The introduction of these is the responsibility of a number of agencies: principally central government and the professional bodies. They include:

1. Creating financial incentives for commissioners

One of the strengths of primary care in the UK has been its ability to act as a 'gatekeeper' to access to secondary health care services. That gatekeeper role is familiar to general practitioners

and policy makers alike. It was at the heart of many previous health reforms, such as Choice, Payment by Results, Practice-based Commissioning, and Care Closer to Home. In all of these cases, the GP, in consultation with the patient/client, provides access to secondary health care services.

It is becoming clear that the GP has a similar gatekeeper role in providing access to welfare benefits associated with worklessness. One of the reasons primary care acts as a gatekeeper to secondary health care services is that it is economically sound. It is cheaper to provide care in the community, and in primary care services, than it is in hospitals. The same argument could be applied to worklessness; not only are there health benefits to people remaining or returning to employment, but there are economic gains as well.

However, there is a significant difference between the gatekeeper role for health care and the gatekeeper role for employment. The savings generated through the gatekeeper role to specialist health care remain within the health sector and can be reinvested in different forms of health care. With employment services, many of the savings generated through return to work are accrued outside the health sector e.g. in the tax and benefits systems. Health services are effectively being asked to invest in a service that will not deliver funds for new services. The argument that return to employment will generate improvements to the national economy is unlikely to be sympathetically considered by a primary care trust (PCT) faced with trying to improve its financial position or a general practice involved in the new practice-based commissioning system. Practice-based commissioning (PBC) is the process whereby practices (acting individually or in groups/clusters) can commission health care services for their local population.

A policy solution to this kind of dilemma does exist – the Local Area Agreement (LAA). LAAs cover large populations, e.g. the entire population of a PCT which can be between 500,000 and one million people. The membership is drawn from NHS bodies and from a variety of other organisations such as the local authority, local ambulance trust, as well as the Department for Work and Pensions (DWP), and the police and criminal justice services. The voluntary sector is also represented at a senior level.

The LAA allows resources to be shared to achieve national targets. But inevitably such an organisation is beset by complex bureaucracy and competing demands. LAAs are blunt instruments that are not good at the sensitivity and lightness of touch needed to change attitudes in primary care,

or to work at the ‘small community’ level of GP practices.

Practice-based commissioning, meanwhile, does provide the tools to change GP culture, as it encourages entrepreneurial skills, but it is limited in being restricted to health care. Practice-based commissioning does not give the same opportunities as a PCT has within a LAA, to deliver on wider public health needs such as employment services.

What is needed is a system with the benefits of the LAA arrangement, but at a practice-based commissioning level – a mini LAA. Such a mini LAA would have all the same benefits of sharing resources experienced by the larger organisations, but at a much smaller population level. It would also provide the governance to allow local authorities and the voluntary sector to have a tangible role in commissioning decisions taken at a community level.

Practice-based commissioners would then have a governance structure to take a broader view of commissioning, to involve other stakeholders who contribute in other ways to the wellbeing of the local population, while ensuring that savings remain within the local area, albeit not in the NHS itself.

We recommend the development of LAA arrangements that allow other statutory stakeholders to be involved in the commissioning of services at the practice-based commissioning cluster level – a mini LAA.

2. Contractual changes

Any contract for providing health care in general practice has to take account of the need to deliver public health gains. The current GP contract (known as nGMS) has a number of mechanisms whereby public health policy can be introduced into the provision of health care. The principal mechanisms that are available are the Quality and Outcome Framework (QOF), the ‘directed enhanced service’ (DES) and the ‘locally enhanced service’ (LES).

The Quality and Outcome Framework is an incentive payment for general practices to deliver high quality essential services. The nGMS contract, introduced in 2004, was revolutionary for a number of reasons, including its description of the level of care that must be provided by all general practices. An incentive scheme was evolved that encouraged the high quality, evidence-based delivery of essential services. Points are awarded for delivering high quality outcomes in the management of a number of conditions such as

diabetes or ischaemic heart disease. Each point has a financial value, and the greater the delivery of high quality care, the greater the rewards earned by the practice.

The current Quality and Outcome Framework rewards GPs for recording a diagnosis of depression. If this was matched with a measure of severity, it could be used as a prompt for taking suitable action such as a referral for CBT, and for predicting possible barriers caused by depressive symptoms that might prevent a return to work.

Beyond that, it is possible to devise a set of evidence-based outcomes that would deliver high quality outcomes for people whose employment is at risk as a consequence of their mental ill health. Such a new set of clinical indicators would be cost neutral, since to include it in the QOF would mean that another clinical indicator would have to be omitted. Such a debate, to decide that one set of indicators has a higher priority than another, requires a commitment from central Government that employment for people with mental health problems is a high public health priority. The Sainsbury Centre has submitted such recommendations to the committee that reviews changes to the QOF on two occasions, in 2004 and 2006. In both cases, although there was no dispute over the research evidence, the submissions have not progressed, as the issue was not considered to be a priority.

It is well recognised that some practices deliver care above that considered to be essential by the nGMS contract. Such care is termed ‘enhanced’ and may be commissioned by an individual PCT, termed a locally enhanced service (LES), or by national directive, termed a directed enhanced service (DES). A LES is dependent on a PCT seeing the local need for a service, and having the resources to commission such a service. A DES by contrast amounts to a national target for primary care. The current political climate, however, is to reduce targets, rather than to increase them.

It is possible to debate the merits of either system of reward, but what is clear is that not to include the issue of worklessness and mental health within the nGMS contract, when it has such a high economic and health cost, is illogical.

We recommend that the nGMS contract includes a requirement to deliver a system of care for people whose employment is at risk because of their mental health.

The decision as to which is the most appropriate system for introducing such a change into the current nGMS contract will depend on a number of

circumstances, not least a government desire to see this included as part of primary health care services. To identify which system is the most effective, it may be appropriate to pilot different methodologies.

3. Cultural changes

A change in culture in general practice may be difficult to achieve as GPs may fear that there is a tension between their role in acting as an advocate on behalf of the patient and in providing the most appropriate advice on capacity to work. Box 3 shows how positive change can be brought about.

We recommend that the National Primary Care Mental Health Collaborative Programme, or a similar quality improvement programme, is made available to all practices in England, so that the cultural shift which is so necessary can be achieved.

Box 3: The National Primary Care Mental Health Collaborative programme

The National Primary Care Mental Health Collaborative was launched in February 2006. Its aim was to improve the care of adults of working age with common mental health conditions in primary care. During the programme all participating practices had to provide the same data each month to a central (electronic) warehouse. This meant that the success, or failure, of a change in service delivery could be reviewed and compared across all participating practices. The data measures used in this programme were:

- Consultation rate with the GP.
- Consultation rate with other members of the primary health care team.
- Referral rate to specialist services.
- The number of people who have been issued a medical certificate for longer than 13 weeks.

Initially there was concern in the participating practices that GPs would be forcing people to return to work against their will, but during the 15 months of the programme many of the participants changed their view about this. Many reported how a return to employment had become an outcome measure of the effectiveness of treatment and described the different techniques that they had used to encourage and support people to return to work. This change in attitude and culture was dramatic.

For further information visit www.improvementfoundation.org.uk.

4. IT changes

All of the foregoing recommendations to policy require that there is accurate recording of the employment status of individuals on practice computer systems.

The experience of the National Collaborative Programme shows that this data is hard to extract from current IT systems and that this represents a significant barrier to implementing change. The participants in the collaborative were able to obtain the necessary information because they are the innovators, the enthusiasts. To ensure that all GPs, the early adopters, the late adopters and the laggards, all start changing the way that they approach employment issues, it is not sufficient to offer better education, financial incentives, and contractual changes. It is also necessary to make the recording of that data much easier.

The current system is complicated because there are a number of different providers; however, there is a national policy drive to complete the Connecting for Health (CfH) programme, to computerise the NHS. At present, there is a hierarchical coding system used by computer software manufacturers (the Read Code) which enables the coding of specific actions in primary care, such as a diagnosis or prescribing medication. There are Read Codes for issuing medical certificates, but there is no way of linking these to the diagnosis for which the certificate was issued. Also the duration of the certificate cannot be recorded in a way that allows for electronic searching, which is essential if individuals are to be helped and supported to return to work at the earliest opportunity.

There are also considerable opportunities for further development of electronic recording of employment status, issuing of certificates, and the collation of information for the variety of reports requested by the Department for Work and Pensions for persons on incapacity benefit etc.

We recommend that changes are made to the system requirements of all software providers of practice computing systems so that Read Codes for medical certification are simplified, and that these link to the underlying medical diagnosis, and duration of the certificate issued.

References

- BMA (2004) *Investing in General Practice. The New General Medical Services Contract*. London: British Medical Association.
- DH (1999) *National Service Framework for Mental Health: Modern standards and service models*. London: Department of Health.
- DWP (2004) *A guide for registered medical practitioners (IB204). Revised with effect from August 2004*. London: Department for Work and Pensions. [http://www.dwp.gov.uk/medical/guides_detailed.asp#IB204]
- Ford, F. (2006) *Coping Strategies in East Lancashire Condition Management Programme*.
- Office for National Statistics (2000) *Psychiatric Morbidity among adults living in private households. Technical Report*. London: HMSO.
- Oxford Economics (2007) *Mental Health and the UK Economy March 2007*. Oxford: Oxford Economics. [www.oxfordeconomics.com]
- Prochaska, J. & Di Clemente, C. (1982) Transtheoretical Therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, **20**, 161-173.
- RCGP (2006) *The Value of General Practice RCGP Fact Sheet (November 2006)*. London: RCGP. [www.rcgp.org.uk/pdf/ISS_INFO_o6_ValueGenPrac.pdf]
- Seymour, L. & Grove, B. (2005) *Workplace interventions for people with common mental health problems*. London: British Occupational Health Research Foundation.
- Shiels, C., Gabbay, M. & Ford, F.M. (2004) Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, **54** (499) 86-91.
- Waddell, G., & Burton, A.K. (2006) *Is Work Good for Your Health and Well-being?* Norwich: The Stationery Office.
- Wanberg, C. (1997) Antecedents and outcomes of coping behaviours among unemployed and re-employed individuals. *Journal of Applied Psychology*, **82** (5) 731-744.
- World Health Organisation (2007) *Mental health, management and depression* www.who.int/mental_health/management/depression/definition/en/ [Accessed August 2007]

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