

Call for evidence by the National Director for Health and Work

How can we **keep working age people healthy** and how can **the workplace be used to promote health**?

- Good management (ie. as in the HSE Management Standards)
- Companies should have health and wellbeing policies driven by reporting at Board level. The company report should include health audits as well as accounts and trading reports. Innovation and excellence should be encouraged by award schemes and learning disseminated through learning networks eg. the National Employment and Health Innovations Network.
- Workplaces can be effective in delivering health messages through company culture, programmes and good management practice. Encouraging openness about mental ill health at work, eg through having positive programmes, also reduces stigma and fear of discrimination and makes it more likely that people will ask for help. BT's suite of programmes is an excellent example of a proactive approach in the commercial sector.
- In addition to improving early identification and reducing stigma so as to encourage help-seeking behaviour among people with mental health problems, we also need to improve access to a range of effective psychological interventions in the workplace. The tendency to separate vocational and health interventions and to deliver them 'in series', rather than in parallel, remains a problem. The dangers of doing this are highlighted in the Australian research, 'Work Outcomes Research and Cost-benefit' project (WORC) which suggested that those who were removed from work and treated outside for psychological problems actually did worse than those who were not identified (WORC website). This means increasing the availability of evidence-based psychological interventions in the workplace as described in the relevant NIHC guidance which recommends a number of approaches – self-help manuals, computerised CBT (CCBT), brief psychological treatments, etc. – to be deployed in a 'stepped care' model. This will be supported by the initiative to improve access to psychological therapies which was launched last year and recently received a further boost of £170 million funding.

How can people best be helped to remain in or quickly return to work when they develop **health conditions** including **chronic disease or disabilities**?

- Early intervention can prevent the psycho-social barriers to return to work from becoming overwhelming. Intervention may be needed 1) to empower the individual to manage their condition and continue to see themselves as workers - CBT is helpful in this respect and has a good evidence base (Seymour & Grove, 2005). 2) to enable the employer, manager and colleagues to understand the psycho-social components of disability and make adjustments accordingly. A *Case Manager* approach has been shown to be effective (Thomas, Secker & Grove 2002).
- Measures may also be needed to enable people to respond appropriately to colleagues/employees who are showing signs of distress, withdrawal, odd communication etc., which may signal a mental health condition. The Australian programmes *Beyond Blue*

and *Mental Health First Aid* are being tested in this country – *Beyond Blue* by The Sainsbury Centre (further details available on request, see also www.beyondblue.org.au).

- GPs must be trained to understand that return to work may be crucial to recovery from mental ill health and trained in how to use the fitness for work interview as a therapeutic tool. Changes in working practices must be built into the GP contract and also IT changes to patient management systems that enable the issuing of sickness certificates to be recorded and monitored (SCMH 2007). A pilot project testing out these changes led by Primary Care Contracting and the Sainsbury Centre will start in the next few months.
- For people with mental health problems who have become unemployed, the field of vocational rehabilitation has been revolutionized in the past 10 years with the advent of the new, 'evidence-based', rapid job search and placement models based on 'Individual Placement and Support' (IPS) (Becker, Drake & Concord, 1994). This approach, developed in the United States, has convincingly demonstrated its effectiveness in achieving superior employment outcomes compared with traditional vocational rehabilitation approaches (Mueser, Clark & Haines, 2004). Longitudinal effectiveness has now been shown in 8-12 year follow-ups (Becker, Whitley, Bailey & Drake, 2007) and IPS has recently been evaluated in a multi-site European study (Burns, Catty & Becker, *in press*), which again confirms its superiority against most control conditions. In England, a 'Cochrane review' of the RCT evidence concluded that IPS was superior to all other alternative approaches (Crowther, Marshall, Bond & Huxley, 2001). It has now been successfully implemented in routine clinical practice by Miles Rinaldi and Rachel Perkins at South West London and St. George's Mental Health Trust with impressive results (Rinaldi & Perkins, 2007). The really impressive thing about IPS is that it was developed and its success achieved mainly with people who have more severe and enduring mental health problems – a group who find it particularly hard to get and maintain employment. The principles however are applicable across the mental health spectrum and should form the basis of what is offered in Pathways to Work and other Government sponsored rehabilitation programmes.
- Rates can also be increased by ensuring that local public and voluntary sector employers make every effort to recruit people with mental health problems into their workforces (as they are required to do under the terms of the Disability Discrimination Act, 2005). A practical guide to setting up such programmes has been provided by the Sainsbury Centre in their '*Leading by Example*' paper (Seebomh & Grove, 2006).

How does the **age of the person** affect the support that is needed?

- It is worth noting that as far as mental ill health in the workplace is concerned there is no age gradient (Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2000). Physical conditions become more significant in both cost and disability terms as people grow older. As far as mental ill health is concerned, younger and older workers are equally likely to suffer and/or be at risk.
- As far as entry into the labour market is concerned, young people with mental health problems are more likely to have had a disrupted education and to lack the kind of entry level work experience that socializes young people into the workplace while finishing their education. Low self-esteem and self-confidence make it difficult for them to acknowledge skills and emotional deficits of which they are all too well aware. Enabling them to find success in a working environment is a priority and can be the foundation of the succeeding growth and development. The priority therefore for Connexions and other agencies in

touch with young people with mhp, including CAMHS teams and Early Intervention in Psychosis Teams, is to help them to get work experiences which give them a sense of achievement rather than continue the long experience of failure that may have characterized their education.

- Older people who have dropped out of the workforce reluctantly as a result of mental ill health are more likely to suffer from double discrimination when they try to re-enter it. Help in finding jobs where life experience, practical experience and social skills are in demand may require labour market analysis and the targeting of particular industries. A universal “career check” interview could be offered to all 50 or 55 year olds to help them think about the next stage of their working lives and how crucial that might be to their health in later years.

How can we **encourage** action to improve **employee health**?

- Business to business communication is the primary means. Recent initiatives by Business in the Community need to be followed through with practical help and learning networks such as that run by the Employers Forum on Disability and the Sainsbury Centre. Insurers can incentivise employers who take preventive measures with lower premiums and Government can use award schemes, lead by example and be proactive in contracting with its own supply chain ie. all suppliers must have or be working towards the IIP health standard.

What underlies the apparent **growth in mental health problems** in the working age population and how can this be addressed?

- The evidence on this is contradictory and open to interpretation. In our review (Seymour & Grove, 2005) we wrote:

“Since 1979 the number of people claiming Incapacity benefit has more than trebled and the proportion whose primary diagnosis is mental or behavioural disorder continues to rise... It is however far from clear that this apparent rise in the numbers of people leaving the labour market due to mental health problems is due to an increase in mental ill health. In fact general health indices and those relating to mental ill health in the general population have remained comparatively static. Rather we may be witnessing a reclassification of less specific disorders with psycho-social dimensions or other issues by patients, doctors or both... It is not possible to reach any firm conclusions about recent trends in the levels of common mental health problems in the workforce. There is no evidence of an epidemic of mental ill health. However there does seem to be a greater willingness to focus on psychological rather than physical distress when explaining sickness absence or claiming welfare benefits”.

- We have not changed our views since then. However we should be under no illusions about the seriousness of the problem. Mental health problems are almost as common in the workforce as in the general population (SCMH, *in press*) and that means they are very common indeed – a normal feature of every workplace in the land. Most employers grossly underestimate the prevalence of mental ill health in their own workforces (Shaw Trust, 2006) and we believe that getting the message across about mental ill health being normal is the first stage to reducing stigma and discrimination, identifying problems in the workplace and dealing with them.

What constitutes **effective occupational health provision** and how can it be made available to all?

From the perspective of a good employer the OH team will:

- advise on adjustments and working arrangements for new employees who are disabled or have a health condition that the employee needs employer support to self-manage
- advise managers from an informed position on likely course of recovery and on what can be done to facilitate this
- liaise with health professionals where needed, i.e. GPs
- know where to access outside help where recovery is not happening as expected
- advise on prevention/promotion (Grove, 2006)

Many good employers (notably BT) have abandoned pre-employment health screening, which some claim is ineffective, a barrier to getting the right person for the job and often leads to discriminatory recruitment practices (Dunn, 2005).

SMEs need OH advice that is independent of the Health & Safety Executive. Workplace Health Connect is probably a good idea, but needs more thinking through especially in relation to the particular circumstances in which small employers need help. This can provide the entry point for advising on a more proactive/preventive approach to the health of the workforce.

What would be the impact on **poverty and social inclusion** of a healthier working age population?

- If people are in work they have a greater chance of being socially included and a better chance of being socially integrated in their communities (geographical communities of identification and communities of interest).
- There is also the impact upon future generations to be considered as highlighted in the Child Poverty Action Group's recent media briefing (CPAG, 2006):

“Although the average risk of a child being poor in 2005/6 was 22% (before housing costs) and 30% (after housing costs), the risk of subgroups of children being poor varies hugely by household characteristics. Children living in workless households are particularly at risk of poverty.”

What are the **costs of working age ill-health** to business and what are **the benefits to companies** of investing in the health of their staff? (SCMH, in press)

- People with poor health are less likely to be in work than their healthy counterparts and more likely to have lower productivity when they are in work. Business is therefore adversely affected in two ways: ill health reduces both the supply of labour and the output of those in employment.
- Concerning the supply of labour, there are currently over 2.6 million people in receipt of Incapacity Benefits, to be compared with an economically active population of 30.9 million. Long-term sickness and disability thus reduce the effective size of the labour force by nearly a tenth. They also account for about a third of all inactivity.

- Among those in employment, the adverse effects of ill health take two main forms: sickness absence (“absenteeism”) and impaired performance while at work (“presenteeism”).
- According to CBI and CIPD surveys, absenteeism is responsible for the loss of 7-8 working days a year per average employee, at a cost to employers of around £15 billion (direct costs only). On a positive note, the number of working days lost has fallen by nearly a quarter since the late 1980s.
- No survey-based evidence is available on the costs of health-related presenteeism in the UK, but international evidence suggests that these costs may be several times larger than those of absenteeism. We suggest that one useful outcome of this evidence review would be a recommendation or proposal for the collection of some statistical information on presenteeism in this country.
- There is little doubt that mental ill health is the single most important cause of health-related losses in productivity, whether these take the form of absenteeism or presenteeism. For example, in the case of absenteeism, mental health problems account for around 40% of all working days lost, and for an even higher proportion of days lost because of health problems which employees say is directly caused by their work or working conditions.
- The importance of mental ill health as a cause of costs to business reflects high rates of prevalence *in all age groups*. Most physical health problems are predominantly problems of old age and impinge on working life to a relatively minor degree. In contrast, the prevalence of mental health problems displays very little by way of an age gradient. Mental ill health is *the* dominant health problem of working age.
- The benefits to companies of investing in the health of their staff are in large measure the reverse of the costs mentioned above, on the logic that a cost saved or averted is a benefit gained. Better health in the workforce, particularly better mental health, will cut rates of sickness absence, improve in-work productivity and also reduce staff turnover. Companies may also derive less tangible benefits such as a general improvement in staff morale and an enhanced reputation as a good employer.

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WORC - for more on WORC see www.qcmhr.uq.edu.au/worc/

The Sainsbury Centre for Mental Health

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 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.

Our Employment Programme focuses on the importance of employment in recovery from mental illness and the promotion of mental health and well being in the public and private sector workforce. We work across the UK, disseminating the lessons learnt through networks, publications and engagement with policy makers.

Our work is relevant to policy makers, practitioners, people who experience or have experienced mental health problems, carers, service commissioners and employers.