



SHIFTING RESPONSIBILITIES, SHARING COSTS

Meeting the Mental Health Challenge
for Welfare Reform



Jessica Prendergrast, Beth Foley and Tom Richmond

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CONTENTS

Acknowledgements	4
About the authors	5
Executive summary	6
1 Introduction	20
2 The cost of mental ill health	24
3 Mental health and employment	31
4 Mental health and welfare reform	38
5 Barriers to remaining in employment	47
6 The case for early intervention	67
7 Prevention, retention and rehabilitation	73
8 Meeting the mental health challenge	93
9 Conclusion: A package of reforms	113

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ABOUT THE AUTHORS

JESSICA PRENDERGRAST

Jess joined the SMF in November 2007 as a senior research fellow, having worked previously as a social researcher in both the Department for Communities and Local Government and the Home Office, and before that in academia. She has a Master's from University College London (SSEES) and a BA in Politics, Philosophy and Economics from Keble College, Oxford. She has a special interest in empowerment, local government and housing.

BETH FOLEY

Beth joined the SMF in October 2007 as a researcher. She has a degree in European Social and Political Studies from University College London, and also studied at the Humboldt University in Berlin. She has a special interest in public service reform and social policy.

TOM RICHMOND

Tom worked as a researcher at the SMF until August 2008, when he moved to Policy Exchange to become a research fellow specialising in education. Before joining the SMF, he completed a Master's degree in Psychology and spent three years as a school teacher.

EXECUTIVE SUMMARY

Reducing the number of people claiming Incapacity Benefits (IB) is a key objective of the Department for Work and Pensions' (DWP) welfare reform programme.¹ Ambitiously, the government has committed to reducing the numbers claiming the benefit by one million by 2015.² At present, the figure is 2.64 million.³ In pursuit of this target, the focus of the welfare reform agenda has been primarily on returning those claiming IB to work. There is however an increasing recognition, as highlighted in the recent DWP Green Paper, that "[h]elping people to stay in employment when they suffer a disability or period of ill-health is the best way to keep them in touch with work and to reduce the numbers moving onto benefits.⁴ Nonetheless, in the last year for which data is currently available (November 2006 to November 2007), almost 590,000 people began claiming either IB or Severe Disablement Allowance, and there remains real scope for solutions which seek to reduce the number of people flowing onto benefits.

Inextricably intertwined with the problem of benefit reform is the challenge of mental ill health in the UK population and workforce. One in six of the population is suffering from a mental illness at any given time, the vast majority being mild to moderate conditions such as depression and anxiety (common mental illnesses). Since the Sainsbury Centre for Mental Health (SCMH) estimates that, on average, the prevalence of mental health problems in the workforce is not very different from in the population at large, employers should expect to find that around a sixth of their workforce is likely to be affected by a mental health

1 IB will be replaced by the Employment Support Allowance in October 2008 under the terms of the Welfare Reform Act 2007, introducing a focus on capacity for work and an element of related conditionality.

2 DWP, *A New Deal for Welfare: Empowering People to Work* (London: HMSO, 2006).

3 DWP, *Quarterly Statistical Summary First Release* (London: HMSO, 2008), 6. This gives figures as of November 2007.

4 DWP, *No One Written Off: Reforming Welfare to Reward Responsibility* (London: TSO, 2008), 16.

condition.⁵ Mental ill health also represents a growing concern for the benefits system as an increasing percentage of IB claimants cite mental health problems. Indeed, the percentage of claimants reporting mental health problems has risen from 26% in 1996 to 31% in 1999 to 42% in 2007.⁶ Although the number of claimants for other illnesses has begun to decline, programmes such as Pathways to Work have been relatively less successful in returning those with mental health conditions to work. Mental ill health now represents the single largest illness category among IB claimants, with around one million citing it as their primary condition, and more citing it alongside physical illness. In a context where successful policies for moving people with mental health conditions from welfare to work remain elusive, the presence of a pathway, which sees an estimated 170,000 people flow onto benefits from employment each year as a result of mental ill health, represents a serious challenge for the welfare reform agenda.

COSTS OF MENTAL ILL HEALTH

The prevalence of mental ill health in the UK population also creates serious costs for individuals (there are strong links between mental ill health and poverty) and society at large (with costs related to health service provision, benefit support and lost tax income). One estimate placed the economic costs of mental ill health at £77 billion per year in England, more than the total sum associated with crime.⁷ The King's Fund has calculated that costs arising from mental ill health reached £48.6 billion in 2007. This figure includes "service costs" – both direct and indirect – and the costs of lost

5 Sainsbury Centre for Mental Health, *Mental Health at Work: Developing the Business Case* (London: SCMH, 2008), 2.

6 DWP administrative data, available at: www.dwp.gov.uk/asd/tabtool.asp; accessed 30/06/08.

7 Sainsbury Centre for Mental Health, *The Social and Economic Costs of Mental Illness* (London: SMCH, 2003), cited in The Future Vision Coalition, *A New Vision for Mental Health Discussion Paper* (London: The Future Vision Coalition, 2008), 4.

employment.⁸ Added to this figure, the government spent nearly £12.5 billion on incapacity-related benefits in 2006/7, 40% of which – or around £5 billion – went to those with mental disorders.⁹

The impact of mental ill health on both business and the productivity of the UK economy is also substantial. For employers, the costs of mental health arise from a number of directions – from absenteeism, presenteeism (reduced productivity while at work), providing cover for absent staff, impact on the productivity and morale of peers, and the training and recruitment of new staff. SCMH has estimated the total cost of mental health problems to employers to be nearly £26 billion each year. In terms of absenteeism, it has calculated that in 2007 some 40% of all days lost due to sickness absence were as a result of mental ill health.¹⁰ And although inconsistent data and the lack of large-scale representative surveys mean that the picture on mental illness as a cause of absence from work is mixed, a number of surveys undertaken by employers' organisations reinforce that mental ill health presents a serious concern for employers.¹¹

The importance of mental ill health as a cause of long-term absences is most pronounced. The survey by the Chartered Institute of Personnel and Development (CIPD), for example, in line with the data from CBI/AXA, found that employers consider

8 King's Fund, *Paying the Price: The Cost of Mental Health Care in England to 2026* (London: King's Fund, 2008), xviii.

9 DWP, "Work is good for you: new medical test to assess work capability – Hain", November 19, 2007, available at: www.dwp.gov.uk/mediacentre/pressreleases/2007/nov/drc055-191107.asp.

10 Sainsbury Centre for Mental Health, *Mental Health at Work*, 1.

11 There are currently three main surveys which address SSP arrangements, but variations in methodology and focus make comparisons between the various figures difficult. The most commonly cited studies are: *ONS Labour Force Survey (LFS)*, *CBI/AXA's Survey of Absence and Labour Turnover*, *CIPD's Absence Management Survey*, and *EEF's Sickness Absence and Rehabilitation Survey*. The LFS has the largest sample and provides data on the number and proportion of working days lost due to sickness over the previous seven days, but is unable to provide information on long-term absence or patterns of sickness spells. The CIPD, CBI/AXA and EEF surveys ask a broader range of questions concerning sickness absence, such as the average length of absences, the costs to employers of sickness absence and the rehabilitation practices used for employees on sickness absence.

common mental illnesses to be a significant cause of long-term absences. They found that 55% of employers listed stress as one of the top five causes of long-term absences for manual workers (42% for short-term) and the same pattern was evident in non-manual workers (68% for long-term, 56% for short-term).¹² “Mental health (e.g. clinical depression and anxiety)” was more than twice as likely to be listed amongst the top five concerns for employers regarding long-term absences, with 43% of employers citing it for manual workers (20% for short-term) and 50% for non-manual workers (29% for short-term).¹³

In addition to absenteeism, the SCMH has calculated that “presenteeism” – reduced productivity at work of those with mental illness – may cost the UK economy as much as £15.1 billion per year.¹⁴ And this is in addition to the £2.4 billion required to cover the costs of recruitment and the re-training of staff to replace employees who leave their jobs because of mental illness.¹⁵

MENTAL HEALTH AND EMPLOYMENT

While the debilitating nature of common mental health conditions should not be underplayed, there is an increasing body of evidence to suggest that, given the right support, those with conditions such as stress, anxiety or depression can generally remain in the labour market and that employment is good for mental health. Indeed, there is broad agreement amongst mental health stakeholders, policymakers and academics that, for those experiencing common mental health problems, remaining in the labour market is an effective mechanism of recovery and condition management. A study of mental health and employment by the Royal College of Psychiatrists, for example, found that employment is important for

¹² CIPD, *Annual Survey Report 2007* (London: CIPD, 2007), 28.

¹³ *Ibid.*, 25–8.

¹⁴ Sainsbury Centre for Mental Health, *Mental Health at Work*, 1.

¹⁵ *Ibid.*

“promoting the recovery of those who have experienced mental health problems” and “maintaining and promoting mental ... health and social functioning. Being out of work creates a vicious circle.”¹⁶ Echoing this, the recent review by Waddell and Burton of the relationship between employment and health (including mental health) unearthed considerable evidence of the detrimental effects caused by being out of work, in addition to identifying a range of psychosocial benefits from being employed.¹⁷

BARRIERS TO REMAINING IN EMPLOYMENT

The case for supporting those with mental health needs in employment is therefore a strong one whether considered from a financial or a moral position. Yet, despite the development of some positive practices amongst the most proactive employers, and increasingly warm words from government, obstacles facing those who wish to remain in, or return to, the workplace remain considerable. Inevitably, it will take time for the message that employment is good for mental health to filter down to employees, employers and healthcare professionals, but the attitudes and practices of GPs, the historical development of and structure of the sickness and benefits system, and the ongoing stigma associated with mental ill health in UK society and the workplace still pose significant difficulties.

In effect, in the UK, responsibility for employee health is left in the hands of employers for the first six months of illness – during which time GPs’ willingness to sign individuals off work may hinder rather than help them to return to work. This results in a “system failure”. Simply signing employees off sick frequently exacerbates a minor problem; once absent, it doesn’t take long for people to become disengaged from their workplaces. After 28 weeks of

16 Royal College of Psychiatrists, *Employment Opportunities and Psychiatric Disability* (London: Royal College of Psychiatrists, 2002), 36.

17 Gordon Waddell and A. Kim Burton, *Is Work Good For Your Health and Well-being?* (London: TSO, 2006).

sickness absence, therefore – or later if an employee is the recipient of a more generous sick pay arrangement than Statutory Sick Pay (SSP) – the costs of absence shift substantially from the employer to the state. Only at this point does the state (in the form of DWP), finding itself with the responsibility for an individual's benefit payments, promptly attempt to return people to work (through Pathways to Work).

THE CASE FOR EARLY INTERVENTION

There exists a growing consensus that getting people with common mental illnesses back into the workplace becomes increasingly difficult as time goes on, and that much earlier intervention is needed if IB on-flows are to be reduced. Recent research on vocational rehabilitation also found “strong evidence that simple, inexpensive healthcare and workplace interventions in the early stages of sickness absence can be effective and cost-effective for increasing return to work rates and reducing the number of people who go on to long-term disability”.¹⁸ However, recent reforms of IB are not able to address this problem. This means that, while reform of the gateway to benefits and the introduction of a revised Personal Capacity Assessment will focus on what an individual is able to do in relation to work, rather than what they cannot do, it will often come too late – after a period of up to 28 weeks' alienation of an individual from the workforce – making the task of returning someone to work that much harder.

Not that determining appropriate time frames for intervention for people with a common mental illness is easy; it is complicated by the ways in which such illnesses develop and the fluctuating nature of these conditions. In addition, ascertaining optimum intervention times and the deadweight costs that might be incurred

18 Gordon Waddell, A. K. Burton and Nicholas A. S. Kendall, *Vocational Rehabilitation: What Works, For Whom, and When?* (London: TSO, 2008), 38.

by intervening too early is severely hampered by the almost complete lack of available data that explores the timings of return to work for employees who have gone off sick. Indeed, the only data which gives an indication is that highlighted in Dame Carol Black's recent review of the health of the working age population – but which relates only to back pain. This data (reproduced as figure 6 in the main report) suggests that the propensity to return to work falls rapidly at around 4–6 weeks, and that after about 3 months, the numbers returning are very limited.¹⁹ In short, this indicates that if someone has not returned to work by the end of 3 months, he or she is unlikely to do so, and that the slide towards benefits is well on its way. Although the turning point may vary for different conditions,²⁰ the similarity of a pathway like this for those with mental health problems is reinforced by expert opinion which suggests that, for employment retention to be successful, interventions need to be well under way by the time someone has been absent from work for 3–6 weeks. Some advocate an even earlier optimal time for intervention on the continuum from wellness to incapacity, for example after one week off sick (and all suggest that low-level contact should be maintained from the start). However, the high deadweight cost of intervening too early (most people will go back to work of their own accord in the first two weeks without support) and the danger of pigeon-holing and medicalising illness too early suggest that there should be a period of “watchful waiting” lasting at least two weeks before any direct intervention, beyond line manager contact, is initiated.

People with mental illnesses are thought to move through three generic phases en route to benefits (warning signs/struggling on/off sick), and early intervention during these periods of development is widely agreed to have significant potential to reduce the likelihood

19 Dame Carol Black, *Working for a Healthier Tomorrow: Review of the Health of Britain's Working Age Population* (London: TSO, 2008), 74.

20 *Ibid.*, 73.

of people progressing to benefits.²¹ Mild mental health problems are manageable, but the longer people are out of the workplace the more they will become disengaged from the structure of their normal lives. Difficulty in returning to work increases as the time of absence extends – fear about the amount of catch-up needed, as well as colleagues’ reactions, are significant inhibitors to returning – and will only worsen as time away from the workplace increases. From the employer’s perspective too, disengagement begins to bed in after a few weeks. Most employer interviewees we spoke to suggested that although they can usually “get by” for a few weeks, after an absence has been sustained beyond 4–6 weeks they will commonly look to find a longer-term solution and will find it harder to accommodate increasingly lengthy sickness absences. Solutions might include, for example, recruiting temporary replacements, which can be time-consuming and expensive.

THE “FIT FOR WORK” SOLUTION

Policy has also sought to tackle other key barriers to those with mental health conditions remaining in active employment: health service provision and the practices of GPs; and stigma and discrimination attached to mental illness. Addressing both of these will, however, require a long-term cultural shift in attitudes, as well as significant investment to enhance timely access to appropriate treatments and services. Most recently, the Black Review of the health of the UK working-age population made a series of recommendations which, by focusing on early intervention and preventative measures, aim to stymie the flow of people moving from work into welfare and find ways of retaining people with mental health conditions in the workforce. The most significant, perhaps, of these is the proposal for the establishment of a holistic “Fit for Work” service, based on a case-managed, multidisciplinary approach, to provide treatment, advice and guidance

21 Roy Sainsbury and Jacqueline Davidson, *Routes onto Incapacity Benefits: Findings from Qualitative Research* (London: DWP, 2006), 13.

for people at around 4–6 weeks of sickness absence and which will aim to integrate occupational with medical and other interventions.

The establishment of an effective such service on a national scale will require an extraordinary and long-term commitment of financial resources and political will. While supporting the idea of such a service in theory, many of those we spoke to expressed serious concerns about the viability of a service that would require such a financial commitment from government. Concerns were also expressed about the capacity of the NHS to deliver, the location of the new service within the remit of the Department of Health, and the extent to which this might reinforce the over-medicalisation of diagnosis and treatment of common mental health conditions. Also, there was concern that the service would be unable to deliver more than a basic level of care; that it might frustrate the more forward-thinking companies that operate their own occupational schemes; and that it would be many years before such a service could be operational across the board.

A final, but serious, concern was the potential for employers to be deterred from investing in occupational health, employee support and vocational rehabilitation services themselves. If the state provides these services as part of the primary care set-up, the incentive for businesses that do not currently provide such services, and indeed those who already do, actively to address mental health needs in the workplace would be drastically reduced. In this way, state provision could effectively endanger the still-developing private market for the provision of these services, as well as the business imperative of employer investment, at a time when employer acceptance of a business and moral case is on the up.

THE CASE FOR EMPLOYER-LED SOLUTIONS

Nonetheless, there remains a need for somebody to take on more responsibility for providing support to employees with common mental health conditions, and the argument for a state-

sponsored “Fit for Work” service recognises the market failure that has prevented sufficient private provision to date. In the UK, the historical development of the sick pay system makes it unclear who is responsible for the provision of services and support to employees during the first 28 weeks of illness, particularly in a context in which occupational health has never been incorporated meaningfully into the NHS. For employers, a decision to invest is influenced by the particular shaping of the UK system, which means that the longer an employee has been off work, the more costs associated with that absence shift towards the state and away from the employer – employers face an increasing disincentive to invest in returning staff to work. Effectively, this means that there exists a market failure for measures that reduce the length of long-term absences.

Moreover, although there is undoubtedly a role for all stakeholders – government, employers, employees and the health service – in investing in improved mental health in the workplace, the distribution of the benefits among several stakeholders means that the incentives for any single stakeholder to pay for additional services for workers are diluted, even if total benefits outweigh total costs.²² In essence, because of the nature of how the costs and benefits accrue, the private costs of intervention do not justify taking action for any one stakeholder. As a consequence, all too often no one invests.²³ This means that, despite the substantial costs of mental ill health to a number of stakeholders and the obvious and well-documented benefits of employment in the treatment of mental health, there exists almost a “no man’s land” in terms of support until an individual reaches the stage of applying for IB and the associated mechanisms for returning to work. And as we have discussed, this period of “no support” precisely coincides

22 Carolyn Dewa, David McDaid and Susan Ettner, “An international perspective on worker mental health problems: who bears the burden and how are costs addressed?”, *La Revue canadienne de psychiatrie* 52/6 (2007), 347.

23 *Ibid.*, 346.

with the time frame when intervention is increasingly thought to be most effective.

Addressing this market failure will mean persuading one or other of the stakeholders to take on more of the responsibility than they currently do, to the benefit of all stakeholders. A combination of factors suggests that employers would be best placed to intervene, and should be encouraged to do so. In addition to the concerns outlined above about the capacity and appropriateness of a “Fit for Work” solution, employers are arguably better placed to spot the warning signs, to identify problems early and to steer employees to appropriate and timely intervention, particularly in a context where occupational health and vocational rehabilitation have traditionally operated outside the NHS.²⁴ In addition, employers bear the burden of costs in the early period of illness, good employers are already acting as role models for taking responsibility beyond their legal responsibilities in these areas and the links between absence and general management practices and employment retention are crucial.

Clarity of shared responsibility is critical, but of course the appropriate role for employers in managing and reducing absences caused by mental ill health is a disputed one. In particular, it is important to recognise that the majority of mental health conditions affecting both workplace absence and IB claims are not related to problems at work. Equally, and understandably, employers may be resistant to anything which means that they and their occupational teams take on the role of GPs, and many businesses would argue that by paying their National Insurance Contributions (NIC), they are already making sufficient contribution to the costs of provision. Finally, as mentioned, good employers (particularly large employers for whom the business case stacks up) are already doing far more voluntarily than is required of them

²⁴ Edward Bramley-Harker, Gordon Hughes and Joshua Farahnik, *Sharing the Costs – Reaping the Benefits. Incentivising Return to Work Initiatives, A Report for Norwich Union Healthcare* (London: NERA Economic Consulting, 2006), 2.

(for example, providing occupational health services, occupational sick pay schemes, stress risk management systems and employee assistance programmes).

This context would seem to rule out a restructuring of the system to force employers to do more. It points instead to a solution which uses fiscal incentives to tackle the existing market failure and encourages employers to invest in products and services which support the employment retention of those suffering from common mental illnesses. A solution that develops the market for such products and services is also likely to be speedier, more innovative and more efficient in delivering results than the primary care-grounded alternative.

INCENTIVISING MARKET-BASED SOLUTIONS

Through our discussions with stakeholders and experts, we have developed a range of recommendations which reflects this approach – incentivising employers to invest in the social good which is employee mental health and well-being. The range also shows up the complexity of the problem – and in particular the fact that different incentives will be required to encourage different kinds and sizes of organisations to take on further responsibilities for the mental health of their workforce. The dilution of benefits means that the business case does not often become manifest until organisations are of a certain size, and this is reflected in the provision of services by larger but not smaller companies, and by employers in certain sectors and not others. In order to be most effective, therefore, hard-to-reach employers, who are currently least likely to invest in health and well-being programmes, will need to be targeted.

Meeting the mental health challenge will only be accomplished by a partnership between employers, employees and the government. By providing positive incentives and subsidies to companies that do invest, the government would signal its

preparedness to play its part, but also its expectation that employers do the same.

We therefore recommend the following (all of which will be discussed in more detail in the main report):

- The government should review the extent and use of employers' access to information in respect of mental health at work, and seek to provide one-stop, one-click access to such information via a trusted and credible source.
- Before a decision is taken on whether to include the "Health and Well-being at Work" elements in the Investors in People standard assessment procedures, they should be reviewed to ensure that the importance of mental health at work is adequately addressed.
- The provision of occupational health and vocational rehabilitation services, and associated treatments, should be wholly removed from benefit-in-kind rules.
- Employee assistance programmes should remain exempt from taxation under benefits-in-kind rules.
- Consideration should be given to reducing or removing income and NI taxation on private medical Insurance products which include mental health conditions.
- The government should consider the development and introduction of a mental health tax credit to incentivise business to invest in mental well-being.
- The government should introduce a targeted system of subsidies for small and medium sized businesses in hard-to-reach sectors for the purchase of occupational health and/

or income protection insurance products which include treatment of mental health conditions and focus on early return to work.

Implementing these kinds of reform will encourage a necessary and genuine sense of shared responsibility for the mental health of the UK workforce, and offers the possibility of real progress in meeting the mental health challenge for welfare reform.

1. INTRODUCTION

The government has made a reduction in the number of people claiming Incapacity Benefits (IB) a key objective of its welfare reform programme led by the Department for Work and Pensions (DWP). Specifically, the government has committed to reducing the numbers claiming the benefit by one million over the course of a decade (by 2015).²⁵ The number of people claiming IB currently stands at 2.64 million.²⁶

Most commentators agree that this is likely to prove very challenging. The chances of an individual returning to work decrease the longer he or she is receiving IB. In fact, for many claimants, the experience of receiving the benefit and being away from the workplace is disabling in and of itself. While recent reforms have largely succeeded in halting the rise in the number of claimants, reversing the trend and bringing about such a significant reduction will require tackling some demanding policy problems.

Recent reforms to the IB regime intended to effect this change have focused primarily on three elements. First, they look at ways of returning IB claimants to work, with the Pathways to Work programme being rolled out nationally this year following successful piloting. Second, reforms have been made to the benefit itself. From October 2008, IB is to be replaced by the new Employment Support Allowance (ESA) for new claimants, introducing a focus on capacity for work and an element of related conditionality. Third, changes are being made to the gateway to benefits, with the introduction of a revised Personal Capacity Assessment that focuses on what individuals are able to do in relation to work, rather than what they cannot do. While the third of these reforms does seek to reduce on-flows to benefits, in the main they all continue to focus more on

25 DWP, *A New Deal for Welfare*

26 DWP, *Quarterly Statistical Summary First Release*, 6.

moving people out of welfare and back into work, rather than on reducing on-flows by retaining people in work so that they never actually reach the gateway to welfare.

Adding complexity to the challenge is the fact that an increasing percentage of incapacity claimants are accessing the benefit because of mental health problems. The percentage of such IB claimants has risen from 26% in 1996 to 31% in 1999 to 42% in 2007.²⁷ Although the number of claimants for other illnesses has begun to decline, programmes such as Pathways to Work have been relatively less successful in returning those with mental health conditions to work. The actual number of those accessing IB due to mental ill health has risen since the mid-1990s; it then plateaued over the past few years at around one million claimants – making mental health the single largest illness category.

More broadly, mental illness presents a major challenge for both the population and the health service, with one in six of the population suffering from a mental illness at any given time; the vast majority of these consist of mild to moderate conditions such as depression and anxiety (common mental illnesses). This creates serious costs for individuals (there are strong links between mental ill health and poverty and people suffering from mental ill health are less likely to be in employment) as well as for society at large (with costs related to both health service provision, benefit support and lost tax income).

There is broad agreement amongst policymakers and academics that the most effective way of managing this issue is for those experiencing only mild to moderate (common) mental health problems to remain in the labour market. It is clear that in order to succeed, the IB reduction agenda will need not only to help people who are currently in IB find jobs but also to stem the flow of people

27 DWP administrative data, accessed 30/06/08.

onto IB. Achieving both these objectives with particular regard to mental illness will be key to its chance of success.

However, there exists a significant gap in the market for the provision of mental health support services, which reflects a dilution of responsibilities for such provision. Primary care support is widely regarded as inadequate and too focused on the medicalisation of problems and solutions. GPs, as gatekeepers to support, have “insufficient time, resources and support to address work issues adequately”.²⁸ They have little incentive to encourage people back to work, and few options for support referrals exist. Occupational health sits, in the main, outside the realm of the health service and is, consequently, only available to larger organisations with the financial muscle to invest. At present, commercial support services simply do not exist on a significant scale. Though organisations such as Remploy have developed a commercial offering for job rehabilitation and retention, and group income protection insurance products can provide such support when combined with vocational rehabilitation, the market for these products and services is still in its relative infancy, and the business case, especially for smaller organisations, has yet to be made convincingly enough to encourage proactive movement by many employers.

In addition, although the focus of this report is on mental health in an employment context, it is important not to overemphasise the work-related element of mental illness in modern society. According to experts, many problems are related to the modern social context, which requires an increasingly complex balancing act involving family commitments, longer working hours and financial pressures, while traditional networks of social support are continually eroded. Mental ill health is a particular issue for socially deprived areas, where these kinds of problems are more acute and employers are generally less well equipped to deal with the costs of

28 Waddell, Burton and Kendall, *Vocational Rehabilitation*, 30.

mental illness and absenteeism. In this context, some believe that employees – and also young people – should be equipped with better coping skills. It has been stressed, for example, that people need to understand that unhappiness is an unavoidable aspect of life and that strategies can be developed to cope with stress.

Nonetheless, employers should also recognise the fact that, although many of the factors affecting the performance of their employees may not be work-related, they can make work more accommodating through practical changes, such as clear networks of advice and support, or, where possible, flexible working hours. Doing so could have beneficial effects on organisational morale, employee loyalty and productivity.

In this context, this project seeks to consider the policy options that might help to meet the challenge of reducing the number of people who leave the workforce and enter the benefits system as a result of mental illness, with particular regard to the role that employers can play in keeping those with mental health in the workforce and how government might encourage them to do so.

2. THE COST OF MENTAL ILL HEALTH

Summary

Around one in six of the UK adult population, and one in six of the workforce, is thought to suffer from common mental illness – such as anxiety or depression – at any given time. This creates major costs for the state, society and the economy. For UK business, significant costs are related to absenteeism and presenteeism (reduced productivity at work), as well as from the provision of staff cover, the impact on the productivity and morale of peers and the training and recruitment of new staff.

With 40% of lost days being attributed to mental ill health – both work and non-work related – and a number of employer surveys suggesting that mental ill health is a major cause of short- and long-term absence from work, statutory and occupational sick pay represent substantial costs to UK business (estimated at over £8 billion annually). Even more substantial are the estimated costs of presenteeism to UK business (as much as £15 billion), not to mention several billion pounds worth of costs for the recruitment and re-training of staff to replace employees who leave their jobs due to mental illness.

On top of these costs to UK business, mental ill health among the working population costs the NHS many more billions in treatments and therapies, and the Exchequer many billions in both forgone taxation and benefits payment. One estimate suggests the total annual cost may be as high as £77 billion – more than the cost of crime.

As many as one in six British adults currently suffers from some form of mental disorder at any one time, the most common being stress, anxiety and depression; the Sainsbury Centre for Mental Health (SCMH) estimates that, on average, employers should expect to find that nearly one-sixth of their workforce is likely to be affected by

mental ill health.²⁹ A further one-sixth of the working-age population experiences symptoms associated with mental ill health – such as sleep problems and worry – which do not qualify as a diagnosable mental disorder, but which affect their ability to function adequately.³⁰ Finally, it is estimated that severe mental illness, such as schizophrenia, bipolar disorder or severe depression, affects between 1% and 2% of the population, requiring intensive and continuing treatment during their lifetime.³¹ While current prevalence rates are expected to remain fairly stable, the numbers suffering from depression and anxiety are still predicted to rise from 3.52 million in 2007 to 4.01 million in 2026, reflecting demographic changes.³²

The growing costs and challenges of mental ill health pose serious problems for the NHS, for the productivity of the British economy and for the state in terms of welfare benefits and lost tax income. One estimate placed the economic costs of mental ill health at £77 billion per year in England, more than the total costs associated with crime.³³

In particular, the prevalence of mental ill health has a significant impact on UK business. The extent of mental health problems in the workforce is not considered to be very different from that in the population at large. As the SCMH points out: “[M]ost people with mental health problems are in paid employment and are almost as likely to be working as anybody.” This indicates that, in the main, employers’ experiences with employees with mental ill health will relate to common symptoms, such as stress, anxiety and

29 Nicola Singleton et al., *Psychiatric Morbidity among Adults living in Private Households*, 2000. (London: HMSO, 2001), cited in Sainsbury Centre for Mental Health, *Mental Health at Work*, 2, 5.

30 Office for National Statistics, “Mental health: 1 in 6 adults have a neurotic disorder”, available at: www.statistics.gov.uk/cci/nugget.asp?id=1333.

31 J. K. Wing, “Mental illness”, in A. Stevens and J. Raftery, eds., *Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews*, vol. 2 (Oxford: Radcliffe, 1994), 202–304, cited in Royal College of Psychiatrists, *Mental Health and Work*, 5.

32 King’s Fund, *Paying the Price*, xviii.

33 Sainsbury Centre for Mental Health, *The Social and Economic Costs of Mental Illness*, cited in The Future Vision Coalition, *A New Vision for Mental Health*, 4.

depression, as well as people showing signs of sleep problems and worry associated with mental ill health.³⁴ As in the wider community, many of these problems are undiagnosed and untreated.³⁵

For employers, the costs of mental health are substantial and arise from a number of directions –absenteeism, presenteeism (reduced productivity while at work), provision of cover for absent staff, impact on the productivity and morale of peers and the training and recruitment of new staff. The SCMH has estimated the total cost of mental health problems to employers to be nearly £26 billion each year. That is equivalent to £1,035 for every employee in the UK workforce.³⁶ The two main costs relate to absenteeism and presenteeism.

ABSENTEEISM

In terms of absenteeism, the SCMH has calculated that in 2007 some 40% of all days lost due to sickness absence were as a result of mental ill health.³⁷ The Health and Safety Executive (HSE) states that 13.8 million working days were lost to *work-related* stress and anxiety in 2006/7,³⁸ and the SCMH puts the total figure for working days lost due to all forms of stress (work and non-work related) at 70 million each year, at a cost of £8.4 billion.³⁹ A European Community survey identified the UK as having the second highest number of workers suffering from long-term sickness, with an average level of 27.2% – far higher than the EU average of 16.4%.⁴⁰ Likewise, in 2007, the International Monetary Fund published a report looking into absence across Europe, which found that, out

34 Office for National Statistics, "Mental health: 1 in 6 adults have a neurotic disorder".

35 Sainsbury Centre for Mental Health, *Mental Health at Work*, 2.

36 *Ibid.*, 1.

37 *Ibid.*, 2.

38 HSE, "Why tackle work-related stress?", available at: www.hse.gov.uk/stress/why.htm.

39 Sainsbury Centre for Mental Health, *Mental Health at Work*, 1.

40 "UK is close to the top of EU long-term sick list", *People Management* 10/1 (8 January 2004), cited in CIPD, *Recovery, Rehabilitation and Retention: Maintaining a Productive Workforce* (London: CIPD, 2004), 3.

of 18 countries, the UK had the fourth worst record in terms of total time lost due to sickness. Indeed, UK performance is below the average; the only countries with worse records are Sweden, Norway and the Netherlands. Perhaps more importantly, our main European competitors – Germany and France – outperformed the UK significantly.⁴¹

Although inconsistent data and the lack of large-scale representative surveys mean that the picture on mental illness as a cause of absence from work is mixed, a number of surveys undertaken by employers' organisations reinforce that mental ill health presents a serious concern for employers.⁴² For example, a study by the Chartered Institute of Personnel and Development (CIPD), which asked employers to provide the top five causes of *short-term* absence, recorded 42% of employers listing stress as a major cause of absence for manual workers and 56% for non-manual workers. On top of this, mental ill health was cited as a major cause of absence by 20% for manual workers and 29% for non-manual.⁴³ A similar survey by AXA and the Confederation of British Industry (CBI) found that work-related and non-work-related stress/anxiety/depression were listed as major causes of absence, particularly for non-manual workers.⁴⁴

For *long-term* absences, the importance of mental ill health is even more pronounced. The CIPD, for example, in line with the data from CBI/AXA, found that the majority of employers consider common mental illnesses to be a significant cause of long-term absences. They found 55% of employers listed stress as one of the top five causes of long-term absences for manual workers and the same pattern was evident in non-manual workers (68%).⁴⁵ "Mental

41 Lusine Lusinyan and Leo Bonato, 'Work absence in Europe', *IMF Staff Paper* 54/3 (2007).

42 See note 11.

43 CIPD, *Annual Survey Report 2007*, 21–4.

44 CBI/AXA, *Absence and Labour Turnover Survey 2008* (London: CBI, 2008), 20.

45 CIPD, *Annual Survey Report 2007*, 28.

health (e.g. clinical depression and anxiety)” was more than twice as likely to be listed amongst the top five concerns for employers on long-term absences, with 43% of employers citing it for manual workers (20% for short-term) and 50% for non-manual workers (29% for short-term).⁴⁶

Trends towards the provision of Occupational Sick Pay (OSP) rather than the basic Statutory Sick Pay (SSP) in the UK inflate the costs of absence for employers. In 2007, the CIPD estimated that 91% of respondents paid OSP instead of SSP, although this falls to 78% for companies with fewer than 50 employees, with 51% of such employers imposing a qualifying period that must be met before employees are eligible for the OSP scheme (the average is 26 weeks).⁴⁷ Furthermore, almost 90% of employers provide OSP at the same level as an employee’s full wage or salary, and the average number of weeks that OSP is paid at the full rate is 15⁴⁸ (small companies still pay OSP at the full rate for the shortest length of time – an average of 12.4 weeks versus 18.3 for companies with more than 10,000 employees).⁴⁹ Other estimates of OSP provision are lower, however, depending on the sample surveyed, and suggest that as many as 40% may administer only SSP rather than OSP systems.⁵⁰ Generally however, SSP today serves as the minimum legal provision for sickness benefit. It is paid at a single basic rate of £70.05 per week, with payments beginning after three “waiting days” and continuing for up to 28 weeks.

In the CIPD survey, 50% of respondents regarded SSP as a “significant” or “very significant” cost. The remaining 50% reported

46 Ibid., 25–8.

47 Ibid., 50–1.

48 Ibid., 51.

49 Ibid., 54.

50 There are some additional variations within these data sets. For example, only 30% of companies offer OSP to at least 75% of their employees across all industry sectors, presumably on cost grounds, although the public sector bucks the trend as 73% of their organisations offer OSP to over 75% of their employees.

that it was not a significant cost. Despite paying OSP for a shorter length of time – and being more reluctant to offer OSP at all – companies with fewer than 50 employees are less likely to consider SSP to be a “significant” (23%) or “very significant” (0%) cost, compared to the largest employers (47% and 24% respectively). This may reflect the absolute quantities of money being dealt with in large organisations, rather than the relative burden on a per-head basis in companies of different sizes, and is reflected in perceptions of the business case for early intervention.

There are certain circumstances in which an employer is exempt from covering SSP costs. If several employees are absent simultaneously, smaller employers are able to recoup a proportion of SSP payments through their National Insurance Contributions (NICs). However, to do so requires a fairly complex calculation to determine the difference between SSP expenditure and NIC liability, and this is widely thought to deter claims. Interestingly, the CIPD also found that only 14% of employers were aware of this Percentage Threshold Scheme (PTS), indicating a serious information problem (possibly contributed to by legal confusion and the inability to access the necessary information from a single reliable source).

PRESENTEEISM

With an estimated 35% of those with depression and 51% of those with anxiety disorders not in contact with health services,⁵¹ the SCMh has calculated that ‘presenteeism’ – reduced productivity at work of those with mental illness – may cost the UK economy as much as £15.1 billion per year.⁵² This is in addition to the £2.4 billion required to cover the costs of recruitment and re-training of staff to replace employees who leave their jobs because of mental illness.⁵³

51 King’s Fund, *Paying the Price*, xix.

52 Sainsbury Centre for Mental Health, *Mental Health at Work*, 1.

53 *Ibid.*

The King's Fund has calculated that costs arising from mental ill health reached £48.6 billion in 2007. This figure includes "service costs" – both direct and indirect – and the costs of lost employment.⁵⁴ Added to this figure, the government spent nearly £12.5 billion on incapacity-related benefits in 2006/7,⁵⁵ 40% of which – or around £5 billion – went to those with mental disorders.

54 King's Fund, *Paying the Price*, xviii.

55 DWP, "Work is good for you: new medical test to assess work capability – Hain."

3. MENTAL HEALTH AND EMPLOYMENT

Summary

Although the debilitating nature of common mental illness should not be underplayed, evidence also increasingly suggests that for those with conditions such as stress, anxiety or depression, remaining in the labour market can bring substantial benefits, and is an effective mechanism of recovery and rehabilitation. The recent review by Waddell and Burton clarified the key message that work is good for your health.⁵⁶

Recognising this, policies are increasingly seeking to focus on mental health within the workforce, and on keeping people in employment. Although the main thrust of the government's focus has remained on moving people from welfare into work, initiatives such as the expansion of the Department of Health's "Improving Access to Psychological Therapies" programme, Shift's "Action on Stigma Campaign", revisions to the sick note and the extension of pilots of employment advisers in GP surgeries all indicate that this agenda is being slowly prioritised. Most recently, the Black Review of the health of the working-age population recommended the establishment of a new "Fit for Work" service based on a model of early intervention to find ways of retaining people with mental health conditions in the workforce.

Among employers, too, there is an increasing awareness of the benefits of preventative measures and early intervention, and stress and absences management policies are increasingly adopted, with some positive results. More and more employers are also providing employee support or occupational health services for their staff, but experts interviewed for this study nonetheless believed that most employers did not appreciate the full extent of the costs of absence, particularly long-term spells, and the potential savings they could make by reducing absenteeism and presenteeism.

56 Waddell and Burton, *Is Work Good for your Health and Well-being?*

THE BENEFITS OF EMPLOYMENT

While the most severe mental conditions, such as schizophrenia or bipolar disorder, may result in extended periods during which an individual is unable to work, those with more common conditions, such as stress, anxiety or depression, can generally remain in the labour market. The evidence suggests that there are substantial benefits to individuals in doing so. This is not to underplay the debilitating nature of such conditions, nor to suggest that time off work should not be granted if it is needed, but, rather, to emphasise the positive impact that work can have on mental health. Indeed, five categories of psychological experience provided by employment are considered to promote mental well-being: time structure, social contact, collective effort and purpose, social identity and regular activity.⁵⁷

Reflecting this, there is broad agreement amongst mental health stakeholders, policymakers and academics that for those who are experiencing common mental health problems, remaining in the labour market is an effective mechanism of recovery and condition management. A 2002 study of mental health and employment by the Royal College of Psychiatrists found employment to be important for “promoting the recovery of those who have experienced mental health problems” and for “maintaining and promoting mental ... health and social functioning. Being out of work creates a vicious circle.”⁵⁸

Echoing this, the recent review by Waddell and Burton of the relationship between employment and health (including mental health) unearthed considerable evidence of the detrimental effects caused by being out of work, in addition to identifying a range of psychosocial benefits from being employed. While it was noted that “job quality” remains a significant influence on the health

57 Gaston Harnois and Phyllis Gabriel, *Mental Health and Work: Impact, Issues and Good Practices* (Geneva: WHO/ILO, 2000), 5.

58 Royal College of Psychiatrists, *Employment Opportunities and Psychiatric Disability*, 36.

benefits of employment, it found “extensive evidence [of] strong links between unemployment and poorer ... mental health and mortality”.⁵⁹ Moreover, surveys have found that as many as 90% of workless people who use mental health services wish to work.⁶⁰ Overall, Waddell and Burton found that remaining in work or returning to work:

- is therapeutic;
- helps to promote recovery and rehabilitation;
- leads to better health outcomes;
- minimises the deleterious physical, mental and social effects of long-term sickness absence and worklessness;
- reduces the chances of chronic disability, long-term incapacity for work and social exclusion;
- promotes full participation in society, independence and human rights;
- reduces poverty; and
- improves quality of life and well-being.⁶¹

THE RESPONSE OF GOVERNMENT AND EMPLOYERS

In recognition of this evidence, and although the main thrust of the government’s focus has remained on moving people from welfare into work, a number of announcements and policies have sought

59 Waddell and Burton, *Is Work Good for your Health and Well-being?*, 13.

60 Bob Grove, “Mental health and employment: shaping a new agenda”, *Journal of Mental Health* 8 (1999), 131–40, cited in Royal College of Psychiatrists, *Mental Health and Work*, 18.

61 Waddell and Burton, *Is Work Good for your Health and Well-being?*, 20.

to focus on mental health within the workforce. The 2007 DWP White Paper *Ready for Work*⁶² announced the piloting of a new advice service for employers to help them manage and support people with mental health conditions to remain in (or retain) work. It also highlighted the expansion of the Department of Health's "Improving Access to Psychological Therapies" programme, and Shift's "Action on Stigma Campaign", which aims to help line managers to deal with employees with mental health conditions.⁶³ In addition, it reiterated the government's intention to develop a national strategy on mental health and work to ensure a coordinated response.

On top of this, the White Paper also highlighted a number of policies which focus on workplace health more generally. For example, it noted policy initiatives to educate GPs about health and work; the development of an online learning tool for nurses; revisions to the sick note; and pilots of employment advisers in GP surgeries. It also noted the demand from employers for more help in relation to sickness absence management, and, in particular, vocational rehabilitation and the setting up of a taskforce to consider guidance in respect of the latter.⁶⁴

More recently still, the Black Review of the health of the UK working-age population made a series of recommendations which, by focusing on early intervention and preventative measures, aim to stymie the flow of people moving from work into welfare and find ways of retaining people with mental health conditions in the workforce. The most significant of these is, perhaps, the proposal for the establishment of a holistic "Fit for Work" service, based on a case-managed, multidisciplinary approach, to provide treatment, advice and guidance for people at around 4–6 weeks of sickness

62 DWP, *Ready for Work: Full Employment in Our Generation* (London: HMSO, 2007).

63 *Ibid.*, 68.

64 *Ibid.*, 67–8.

absence, and which will aim to integrate occupational with medical and other interventions. Recognising that many people will need non-medical help, a case manager, based in or near to a primary care setting, would refer patients to a wide range of non-traditional services, which could include advice and support for social concerns such as financial and housing issues as well as more traditional NHS services such as physiotherapy and talking therapies.⁶⁵

Responding to the Black Review, and in recognition of the lack of access to occupational health (OH), especially for employees of small- and medium-sized enterprises (SMEs), the government has announced that an £11 million capital fund would be established to set up six new NHS Plus demonstration sites to look at innovative ways of supporting SMEs with OH services.⁶⁶ Lord Darzi's recently concluded *NHS Next Stage Review*⁶⁷ commended the work and recommendations of the Black Review and stated that a "Fit for Work" scheme would be piloted in 2009, though further details of the nature of such a service are yet to be revealed and will not be announced until the government formally responds to the Black Review this autumn.⁶⁸

Awareness of the positive case for mental health in the workplace is undoubtedly developing amongst the most proactive employers. Some organisations have accepted the business case for addressing common mental illnesses in the workplace and generous OSP is used competitively as a "fringe benefit" to employees, helping to attract and retain qualified staff. Stress-management policies at the best organisations have achieved significant reductions in stress-related absence and the associated

65 Black, *Working for a Healthier Tomorrow*, 12.

66 James Purnell, Speech to the House of Commons, 17 March 2008, *Parliamentary Debates*, Commons, vol. 473 (2007–8), part no. 68, col. 51WS.

67 Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*, by Lord Darzi of Denham, KBE (London: TSO, 2008).

68 *Ibid.*, 38.

costs; a prime example is Bradford & Bingley, which achieved a 34% reduction in stress absences in 2007 (10% in the previous year) and where stress absences have been reduced from a peak of 6,000 days lost per year to just 3,000.

Other absence-management policies also appear to have been adopted widely, such as return-to-work interviews.⁶⁹ Similarly, use of disciplinary procedures is very common, as is the provision of sickness absence information to managers, and flexible working.⁷⁰ A survey by the Federation of Small Businesses (FSB) found that collecting data on sickness absence (47% of respondents) and providing paid leave entitlement for routine appointments (45%) are the main methods used by small employers for managing sickness absence.⁷¹

In terms of occupational health provision, the CIPD survey found this to be adopted as an absence-management technique by 47% of respondents for short-term absence and 70% for long-term absence.⁷² An EEF survey found that 15% of its members have fully or partially in-house occupational health teams, while 50% used external providers and 35% had no occupational health provision (this rose to 66% for companies with fewer than 50 employees).⁷³ Of the companies using external providers, 66% use private providers instead of GPs or other NHS services, which may be the result of a high proportion of manufacturing companies responding to the EEF survey that need specialist services.

69 Return-to-work interviews are used by 85% of employers for short-term absences and 76% for long-term absences, according to the CIPD survey.

70 Disciplinary procedures are used by 79% of employers for short-term absences and 53% for long-term absences, sickness absence information being provided to line managers is used by 76% of employers for short-term absences and 66% for long-term absences, flexible working is used by 46% of employers for short-term absences and 58% for long-term absences.

71 Federation of Small Businesses, *Health matters: the small business perspective* (London: FSB, 2006), 16.

72 CIPD, *Annual Survey Report 2007*, 33-35.

73 EEF, *Sickness Absence and Rehabilitation Survey 2008* (London: EEF, 2008), 14.

Perceptions of the effectiveness of various policies from the employers' point of view can vary considerably, perhaps reflecting a lack of information and guidance on these issues (which may in turn be related to a lack of robust evaluations). In the CBI/AXA survey, five were rated as being in the top three most effective policies by at least 20% of respondents,⁷⁴ demonstrating a broad consensus on what is most beneficial to the employer. These were (in order of most effective): return-to-work interviews, disciplinary procedures, giving absence statistics to supervisors, employer-funded medical/occupational health provision and flexible working hours. Data from the CIPD survey suggests a more positive response to the effectiveness of policies that deal with long-term absences, with the most effective strategies being listed as: occupational health involvement (76% of employers listed it as one of the three most effective strategies); rehabilitation programmes (70%); flexible working (67%); return-to-work interviews (66%); changes to working patterns or environment (58%) and restricting sick pay (58%).

Despite variations in the data gathered by the available surveys, it is clear that larger companies (and some small companies as well) are beginning to take their responsibilities in respect of employee health and well-being more seriously. Many companies now recognise the need, if not always the effectiveness, of providing services such as OH access and the importance of active absence management. Nonetheless, the experts interviewed for this study believed that while many employers could theoretically afford to put money into OH, most did not appreciate the full extent of the costs of absence, particularly long-term spells, and the potential savings they could make by reducing absences.

74 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 23.

4. MENTAL HEALTH AND WELFARE REFORM

Summary

With a long way to go to meet the government target of one million fewer claimants on Incapacity Benefit by 2015, there is an increasing recognition that efforts must focus not only on returning people from welfare to work, but also on preventing the slide from employment towards benefits in the first place. In this context, mental health conditions represent a growing concern for the benefits system – with an increasing percentage of incapacity claimants accessing the benefit because of mental ill health. Indeed, the percentage of IB claimants reporting such conditions has risen from 26% in 1996 to 31% in 1999 to 42% in 2007.⁷⁵

While the number of claimants for other illnesses has begun to decline, programmes such as Pathways to Work have been relatively less successful in returning those with mental health conditions to work. Mental ill health now represents the single largest illness category among IB claimants, with around one million people citing it as their primary condition. Importantly, there is also a strong correlation between mental and behavioural disorders and levels of social deprivation, in part reflecting patterns of worklessness amongst those with mental health problems. Relatedly, claimants for IB are mostly low paid, and job tenure of claimants tends to be much shorter than in the general population

In a context where successful policies for moving people with mental health conditions from welfare to work remain elusive, the presence of a pathway, which sees an estimated 170,000 people flow onto benefits from employment each year because of mental ill health, represents a serious challenge for the welfare reform agenda.

The prevalence of mental health problems in the UK's working-age population and the growth of long-term absence due to stress,

75 DWP administrative data, available at: www.dwp.gov.uk/asd/tabtool.asp, accessed 30/06/08.

anxiety and depression also pose significant problems for the government's welfare reform agenda. In 2006, the government's Green Paper, *A New Deal for Welfare: empowering people to work*,⁷⁶ set out the ambitious target of reducing the number of people claiming IB by one million over the course of a decade. While the total working-age population claiming incapacity-related benefits in 1979 stood at 0.7 million,⁷⁷ by November 2007 this figure had reached 2.64 million, or 7.5% of the working-age population.⁷⁸ The recent focus on this issue has had some positive effects; the success of return-to-work programmes for those with physical impairments, coupled with the general decline in manual labour in the UK, has led to a drop in cases of incapacity due to physical and other conditions. But these have now been overtaken by mental and behavioural disorders as the single biggest reason for claiming IB and Severe Disablement Allowance (SDA).

IB MENTAL ILL HEALTH CASELOAD

In 2007, as shown in figure 1, some 1.1 million people were claiming IB or SDA because of mental or behavioural disorders.⁷⁹ This number had risen steadily between 1999 and 2003, from 834,000 to just over a million – an overall increase of 32%. Since 2003, increases have been smaller – just a few thousand each year – but the increase nonetheless amounts to an average year-on-year rise of 3.6% between 1999 and 2007. By contrast, the caseload for other illnesses declined from 1.8 million in 1999 to 1.5 million in 2007, in particular with notable decreases for numbers claiming benefits due to musculoskeletal problems (down 22%) or circulatory and respiratory conditions (down 37%). This is compounded by the fact

76 DWP, *A New Deal for Welfare*.

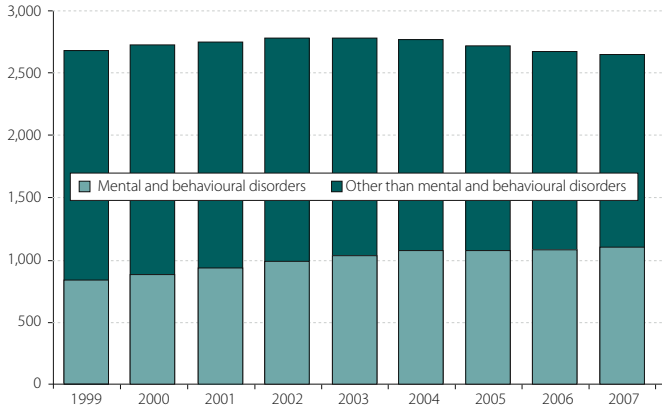
77 S. Fothergill and J. G. Smith, *Mobilising Britain's Missing Workforce: Unemployment, Incapacity and the Regions* (London: Catalyst, 2005), cited in Sainsbury and Davidson, *Routes onto Incapacity Benefits*, 17.

78 DWP administrative data, accessed 30/06/08. Note that this figure includes claimants for Severe Disablement Allowance.

79 *Ibid.*

the people with mental health conditions move off benefit more slowly compared to other claimants.⁸⁰

Figure 1: Number of people claiming Incapacity Benefit and Severe Disablement Allowance, 1999–2007, thousands



Source: DWP Administrative data

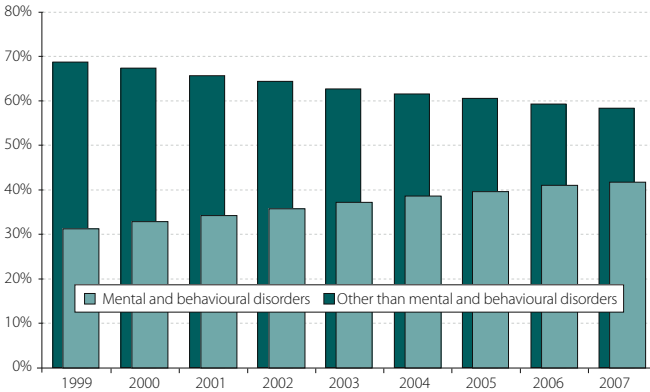
Reflecting these factors, the change over time in percentage terms is dramatic, as shown in figure 2. In 1999, mental and behavioural disorders accounted for just 31% of claimants for IB/SDA. By 2007, this figure had risen to almost 42%. By contrast, claims related to musculoskeletal conditions accounted for 22% of all claimants in 1999 and 17% in 2007, while claims related to circulatory or respiratory illness accounted for 12% in 1999 and just 7% in 2007.

Encouragingly, although growth rates remain positive for mental illness claims and negative for other illnesses, for the mental health caseload they do show signs of slowing, as depicted in figure 3. The average growth rate in the past three years for mental health-related claims was just 1.0%, compared to 5.1% between

80 DWP, *No One Written Off*, 84.

1999 and 2004. However, although this is promising, numbers of mental health claimants are still increasing, while those for non-mental health reasons are on the decline – with an average annual decrease of 3.3% over the past three years.

Figure 2: Incapacity Benefit and Severe Disablement Allowance, 1999–2007, percentage



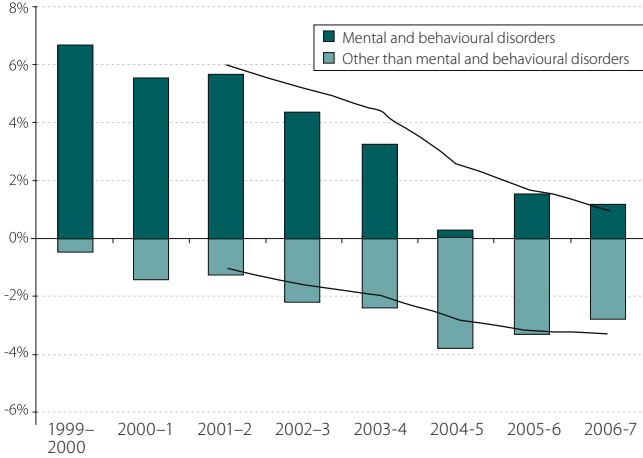
Source: DWP Administrative data

In addition, work undertaken by Oxford Economics, which sought to project the numbers of IB claimants related to mental health over the coming years, demonstrates that, even with relatively low and steady growth, demographic trends will mean that numbers can be expected to rise.⁸¹ In figure 4, which is reproduced from the Oxford Economics paper, the blue line shows their projection of how IB claims due to mental and behavioural disorders may grow over time given the likely changes in the age structure of the population. As can be seen, the growth is expected to be very modest, in line with recent slower growth in claims. The red line indicates the path that IB claimants due to mental and behavioural disorders would have to follow to meet the government's aspiration, if the reduction of one

81 Oxford Economics, *Mental Health and the UK Economy* (Oxford: Oxford Economics, 2007), 7–8. See figure 3.6.

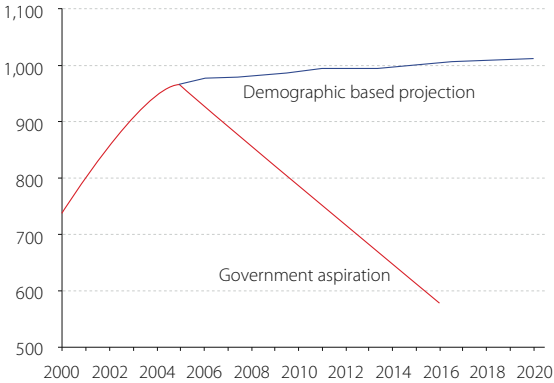
million is to be achieved proportionally for those with mental illness as for other illnesses.

Figure 3: Year-on-year percentage growth in number of Incapacity Benefit and Severe Disability Allowance claimants, 1999–2007



Source: DWP administrative data, 3-year moving average trendlines

Figure 4: Projection of Incapacity Benefit claimants due to mental and behavioural disorders to 2020, thousands



Source: Oxford Economics/DWP administrative data

PROFILE OF MENTAL ILL HEALTH IN THE IB CASELOAD

Mental illness does not lend itself well to simple categorisation, but it is important to recognise the differences between common mental illness and severe mental illness, while also recognising the lack of a binary distinction. A typology of mental illness would seem to reflect a continuum of conditions rather than easy categorisation. That said, the severity of mental illness will obviously impact on the ease of remaining in employment and the extent of flexibility required. Severe mental illnesses such as schizophrenia may require care over extended periods of time and rely on intensive interventions,⁸² making continued presence in the workplace problematic from the employers' perspective. Reflecting this, estimates of employment rates for the severe mental illness group are typically around 10–20%, well below the average of 47% for all disabled people.⁸³

While more detailed breakdowns of condition type are not available within the DWP administrative data set for mental illness, two recent DWP studies of IB claimants demonstrate that common, rather than severe, mental illness is the primary cause of incapacity for those claiming IB for mental ill health. Kemp and Davidson's study found that for those reporting mental illness as their main condition, around 80% were suffering from stress, anxiety or depression.⁸⁴ Common mental health problems were more often experienced by women, with 36% reporting stress or anxiety and 43% suffering from depression. The respective figures for men were 25% and 28%.⁸⁵ The highest incidence of mental health problems was amongst 25–34-year-olds, who made up 40% of mental health claimants.

82 Royal College of Psychiatrists, *Mental Health and Work*, 31.

83 *Ibid.*, 32.

84 Peter Kemp and Jacqueline Davidson, *Routes onto Incapacity Benefit: Findings From a Survey of Recent Claimants* (London: DWP, 2007), 53.

85 *Ibid.*, 49.

There is also a strong correlation between mental and behavioural disorders and levels of social deprivation, with those affected more likely to lack formal qualifications and employment, to come from Social Class V and to be a tenant of a local authority or housing association.⁸⁶ Research has identified that “the effect of permanent sickness or disability on mental health was significantly greater for people living in wards with high levels of economic inactivity [which] supports the hypothesis that living in a deprived neighbourhood has the most negative health effects on poorer individuals”,⁸⁷ and that “common mental disorders are significantly more frequent in socially disadvantaged populations”.⁸⁸ Social deprivation, unemployment and mental ill health appear to compound one another.

The DWP study also showed that 40% of IB claimants had been working in firms with fewer than 50 employees, which greatly outweighs the proportion of employees who actually work in such companies in the UK economy (26%). What is more, 59% of claimants worked in an SME (fewer than 250 employees), again outweighing the proportion of those who work in such organisations (38%). Of recent claimants, 73% worked in the private sector, and 23% in the public sector. Finally, the report showed that recent claimants to IB were generally low paid, and that job tenure of claimants tends to be much shorter than in the general population, with 26% reporting they spent fewer than six months in their last job.⁸⁹

ON-FLOWS TO IB

The data on on-flows to benefits reveals that, while both have declined since 2000/1, the decreases have been greater for non-

86 Singleton et al., *Psychiatric Morbidity Survey among Adults Living in Private Households*, cited in Royal College of Psychiatrists, *Mental Health and Work*, 6.

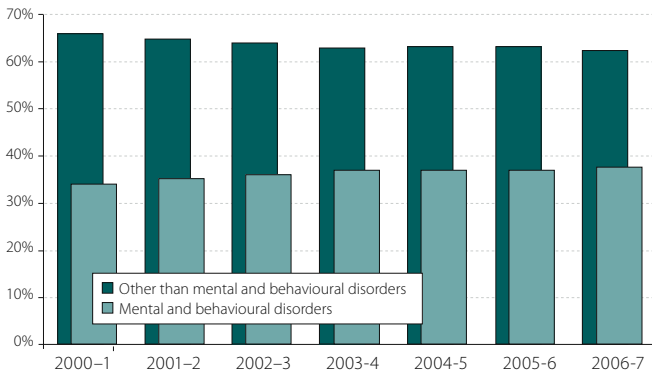
87 David Fone et al., “Places, people and mental health: A multilevel analysis of economic inactivity”, *Social Science & Medicine* 64 (2007), 633.

88 Tom Fryers, David Melzer and Rachel Jenkins, “Social inequalities and the common mental disorders: A systematic review of the evidence”, *Social Psychiatry and Psychiatric Epidemiology* 38 (2003), 229.

89 Kemp and Davidson, *Routes onto Incapacity Benefits*.

mental health-related conditions – down 20% since 2000/1 – than for those related to mental ill health – down almost 6% since 2000/1. This is illustrated in figure 5, which shows how the percentage share of on-flows accounted for by mental ill health has risen over time. As noted in the Black Review of the health of the working-age population, “the most common primary health conditions among those flowing onto IB are those associated with mental ill health” and “the on-flow with mental health conditions has remained stubbornly high”. Further, the review notes: “Adding in claimants who have other primary health conditions, but also have mental health conditions, is likely to bring the proportion of those coming onto IB with mental health conditions to well over a half.”⁹⁰

Figure 5: On-flows to Incapacity Benefit and Severe Disablement Allowance, 2000/1 to 2006/7, percentages



Source: DWP Administrative data

In the last year for which data are available (November 2006 to November 2007), on-flows due to mental ill health numbered around 220,000. However, not all these claimants followed a route from employment to IB. The Kemp and Davidson study, which

⁹⁰ Black, *Working for a Healthier Tomorrow*, 85.

considered the pathways from employment to IB, found that around 49% of those with mental health problems moved directly from work or sickness absence onto IB, and a further 28% moved from sickness absence into a short period of non-work before claiming IB.⁹¹ The remainder moved onto IB following a sustained period (more than two years of unemployment). Applying these percentages to recent on-flows suggests that of the 220,000 who began claiming IB/SDA between November 2006 and November 2007, some 108,000 can be expected to have moved directly from employment or sickness absence from employment onto IB and around 62,000 made the journey via a short period of non-work. Clearly, these figures suggest the existence of a significant pathway from work to IB related to common mental health conditions, and that reducing these numbers could have a notable impact on the government's target to reduce the numbers claiming IB by one million by 2015.

91 Kemp and Davidson, *Routes onto Incapacity Benefits*, 90.

5. BARRIERS TO REMAINING IN EMPLOYMENT

Summary

Despite the strong case in favour of supporting those with mental health needs to remain in employment, many barriers remain. In particular, the attitudes and practices of GPs, the historical development of and structure of the sickness and benefits system, and the ongoing stigma associated with mental ill health in UK society and the workplace still pose significant difficulties.

Most significantly perhaps, the historical development of the sick pay system and a context in which occupational health has never really been part of the NHS mean that, in effect, employee health is left in the hands of employers for the first six months of illness. During this time, however, GP willingness to sign individuals off work may hinder rather than help their return to work. Indeed, signing employees off sick may exacerbate a minor problem; once absent, it doesn't take long for people to become disengaged from their workplaces. After 28 weeks of sickness absence – or later if an employee is the recipient of a more generous Occupational Sick Pay (OSP) scheme – the costs of absence shift substantially from the employer to the state, which then attempts to return people to work (through Pathways to Work).

During the first six months, however, the dilution of costs and benefits amongst various stakeholders, as well as a system that gives employers an increasing disincentive to invest in returning staff to work, mean that there exists a market failure for measures that reduce the length of long-term absences. While there is undoubtedly a role for all stakeholders – government, employers, employees and the health service – in investing in improved mental health in the workplace, the distribution of the benefits among several stakeholders means that the incentives for any single stakeholder to pay for additional services for workers are diluted – even if total benefits outweigh total costs.

In essence, the private costs of intervention do not justify taking action for any one stakeholder. As a consequence, too often no one invests, and for smaller businesses particularly, the business case for investment may simply not stack up.

The case for supporting those with mental health needs in employment is a strong one whether considered from a financial or a moral position. Yet, despite the development of some positive practices amongst the most proactive employers, obstacles facing those who wish to remain in, or return to, the workplace are considerable. Inevitably, it will take time for the message that employment is good for mental health to filter down to employees, employers and healthcare professionals, but weaknesses in the existing benefits system for mental health needs, its historical development and the ongoing stigma associated with mental ill health in UK society and the workplace still pose significant difficulties.

STRUCTURE OF THE SICK PAY SYSTEM

The nature of the sickness and benefits system may play a major role in determining the pathways towards benefits. Sick pay models must strike a complex balance between the state or employer's duty of care and the need for incentives to help people return to work. For example, it has been suggested that the length of time for which sickness benefits are paid at a higher rate may impact on the timing of return to work. In their discussion of sickness absence, Sainsbury and Davidson argue: "The length of the period was often determined by sick pay arrangements and sickness management procedures, and by the responses of employers. Where employers kept in contact with employees to find out how they were, employees often took this as a sign that they were valued in their job."⁹²

The majority of our experts identified problems with the UK's current sickness benefits framework. For example, the six-month duration of Statutory Sick Pay (SSP) is regarded as being based on what was traditionally deemed to be a "reasonable" period, rather than on evidence of effectiveness. Further, the historical features of current sick pay arrangements mean that benefits still tend to be

92 Sainsbury and Davidson, *Routes onto Incapacity Benefits*, 3.

geared towards people with physical ailments; the model rests on the assumption that there is a clear distinction between illness and health and tends to assume that people will fall ill, get better and then return to work. However, these arrangements fail to account for the fact that the past few decades have seen a rapid growth in chronic or long-term conditions, affecting both physical and mental health. Such conditions cannot simply be treated until recovery occurs, but require long-term management. This is particularly the case for mental disorders, which can often cause fluctuations in an individual's capacity to work – an issue which SSP arrangements cannot address.

In effect, in the UK, responsibility for employee health is left in the hands of employers for the first six months of illness – during which time a GP's willingness to sign individuals off work may hinder rather than help their return to work. This results in what one interviewee described to us as a "system failure". Simply signing employees off sick frequently exacerbates a minor problem; once absent, it doesn't take long for people to become disengaged from their workplaces. After 28 weeks of sickness absence, however – or later if an employee is the recipient of a more generous sick pay arrangement than SSP – the costs of absence shift substantially from the employer to the state, which, finding itself with the responsibility for an individual's benefit payments, promptly attempts to return the person to work. The consensus now is that much earlier intervention is needed if IB on-flows are to be reduced, but the system discourages this.

Although reducing the period of coverage might be one option which could benefit employers and incentivise intervention at an earlier stage, bringing about such reforms would be politically very difficult. Yet, at present, without any requirements to intervene early, the only formalised point of contact with the state is 28 weeks into sickness absence, when the period of employer-sponsored sick pay comes to an end.

The development of the UK SSP system

The sick pay system in the UK is the result more of historical accident than design. Before 1983, Sickness Benefit (SB) was administered and paid for solely by government, and covered the first 28 weeks of sickness absence. A 1980 Green Paper⁹³ noted, however, that in addition to state-sponsored SB payments, numerous employers were now operating schemes of their own, termed Occupational Sick Pay (OSP). This meant that many employees were now claiming SB in addition to the OSP they were already receiving, making some “better off financially in sickness than in health.”⁹⁴ The proposed solution was to transfer the administration of sickness benefits to employers, with government reimbursing them for the costs of payments. This transfer of administrative responsibility was supposed to end the “doubling up” of administration costs between employers and government and subsequently make employers more aware of the levels and costs of sickness absence. It was hoped that increased awareness would result in employers taking steps to minimise absence levels. These proposals resulted in the introduction of SSP in April 1983, payable over eight weeks with full financial reimbursement for employers.

In 1986, the duration of SSP was increased from 8 to 28 weeks to reflect the original duration of SB. However, in 1991, with the costs of SSP to the Exchequer increasing, it was decided to reduce the government’s reimbursement of SSP payments from 100% to 80%. This was a trend which continued and, in 1994, reimbursement for employers was abolished altogether, completing the shift of responsibility for provision of sick pay, now termed Statutory Sick Pay (SSP), from a state-administered benefit to the present situation, in which it is now a duty of the employer.

With employers facing heavily increased costs, legislation in 1996 and 1997 sought to provide a concession by relaxing laws on record-

93 Department for Health and Social Security, *Income During Initial Sickness: A New Strategy*, Cmnd 7864, (London: HMSO, 1980), cited in Jane Barrett “Simplifying Statutory Sick Pay: The evidence could be better”, in *Benefits* 14/3 (2006), 180.

94 *Ibid.*

keeping; there has now been “considerable deregulation to ease administrative burdens and red tape for employers”.⁹⁵ As a consequence, one of those early aims driving the introduction of SSP – that of raising employer awareness of absence trends and costs – looks less likely to be realised. According to the CIPD, 21% of employers do not maintain annual records on employee absence, a figure which rises to 32% for private service companies.⁹⁶ A further problem is that, with recording of absence levels dependent on the arrangements of individual employers, there is now very little centrally collated evidence with which to analyse current SSP arrangements.

With welfare reform high on the government’s agenda, the rather complicated administrative arrangements for SSP have been under scrutiny again in recent years. The 2006 Green Paper, *A New Deal for Welfare: empowering people to work*, made a recommendation to simplify the framework for SSP as part of a strategy to reduce the numbers moving onto IB. Suggestions put out for consultation included the abolition of the requirement to link periods of sickness absence separated by fewer than eight weeks and the need to apply three “waiting days” before an employee is able to claim SSP. Both these provisions would lead to increased costs for employers, particularly the elimination of the waiting period, since the majority of sickness absences are short. In a concession to smaller employers, the consultation proposed scrapping the complex calculations involved in the Percentage Threshold Scheme (PTS), and replacing this legislation with additional support for small organisations to manage absence more effectively.⁹⁷

However, the response to the SSP proposals laid out in this consultation was mixed, and the SSP Review Group set up to consider

95 Barrett, “Simplifying Statutory Sick Pay”, 187.

96 CIPD, *Annual Survey Report 2007*, 9.

97 DWP, *A New Deal for Welfare*, 37.

them concluded that radical change would be inappropriate. Employers felt that a simpler framework would not be sufficient to offset increased costs, particularly from the abolition of the waiting period, and were primarily concerned about effective absence management.⁹⁸ DWP therefore decided not to proceed with reform of SSP though it remains minded to replace the PTS.⁹⁹

The rejection of the government's proposals to simplify SSP means that the absence of centrally collated data may remain an issue. The three main employer surveys – from the CIPD, CBI/AXA and EEF – are all voluntary surveys of employers, and “are more limited in terms of sample size” and have “a lack of weighting and low response rates [relative to government datasets], which reduces their comparative validity and reliability”.¹⁰⁰ A DWP-commissioned report on the issue of data collection found that organisations use a wide range of systems and processes for collecting and recording sickness absence data. This is often compounded by the fragmented distribution of such data within most organisations between HR, personnel and payroll departments, in addition to the use of different computer systems.¹⁰¹ Furthermore, “sickness absence management is a proactive task and although an important issue for many employers, it takes second place during periods of greater demand”.¹⁰² It is therefore recommended that findings from the employer surveys should be “treated with caution”.¹⁰³

The lack of any clear evidence base on SSP will have to be addressed if further reforms are to be made possible. As Barrett puts it: “[The lack of data] restricts analysts’ ability to understand

98 Statutory Sick Pay Review Working Group, *Report of the Statutory Sick Pay Review Working Group* (2007).

99 Bill McKenzie, MP, DWP Minister, Letter sent to the participating members of the Statutory Sick Pay Review Working Group in response to their report (2007).

100 Susan Woolf et al., *DWP Project on the Feasibility of SSP Data Collection* (London: DWP, 2007), 2.

101 *Ibid.*, 34–5.

102 *Ibid.*, 39.

103 *Ibid.*, 26.

accurately trends of sickness absence covered by SSP rules, the administration and payment costs of operating SSP and OPS and, in turn, to model the effects of making changes.”¹⁰⁴ DWP has acknowledged this problem and is now looking into the feasibility of more rigorous data collection on sickness absence. In order to improve the quality of data on SSP, it was concluded that the most sensible options to pursue would be either to adapt a current government dataset (the Workplace Employee Relations Survey (being the preferred option)¹⁰⁵ or to create a new independent survey that links health and occupational data.¹⁰⁶

A DILUTED BUSINESS CASE

Internationally, sickness benefit systems differ in how they assign responsibility for sickness absence and, correspondingly, for workplace health, from state-funded and managed compulsory schemes to those with little or no state provision and a free market approach to the offer of whatever exists.¹⁰⁷ In most cases, the reasons for adoption of a particular model have been largely historical; once a country has chosen certain arrangements, it has tended to remain faithful to the original basis of the system. In his review of the institutional framework for sickness benefits in 18 OECD countries, Kangas outlines the different approaches adopted:¹⁰⁸

- “*Corporatist*” models – adopted in Germany, France, Italy, Japan and the Netherlands – base entitlements “on contributions and the claimant’s membership of a specific occupational group” and representatives of employers, employees and sometimes the state participate in running the scheme.

104 Barrett, “Simplifying Statutory Sick Pay”, 187.

105 Woolf et al., *DWP Project on the Feasibility of SSP Data Collection*, 49.

106 Ibid., 52.

107 Tom Cox et al., “Work, employment and mental health in Europe”, *Work & Stress* 18/2 (2004), 183.

108 Olli Kangas, “Institutional development of sickness cash-benefit programmes in 18 OECD countries”, *Social Policy & Administration* 38/2 (2004), 194. See figure 1.

- *“Basic” or “encompassing” models* – adopted in the UK, Ireland, Finland, Sweden and Canada – provide a basic rate of cover to all citizens regardless of their occupation, with public authorities either setting the guidelines or taking full responsibility for legislation and administration.

Whichever the model, there is a undoubtedly a role for all stakeholders – government, employers, employees and the health service – in providing support for workplace mental health and there are benefits for all in promoting it.¹⁰⁹ However, in the UK the historical development of the sick pay system makes it unclear who is responsible for the provision of services and support to employees during the first 28 weeks of illness, particularly in a context where occupational health has never been incorporated meaningfully into the NHS. The employee benefit system in the UK does not require employers to make arrangements for employee healthcare unless they want to, or unless an employee was injured or made ill as a result of their work. Even when this happens, the NHS Cost Recovery Scheme bears the cost of the healthcare, through which insurers (who pay for the costs as a result of Employers’ Liability insurance) pay around £200 million per year to the NHS.

Moreover, although everyone could benefit from investment in improved mental health in the workplace, the distribution of the benefits among several stakeholders means that the incentives for any single stakeholder to pay for additional services for workers are diluted – even if total benefits outweigh total costs. In essence, the problem is that the private costs of intervention do not justify taking action for any one stakeholder. As a consequence, too often no one invests.¹¹⁰

109 Dewa, McDaid and Ettner, “An international perspective on worker mental health problems”, 347.

110 Ibid., 346.

As articulated in a report published by NERA for Norwich Union:

A characteristic of the potential market for workplace health initiatives is that no one stakeholder has an over-riding incentive to invest in programmes because of the nature of how the costs and benefits accrue. For example:

- The costs of illness are spread across many different stakeholders (e.g. employers, the NHS, the social security budget and individuals).
- There is uncertainty over when and how the benefits from early intervention accrue. As an example, employees are mobile, so investment in workforce will not always generate a return to the investing employer. Benefits will also accrue over time – the payback from investment may be five or ten years down the line – which increases both the uncertainty about the scale of benefits and about to whom they will accrue.¹¹¹

The report goes on: “From society’s perspective, no one stakeholder has an incentive to invest in programmes in a socially optimal perspective because each stakeholder considers the private costs and benefits rather than the social costs and benefits.”¹¹²

Examples discussed with experts suggest that employers are rarely presented with the economic advantages of intervention. Indeed, many businesses believe that by paying their NICs, they are already contributing to the costs of the NHS. Moreover, a number of employers seem to believe that it takes a long time for investments in health and well-being to feed through into greater employee loyalty or productivity growth. Or, interventions are deemed too costly, given the costs of long-term absence, which may not be significant enough to justify taking action.

111 Bramley-Harker, Hughes and Farahnik, *Sharing the costs – Reaping the benefits*, iii.

112 *Ibid.*

Indeed, despite the substantial costs of mental ill health to a number of significant stakeholders and the obvious and well-documented benefits of employment in the treatment of mental health, there exists almost a no man's land in terms of support until an individual reaches the stage of IB and the associated mechanisms for return-to-work. As we shall see, this period of "no support" precisely coincides with the time frame when intervention is thought to be most effective.

For employers, the decision to invest is influenced by the particular shaping of the UK system, which means that the longer an employee has been off work the more costs associated with that absence shift towards the state and away from the employer.¹¹³ As a result, employers face an increasing disincentive to invest in returning staff to work. Effectively, this means there exists a market failure for measures that reduce the length of long-term absences. Even though the costs of the intervention represent only a small portion of the overall loss that could be avoided, they may nonetheless be higher than the potential gain to the employer. At the same time, the government is unable accurately to predict which cases may end up on long-term benefits, and, therefore, which cases will entail high deadweight costs. This shift in costs towards the state and employee over time may explain why a disproportionate number of those who are off work are in that position on a long-term basis. It may also explain the high incidence of claims for incapacity benefit.

Clarity of shared responsibility is critical, but of course the appropriate role for employers in managing and reducing absences caused by mental ill health is a disputed one. In particular, it is important to recognise that, according to DWP research, 61% of IB claimants who suffer from mental health problems claim that their condition is not work-related.¹¹⁴

113 We are grateful to Matthew Young for highlighting this observation.

114 Kemp and Davidson, *Routes onto Incapacity Benefits*, 56.

Equally, and understandably, employers may be resistant to anything which means that they and their occupational teams take on the role of GPs. Yet, at the same time, the British Medical Association (BMA) has argued that, for short-term absences at least, “absence management is a human resource issue not a medical issue, and thus it should not fall under the remit of GPs or even the NHS”. Instead, it suggests this is best assessed by employees and employers, with advice from occupational health professionals and factual information from GPs.¹¹⁵

With half of all employers surveyed identifying sick pay as a “significant” or “very significant” cost to their organisation,¹¹⁶ there is surely a strong case for re-evaluating an employer’s role when it comes to the mental health and sickness absence of their employees. As highlighted by the then Disability Rights Commission in its evidence to the Work and Pensions Committee, it is clear there is scope for the SSP process to become better managed in order to enable individuals and employers to work together at an early stage of a person’s illness, with the aim of identifying what adjustments might be needed to enable that person to remain in work.¹¹⁷

Case study: The Netherlands

Sickness benefits in the Netherlands adhere to the corporatist model. Until 1996, the Sickness Benefit Act entitled employees to at least 70% of their gross wage earnings. These payments were collectively financed through sector-specific insurance funds, which were under public administration. In all cases, the collective bargaining agreements reached between employers and employees guaranteed supplements on the basic rate, so, for 90% of Dutch employees, the effective replacement rate was 100%.¹¹⁸

115 House of Commons Work and Pensions Committee, *Incapacity Benefits and Pathways to Work: Third Report of Session 2005–06: Volume I* (London: HMSO, 2006), 23.

116 CIPD, *Annual Survey Report 2007*, 3.

117 House of Commons Work and Pensions Committee, *Incapacity Benefits and Pathways to Work*, 64.

118 Philip De Jong and Maarten Lindeboom, “Privatisation of sickness insurance: evidence from the Netherlands”, *Swedish Economic Policy Review* 11 (2004), 14.

These arrangements led to some of the highest absence rates in Europe; in the 1980s, Dutch employees reported sick about 50%–100% more often than German or Belgian workers.¹¹⁹

In March 1996, the Sickness Benefit Act was repealed. It was replaced by the Civil Code, which stipulated that Dutch employers must take on the full financial burden of sickness benefit payments. Employers were also banned from requesting medical examinations as part of the application process to prevent them from discriminating against potentially “unhealthy” workers. Furthermore, since 1998 the insurance-based system for administering Disability Benefit (equivalent to IB) has been altered, so that employers whose employees are recipients of the benefit pay higher premiums. It was hoped that, by confronting employers with the full costs of sickness absence, they would take steps to reduce it. Changes in 1996 gave employers a legal obligation to contract with a private occupational health agency and buy a package of services on sickness prevention and management of absenteeism. Incentives for employees, however, are much weaker; the wage replacement rate is close to 100%, and employers are unable to issue dismissals during the first two years of sickness.

Dutch firms can now choose whether they want to bear the increased cost of sick pay themselves or reinsure their sick pay risks. About 80% of firms opted for private insurance, with the vast majority of this group made up of small organisations; while firms with fewer than 20 employees have a coverage rate of about 83%, only 25% of those with 100 or more workers purchase insurance.¹²⁰ Insurance policies must cover every employee and insurers can, in turn, stipulate which set of occupational health services are contracted out.

These changes produced a marked decline in absenteeism. Sickness absence rates dropped from 6.4% in 1991 to 5.4% in 2001 – roughly a 15% decrease. Furthermore, this drop took place during

119 J. H. Van Dijk and R. Prins “Occupational healthcare and work incapacity: recent developments in the Netherlands”, *Occupational Medicine* 45/3 (1995), 159.

120 De Jong and Lindeboom, “Privatisation of sickness insurance”, 21.

a period of high economic growth, in which one would normally have expected an increase in absence rates.¹²¹ Nonetheless, sickness absence still remains very high in the Netherlands compared to other European countries, and the generosity of benefits to which employees are entitled – up to two years of employer-paid sick pay – is regarded as a perverse incentive for their to return to work.

Expert opinion and the available data also highlight that in the current system of shared responsibilities, the business case simply will not always be relevant until an organisation reaches a certain size – this is reflected in the provision of services by larger but not smaller companies. While SMEs may be less able to withstand the costs of losing qualified staff, some feel that unless they lose key workers, it is easier to dismiss and replace someone than channel funds into support services. Large companies, by contrast, may find it much easier than their smaller counterparts to invest in occupational health.

The FSB has stated that only 6.5% of small businesses provide any access to occupational health (OH) services¹²² and it was estimated that only 3% of small employers have access to comprehensive OH services. In a separate FSB survey, some 57% of respondents said they have too few staff to make OH/vocational rehabilitation services worthwhile and 33% were concerned about cost.¹²³ The relationship between company size and access to OH is also born out in a survey of recent IB claimants. It found that 57% of those who had worked in organisations of more than 1,000 employees had access to OH services through their workplace, compared to just 9% of those in companies of fewer than 10 employees.¹²⁴

121 Ibid., 18.

122 Federation of Small Businesses, *Health Matters*, 16.

123 Federation of Small Businesses, *Whatever Happened to Common Sense? Occupational Health and Safety in Small Businesses Report 2007* (London: FSB, 2007), 21.

124 Kemp and Davidson, *Routes onto Incapacity Benefits*, 72.

Of those who had access, 78% found these services very or fairly helpful.¹²⁵

These factors also help to explain the findings of the DWP study of routes onto IB, which identified that disproportionate numbers of those moving onto IB came from SMEs. Some 71% of those who had been either in work or off sick immediately prior to claiming reported having no access to OH services, and 83% that no workplace changes had been made to accommodate them.¹²⁶

However, although smaller employers will often not have the financial muscle to invest in costly services, the smallest businesses benefit from the closer interpersonal relationships between staff that tend to foster loyalty between employers and employees. This may also be reflected in the inverse correlation between company size and average sickness absence which is highlighted in a number of surveys. A number of interviewees also suggested that it might be most productive to focus efforts on medium-sized businesses, of between around 50 and 500 employees, where HR procedures are often lacking, but maintaining personal relationships between various staff members is more difficult.

HEALTH SERVICE PROVISION AND GPS

Interviewees and research evidence also suggest that the approach taken by GPs or occupational health practitioners can have a significant role in determining the pathways towards benefits or recovery and retention. For example, a number of interviewees suggested that being signed off work may itself compound an illness. Doctors often repeatedly give sick notes, so that they can have some time to understand more about the employee's illness. Moreover, if the person has been referred to a hospital for in- or

¹²⁵ Ibid., 73.

¹²⁶ Ibid., 4.

outpatient treatment, or to community services, GPs may not recommend a return to work until the patient has been seen, regardless of the treatment. Throughout this process, the individual is at risk of becoming increasingly isolated from work.

Research also suggests that it is not uncommon for GPs and OH workers to warn people to stop working or change their job when signs of mental health problems begin to emerge.¹²⁷ In her review of health and work, Black argued that a “lack of understanding about the relationship between work and a patient’s health, and the omission of this evidence from professional training, has meant that despite the best intentions, the work-related advice that healthcare professionals give their patients can be naturally cautious and may not be in the best interests of the patient for the long term”.¹²⁸ In order to help tackle this issue, professional bodies have all signed a consensus statement as a sign of commitment to promoting the link between good work and good health.¹²⁹

Further, it has been argued that the existing system means that GPs are focused on whether their patient is sick – not on whether he or she is capable of a return to work – and that they may not consider the long-term implications of issuing a sick note to a patient.¹³⁰ In addition, a tendency has been identified amongst GPs and OH workers to “underestimate the capacities and skills of their clients”,¹³¹ suggesting that medical professionals may be less than effective at raising the subject of returning to work once an individual has taken sickness absence. In response to such concerns, Black has suggested that the paper-based sick note be replaced with an electronic fit note, “switching the focus to what people can do and improving communication between

127 Sainsbury and Davidson, *Routes onto Incapacity Benefits*, 28.

128 Black, *Working for a Healthier Tomorrow*, 11.

129 *Ibid.*, 12.

130 House of Commons Work and Pensions Committee, *Incapacity Benefits and Pathways to Work*, 20.

131 Royal College of Psychiatrists, *Employment Opportunities and Psychiatric Disability*, 26.

employers, employees and GPs".¹³² These changes are under way and the fit note is in development.

In addition, the Royal College of Psychiatrists found that GPs fail to diagnose correctly around half of those suffering from common mental illnesses or they diagnose the condition only after a considerable amount of time has passed, perhaps reflecting training and knowledge gaps.¹³³ This is compounded by the fact that "people with mental health problems can go to their GP or employer complaining of physical symptoms that have no physical cause [which] can sometimes lead to missed or delayed detection of the underlying mental health problem".¹³⁴ Having said this, employers may also be misdiagnosing mental health in the workplace; research has suggested that "mental ill health sufferers experienced a significantly higher number of incidences of discipline at work than any other group"¹³⁵ and "managers do not recognise any but the most severe cases of mental ill-health".¹³⁶

On a national scale, the limited supply of therapists, coupled with having separate government departments for health and employment, is also considered as a hindrance to the provision of mental health services.¹³⁷ Absences can be prolonged by long NHS waiting times. In cases of mental health, extended waiting periods result from over-stretched services, and these cases are given a lower priority in comparison to acute and chronic conditions.

Nonetheless, while contact with employers is crucial to helping those suffering from common mental disorders to return to work,

132 Black, *Working for a Healthier Tomorrow*, 17.

133 Royal College of Psychiatrists, *Mental Health and Work*, 22.

134 *Ibid.*, 6.

135 David Imber and Fran Włodarczyk, *Mapping Effective Responses to Job Retention: Report of the Research Survey and Analysis* (Reading: KMG Health Partners, 2007), 67.

136 *Ibid.*, 70.

137 Royal College of Psychiatrists, *Mental Health and Work*, 20.

the first port of call for employees suffering from stress or depression will, realistically, be their GP. For those working in organisations that do not run their own occupational health services, GPs will be the main source of advice and support. Ideally, consulting primary care services would allow individuals to access advice inside and outside the workplace – particularly when some employees might be unwilling to share information about personal problems with their employer. Yet mental health charities frequently point to the variations in the levels of quality and expertise in primary mental healthcare. Since NHS mental health expenditure is limited, few patients are offered therapy, which is generally considered unaffordable. A second problem with primary care is that it can be overly focused on the medical aspects of mental ill health, ignoring the wide range of external factors which can trigger mental illness. Some experts felt there could be better integration between occupational health, social and primary care.

Recent research commissioned by Remploy has also suggested that the relationship between employers and GPs is not necessarily constructive. Even though “doctors and medical specialists” were the most widely used source of help for disabled employees, they were given a negative rating of “helpfulness” by the employers.¹³⁸ This, the report argues, may be because employers feel that approaching a GP “may be seen as an act which is motivated by hostility towards sickness absence”.¹³⁹ Regardless of the cause, there appears to be some tension between companies and doctors that impedes the identification and treatment of mental health conditions at work to the point at which “doctors and local authority services have some way to go if they are to be seen as a positive influence on job retention by employers and by service providers”.¹⁴⁰

138 Imber and Włodarczyk, *Mapping Effective Responses to Job Retention*, 34.

139 Ibid.

140 Ibid., 26.

With these problems in mind, as previously mentioned, the Black Review proposed an innovative new service which would create this link between primary care and employment advice. The idea is to place advisers in GPs' surgeries to provide on-the-spot guidance on a range of issues, from employment to finance and housing concerns. The general feeling amongst the experts we consulted was that, although this idea was good in theory – with the potential to standardise and provide definitive guidance on occupational health – successful practical implementation would pose a number of challenges. These are explored in more detail in chapter 8 of this report.

STIGMA AND EMPLOYEE EXPERIENCES

The ongoing stigma attached to mental illness, referred to as “the last workplace taboo” by the Shaw Trust, continues to reduce the opportunities available to those who suffer from mental illness. The stigma and discrimination suffered may in fact be more disabling than the illness itself, and recently prompted Trevor Phillips, Chair of the Equality and Human Rights Commission, to call for a “radical rethink” by employers in their approach to mental ill health at work.¹⁴¹ Although a study for the DWP found “limited evidence of unsympathetic attitudes towards long-term sick employees” from employers,¹⁴² it also identified enormous variations in reactions to diagnoses. In addition, it identified “some lack of sympathy towards days off for ‘minor’ complaints, suspicions that short-term absences were not always ‘genuine’ and suggestions that the seven-day self-certification period encouraged illegitimate days off and longer spells than warranted”.¹⁴³

141 Trevor Phillips, “We need a radical rethink to help mentally ill at work”, 7 May 2008, available at: www.equalityhumanrights.com/en/newsandcomment/speeches/Pages/Weneedaradicalrethinktohelpmentallyillatwork.aspx.

142 Katharine Nice and Patricia Thornton, *Job Retention and Rehabilitation Pilot: Employers' Management of Long-term Sickness Absence* (London: DWP, 2004), 20.

143 *Ibid.*, 1.

The experiences of recent IB claimants affected by mental health problems in the workplace reveals the impact of such attitudes for those who are ill. IB claimants with mental illness were the least likely to have discussed their problems with their employer, with 37% reporting they had never raised the issue.¹⁴⁴ This was echoed by recent DWP research, which found that “most people who went off sick before leaving work did so without having discussed their mental health condition with their employer”.¹⁴⁵ Those who had attempted to do so frequently reported a negative experience, with 44% describing their employer as “fairly or very unhelpful”, compared to only 20% of those with musculoskeletal conditions.¹⁴⁶ Only 16% reported that changes had been made to help accommodate their condition, but 26% felt that other changes might have helped them stay in work longer.¹⁴⁷ Finally, when asked about the barriers to their returning to employment, 33% of those with mental health problems cited “low confidence” as an obstacle – a concern for only 8% of those with physical health conditions.¹⁴⁸

Similarly, studies have identified that problems of resentment and morale may appear “when duties are reassigned from disabled to non-disabled workers or when employers make other adjustments for disabled workers, especially those whose health conditions are not apparent to other workers”.¹⁴⁹ This can be exacerbated as the “employer may incur ... costs due to uncertainty in the amount of output that the worker will produce”¹⁵⁰ that are over and above the cost of making adjustments to the workplace.

144 Kemp and Davidson, *Routes onto Incapacity Benefits*, 69.

145 Roy Sainsbury et al., *Mental Health and Employment* (London: DWP, 2008), 88.

146 Kemp and Davidson, *Routes onto Incapacity Benefits*, 71.

147 *Ibid.*, 73 and 77.

148 *Ibid.*, 109.

149 Karen Needels and Robert Schmitz, *Economic and Social Costs and Benefits to Employers of Retaining, Recruiting and Employing Disabled People and/or People with Health Conditions or an Injury: A Review of the Evidence* (London: DWP, 2006), 37.

150 *Ibid.*

In our discussions with mental health charities, employers and employers' organisations, the failure to address stigma in the workplace and employer inhibitions about communicating with employees with mental health problems was cited several times as a barrier to the employment and retention of those with mental illness. The unwillingness of employers – and even those affected – to address such issues is closely linked to widespread ignorance about mental illness, making it doubly difficult to cope with the problem. Employees, on their part, tend to be reluctant to disclose cases of stress or depression, instead allowing the problems to develop until they are unmanageable. Employers, in turn, are often reluctant to become involved in mental health issues – while most may be sympathetic in principle, in practice few are aware of the best means of addressing such situations. De-stigmatising mental health problems through advice and information will therefore be important for both employers and employees.

Interviewees stressed that the provision of toolkits and guidelines to raise awareness of best practice will be crucial. Such guidance needs to be simple, clear and unambiguous; employers consistently report that they are worried about the adverse effects they could cause if they intervene inappropriately. Most employers are hesitant to contact an employee during a long period of mental health-related absence; they are generally nervous about being accused of "harassment" and don't want to risk making things worse. However, most of those to whom we spoke agreed that their reluctance to step in tends to prolong spells of absence and significantly diminish the chances of an employee successfully returning to work. Many also state that there is considerable variation in advice from HR departments, OH services, GPs and lawyers. On the other hand, most agreed that employees tend to respond positively to employers who are conscious of mental health issues.

6. THE CASE FOR EARLY INTERVENTION

Summary

There exists a growing consensus amongst academics, practitioners and the policy community that getting people with common mental illnesses back into the workplace becomes increasingly difficult as time goes on, and that much earlier intervention is needed if IB on-flows are to be reduced. Recent research on vocational rehabilitation also found “strong evidence that simple, inexpensive healthcare and workplace interventions in the early stages of sickness absence can be effective and cost-effective for increasing return to work rates and reducing the number of people who go on to long-term disability”.¹⁵¹

Determining appropriate time frames for intervention for people with a common mental illness is, however, complicated by the ways in which such illnesses develop and fluctuate, and by the lack of available data that explores the timings of return to work for employees who have gone off sick. The limited evidence that is available suggests that the propensity to return to work falls rapidly at around 4–6 weeks, and that after about 3 months the numbers returning are very limited. Difficulty in returning to work increases as the time of absence extends – fear about the amount of catch-up needed as well as colleagues’ reactions are both significant inhibitors to returning – and will only worsen as time away from the workplace increases. From the employers’ perspective, too, disengagement begins to bed in after a few weeks, after which they will look for longer-term solutions – for example, recruiting temporary replacements – and will find it harder to accommodate increasingly lengthy sickness absences. All this implies that, for successful employment retention, interventions need to be well under way by 3–6 weeks of absence, with some advocating an even earlier optimal time, and certainly line manager contact from the start.

There exists a growing consensus that the longer someone remains off sick, the less chance there is of his or her returning to work; much of the available evidence suggests that getting people with

151 Waddell, Burton and Kendall, *Vocational Rehabilitation*, 38.

common mental illnesses back into the workplace once they have left becomes increasingly difficult as time goes on. A review by Hill et al. of common mental illness interventions for the Health, Work and Well-being Executive, for example, recommended that early contact with employees who have started sick leave and early referral to an OH team would improve work outcomes.¹⁵² Echoing this, the Black Review advocates focusing on illness prevention and health promotion alongside early intervention as the most effective ways of retaining people in the workforce, and noted that sickness absence due to mental ill health is compounded by a lack of appropriate and timely diagnosis and intervention.¹⁵³ Research on vocational rehabilitation also found “strong evidence that simple, inexpensive healthcare and workplace interventions in the early stages of sickness absence can be effective and cost-effective for increasing return to work rates and reducing the number of people who go on to long-term disability”.¹⁵⁴

However, for people with a common mental illness, determining appropriate time frames for intervention is made more complex by the ways in which such illnesses develop. In contrast to the more observable symptoms associated with both physical disabilities and severe conditions such as schizophrenia and bipolar disorder, disorders such as stress and anxiety can develop and manifest themselves in a different fashion. Even though two-thirds of people with mental health needs report that the “emergence or exacerbation of mental ill health had been a main factor in their leaving work”,¹⁵⁵ common mental illnesses may not necessarily lead to an inability to work or occur in a short space of time. For example, Kemp and Davidson’s study found that the mental health conditions of around two-thirds of people (64%) developed

152 Darcy Hill et al., *What Works at Work? Review of Evidence Assessing the Effectiveness of Workplace Interventions to Prevent and Manage Common Health Problems* (London: Health Work and Well-being Executive, 2007), 4.

153 Black, *Working for a Healthier Tomorrow*, 9-10.

154 Waddell, Burton and Kendall, *Vocational Rehabilitation*, 38.

155 Sainsbury et al., *Mental Health and Employment*, 43.

gradually over time, compared with less than half (49%) of those with physical conditions.¹⁵⁶ Nonetheless, people with mental illnesses are thought to move through three generic phases en route to the final stage of being on benefits:

- initial health/capability change (“warning signs”)
- health change affecting work (“struggling on”)
- sickness absence from work (“off sick”)
- on benefits.¹⁵⁷

Early intervention during these periods of development is widely agreed to have significant potential to reduce the likelihood of people progressing to benefits. Once an employee takes time off with a mental health condition, employers must decide if and when to intervene. In many cases, intervention will not be necessary; “stress” may be termed a genuine and reasonably serious mental health condition, but may also be far milder, cited when an employee is suffering from a short period of exhaustion, for example. Mandating intervention too early could lead to a deadweight cost, as many employees return of their own accord after a brief absence. EEF estimates that 50% of those with stress are off for one or two weeks before returning to work, while 25% are absent for four weeks or more. For those experiencing depression and anxiety, however, this period is generally longer, with around a quarter off for ten weeks or more. The general consensus amongst mental health charities and employers’ organisations was that those suffering from mild to moderate mental health problems should be able to return to work within 4–6 weeks, and certainly no later than

156 Kemp and Davidson, *Routes onto Incapacity Benefits*, 56.

157 Sainsbury and Davidson, *Routes onto Incapacity Benefits*, 13.

two months. Mild mental health conditions are manageable, but if a person is out of the workplace for longer than two months, mental illness can become a generic state as he or she becomes increasingly disengaged from the structure of their normal lives.

Evidence gathered from our expert interviews also revealed a general consensus that the period around 3–6 weeks after a person first stops work due to mental ill health is the time at which interventions should be under way to encourage their return. Some interviewees have advocated an even earlier optimal time for intervention on the continuum from wellness to incapacity, for example after a person has been of sick for one week (and all suggest that low-level contact should be maintained from the start). However, the high deadweight cost of intervening too early (most people will go back to work of their own accord in the first two weeks without support) and the danger of pigeon-holing and medicalising illness too early suggest that there should be a period of “watchful waiting” lasting at least two weeks before any direct intervention, beyond line manager contact, is initiated.

From the employer’s perspective, interviewees have suggested that although they can usually “get by” for a few weeks, they will commonly look to find a longer-term solution after an absence has been sustained beyond 4–6 weeks, and will find it harder to accommodate increasingly lengthy sickness absences. Solutions might include, for example, recruiting temporary replacements, which can be time-consuming and expensive. Equally, for the employees who are off sick, it is suggested that the difficulty in returning to work increases as the time of absence extends – fear about the amount of catch-up needed as well as colleagues’ reactions are both significant inhibitors to a return to work – and will only worsen as time away from the workplace increases. Indeed, employers are well aware that, in many cases, “the main impact of mental health conditions was felt by colleagues”¹⁵⁸ in addition to the “very time-

158 Sainsbury et al., *Mental Health and Employment*, 59.

consuming” demands placed on managers.¹⁵⁹ All these factors indicate that an emphasis on keeping people with common mental illnesses in the workplace will be central to stemming on-flows to benefits.

Despite the lack of data on this subject, some indication of the time frames of concern from an employer’s point of view can also be discerned from the CBI/AXA survey data which recorded the point at which some employers utilise “trigger” mechanisms to alert them to the need for action in respect of absence management. It found that 82% of employers use some form of ‘trigger’ to alert them to a problem of absenteeism, regardless of the reason.¹⁶⁰ The average level of absence that triggered a response from employers was ten days off work or three spells of absence, although smaller organisations waited just five days – possibly due to the increased urgency in getting people to return to work out of necessity – and private sector companies (eight days) did not wait as long as the public sector (ten days).¹⁶¹ This may reflect the fact that smaller organisations are less able to cope financially with lengthy absences, hence the desire to intervene earlier, while public sector delays relative to the private sector could reflect a more generous sickness absence system. It is also worth noting that most organisations regard absences of more than a few weeks as constituting long-term absence. The CBI/AXA survey asked employers to state what they regarded to be long-term absence and found that the majority of organisations defined it as being away from the workplace for 20 days or more. For smaller businesses, the average was 17 days or more.¹⁶²

An understanding of the optimum intervention times and the deadweight costs that might be incurred by intervening too early is severely hampered by the almost complete lack of available data that explores the timings of return to work for employees who have gone

159 Ibid., 60.

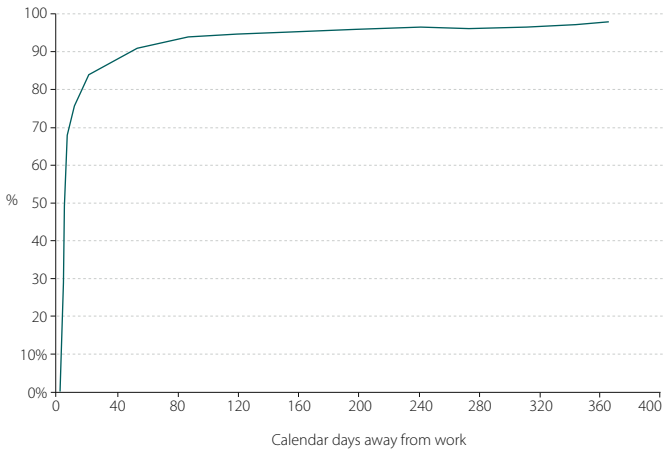
160 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 22.

161 Ibid.

162 Ibid., 19.

off sick. Similarly, a lack of evidence has been identifiable in relation to average or anticipated durations of common mental and other illnesses, making any attempts to assess timescales for intervention problematic.

Figure 6: Cumulative proportion of people returned to work with back pain, 1994



Source: Clinical Standards Advisory Group, London, HMSO, cited in the Black Review

Indeed the only data which gives an indication is that highlighted in the Black Review, which relates to back pain. This data, reproduced here as figure 6,¹⁶³ suggests that the propensity to return to work falls rapidly at around 4–6 weeks, and that after about 3 months, the numbers returning are very limited. In short, this indicates that if someone has not returned to work by 3 months, they are unlikely to do so, and the slide towards benefits is well on its way. Although, as the Black Review suggests, the turning point may differ for different conditions,¹⁶⁴ and this would require robust evidence, it still makes more sense for intensive interventions to begin at an earlier stage if real impacts on the slide to benefits are to be made.

¹⁶³ Black, *Working for a Healthier Tomorrow*, 74.

¹⁶⁴ *Ibid.*, 73.

7. PREVENTION, RETENTION AND REHABILITATION

Summary

A range of treatments or interventions to help and support people with common mental health conditions is appropriate at varying stages in the pathway from wellness to benefits, and can be garnered from a combination of intervention trials, good practice guidelines and international evidence.

The range of interventions lies along a continuum from *prevention* of mental illness from manifesting itself, to *retention* of those at risk from developing mental illnesses in the workplace, to *rehabilitation* of those who have developed symptoms. Such approaches seek to tackle a number of interrelated barriers such as stigma, unhealthy work cultures, GP medicalisation, employer nervousness, poor management and so on. These three periods also align broadly with the known common pathways from mental health to ill health, through sickness absence and on to benefits.

- *Prevention*: Preventative and/or health promotion measures have been found to offer measurable workplace outcomes, particularly where employees are engaged actively in the processes. In particular, links are made between mental health in the workplace and general management and stress management practices, as well as good practice around job control and clarity of roles and responsibilities.
- *Retention*: Retention strategies may involve flexibility on the part of employers and employees – for example, in terms of working hours or changes in duties. In addition, treatments such as relaxation training, counselling and cognitive behavioural therapies have met with some successes.
- *Rehabilitation*: Mechanisms as simple as regular line manager contact during a spell of absence can have a notable impact on early return to work, alongside a range of medical and psychological interventions and treatments.

This paper does not seek to clarify which specific treatments are the most appropriate or cost-effective. This is beyond the expertise of the current authors and has been covered in detail in a variety of reviews and academic papers – most recently a comprehensive review of vocational rehabilitation.¹⁶⁵ It is worth highlighting, however, the kinds of treatments or interventions that may be appropriate at varying stages in the pathway from wellness to benefits. This information can be garnered from a combination of intervention trials, good practice guidelines and international evidence. Although generally concluding that the evidence base is patchy, a number of academic studies have sought to review the robustness of the evidence in relation to such interventions.

In a review of workplace interventions for people with common mental health problems, Seymour and Grove provide a useful distinction between interventions that aim to prevent mental illness from manifesting itself (prevention), those that retain people at risk from developing mental illnesses in the workplace (retention) and those that rehabilitate people who have developed symptoms (rehabilitation).¹⁶⁶ Such approaches seek to tackle a number of interrelated barriers, which include stigma, unhealthy work cultures, the medicalisation of mental health by GPs, employer nervousness, poor management and so on. The classification of interventions also aligns broadly with the known common pathways that lead from mental health to ill health, through absence from work and onto benefits. Most of the employers whom we consulted argued that best practice tends to involve strategies that prevent employees from suffering from stress, retain those who do develop symptoms within their positions and intervene appropriately to prevent mental health issues from worsening.

165 Waddell, Burton and Kendall, *Vocational Rehabilitation*.

166 Linda Seymour and Bob Grove, *Workplace Interventions for People with Common Mental Health Problems* (London: British Occupational Health Research Foundation, 2005).

PREVENTION

As discussed previously, although government policy has, to date, focused primarily on moving people from welfare to work, some initiatives have also focused on improving workplace health at the organisational level. For example, the 2006 Green Paper argued that a reduction in the number of people moving onto benefits might be aided by improving workplace health and effecting a cultural change in attitudes towards sickness absence (building on the 2005 Health, Work and Well-being Strategy).¹⁶⁷

Most recently, Lord Darzi's review of the NHS has proposed that every primary care trust (PCT) should commission well-being and prevention services tailored to meet the needs of the local population – one of the goals of which will be improving mental health (alongside tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates and improving sexual health).¹⁶⁸ Darzi also argues that our increasingly detailed understanding of the factors that determine physical and mental health will enable the NHS to focus on the prevention of ill health rather than on reactive diagnosis as is currently the case.¹⁶⁹ Finally, the review argues that investment in health prevention in the workplace can bring about benefits in terms of motivation, productivity and profit.¹⁷⁰ This investment is being encouraged through a joint programme run by the DWP, the NHS and Business in the Community to ensure that reporting on health and well-being is done at board level by more than 75% of FTSE 100 companies by 2011.¹⁷¹

167 Department of Health, DWP and Health and Safety Executive, *Health, Caring For Our Future: A Strategy for the Health and Well-being of Working Age People* (London: HMSO, 2005).

168 Department of Health, *High Quality Care For all*, 9.

169 *Ibid.*, 29.

170 Phillip Wang et al., "The costs and benefits of enhanced depression care to employers", *Archives of General Psychiatry* 63 (2006), found that both employees and employers would benefit if employers improved access to mental health services for their employees; cited in Department of Health, *High Quality Care For all*.

171 Department of Health, *High Quality Care For all*, 37.

Seymour and Grove’s comprehensive review of the academic evidence found that preventative interventions such as these “typically produced moderate or short-term benefits”, although the measured outcomes and intervention techniques found across the studies under review were rarely comparable.¹⁷² Hill et al.’s review on behalf of the cross-government Health, Work and Well-being Executive argued that “the workplace is a potentially effective setting for promoting and preventing mental health problems”, though it also acknowledged that the “quality and nature of the interventions are crucial”.¹⁷³ Importantly, the authors identified that “workplace health promotion interventions which include some consultation with employees or include some other type of employee–employer partnership, have been shown to be more effective on a range of outcomes, than those interventions which did not involve employee consultation”.¹⁷⁴

A review by Michie and Williams focused on work-related psychological ill health and sickness absence. It was found that training programmes focusing on decision-making, support and communication can have a positive impact, as employees reported “more supportive feedback, more ability to cope, and better work team functioning and climate” in addition to reduced depression and lower levels of stress hormones, even if the training programmes only lasted for a few hours a week over no more than 2–3 months.¹⁷⁵ Other strategies that led to improved outcomes have included improving communication and empathy skills, an increased sense of job control, improving the quality of management and reducing the length of time that employees must wait before being able to access occupational health services

172 Seymour and Grove, *Workplace Interventions for People with Common Mental Health problems*, 27.

173 Hill et al., *What Works at Work?*, 32.

174 *Ibid.*, 31.

175 S. Michie and S. Williams, “Reducing work related psychological ill health and sickness absence: a systematic literature review”, *Occupational and Environmental Medicine* 60/1 (2003), 5–7.

after going on sick leave.¹⁷⁶ This supported a previous study of using organisational changes to reduce or remove workplace stressors, which indicated that increased job control was responsible for improvements in “general mental health, motivation levels and sickness absenteeism rates”.¹⁷⁷

These kinds of organisational changes are also advocated by the Health and Safety Executive (HSE) in its stress-management standards. These guidelines outline six key areas to be addressed by managers as part of the promotion of mental health in the workplace: “demands, control, support, relationships, roles and changes”.¹⁷⁸ In terms of the position of individual employees, managers need to ensure that the demands placed on their staff are reasonable, that employees have a degree of control over their work and working conditions and that everyone has a clear understanding of their role and responsibilities. In terms of the organisational context, managers should take steps to ensure that adequate support systems are in place, particularly at the local level; that employees are involved in, and consulted on, organisational changes; and that positive working relationships are promoted, with procedures to prevent or resolve unacceptable behaviour.

Yet, in discussing the implementation of these standards, the HSE was keen to point out that it is impossible to consider effective stress management independent of general managerial competence. The study of workplace stress leads to a “broader focus on good management and healthy organisational cultures ... stress management is a part of normal general management activities. It is about the way managers behave on a day-to-day

176 Ibid. 5–6.

177 Frank Bond and David Bunce, *Reducing Stress and Improving Performance Through Work Reorganisation: Final Progress Report for the British Occupational Health Research Foundation* (London: Goldsmiths College, 2005), 8.

178 HSE, “The Management Standards”, available at: www.hse.gov.uk/stress/standards/standards.htm.

basis towards those that they manage.”¹⁷⁹ Earlier this year, the HSE published the second “phase” of research into the relationship between management behaviour and stress at work, having reached the conclusion that “manager behaviour is an important determinant of employee stress levels” during Phase One,¹⁸⁰ and identified a number of management “competencies” that could help to prevent and reduce stress. The subsequent creation and refinement of a “stress management competency indicator tool: also produced encouraging results in terms of the usability and relevance from the perspective of employers.¹⁸¹

The CIPD’s 2007 absence management survey also recommended that companies should provide line managers with specific training, and identified that 40% of companies that have such training in place reported a decrease in all types of sickness absence, compared to the 26% of companies that saw a decrease in sickness absence where no absence management training was carried out.¹⁸² Similarly, many of those interviewed focused on the need to incentivise preventative actions through person- and workplace-focused solutions. The well-being strategies of organisations such as BT, which are widely considered to be good examples of employer practice, focus heavily on preventative measures and highlight the importance of management skills – one-to-ones, coaching, stress management tools and supportive management styles – and training as an effective means of reducing absences and supporting those with mental illnesses in the workplace.

The issue of management skills and workplace culture was generally agreed by all stakeholders to be central to the successful

179 Joanna Yarker, Rachel Lewis and Emma Donaldson-Feilder, *Management Competencies for Preventing and Reducing Stress at Work: Identifying and Developing the Management Behaviours Necessary to Implement the HSE Management Standards: Phase Two* (London: Goldsmiths, 2008), 58 and 61.

180 *Ibid.*, 1.

181 *Ibid.*, 48.

182 CIPD, *Annual Survey Report 2007*, 10.

resolution of the mental health challenge in the workforce. Often, absence persists because of the way it is managed in the workplace. Indeed, because it is often poorly managed, employees are left isolated from their work, which contributes to their being away for longer periods. Experts who have previously dealt with stress-related issues in the workplace point out that, within large organisations, there are often significant discrepancies between the absentee rates of different teams. These differences can usually be attributed to the quality of line management. A manager's ability to resolve disputes, oversee the well-being of his or her staff and intervene at appropriate moments was a central factor in preventing and tackling stress-related absence. Many experts cited poor management as a key cause of stress and anxiety at work, while more competent managers have fewer stress-related absences within their teams and are better equipped to deal with situations that might arise. Employees also feel more comfortable approaching competent and sympathetic managers, allowing adjustments to be made before problems develop. Mental health charities have pointed out that many of the techniques employed by cognitive behavioural therapy (CBT) practitioners are not dissimilar from those employed by a good manager. Smaller firms may have an advantage in this respect, in that senior managers have a closer working relationship with their staff.

Even so, a large degree of management is marked by entrenched, habitual methods and outdated leadership styles. The firms that tackle this issue most successfully, both large and small, provide appropriate training for all managers, particularly line managers, who then serve as a localised point of contact to resolve problems arising amongst the staff. For example, Bradford & Bingley provide all 500 of its line managers with training on dealing with stress-related issues. Recent research conducted by DWP identified a similar pattern, in which line managers sometimes felt able to "intervene directly in relatively challenging situations" if they were adequately supported, even in small organisations, but "there was also evidence that line

managers had struggled to deal with cases on their own¹⁸³. External organisations can serve as a useful source of advice for employers, but internal action is needed to achieve effective solutions.

Although the majority of large organisations already have stress management policies in place, only a few train their managers to implement them. They are often further hampered by a lack of clear divisions of responsibility between senior and local managers and HR departments. This leads to a situation in which many organisations are concerned about stress and its impact on long-term absence, but are not proactive when it comes to tackling the issue. This situation can largely be put down to ignorance on the part of managers. While the vast majority are compliant with work-related legislation and aware of the business case for minimising long-term absence, many do not possess a full understanding of mental health issues or are afraid of doing the wrong thing, leading to inertia. It has now been suggested that a product should be provided to help managers deal with mental health issues alongside better promotion to raise awareness. There has been extensive exploration of this area in recent years and several bodies, such as EEF and Remploy, are now working on toolkits which could help to fill this gap.

This linking of management skills to mental ill health at work may also be reflected in the growing body of research evidence which indicates that better management practices could make a significant contribution to raising productivity levels in the UK economy. So far, however, there have been few attempts by government to address this correlation. In a recent HM Treasury review, for example, competition, enterprise, investment, innovation and skills were all highlighted as key factors influencing productivity, but the role that management skills might play was not specifically emphasised. The government itself admits that although progress

183 Sainsbury et al., *Mental Health and Employment*, 72.

has been made with higher-level skills, “UK management skills ... appear to be worse than those of our main competitors”.¹⁸⁴

The aforementioned surveys identify the extent to which employers are making use of practices that can be considered preventative, such as stress management, “health and well-being” and “health promotion”. For example, the joint CBI/AXA survey in 2008 found that more than three-quarters (79%) of employers have a policy in place for managing stress – a 13% rise from 2005 – and 45% of these policies are now formal, compared to only 31% in 2005. Somewhat predictably, larger organisations were more likely to have stress management policies and these were more likely to be formal: “85% of firms with 5,000 or more employees have a formal stress management policy, compared with just 3% of organisations employing fewer than 50 staff. However, SMEs balance a low incidence of formal stress policies with a fairly high rate of informal ones, as 33% of the smallest firms operate an informal policy.”¹⁸⁵

However, evidence suggests that the existence of policies alone is not sufficient to tackle the problem of mental ill health in the workplace. For example, 80% of public sector organisations reported providing employees with access to counselling, compared with just 34% of private sector organisations, and 59% of public organisations had some form of employee well-being strategy, compared to only 38% in the private sector.¹⁸⁶ Despite the presence of these policies, absence levels in the public sector were consistently well above average; they rose to 4.5% in 2007, compared to 3.2% for private service organisations,¹⁸⁷ while 29% of all absences in the public sector are long term (spells of four weeks or more), a figure that drops to 15% for the private sector.¹⁸⁸ This

184 HM Treasury, *The 2007 Productivity & Competitiveness Indicators* (London: HMSO, 2008), 3.

185 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 25.

186 CIPD, *Annual Survey Report 2007*, 41–2.

187 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 4.

188 *Ibid.*, 11.

may be due in part to the nature of public sector work, the more rigorous recording of employee absence in public organisations and the age profile of public sector employees, but these findings also suggest that the existence of policies alone does not significantly curtail absences, particularly the long-term absences than can be caused by mental illness.

In addition, many organisations increasingly have ‘employee well-being’ initiatives in place. Although not specifically aimed at mental health, they provide employees with access to additional services in an effort to maintain their overall level of health and possibly improve it. According to the CIPD, some 42% of firms now have an employee well-being strategy, or something similar,¹⁸⁹ and 42% of respondents indicated that their organisation’s well-being expenditure will increase in 2008 (41% will maintain the current level, 2% will reduce it).¹⁹⁰ “Health promotion” was used by 30% of employers to manage short-term absences¹⁹¹ and by 29% of employers to manage long-term absences.¹⁹² Having said this, “despite the considerable sums being invested in employee well-being, just 13% of organisations evaluate the impact of their employee well-being spend”.¹⁹³

Despite such positive movements from employers, a note of caution exists. Seymour and Grove found only “moderate to limited evidence” in support of stress management interventions being effective, even when restricted to a single profession, and that individual rather than organisation-led preventative programmes (e.g. skills acquisition) may be more effective.¹⁹⁴ They also found that well-

189 CIPD, *Annual Survey Report 2007*, 41.

190 *Ibid.*, 48.

191 *Ibid.*, 34.

192 *Ibid.*, 37.

193 *Ibid.*, 49.

194 Seymour and Grove, *Workplace Interventions for People with Common Mental Health Problems*, 27.

being interventions such as online support¹⁹⁵ and physical exercise¹⁹⁶ appeared to have a minimal impact on common mental illnesses.

RETENTION

Mental health charities agreed that remaining in work had a positive impact on mental health for those suffering from stress or depression. Holding a job comes to symbolise people's social status, their employer's belief in their ability, financial security and aspirations for the future. Most experts also agreed that the most effective way to retain those suffering from mental illness in the labour market is to help them remain in their original jobs. This may involve adjustments, such as flexible working patterns or a change in duties.

Good practice guidance suggests that good employers use a range of retention strategies, and surveys also reveal that many organisations offer services that could be best characterised as retention tools, which are commonly targeted at the individual rather than the organisational level of many preventative measures. For example, CBI/AXA found that 56% of companies offered personal counselling to employees and 13% of companies offer counselling to the families of employees as well, with work-life balance advice/support, physical fitness advice/encouragement and healthy diet advice/encouragement also offered by more than 30% of companies. Notably, access to mental well-being support is offered by exactly 30%. The CIPD also identified a variety of services on offer, such as counselling (offered by 47% of employers), an employee assistance programme (31%), long-term disability/permanent health insurance/income protection (18%), critical

195 A. Meier, "An online stress management support group for social workers", *Journal of Technology in Human Services* 20/1-2 (2002), cited in Seymour and Grove, *Workplace Interventions for People with Common Mental Health Problems*, 23.

196 H. Gronningsaeter et al., "Improved health and coping by physical exercise or cognitive behavioral stress management training in a work environment", *Psychology and Health* 7/2 (1992), cited in Seymour and Grove, *Workplace interventions for People with Common Mental Health Problems*, 24.

illness cover (12%) and even on-site massages (10%). More public sector organisations offer these services – twice as many in the case of counselling – than do other sectors, with the exception of private medical insurance and healthcare cash plans.¹⁹⁷

In terms of the academic evidence on the most effective methods of keeping those with mental health needs in the workplace, several reviews have aggregated the results from research studies. For example, a meta-analysis of 48 studies of stress reduction techniques¹⁹⁸ sought to identify the effectiveness of cognitive behavioural therapy (CBT), relaxation training, multimodal interventions (typically a combination of education, role plays, relaxation training or communication skills) and interventions focused on organisations as a whole. It found that CBT produced the greatest reduction in stress levels, while interventions focused on the organisation had the smallest impact, echoing Seymour and Grove’s finding. The authors also remarked that “an intervention that focuses on individual employees is the first choice in the case of employees with stress-related complaints”.¹⁹⁹

The same study found “moderate evidence that brief therapeutic interventions (e.g. counselling) are effective for employees experiencing job-related distress” and, reflecting the preventative evidence, that “training and organisational interventions can be successful in improving psychological health and reducing sickness absence, if they focus on improving decision-making and problem-solving, increasing support and feedback and improving communication skills”.²⁰⁰

197 CIPD, Annual Survey Report 2007, 42.

198 Jac van der Klink et al., “The benefits of interventions for work-related stress”, *American Journal of Public Health* 91/2 (2001).

199 *Ibid.*, 274.

200 John Campbell et al., *Avoiding Long-term Incapacity for Work: Developing an Early Intervention in Primary Care* (Exeter: Peninsula Medical School, 2007), 31.

On the subject of retention, a number of sources and interviewees have highlighted the importance of effective case management, though the CIPD recognise that “it’s not always possible in small organisations to have a dedicated person with the time and skills to undertake this work”.²⁰¹ Research commissioned for Remploy concurs that “employers have few employees with any skill in mental health and job retention”,²⁰² even though “the support of well motivated and trained colleagues is arguably the most important contribution to job retention”.²⁰³ It claims that the “heterogeneity of clients is central to the arguments for a ‘case management’ approach”, because “small differences between individuals can have a large impact on the success of outcomes”.²⁰⁴ Evidence from programmes such as Workstep, which help to retain people with mental health in work (albeit after a period on benefits), have also highlighted the importance of a named contact or personal advisor available to intervene quickly and offer support if problems develop.

The benefits of work flexibility and the provision of flexible working arrangements are commonly cited as being central to job retention (as well as rehabilitation). More than 50% of employers include flexible working as part of their absence management strategy²⁰⁵ and 79% include it as part of their rehabilitation programme.²⁰⁶ Employers also offer flexible working in many different guises as a matter of course, with the most popular being part-time work (90% of employers), job-sharing (56%), flexitime (52%), career breaks/sabbaticals (44%) and term-time working (34%).²⁰⁷ However, the research evidence on flexible

201 CIPD, *Recovery, Rehabilitation and Retention*, 12.

202 Imber and Włodarczyk, *Mapping Effective Responses to Job Retention*, 9

203 *Ibid.*, 24.

204 *Ibid.*, 17.

205 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 22.

206 *Ibid.*, 24.

207 The Black Review also recommended flexible working as a possible means of “facilitating a return to work as soon as appropriate” (79) within the context of the proposed Fit For Work service (77).

working is limited, with only one study being mentioned in any of the recent academic reviews of mental health needs in the workplace. In this meta-analysis, it was suggested that flexible work schedules can produce “significant improvements in absenteeism, productivity, job satisfaction and satisfaction with work schedule”,²⁰⁸ although the effects diminished over time and mental health patterns were not recorded. Having said this, a review of vocational rehabilitation research unearthed “strong evidence that temporary provision of modified work reduces duration of sickness absence and increases return to work rates [and] it is often low-cost, and can be cost-effective”.²⁰⁹

REHABILITATION

Despite the emphasis on prevention and retention, it is important to recognise that even mild mental health conditions can have a severe adverse effect on sufferers and may well necessitate a period of absence from work. The challenge for employers once sickness absence has been taken is to encourage and facilitate their employee’s return to work as soon as it is possible. Most simply, experts recommend that managers remain in contact with employees over a period of absence. Since most spells of illness resolve themselves within a week, establishing contact is most appropriate after the sixth day of absence.

Studies on the rehabilitation of those with common mental illnesses are generally regarded as more robust, in terms of both quality and quantity, than the more limited and anecdotal evidence in terms of prevention and retention strategies. Though there is no consensus on the optimum content of a multidisciplinary rehabilitation intervention for common mental health problems, CBT has received strong backing as an intervention technique for those

208 B. B. Baltes et al., “Flexible and compressed workweek schedules: a meta-analysis of their effects on work-related criteria”, *Journal of Applied Psychology* 84 (1999), 496–513, cited in Waddell and Burton, *Is Work Good for Your Health and Well-being?*, 10.

209 Waddell, Burton and Kendall, *Vocational Rehabilitation*, 31.

with “imminent or existing common mental health problems”.²¹⁰ Even computer-delivered interventions provided strong evidence in favour of using CBT, and research has found that shorter programmes of CBT (up to 8 weeks) may be more effective than longer ones (the impact was greater for employees in high-control roles).²¹¹

National Institute for Health and Clinical Excellence (NICE) guidelines state that patients with anxiety disorders should be offered CBT alongside medication and that patients suffering from depression who fail to respond to antidepressant medication should then be offered CBT. The Department of Health’s Improving Access to Psychological Therapies programme has demonstrated that quicker access to therapy services can help people recover from mental illness. If 2.7 million people consult their GP with new cases of depression or anxiety each year, it is now estimated that a third of these patients will require CBT,²¹² yet current figures indicate that only 1% of mental health patients receive CBT, 3% some other form of psychotherapy and a further 4% receive counselling.²¹³ This is largely due to a severe lack of qualified therapists. To implement the guidelines fully by 2010–11, it is estimated that aggregate staff numbers will need to be increased by 38% relative to the numbers employed in mental health care in 2006. To fund this transition would require an average real increase in spending on mental health services of 8.8% per year.²¹⁴

However, in terms of employment outcomes, insufficient data collection means that the effect of many interventions on sickness absence remains unclear. For example, a review of the evidence on

210 Seymour and Grove, *Workplace Interventions for People with Common Mental Health Problems*, *ibid.*, 25.

211 P. R. Grime, “Computerised cognitive behavioural therapy at work: a randomized controlled trial in employees with recent stress-related absenteeism”, *Occupational Medicine* 54/5 (2004), cited in Seymour and Grove, *Workplace Interventions for People with Common Mental Health Problems*, 25.

212 Jed Boardman and Michael Parsonage, *Delivering the Government’s Mental Health Policies: Services, Staffing and Costs* (London: SCMH, 2007), 22.

213 Lord R Layard et al., *Implementing the NICE Guidelines for Depression and Anxiety: A Cost-benefit Analysis* (London: Centre for Economic Performance, LSE, 2006), 3.

214 Boardman and Parsonage, *Delivering the Government’s Mental Health Policies*, 6.

vocational rehabilitation found “strong evidence that various medical and psychological treatments for anxiety and depression can improve symptoms, clinical outcomes and quality of life”,²¹⁵ yet these are not employment outcomes in themselves, and the additional finding that “recipients are generally satisfied with counselling” is somewhat undermined by the fact that “there is no high quality evidence that counselling ... [improves] work outcomes” in the absence of any other assistance in the workplace.²¹⁶ In addition, it has been suggested that the “choice of intervention for a particular individual or group may be determined by the outcome sought”²¹⁷ as the different techniques have variable effects on the quality of work life (e.g. job demands), psychological resources (e.g. coping skills), physiology (e.g. adrenalin levels) and verbal complaints (e.g. burnout).

Even so, findings such as the advantage of using CBT and relaxation training versus other interventions have been echoed elsewhere²¹⁸ and a few programmes have isolated employment outcomes as a key objective, albeit with mixed results. Most notably, the Job Retention and Rehabilitation Pilot (JRRP) tested three potential intervention programmes to increase the return-to-work rate for people with severe stress, depression or anxiety who had been on sickness absence for between 6 and 26 weeks. The intervention strategies were classed as either “health” (e.g. cognitive-behavioural approaches), “workplace” (e.g. liaising with employers) or “combined” (containing elements of both health and workplace interventions), with a separate control group.

Somewhat unexpectedly, the evaluation of the programme found that the control group had a higher return-to-work rate (59%)

215 Waddell, Burton and Kendall, *Vocational Rehabilitation*, 21.

216 *Ibid.*, 22.

217 Van der Klink et al., “The benefits of interventions for work-related stress, 274.

218 See for example L. R. Murphy, “Stress management in working settings: a critical review of the health effects”, *American Journal of Health Promotion* 11 (1996); A Marine et al., *Preventing Occupational Stress in Healthcare Workers*, Cochrane Database of Systematic Reviews (Online), no. 4: CD002892; and Lord R. Layard, *The Depression Report: A New Deal for Depression and Anxiety Disorders* (London: LSE, 2006).

than those who received either the health programme (46%), the workplace programme (46%) or a combination of the two (50%).²¹⁹ Several possible explanations have been put forward for this finding, including the possibility that the JRRP may have encouraged dependency on the pilot instead of fostering a sense of self-reliance, or that those individuals with mental health needs may have been discouraged from returning to employment. In addition, it has been suggested that the intervention came too late – only those with common mental illnesses who had already been off work for at least six weeks were included. This may add weight to the suggestion by many of those interviewed for this project that interventions beyond six weeks will be too late to have a significant effect.²²⁰

In terms of programmes designed to rehabilitate those already in receipt of benefits (and who have therefore often been out of work for a considerable period of time), the Pathways to Work pilots have achieved similarly disappointing outcomes. A recent analysis found that “it was not possible to detect a statistically significant effect of Pathways on the employment or self-reported health of those whose main health condition at the time they were first interviewed involved mental illness”.²²¹

The evidence from the JRRP and Pathways to Work suggests that getting people with common mental illnesses back into the workplace after no more than a matter of weeks may pose a considerable challenge and cost to policymakers. These factors all indicate that it may be more appropriate to put the stress on keeping people with common mental illnesses in the workplace instead of engineering their return to work after an extended absence.

219 Rebecca Taylor and Jane Lewis, *Understanding the Impact of JRRP for People with Mental Health Conditions* (London: DWP, 2008), 2.

220 *Ibid.*, 31.

221 Helen Bewley, Richard Dorsett and Getinet Haile, *The impact of Pathways to Work* (London: DWP, 2007), 82.

A number of surveys have asked employers directly about the provision of rehabilitation services. The CBI/AXA survey found that 81% of employers operate some form of rehabilitation policy to help people to get back into work – almost three times the figure in 2001 – and 94% of the largest employers have a rehabilitation policy, compared with just 36% of the smallest.²²² The largest firms are also more likely to have a formal procedure – 68% did, compared with only 3% of the smallest organisations. Flexible working as a rehabilitation policy was offered by 79% of firms, occupational health support by 71%, job reorganisation/redesign by 66%, counselling by 55% and training programmes by 29%.²²³

Findings from the EEF also reflect the kind of policies identified by the CBI/AXA survey and suggest that employers consider the most effective rehabilitation policies to be:

- maintaining contact with employee during absence (used by 83% of employers);
- allowing time off to attend appointments after returning to work (81%);
- altering pre-absence work hours/arrangement for a phased return (80%);
- changing/modifying previous tasks to allow a phased return to work (76%);
- setting up a medical examination or a review of medical records to assess fitness for work (67%); and
- preparation of a return to work plan (48%).²²⁴

222 CBI/AXA, *Absence and Labour Turnover Survey 2008*, 24.

223 Ibid.

224 EEF, *Sickness Absence and Rehabilitation Survey 2008*, 15.

The Federation of Small Businesses (FSB) also found “interviewing or maintaining ongoing contacts with employee during absence” to be the most popular method of supporting employees on their return to work (used by 23% of respondents) with a “return to previous role with modifications to hours, tasks or location” also being relatively common (13%).²²⁵ Revealingly, however, the FSB survey also found that 66% of business ticked “not applicable” in response to this question, which may indicate both the lack of demand for rehabilitation services in many small businesses (which may never have experienced such a situation) and that workplace flexibility is more limited in small businesses, with only 4% suggesting they might utilise a “change of role” to aid rehabilitation.²²⁶

Furthermore, the EEF and FSB surveys asked respondents to put forward what they saw as significant barriers to the effective rehabilitation of employees after a long-term absence. According to the EEF survey, the employee’s health condition was the biggest barrier (cited by 56% of employers), followed by employees being resistant to rehabilitation (34%), GPs (34%), the limited availability of NHS services at short notice (30%), having to wait for sick notes to expire before offering rehabilitation (26%) and concern that the employee may become “protected” under disability legislation if their absence continues beyond 12 months (22%).²²⁷ For small businesses, the FSB survey found that the most commonly identified barrier to rehabilitation was “confusion/lack of clarity about employer’s and employee’s rights” (38.5% of respondents), followed by “lack of timely access to NHS treatment or diagnosis” (26.2%) and “not possible to adapt working terms and conditions or find alternative work for employees” (25.2%).²²⁸ This suggests that even though small firms may be more effective at preventing short-

225 FSB, *Health matters*, 17.

226 *Ibid.*, 17.

227 EEF, *Sickness Absence and Rehabilitation Survey 2008*, 16.

228 FSB, *Health Matters*, 18.

term absences caused by mental health problems, their options and sources of support appear to be limited once a problem has developed (relying as they commonly do on publicly funded services rather than private provision).

8. MEETING THE MENTAL HEALTH CHALLENGE

Summary

A prevailing context of shared responsibility, concern about competitiveness and burdensome regulation, occupational health being outside the provision of the NHS and where the majority of common mental illnesses are not directly work-related all argue against a restructuring of the system to force employers to do more. It points instead to a solution which uses fiscal incentives to tackle the existing market failure and encourages employers to invest in products and services which support the employment retention of those suffering from common mental illnesses.

A solution which develops the market for such products and services is likely to be speedier, more innovative and more efficient in delivering results than the primary care-grounded Fit for Work alternative, about which many concerns are raised. Not least is the danger that the establishment of the alternative would further disincentivise employers from investing in workplace and occupational mental health.

A range of recommendations is set out in this chapter, which seeks to encourage employers to invest in the social good – namely, employee mental health and well-being. The range reflects the complexity of the problem – and in particular the fact that different incentives will be required to encourage different kinds and sizes of organisations to take on further responsibilities for the mental health of their workforce.

SHIFTING RESPONSIBILITIES

In a context of diluted responsibilities and shared costs, ensuring that employees have access to appropriate facilities and treatment for common mental health conditions is challenging. In particular, the structure of the system means that for the first six months of illness there is often insufficient incentive to employers to support

people with common mental health conditions, meaning that employees often do not have access to the support needed that might enable them to remain in the workforce. Since the only legal obligation on employers is to have liability cover in case of injuries or illness caused by work, decisions about whether or not to invest in employee health and mental well-being tend, understandably, to be made on economic grounds. Whether to invest will be determined by business imperatives and companies' understanding of how mental ill health is affecting their bottom line. Even then, employers must consider whether to intervene themselves or wait for NHS provision.

It would of course be possible to legislate for a tougher legal framework and require employers to provide access to health and well-being support, as in the Netherlands, where employers bear the full cost of sickness benefits for two years. Indeed, employer involvement in occupational health and safety has traditionally been incentivised through regulation. Legal minimum standards are now in place to protect people's physical health at work and, to some extent, this legislation being extended to include employees' mental health. The Hatton judgment of 2002 decreed that – as with work-related physical conditions – employers could be held legally responsible for stress caused by work. Options include, for example, requiring employers to undertake mental well-being risk assessments or to offer occupational health services. Likewise, employers could be required to purchase compulsory insurance, or rights of flexible working could be extended to employees with a mental health condition.

Unsurprisingly, discussions with employer organisations about further regulation met with resistance, and across the board the experts we spoke to tended to be fairly sceptical about the potential role of further regulation. Interviewees pointed out that employers already face substantial regulatory burdens in respect of employees' rights, which have grown substantially over the past ten

years. Several pointed out that, while legislation may ensure that employers were “doing the bare minimum”, it would be impossible to use it to promote best practice. Effective and innovative stress management solutions are only possible once an employer is not simply coerced, but genuinely convinced of the need to take action. Nevertheless, where legislation exists on this matter, guidance and enforcement may need to be reassessed.

IMPROVING INFORMATION

Most experts agreed that there existed a chronic lack of information about the frameworks and services already in place for dealing with mental illness which contributed to the market failure in provision. The provision of a clearer set of guidelines on dealing with mental health issues was therefore suggested by many of our interviewees. It was noted that, although there is a significant body of legislation which deals with issues such as workplace stress and the employment of people with mental health problems, these provisions are distributed across various different sources such as the guidelines set out by the Hatton principles on the liability of employers for the mental health of their workforce, the Disability Discrimination Act and HSE Management Standards. This suggests that, rather than new regulation, the legal guidance which currently exists could be better presented to both employers and employees, perhaps as an Approved Code of Practice.

We recommend that the government review the extent and use of employers’ access to information regarding legislation, promotion, prevention, retention and rehabilitation in respect of mental health at work and seek to provide one-stop, one-click access to such information via a trusted and credible source.

RECOGNISING GOOD PRACTICE

Another possibility would be to make better use of indirect incentives: attempting to highlight the importance of the issue to employers and persuading them to take action. In this context, it is important to recognise that many employers are doing much more than required, and that effort should be praised and rewarded as appropriate. Some interviewees, for example, acknowledged that employers were beginning to accept the moral case for tackling mental distress within their organisations, regardless of whether or not this was work-related.

It was suggested that the inclusion of criteria on workplace health and safety as part of the Investors in People awards to exemplify employers who take such responsibilities seriously would act as an incentive by recognising positive practice. Indeed, in light of the growing focus on health and work, Investors in People (IiP) have announced that they will be working with the Department of Health to develop a new set of standards on “Health and Well-being at Work”. These guidelines have been piloted with more than 350 UK organisations; further pilot projects are taking place this autumn after which a decision will be made on whether to include them in the IiP’s standard assessment procedures. While the resource pack for employers participating in these pilots does include guidance on identifying and tackling stress at work, the evidence requirements for the Health and Well-being at Work project do not explicitly mention stress.²²⁹ However, IiP states that the new framework can help, in that it encourages employers to address the impact that their organisation’s business strategy is having on people’s health and well-being, to train line managers to manage workplace health problems more effectively and to continuously measure and evaluate health and well-being strategies. The project also supports training

229 Investors in People, *Health and Well-being at Work Resource Pack*, available at: www.investorsinpeople.co.uk/Documents/Health%20and%20Well-being/Resource%20Pack%20-%20Preventing%20Harm%20and%20Risk.pdf, 6.

and development programmes for employees, helping them to manage their workload and achieve objectives.

We recommend that, before a decision is taken on whether to include them in the liP standard assessment procedures, the Health and Well-being at Work elements are reviewed to ensure that the importance of mental health at work is adequately addressed therein.

SHARING COSTS

More broadly, concerns about competitiveness and burdensome regulation counsel against a tougher regulatory move, particularly given the fact that the majority of common mental illnesses are not directly work-related. Socio-economic factors, such as relationship breakdown, unstable housing and family or childcare problems, may influence an individual's mental well-being as much as workplace culture or stress at work. In such a context, it is not clear why the employer, in the absence of a business case imperative, should take on financial responsibility for the management or treatment of mental health conditions.

An alternative would be to seek to shift the balance of responsibility (and costs) towards the state (DWP in this case), by reducing the statutory sick pay period. Bringing forward the point at which individuals move from the workforce to the benefits system would bring forward the point at which they are able to access a dedicated support programme – namely Pathways to Work. And, certainly, reducing the SSP time frame would, by bringing with it significant costs in terms of benefits payments, focus minds more clearly on earlier intervention. By placing the responsibility (and cost) firmly at the feet of the government, it is posited that the state would be more likely to focus its efforts at an earlier stage rather

than waiting until people have been ill for an extended period of time before helping them re-enter the workforce, as happens under the current system.

A number of difficulties exist with such a reform, however. First, since the data currently available to make an assessment is inadequate, detailed research would need to be undertaken to ascertain the most appropriate point for intervention (or SSP reduction). Likewise, any change would need to work for all conditions, not just mental health ones, making a decision on the overarching optimum point very complicated. Second, we have not uncovered a much demand by employers for such a change – not least because many large employers already have absence management systems in place and offer OSP schemes that are more generous than SSP. Third, in the absence of an effective intervention system at whichever point the SSP cut-off was moved, such a change would result in an earlier definitive break from the labour market for many people, potentially hindering their recovery. It would also mean, initially, a rise in the number of people on Incapacity Benefit or Employment Support Allowance. Finally, it is likely that employees' organisations would resist such a change, seeing it as a reduction in the rights of employees.

On the other hand, there are positive moves by government which suggest enthusiasm for a focus on mental health promotion and early intervention, and suggest that the state may be willing to take on more of the financial burden of responsibility at an earlier stage (and before the 28-week point when the costs currently shift overwhelmingly towards the state). The emphasis on mental health promotion in the Darzi Report is a positive step in this regard, as is the coverage of mental health in the Black Review and the commitment from the Department of Health to begin piloting Fit for Work in 2009. However, a significant realignment of spending within the NHS will need to be achieved if mental health rehabilitation services are to be publicly funded in this way.

In particular, the vast majority of the NHS mental health budget continues to follow the model in place to treat physical conditions, with the bulk of spending going to deal with conditions once they have developed; just 0.1% of the mental health budget is directed towards preventative interventions.²³⁰

The details of the Fit for Work service have understandably yet to emerge, but the Black Review advocates that any pilots for the scheme should test different models of delivery and explore the use of private and voluntary sector providers. If Fit for Work is to be taken forward, the incorporation of private providers seems a logical step to take. Many of the skills and services required to enable a swift return to work are already being developed or closely mirror the kinds of expertise that commercial providers have developed. Organisations such as Remploy, for example, already have a commercial offering which provides these kinds of programme and support.

Having said that, concerns remain over the appropriateness of locating Fit for Work within the remit and budget of the Department of Health, and this was raised in our interviews. While the primary care focus of the Black Review recommendation is understandable, there was some scepticism about the effectiveness of such a model in practice. In particular, concerns were raised about the gatekeeper role of GPs and the setting of such a service (which was expected to continue the over-medicalisation of interventions, rather than concentrate on the social and vocational elements of rehabilitation). Organisations such as Remploy have successfully pioneered vocational rather than medical approaches to helping those suffering from mild mental health problems to return to work. For example, it has been suggested that out of 100 cases, perhaps only 5% would require medical treatment. It may be appropriate in such a context to incentivise GPs to make referrals to any such

230 King's Fund, *Paying the Price*, 1.

service by making use of their Quality and Outcomes Framework, or to pilot Fit for Work outside a primary healthcare setting.

There were also a number of other concerns:

- the role of GPs would become more complicated as they became negotiators between patients, employers and Fit for Work advisers;
- advisers would need recognised standards and accreditation;
- the placing of the responsibility for the service under the aegis of the Department of Health would not engender sufficient linkages to DWP and a work-focused agenda;
- a centrally driven service would be unable to deliver interventions in a timely manner (with predictions of long waiting times hindering effectiveness);
- the political will did not exist for the NHS to take on the financial burdens of a nationwide Fit for Work scheme; and
- the service would be unable to deliver much more than a basic level of care, frustrating the more forward-thinking companies who operated their own schemes.

A final, but serious, concern is the potential for an unintended consequence in which employers are deterred from investing in occupational health, employee support and vocational rehabilitation services themselves. If the state provides these services as part of the primary care set-up, the incentive for businesses that do not currently provide such services, and indeed those that already do, actively to address mental health needs in the workplace would be drastically reduced. State provision could effectively endanger the

still-developing private market for the provision of these services at a time when employer acceptance of a business case is on the up. Indeed, state provision may further undermine the business imperative of employer investment.

MARKET-DRIVEN SOLUTIONS

With these concerns in mind, encouragement of market rather than public provision of absence management, early intervention, occupational health and vocational rehabilitation for mental health conditions may provide a more appropriate and efficient solution. This is particularly the case given that, to a large degree, both occupational health and mental health provision for common illnesses have, to date, operated outside the aegis of the public sector. A reversal of this trend will be unlikely to make best use of the established expertise or be the most cost-effective.

As recently argued by DWP, the most important element is not which of the private, public or voluntary sectors delivers a service per se, but which is able to do it best.²³¹ The context is one of scepticism about the capacity and willingness of the DoH to deliver Fit for Work effectively, given that provision has historically been led by the private rather than the public sector and that good employers (particularly large employers for whom the business case stacks up) are already doing far more voluntarily than is required of them. (Employers have never been expected to provide occupational health services, for example, but many have done so nonetheless, as well as providing occupational sick pay schemes, and having stress risk management systems and employee assistance programmes in place.) Set against this increasing drive among employers towards a private market for occupational health and well-being services, it seems that incentivising the development of the private market with associated benefits such as a higher level of innovation and

231 DWP, *No One Written Off*, 17.

competition might well provide a more cost-effective solution for a government committed to mental well-being at work.

In this context, the government would seem to be well placed to reinforce this developing market for private provision by rewarding (or at least not penalising) larger employers that invest in mental health, and this prospect was repeatedly raised in our discussions with stakeholders. Indeed, opportunities to incentivise and encourage employers to take action remain under-utilised and a number of options present themselves as ways in which the balance of responsibilities and costs could be altered to do just this, making it more cost-effective for employers to help absent workers back to work, and making substantial savings for the exchequer in the longer run from costs associated with benefits payment and treatment.

We recommend that the government focus its efforts (including financially) on incentivising the development of market-driven and employer-led services to tackle mental ill health in the workplace.

INCENTIVISING ACTION

Financial incentives might involve tax breaks, tax credits or direct subsidies for services which benefit mental well-being. Despite some concerns about tax breaks or rebates often being complex, costly to administer and poorly advertised, such changes would seem to offer scope to encourage employers to make greater use of private mental health services.

Many interviewees pointed out that, on the contrary, there currently exist numerous financial deterrents for employers wishing to provide services, the removal of which should make

it more palatable for them to invest. Benefits-in-kind rules, for example, are complex and inconsistent, and when set alongside the market failure associated with the diluted responsibilities for such services, taxation in the markets for services like occupational health and vocational rehabilitation acts as a disincentive to private employer-led provision. Although there are some circumstances where benefits charges do not apply (such as in the treatment of work-related conditions, the provision of health screening and check-ups, welfare counselling, equipment and services for disabled workers, and recreational and sporting facilities²³²) there is inconsistency and ambiguity about others (such as occupational health), and some services (such as treatment of non-work related mental health problems and health improvement and promotion initiatives) are usually regarded as taxable benefits for the employee. Most experts felt that the removal of these perverse disincentives by changes to the taxable benefit rules to products that include treating mental health conditions, such as occupational health, would encourage employers to take provision more seriously and incentivise private access to appropriate therapies and support.

In particular, the tax status of occupational health (OH) and vocational rehabilitation (VR) services is unclear. The confusion stems from the government not publishing guidelines on what OH provision can be said to include, resulting in a paucity of information on which accommodations and services are likely to be exempt from tax. It is unclear, for example, whether standard OH services like stress management or CBT are to be considered as welfare counselling (and thus tax-exempt) or as medical treatment (and thus taxable).

At present, unless illness is work-related, tax and NI tend to be applied to VR as a benefit-in-kind, and employers are consequently hesitant to pay what will be significant costs, causing delays in the interventions which

232 HMRC, "Particular benefits: exemption for welfare counselling", available at: www.hmrc.gov.uk/manuals/eimanual/eim21845.htm; HSE, *Tax Rules and the Purchase of Occupational Health Support* (London: HSE, n.d.).

might help them make an early return to work. However, since it is now recognised that VR services are beneficial (exemplified for example in the national roll-out of Pathways to Work) in order to make these services available to as many UK employees as possible, the key elements of VR and OH, and the therapies that work alongside them, should be made tax and NI exempt. At present, only those whose mental health conditions are work-related have access to treatment and support. Removing the NI and benefit charge responsibility from employers for provision of such services would make it more economically palatable for them to assist their employees and would remove a major disincentive for employees themselves (who currently pay at least 30% of the cost of any privately provided intervention). Furthermore, it would allow these services to be included in mainstream insurance policies.

We recommend that the provision of Occupational Health and Vocational Rehabilitation services, and associated treatments, be wholly removed from benefit-in-kind rules.

Furthermore, the government is currently deliberating whether to end the tax exemption on Employee Assistance Programmes, after some were broadened in recent years to include legal and financial advice services, even though employers and employee assistance groups maintain that this is within the context of a mental health model and does not offer employees specific advice on how to solve their legal and financial problems.²³³

We recommend that Employee Assistance Programmes remain exempt from taxation under benefits-in-kind rules.

233 Nick Golding, "Employees need to trust in EAPs for effective stress busting", *Employee Benefits*, 1 October 2007, available at: www.employeebenefits.co.uk/Item/3414/23/318/3.

