Mental health and employment: much work still to be done

Samuel B. Harvey, Max Henderson, Paul Lelliott and Matthew Hotopf

Summary
Mental illness is now the leading cause of both sickness absence and incapacity benefits in most high-income countries. The rising economic and social costs make health and work an increasing priority for policy makers. We discuss the findings from Dame Carol Black’s recent review of the health of Britain’s working-age population and examine how her recommendations may impact and challenge mental health services.

Health of the working-age population
Across the UK economy, about 175 million working days were lost owing to sickness absence in 2006, equivalent to 7 days for each worker. The proportion of the working-age population on incapacity benefits has increased from just over 2% in the 1970s to around 7% today. As a result, the total annual cost of sickness-related absence and worklessness in Britain has risen to more than £100 billion, greater than the entire NHS budget. Similar figures can be quoted for other high-income countries. The corollary of this is that there is good evidence that in most situations the benefits of work for an individual’s mental and physical health outweigh any risks.

Mental health and work
Mental disorders are now the leading cause of sickness absence in most high-income countries, accounting for around 40% of the total time covered by sick notes. Within Organization for Economic Cooperation and Development (OECD) countries (comprising much of Europe, the USA, Canada, Mexico, Australia, New Zealand, Japan and Korea) mental illness now accounts for 35% of all disability benefits. In recognition of the importance of mental illness, Professor Black commissioned a separate report on work and mental health from the Royal College of Psychiatrists’ Research and Training Unit. This describes two separate groups; those with symptoms of common mental disorders, who account for the majority of the costs related to mental ill-health, and a smaller group with severe mental illness, of whom it is estimated only 10–20% are in paid employment.

Although these two groups have somewhat different needs and experiences, they do share a number of employment-related problems such as stigma, discrimination and a benefits system which provides perverse incentives for them to remain out of the workforce. There is, however, a significant difference in the evidence base for occupational interventions in these two groups, with much more known about how to help those with severe mental illness. There have been a number of randomised controlled trials that have evaluated the effectiveness of supportive treatment, in particular individual placement and support. These show that this is an effective occupational intervention for people with severe mental illness who believe that they are ready for open employment. However, it tends to lead only to entry-level jobs and there remain questions about long-term outcomes. Supportive employment programmes differ from more traditional ‘train and place’ programmes by providing direct job placements, then providing support to both the client and the employer. Although their economic benefits are not yet proven, supported employment schemes have been found to be effective within first-episode services, where the economic returns to the labour market are likely to be greatest. The UK government has acknowledged this evidence base by recommending an individual placement and support approach in its recent Commissioning Guidance on vocational services for people with severe mental health problems. Common mental disorders have a greater public health impact. Arguably, much of the long-term sickness absence caused by such disorders is preventable, but evidence is lacking on schemes to prevent such outcomes and to help those with long-term sickness absence get back to work.
Professor Black makes a number of bold recommendations.1 She concludes that a fundamental shift is needed in the perception of fitness for work; specifically, the commonly held idea that it is not appropriate for people to work unless they are 100% fit and healthy. She acknowledged that this can only be achieved by engaging with and educating the wider public, employers and employees and by better training of healthcare professionals on employment issues. Her report proposed a switch from the current paper-based sick-note system to an electronic ‘fit note’ which focuses on what people can do rather than what they cannot. The introduction of these changes would require a highly responsive service for people referred by their general practitioner in the early stages of sickness absence and much closer joint working between occupational health services and the NHS. The exact model of this proposed new ‘fit for work’ service is yet to be decided, making it difficult to know how this will interact with current primary and secondary health services.

Although much of her focus is on early intervention, Professor Black’s report also highlighted the economic, social and moral arguments for not overlooking those already on long-term sick leave or incapacity benefits, many of whom suffer from mental illness. The UK government has already committed to a national roll-out of the ‘Pathways to Work’ programme which is intended to divert people from the path that leads to long-term sickness absence, and work is now beginning on a new national strategy for mental health and employment.

Key recommendations from the report

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Implications for mental health services

The majority of people not working owing to mental health problems have common mental disorders such as depression and anxiety. Furthermore, many patients with physical symptoms and disorders (particularly back pain and other musculoskeletal symptoms) have undiagnosed mental disorders. The management of these conditions is usually undertaken within primary care services where rates of detection are low and treatment often sub-optimal.15 Because most secondary mental health services focus on severe mental illness, they have limited capacity to advise and support primary care workers to manage their more difficult cases. This increases the risk that people with more complicated forms of common mental disorder end up on long-term sickness absence or incapacity benefits. The Improving Access to Psychological Therapies (IAPT) initiative may reduce some of this service gap in England.16 The UK government has now announced that they will begin placing employment advisors as part of the IAPT programme in a pilot project beginning in early 2009.2

Early evidence suggests that, for those people on the road to long-term sickness absence, schemes such as the ‘Pathways to Work’ programme are less effective in reducing the rates of incapacity benefits owing to mental illness compared with physical ill health.17 The reasons for this failure are not clear, although evaluation of employment schemes in the USA suggests the more successful employment support programmes tend to be those closely integrated with clinical care.18 On 27 October 2008 Britain’s incapacity benefit scheme was replaced by the employment support allowance (ESA). Under ESA, claimants who are suffering from severe mental illness will receive the same benefit as those suffering from severe physical ill health. It is likely that the support group will contain a disproportionately high number of people with mental illness. These concerns are further heightened by recent comments from David Freud, an advisor to the government on welfare reform.


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