Mental health and employment: much work still to be done

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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.

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.

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. In the USA, 10% of all social expenditure is on disability benefits, while in Norway the proportion is just over 20%. However, these figures do not capture the full health and social costs. The adverse economic and health effects of worklessness are felt not only by the individuals who are not working, but also by their children. 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.
In an interview with the Daily Telegraph newspaper he described a system where the market would decide who should receive benefits. He stated:

"The private sector will have to start making assessments about who they can get back into work at what cost. If somebody is really clinically depressed, for example, the company might say, 'I'm not going to get this guy to hold down a job for 3 years because he's not up to it, so I'm not going to expend my efforts on him at the moment.'"[19]

Such comments hint at a system that will further stigmatise those with mental illness and ignores evidence demonstrating that most people with depression respond to treatment with improved occupational functioning.[20]

Despite the rhetoric of social inclusion and recovery, secondary mental health services tend to focus on crisis care and risk management for those with more severe mental illness. This is due to a combination of financial constraints and public and political preoccupation with risk. The emphasis on risk management has been at the expense of other rehabilitation goals, including employment. Work rehabilitation programmes are poorly developed and unevenly distributed, and many specialised rehabilitation professionals, such as occupational therapists, are now working as generic mental healthcare workers.[21] Mental health teams were criticised in a recent Healthcare Commission review for their 'low expectations' of what people with mental illness should be able to achieve in terms of employment.[22]

The Black review and the expected new policy initiatives that will follow should cause us to reconsider how mental health services address the employment needs of patients. Ironically, just as the move away from rehabilitation appears to have been driven by external financial and policy pressures, it is political and economic concerns regarding the relationship between mental health and work that may now provide an opportunity for mental health services to extend their remit. Both service users and mental health workers must be involved in shaping the changes to service delivery that will be required to meet the recommendations in Professor Black's report. We must acknowledge the importance of work for people with mental illness and begin to fill the research gaps, especially with regard to common mental disorders. The Royal College of Psychiatrists has signed a consensus statement on health and work,[23] which pledges a commitment to promote and develop ways of supporting individuals to achieve the socio-economic and health benefits of work. If this pledge is to be met, we must examine how employment and other rehabilitation issues are addressed within mental health services and actively campaign for the resources to improve them.
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