



Psychological Wellbeing and Work

Improving Service Provision and Outcomes

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Key messages

We know that being in work is good for wellbeing and that mental health problems are an increasing issue for the nation and so the Minister for Welfare Reform and the Minister for Care and Support jointly sought to expand the evidence base on common mental health problems.

A number of Government programmes assess and support those with mental health difficulties to work, but it is internationally recognised that the evidence base for successful interventions is limited.

The Contestable Policy Fund gives ministers alternative avenues to explore new thinking and strategies that offer cross-Government benefits. This report was commissioned through this route; these are our key findings:

1. Common mental health problems are different forms of depression or anxiety disorder. They are common among the working-age population and their costs to Government, employers and individuals are considerable.
1. This study investigates how the employment outcomes of people with common mental health problems can be improved and what policies and interventions could help them maintain or gain work.
2. A range of public services are provided for people with mental health problems that could potentially support participation in employment but there are significant challenges with provision for this purpose. The report found that:
 - The assessment of employment and health needs of people with mental health problems is difficult and there are low rates of diagnosis or referral to specialist health and employment support;
 - The services often work in isolation and tackle either the mental health problem or the employment need discretely; addressing both is important as there is no systematic evidence that better health treatment alone will deliver employment outcomes;
 - Service provision is often delayed and both health and employment problems can worsen as a result, whereas early access is important to prevent people from falling out of work or bringing them back into work;
 - Although there is some evidence for what works to help employees retain work when mental health problems arise, evidence of what works for people in the benefit system is limited;
 - The interaction between mental health and employment is complex and unlikely to lend itself to a “one size fits all” solution.
3. A longlist of policy options was generated for the Government to consider. They include workplace interventions, influencing the behaviour of key gatekeepers, improving assessments of employment and wellbeing needs of people with common mental health problems, building up employment advice in current programmes, and more.
4. Four shortlisted options propose models of service delivery that:

- Provide earlier access to specialist services;
- Address both employment and mental health needs; and
- Introduce more integration between current services or propose new or innovative applications of existing evidence-based models.

Option 1: Embed vocational support based on the Individual Placement and Support (IPS) model in primary care settings. The key principles of IPS are specified and the model has been tested in secondary care settings for people with severe mental illness. This intervention would be accessed through services offering psychological therapy or even through GP practices.

Option 2: Use group work in employment services to build self-efficacy and resilience to setbacks that benefit claimants face when job seeking. This intervention would be based on the JOBS II programme that has been tested in several countries but not yet in the UK. It would be accessed through Jobcentre Plus but delivered in neutral settings.

Option 3: Provide access to online mental health and work assessment and support. This intervention would build on models of online mental health assessment and Cognitive Behavioural Therapy (that have been tested). It would include a vocational element, which would have to be developed, and it could be open to the general population.

Option 4: Jobcentre Plus commissions third parties to provide a telephone-based specialist psychological and employment-related support. Telephone based services offered through this intervention would be very similar to the support provided by Employee Assistance Programmes and models designed for the Work Programme. It would be offered accessed through Jobcentre Plus.

5. The report concludes that these policy options are complementary – they serve slightly different objectives and client groups. They imply different models of integration, commissioning and funding. They have different estimated costs per participant but for most the benefits to Government are estimated to exceed the costs, providing a case for investment. The effectiveness of each option should be tested to build an evidence base in this area.

Executive summary

This study has been developed to support policy development and has been funded by the Department of Health, the Department of Work and Pensions and the Cabinet Office Contestable Policy Fund. It aims to examine the existing evidence on mental health interventions and propose new approaches to develop the evidence base for future policy development. In commissioning this, Ministers sought further understanding of how employment outcomes of people with common mental health problems such as anxiety and depression can be improved. This report suggests and develops a range of approaches to improve the alignment of mental health and employment services for people with common mental health problems. The intention is to contribute to building a stronger evidence base and improving service delivery in this area, through the piloting of one or some of these approaches by the Government.

Mental health and behavioural disorders are common. At any point, up to 18 per cent of the working age population has a mental health problem (McManus et al., 2010). More pressing, the prevalence of mental health problems among sickness benefit claimants is increasing with over 40 per cent of sickness claims recording a mental or behavioural disorder as a primary condition.¹ The costs to the Government and employers of sickness benefits and sickness absence respectively are considerable. Moreover, more effective treatment and employment advice may reduce healthcare utilisation and improve the general health and wellbeing of the population.

A range of government services are already involved in mental health and employment. These include employment services and the benefit system (i.e. Jobcentre Plus), the Work Programme and its providers, health services and in particular general practitioners (GPs) and the Improving Access to Psychological Therapies (IAPT) service (in England) and occupational programmes such as the Fit for Work Service pilots (now concluded) and the English Occupational Health Advice Services aimed at employers among others.

There remain significant challenges in current service provision. It has already been recognised that multiple access points and separate services add to the challenge of effective delivery. Our consultations for this study revealed that service provision is often delayed and protracted and the problem can worsen as a result. In line with worldwide trends, the UK's assessment of the employment and health needs of people with common mental health problems by service providers is often poor, with relatively low rates of diagnosis and referral to specialist services (see, eg, Gask et al., 2009). Even with the introduction of the IAPT service, expert interviewees indicated that there remain challenges around access to services for people with

¹ Own calculations based on 5% sample of administrative data and the Work and Pensions Longitudinal Study, available from the DWP tabulation tool: <http://83.244.183.180/5pc/tabtool.html>. IB, SDA and ESA claimants are included.

common mental health problems and significant variances in access times between locations. Finally, the employment outcomes for this group can be disappointing, with relatively few placed into employment compared to other client groups.

As part of this study, we reviewed the evidence of interventions that work for employment and wellbeing in this area. The conclusion of this review is that the evidence base is limited and there is no systematic evidence that better health treatment alone will deliver employment outcomes. We undertook a range of consultations with: researchers whose areas of interest include psychology, mental health and wellbeing, occupational health, health at work, and reemployment; representatives of healthcare services and mental health services in England, Scotland and Wales; and representatives of the DWP and Work Programme providers with responsibilities for employment support. The aim of these consultations was to gauge what stakeholders thought would be effective in improving employment outcomes for people with common mental health problems.

On the basis of the evidence review and consultations, we produced a longlist of policy options for the Government to consider. For each of the policy options we, together with our project partners, scored the policy options on how acceptable they are likely to be to stakeholders, how feasible they are to implement, and how suitable they are in terms of effectiveness and efficiency. We included over 30 policy options covering a range of different areas including workplace interventions, influencing the behaviour of service gatekeepers, improving employment and wellbeing assessments of people with mental health problems in the benefit system, building capacity in IAPT for employment advice and innovative interventions.

We tested a number of these options in workshops and meetings. In arriving at the shortlist of four options, we looked in particular at new evidence-based models of service delivery that combine addressing employment needs and mental health treatment, more integration between existing mental health treatment and employment services, new applications of existing evidence-based models in this area, or indeed a combination of all three. Furthermore, we looked at options that provided earlier access to specialist services than is the case currently. Finally, we selected options which could be capable of being tested, given the need to build an evidence base in this area.

We provide business cases for each option, outlining the proposition and the benefit-cost ratio. Our estimates are conservative and only include monetisable benefits. It is envisaged that there will be wider benefits in terms of improvements in self-efficacy, wellbeing and job readiness that we could not quantify. In all business cases, we see an employment outcome as a person moving from sickness or unemployment benefits into employment for a period of at least six months.

The four policy options combine different approaches: intensive individual case management; group support; online; and telephone-based intervention. They are:

1) Embed vocational support based on the Individual Placement and Support (IPS) model in IAPT or other suitable psychological therapy services.

IPS is a fidelity/specified model and has been tested in secondary care settings for people with severe mental illness. IPS would be offered through IAPT (as currently is the case in some locations) and referrals to the IPS service would be made by IAPT therapists. A greater group of individuals with common mental health problems would be able to access to evidence-based support that addresses both their mental health problem and supports them into employment. This option would also place more employment advisers (EAs) in primary care, and increase the number of EAs overall.

On the basis of available evidence, we estimate a benefit-cost ratio of 1.41. This means that for each £1 spent to achieve an employment outcome, the Government would save about £1.41. This option has a relatively high cost per participant (about £750) and appears particularly effective in terms of achieving an employment outcome compared to the other options proposed.

2) Use group work in employment services to build self-efficacy and resilience to setbacks that benefit claimants face when job seeking.

This intervention would be based on the JOBS II model (also known as the 'Winning New Jobs' programme). The focus of JOBS II is to build resilience and inoculate the participant against setbacks in the job searching process. The approach has a supporting evidence base as to its effectiveness. The intervention could be offered through Jobcentres, whose advisers could assess participant suitability using an employment strengths and needs assessment tool or, if necessary, other agreed criteria. Other referral paths could be considered such as IAPT and the Work Programme. The intervention would target the Jobseeker's Allowance (JSA) group or the Employment and Support Allowance (ESA) group before they enter the Work Programme. The programme will need to be modified for the ESA group.

JOBS II costs around £875 per participant. The annual net benefit to the Government would be about £280 per employment outcome with an estimated benefit-cost ratio of 1.07. This means that for each £1 spent to achieve an employment outcome, the Government would save £1.07. This policy option has the highest estimated cost per participant of all options. It appears reasonably effective in terms of achieving employment outcomes compared to the other policy options proposed (though less effective than the estimated effectiveness of Option 1).

3) Provide access to online mental health and work assessments and support.

This option would build on eHealth models of online mental health assessment and Cognitive Behavioural Therapy (CBT) (which have been tested) with a vocational element, which would need to be developed. The service could potentially be opened up to the general population (including the in-work group). People with common mental health problems often find it difficult to actively seek and obtain support. Providing online assessments and interventions will enable greater access to specialist services which have an inbuilt vocational element. This in turn could lead to better health and employment outcomes for these individuals.

Careful consideration would need to be given to where the platform would be hosted and to its functionality. It could be hosted in the NHS. The platform could combine assessment of common mental health problems with signposting and potentially treatment (such as Computerised CBT). There is very little information on likely costs of the intervention. We estimate the cost between £200 and £400 per participant including set-up and licensing fees, though this per participant ratio is likely to fall as scale is increased. There are challenges with measuring employment impacts.

This intervention is the least costly per participant, and is less effective in achieving employment outcomes compared to the other options.

4) Jobcentre Plus Districts procure third party telephone-based psychological and employment-related support.

Telephone-based services offered through this model would be similar to Employee Assistance Programmes and interventions designed for specialist service provision in the Work Programme. In this case, the intervention would be used for the JSA group or ESA group before they enter the Work Programme. Jobcentres would assess claimants using an assessment tool and refer them to the service.

We estimate a benefit-cost ratio of 1.12. This means that for each £1 spent to achieve an employment outcome, the Government would save £1.12. Compared to other options proposed, this option has a low cost per participant (about £ 250), is not as effective in terms of achieving employment outcomes, but can potentially reach a good number of people with common mental health problems.

Improving the employment outcomes of those with common mental problems is a complex issue. There is no single 'one size fits all' solution. It is likely to need a variety of interventions. The policy options proposed are complementary. Where we have data, the benefits to the Government are estimated to exceed the costs. They have slightly different aims and client groups. They offer different approaches, some more intensive than others. They have different estimated costs per participant and levels of effectiveness. They imply different models of integration, commissioning and funding. The aim should be to test of the effectiveness of each.

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Abbreviations

CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHS	Community Mental Health Service
CQUIN	Commissioning for Quality and Innovation
DEA	Disability Employment Adviser
DH	Department of Health
DWP	Department for Work and Pensions
EA	Employment Adviser
ESA	Employment and Support Allowance
GP	General Practitioner
HoC	House of Commons
HWS	Health and Work Service
IAPT	Improving Access to Psychological Therapies
IPS	Individual Placement and Support
IT	Information Technology
JCP	Jobcentre Plus
JOBS II	Winning New Jobs Programme
JSA	Jobseeker's Allowance
MACA	Mental After Care Association
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Cooperation and Development
OSP	Occupational Sick Pay
QALY	Quality-Adjusted Life-Years
RCT	Randomised Control Trial
SSP	Statutory Sick Pay
SME	Small and Medium-sized Enterprises
UK	United Kingdom
US	United States
VfM	Value for Money
VR	Vocational Rehabilitation
WP	Work Programme
WCA	Work Capability Assessment
WFHRA	Work-Focused Health Related Assessment
WFI	Work Focused Interview
WRAG	Work-Related Activity Group

1. Introduction

1.1. Rationale

Reducing poor mental health in the UK is a significant policy challenge. Mental ill-health is prevalent in the working age population and is associated with high economic and social costs to individuals and society at large. This project, funded by the Cabinet Office's Contestable Policy Fund,² aimed to identify evidenced, new, innovative or reformed approaches that will improve the effectiveness and alignment of health and employment services to achieve better employment outcomes for individuals with common mental health problems.

According to data taken from the Adult Psychiatric Morbidity Survey (2007)³, around one in six working age people in England has a mental health condition at a given point in time (McManus et al., 2009), which corresponds to an estimated six million people. Of these, the majority has either depressive disorders, anxiety disorders, or a mixture of the two conditions, while about 1 in 200 adults is likely to have more severe mental health conditions such as bipolar disorder or schizophrenia (McManus et al., 2009). Mental health problems appear to be more common among people who are on benefits and out of work than those in employment:

- Among individuals in work the prevalence of mental health problems is around 14 per cent (Adult Psychiatric Morbidity Survey, 2007).
- Almost a quarter (23 per cent) of Jobseeker's Allowance claimants have a mental health problem (McManus et al 2012).
- More than 40 per cent of incapacity benefits claimants have mental health problems.⁴

The Centre for Mental Health estimates that the total economic and social cost of mental health problems amounts to £105 billion per year of which the largest component represents individual human costs (Centre for Mental Health, 2010). Individual human costs include losses in quality-adjusted life years (QALY) or loss of income. To improve the wellbeing of people with mental health problems and to help them find sustained employment remains a challenge to health and employment services alike. However, if these challenges are overcome, substantial benefits can be generated.

² The Contestable Policy Fund was announced by the Civil Service Reform Plan. The fund is a tool for ministers to use to seek policy advice from beyond Whitehall. See <https://www.gov.uk/contestable-policy-fund>

³ The survey assesses psychiatric disorder, where possible, to actual diagnostic criteria.

⁴ Own calculations based on 5% sample of administrative data and the Work and Pensions Longitudinal Study, available from the DWP tabulation tool: <http://83.244.183.180/5pc/tabtool.html>. IB, SDA and ESA claimant are included.

The purpose of this work is to develop reformed or innovative approaches with the aim of improving employment outcomes for people with common mental health problems. We take common mental health problems to mean general anxiety and depression disorders. They can include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder and social anxiety disorder.⁵ There are some definitional issues. We are interested in the group with diagnosed and undiagnosed common mental health problems. Clearly, some of these disorders can be severe and people present with complex needs. Comorbidity can also complicate how people are categorised. This makes targeting and distinguishing between groups more difficult. We have to acknowledge this upfront.

This report is primarily targeted at an UK audience and it provides only a brief explanation of local initiatives, the benefits system and other issues. Below, we provide a summary of current [government] provisions that aim to support people with common mental health problems. We start by describing the role of workplace services. We then move on to present primary healthcare services and we conclude with outlining available employment services.

- Support in the workplace

The English Occupational Health Advisory Service is a government-funded pilot of NHS professionals who provide information and advice on managing health issues in the workplace (statutory health surveillance, opinions on fitness for work and rehabilitation, advice on legal compliance with health and safety legislation and the Disability Discrimination Act).

Following the recommendations of the independent review of sickness absence (Black and Frost, 2011), the Government aims to create a new independent assessment and advice service to assist employers and employees and assist individuals on sickness absence to return to work.⁶ The DWP is now determining the scope and remit of the Health and Work Service to be implemented in 2014.

- Primary healthcare services for people with mental health problems

Data from the Adult Psychiatric Morbidity Survey (2007) indicates that most people with mental health problems first seek support from a general practitioner (GP). GPs act as gatekeepers to the benefit system (and to more specialised forms of healthcare⁷) for people with symptoms of mental health problems. Once diagnosed, most patients receive treatment in the form of medication or they are offered counselling or therapy (McManus et al., 2009).

⁵ We adopt these definitions from NICE publications, see eg <http://www.nice.org.uk/nicemedia/live/13476/54520/54520.pdf> [accessed December, 2013].

⁶ The 'Health and Work Service' is designed to make occupational health expertise more widely available to GPs, employers and employees and will be introduced in 2014. GPs will be able to access specialist advice to support their patients after an employee has been off work for four weeks and employers will receive assistance they need to manage their employee's sickness absence.

⁷ Services for people with severe mental health conditions are provided in the secondary care by Community Mental Health Teams.

The Improving Access to Psychological Therapies (IAPT) programme introduced in 2008 aims to significantly increase the availability of psychological treatments for common mental health conditions such as anxiety and depression disorders within NHS-commissioned services. The IAPT National Implementation Plan (2008) specifies general operational service principles but leaves considerable scope for CCG commissioning to be determined locally.

IAPT is open for individuals who are in and out of work and it creates incentives to move them off sick pay or benefits. While the route into IAPT is through referral by GPs, individuals can self-refer, and Jobcentres and employers may encourage people who need help to self-refer.

- Employment services

The DWP offers claimants (including people with mental health problems) support tailored to their individual circumstances.⁸ First, support for claimants on out-of-work benefits is provided by the Jobcentres, where a proportion of claimants will be supported by Jobcentre advisers throughout their benefits. ESA claimants receive less employment support than JSA customers and they receive it later on in the claim process. Claimants are further referred to a range of support interventions including the Work Programme, or specialist disability employment programmes including Work Choice and Access to Work.

- The Work Programme

The Work Programme was introduced in June 2011 (DWP, 2012). It is a service that pays providers of employment advice on the basis of performance, including sustained employment outcomes. Providers from the public, private and voluntary sectors are given freedom to design and deliver services to the benefit claimants, including those with mental health problems. Some providers offer in-house specialist support (prime providers), while others follow fully outsourced delivery models. Claimants are referred to the Work Programme by Jobcentre advisers. Providers have two years to work with a claimant, aiming to help them join the labour market and receive financial rewards for placing claimants into sustained employment.

- Specialist disability employment programmes

Work Choice⁹ is a programme dedicated for people with disabilities, including individuals with severe mental health conditions and more intensive support needs. The intervention is currently delivered by eight contracted providers.

Access to Work¹⁰ provides additional support for individuals whose disability or health condition affects their performance at work. It offers grants to pay for practical support so individuals with a disability or a mental health condition may start or remain in work. The programme includes a specific Mental Health Support Service (MHSS) for people who require support while in employment.

⁸ See <https://www.gov.uk/browse/benefits> [accessed December 2013].

⁹ <https://www.gov.uk/work-choice> [accessed December 2013].

¹⁰ <https://www.gov.uk/access-to-work> [accessed December 2013].

1.2. Approach

The Psychological Wellbeing and Work project aimed to address the following central question:

What is the best approach to improve employment outcomes for people with common mental health problems (both diagnosed and undiagnosed)?

We looked at two aspects of the main research question, namely: 1) What is the best approach to maintain people with mental health problems (diagnosed and undiagnosed) in work? 2) What is the best approach to get people with mental health problems into work? We found this distinction useful as these questions imply slightly different outcomes which require potentially different interventions and policy options.

Overall, the project was implemented in the following steps (see also Figure 1):

- 1) We conducted a targeted evidence review and consulted key stakeholders in order to fill in the gaps in the evidence and identify effective and innovative approaches for consideration. We synthesised the evidence and developed a long list of options.
- 2) We discussed these options with senior policy advisers, project partners and stakeholders at a series of workshops which led to shortlisting selected policy options for a more detailed assessment.
- 3) We collected and analysed further information on the shortlisted policy options and we explored whether a business case could be made for each drawing on data provided by individual IAPT locations.

Figure 1: Process of selecting the policy options



Source: RAND Europe

1.3. Structure of the report

In Chapter 2 we provide information on the prevalence of common mental health problems, current service provision and challenges therein, and evidence on practices that work. Chapter 3 contains the main findings of the stakeholder consultation. We provide a longlist of policy options in Chapter 4. Chapter 5 consists of descriptions of the shortlisted policy options. We make some concluding comments and recommendations in Chapter 6.

2. Evidence Review

2.1. Introduction

In this section we report on our review of empirical literature and official statistics on the prevalence of mental health conditions, relationships between mental health and employment, and treatment and support options for people with mental health problems. Specifically, the review seeks to identify evidence-based interventions that support people with common mental health problems to work.

2.2. Method

We took an iterative approach, based principally on a network search to identify scholarly work of relevance to the topic under review. We applied a variation of the 'systematic snowball process' that builds on a non-keyword-based reviewing process as proposed by Contandriopoulos et al. (2010). This type of search allows for newly found concepts and emerging ideas to be incorporated into the review (Nutley et al., 2002).

We drew heavily on available statistics (Adult Psychiatric Morbidity Survey, 2007) and existing reports (eg McManus et al., 2009 and 2012) to gain an understanding of the problem for the working age population in general and its subgroups depending on their employment status.

We identified documents considered to have made an important contribution to the understanding of the nature of the relationship between work and health and the economic effectiveness of mental health interventions in general. The identification of what we considered 'important' contributions was by consensus among the research team. Although we acknowledge that this approach may have risked omitting relevant sources, a relatively narrow focus of the study reduced this possibility. We also included the existing briefing made available through the DWP and DH.

Additionally, we employed a targeted online search to identify evidence-based interventions in a selection of countries which had relevant policies for improving employment outcomes. These countries included Australia, Sweden and the United States (US).

We also obtained documents suggested as especially relevant by our partners and the stakeholders consulted during this project (see Chapter 2). We should reiterate that this review does not represent a synthesis of the empirical evidence in the field; rather, empirical evidence was considered as a means to illustrate the effectiveness of various interventions.

Within the time and resources available for this study the research team did not undertake extensive assessment of the quality of the evidence base (eg assessing the research design and methodology of previous studies).

2.3. Findings from the evidence review

2.3.1. Mental health and employment

The evidence reviewed indicates that the effect of work on mental wellbeing is twofold. On the one hand, work can be beneficial; unemployment and being out work are seen as key drivers behind mental ill-health (Pevalin and Goldberg, 2003; Paul and Moser, 2009) and returning to work appears to help to improve mental wellbeing (Paul and Moser, 2009; McManus et al., 2012). On the other hand, inappropriate work environments can exacerbate mental health problems (Waddell and Burton, 2006; van Stolk et al., 2012) and paid work for some people with mental health conditions may not be an appropriate solution.

In general, people with mental health conditions show lower employment rates (37 per cent compared to 45 per cent among people with any disability and 71 per cent for the whole economy working age employment rate) (DWP, 2013). Also, a mental health condition negatively affects the likelihood of returning to work (McManus et al., 2012; Paul and Moser, 2009). Simultaneously, people with mental health conditions willing to work can be excluded from the labour market due to stigmatisation (Perkins, Farmer and Litchfield, 2009). This is driven by the fact that mental health problems are perceived as more challenging than other conditions by employers who fear that their illness may lead to future difficulties and financial pressures for the business (Dawson et al., 2010), by GPs (Fylan et al., 2012) and by the general public (Staniland, 2011).

One of the key barriers to employment for people with mental health problems is the stigma and discrimination embodied in the reluctance of employers to take on an individual with a mental health problem (Centre for Mental Health, 2013). Another barrier is the 'benefit-trap' when benefits create stronger incentives to remain in the system rather than return to work (see Lelliott et al., 2008). Other obstacles to employment for people with mental health problems include low expectations of people with mental health problems about their employment prospects. These could be further reinforced by health professionals (Marwaha et al., 2009).

Some studies indicate that the UK has had the highest prevalence of common mental health disorders in general practice (GP) attendees across Europe (Torres-Gonzalez et al., 2008). Only one quarter (24 per cent) of people with mental health problems are estimated to be receiving treatment (McManus et al., 2009). Only about 40 per cent of adults with mental health conditions consulted a healthcare service, mainly their GP, for a mental health disorder (McManus et al., 2009; Royal College of Psychiatrists, 2013). This is in part driven by the fact that some people do not seek help because they are not aware that they could access help or do not recognise symptoms that might require help. For those who do seek help, some of

these problems do not manifest themselves in an actual diagnosis that would then label patients as ‘diseased’ and yet some are incorrectly diagnosed. Studies suggest that, on average, GPs detect only about 50 per cent of cases of anxiety or depression (Gask et al., 2009; Mitchell et al., 2009; Kessler et al., 2002).

2.3.2. Evidence on interventions that improve wellbeing and employment outcomes for people with mental health conditions

The evidence base for types of interventions that are likely to be effective in improving the wellbeing and in supporting people with common mental health conditions back to work is rather limited¹¹ when compared with the evidence available for other causes of sickness absence, such as musculoskeletal conditions. We focused on identifying evidence in relation to interventions that are, simultaneously, aimed at improving health and employment outcomes for people with common mental health problems. Below we present an overview of the evidence and interventions that we identified. These feed into our work on developing policy options (Chapters 4 and 5):

- **Workplace interventions:** The evidence suggests that employers in the UK can do more to manage psychological risks for employees. For instance van Stolk et al. (2012) highlighted a number of approaches, such as stress recognition schemes, that are effective in improving mental health of employees. Other possible approaches, where the evidence base is still emerging, include interventions such as training line managers to recognise health conditions (Black, 2008; Hassan et al., 2009).
- **Psychological therapy:** Psychological therapy improves wellbeing of people with mental health problems but there is limited evidence on improvements in employment outcomes. The available evidence from the targeted analysis conducted, which mainly relates to individual-level interventions, indicates that cognitive behavioural approaches can be effective in reducing mental ill-health, presenteeism and absenteeism (McDaid et al., 2008).

Dibben et al. (2012) conducted an evidence review including recent studies on interventions supporting ill-health employees back to work. The evidence with regards to mental health conditions shows positive effects of cognitive behaviour and workplace interventions, including interventions such as telephone-based cognitive behavioural therapy support or occupational therapy.

- **Online interventions:** Online interventions appear to help to improve the wellbeing of people with mental health conditions (Espie et al., 2012; Krusche et al., 2012; Morledge et al., 2013; Bowden, 2011) but these studies do not measure employment outcomes.

¹¹ A similar conclusion was also reached by Underwood et al (2007).

- **Individual Placement and Support (IPS):** IPS targets individuals with severe and enduring mental health conditions. Secondary care services are delivered by supported employment teams that operate within community mental health centres in close collaboration with clinical staff (see more on IPS in Appendix D). IPS is recognised in the literature as an effective rehabilitation programme for severe mental health problems (Burns et al., 2007; Knapp et al., 2013; Marshall et al., 2013; Kinoshita et al., 2013). It is also a cost-effective intervention (Drake et al., 2009). Whereas IPS is effective for people with severe mental health conditions, there is only anecdotal evidence on its effectiveness for people with common mental health problems from specific locations in the UK.
- **JOBS II:** The JOBS II peer-led group programme shows positive results for wellbeing and employment outcomes. JOBS II is a group programme for 12–20 unemployed individuals and it is run for around four hours a day, four days a week over six weeks (see Vinokur, Price and Schul, 1995 and more in-depth description in Appendix D). The evidence on the intervention shows improvements in emotional functioning, wellbeing and increased rates of reemployment. However, the evidence is mainly for the US and it has not been tested in the UK.
- **Work Programme**

Pay for performance schemes such as the Work Programme can be cost-effective in achieving employment outcomes (van Stolk et al., 2010). However, we know from reviews of the international experience that outcomes for those who are harder to place in employment in pay for performance schemes similar to the Work Programme are often below expectations (van Stolk et al., 2010). This is typically because providers have a greater incentive in pay for performance schemes to offer general support, and onward referrals to more specialist providers are often less frequent.. Data have been published by the DWP (2013c) on the outcomes from the Work Programme. Between June 2011 and June 2013, 1.31 million individuals have been referred to the Work Programme, of which 149,000 claimants were placed in employment and nearly two thirds of them remained in employment and 14,000 claimants have stayed in sustained employment long enough to qualify for the maximum number of sustainment payments possible. We used DWP Work Programme Tabulation Tool to estimate how many of these claimants had mental health problems.¹² We estimate that 2,080 claimants with mental health problems were reported to be supported into employment.¹³ The evidence from similar schemes in Australia and the Netherlands suggests that incentivising a wider range of outcomes and cross-incentivising across payment categories may lead to some improvements in

¹² These estimates underrepresent the true numbers of people with mental health problems supported by the Work Programme as this tool captures only those individuals with a mental health problem as their primary or secondary condition.

¹³ See the DWP tabulation tool: <http://83.244.183.180/5pc/tabtool.html>.

outcomes for 'harder to place' groups (OECD, 2012; Bruttel, 2004; Finn, 2009)

- **Work Choice**

DWP statistics show that between 2010 and June 2013 10,640 customers with severe mental illness or common mental health conditions were referred to the Work Choice programme. Of those 7,680 (72 per cent) started the programme and 2,740 (25 per cent) achieved a job outcome (DWP, 2013d).

- **IAPT**

From the beginning, the programme had a strong emphasis on how to help people with common mental health problems to retain or gain work. In the original design of the IAPT programme it was envisaged that there would be one special employment advisor for every eight IAPT therapists (Layard, 2006). While this ratio has not been achieved, in the last three years, more than one million people have been treated in IAPT services, more than 680,000 people completed a course of treatment and more than 45,000 people were helped off sick pay and benefits (DH, 2012).

- **Integration of health and employment services**

Integrated employment support in IAPT: The pilot aimed to look at whether employment advice in combination with therapy improved job retention outcomes but the findings of the evaluation were inconclusive (Hogarth et al. 2013). Nonetheless, the study found that people who sought employment advice as well as therapy were generally more unwell than others and had specific employment problems that required employment expertise.

Working for Wellness Employment Support Service: The service aimed at getting people with common mental health problems into work or to retaining their current employment. The evaluation showed that of 865 service users who entered the service across the five sites, 260 were supported in retaining employment, 95 of those who were off sick or unemployed were successfully placed into work and 41 took up further education and/or training. The services seem to be effective with an outlined return on investment of every £1 spent that generated £2.02 of benefits, of which £0.61 benefits the individual and £1.41 the state after 12 months. Total benefit increases to £2.79 and £3.89 after 18 and 24 months (Office for Public Management, 2011). However, the evaluation did not have an appropriate control group.

Co-location of employment support service in GPs surgeries: Pittam et al. (2012) studied co-location in three localities where each EA is working alongside a number of urban and rural GP surgeries. The study showed some positive outcomes: for those who were on sick leave at time of referral 10 out of 11 were back to work in a short time (in the long-term all of them returned to work). Sainsbury et al. (2008) evaluated a pilot project to locate employment advisors from JCP in GP surgeries. In this pilot, advisers acted as a broker between patients at the surgery and services offered at the JCP.

Ninety-one per cent of participants found the meetings with the EA helpful. Other examples of integration include strengthening referral routes between Jobcentres, primary care and Work Programme providers: this is happening in areas such as the Borough of Newham, where the reported number of IAPT service users coming off sick pay and benefits appear to be among the highest in London (Newham CCG Mental Health Board, 2013).

- **Awareness and training of EAs and health professionals:** There is some data that suggests that changes in training practice and creating awareness around medical conditions can be effective in terms of shaping referral decisions to support services by medical professionals (Stevenson and Elvy 2007).

2.3.3. Key Points from the Evidence Review

Overall, the key points from the evidence review can be summarised as follows:

- While the prevalence of common mental health problems is widespread, only some people with mental health problems seek help and only a small proportion receives treatment.
- While there is evidence that good work¹⁴ appears to help to improve mental health and wellbeing, the employment rate for people with mental health problems (37 per cent) is significantly lower than the national average (71 per cent).
- Early workplace interventions, including CBT, appear to be successful in retaining employees who develop a mental health problem.
- Whereas online interventions prove effective in improving health and wellbeing, the evidence on employment outcomes of these interventions is more limited.
- The effectiveness of interventions designed for people with severe mental illness, like IPS, was not systematically examined for the group with common mental health problems. Programmes that worked in other countries, like JOBS II, were not tested in England.
- Comparing outcomes of the Work Programme with IAPT, it appears that the latter is somewhat more effective in supporting people with mental health conditions and moving them off benefits, although the potential of IAPT has not been fully utilised yet and the Work Programme has only just finished a complete cycle of assisting the unemployed back into work.
- There is some evidence as to the effectiveness of EAs in IAPT services and of their co-location in GP surgeries. However, studies focusing on EAs suffer from either lack of appropriate control groups or small sample sizes. In terms

¹⁴ By 'good work' we mean work that is stable and safe, allows to take part in decisionmaking, is fair paid, provides opportunities for development, and promotes health and wellbeing.

of the local settings of different services, the evidence suggests that delivering services in a more joined-up manner is likely to be more effective and improve employment outcomes.

3. Stakeholder Consultations

3.1. Introduction

For a wider set of insights we engaged with 21 key informants. The majority of the interviewees were identified jointly with the DWP and DH and our project partners. We aimed to ensure the sample was well-balanced and varied, in that it included a wide range of opinion leaders, government officials and practitioners delivering services to people with mental health problems. A few additional informants were suggested by the interviewees (chain-referral sampling).

In particular, the interviews were conducted with:¹⁵

- policy advisers whose areas of interest include psychology, mental health and wellbeing, occupational health, health at work, and reemployment;
- representatives of healthcare services, including officials from the Department of Health, Public Health England, NHS England and mental health services in England, Scotland and Wales; and
- representatives with responsibilities for employment support, including officials from the Department for Work and Pensions, Jobcentre Plus, selected primes and specialized providers delivering services under the WP.

The aim of these discussions was twofold: 1) to arrive at a better understanding of why government interventions are not as effective or well-aligned as they could be (including how to incentivise service providers to engage more with employment outcomes of people with common mental health problems); 2) to collect suggestions on how service delivery could be improved and how innovative approaches could be accommodated within the existing policy framework.

3.2. Method

The discussions, which were conducted over the telephone or face-to-face, were based on a topic guide to ensure that all relevant aspects were covered and so that the discussions were conducted as semi-structured interviews.

A mix of general questions (related to gaining and maintaining employment for people with mental health problems; problems faced; examples of interventions and evidence on their effectiveness; and ideas for possible solutions to identified problems), and more specific questions (related to health service, benefits and

¹⁵ For confidentiality reasons the names of interviewees are not disclosed and findings are presented in an aggregated way.

payments, in-work and employment services) were included. Please refer to Appendix A for the full topic guide.

Interviews were recorded with the permission of the interviewee and subsequently paraphrased (while these interviews were not fully transcribed, all paraphrases were quite extensive). In conducting the analysis we examined the notes to gain a good understanding of what the data contains. In this process recurring themes and sub-themes (that reflected specific pattern or meaning found in the data) were identified and categorised. These are presented in the section below.

3.3. Findings from key informant interviews

3.3.1. Main challenges in gaining and maintaining employment for people with common mental health problems

Concerns about the mental health and wellbeing of the workforce and pressures on primary care

The interviewees commonly held that mental health problems, such as depression and anxiety disorders are, after musculoskeletal disorders, the second biggest cause for self-reported illness and increased demand on primary care. However, key informants reported that spending more money on healthcare would not solve the problem as there is no evidence that treatment alone improves employment outcomes. In particular informants felt that there was a risk of repeating the same mistakes that have been made when dealing with musculoskeletal disorders in the past (i.e. spending in healthcare, rather than investing in prevention in workplace environment). Some inferred the problem of gaining and maintaining employment for people with common mental health problems had to be approached from a different angle. Given that a mental health problem often started at work or else related to unemployment, many interviewees thought that the healthcare and employment dimensions of the problem should be addressed simultaneously.

Insufficient integration of services

Most informants suggested that the main problem in helping people with common mental health problems was that the existing services were not sufficiently aligned. Generally, the interviewees acknowledged that, while there were many institutions, organisations, and services that provided entry points for support for people with mental health problems, they did not form a comprehensive system. For example Jobcentre Plus offices were not linked with Improving Access to Psychological Therapies (IAPT) or other primary care services; Work Programme (WP) providers did not have a clear picture of local mental health services, and so forth. In fact, the majority of the interviewees agreed that the services were disconnected, often worked in isolation and towards different objectives, and they 'did not speak the same language'. Informants reported for instance that some GPs and organisations

working with people who experienced mental health problems did not necessarily consider that good work might help to improve health outcomes. Some patients may be advised to take time off and focus on getting better, leaving the actual problem, which may be work-related, unsolved and increasing the risk of keeping people out of the labour market for too long. On the other hand, employment services and providers would try to bring these people back to work. Interviewees thought that this could be confusing from the client perspective and add to their psychological distress.

Gatekeepers lack confidence

Many interviewees reported that different groups of stakeholders felt unsure and unsupported in providing services to people with mental health problems. These groups included:

- GPs, who – according to nearly half of the interviewees – did not receive adequate education, training or guidance to identify, diagnose and offer treatment options to patients with common mental health problems. Interviewees also pointed out that GPs only had a ten-minute window to make an assessment and diagnose a patient.
- EAs at Jobcentre Plus offices and WP providers were (according to some interviewees) familiar with the Mental Health Toolkits¹⁶ but needed training to use it and support from their superiors confirming their commitment to the pledge they made to people with mental health problems.¹⁷ A few interviewees also mentioned that the advisers often did not have time to make an assessment in the short meeting or consultation with a claimant. Through our consultations, we also received anecdotal evidence from Manchester that Jobcentre Plus staff with greater awareness about how to identify mental health issues will make better referrals to specialist support services.
- Employers, some interviewees thought that most employers were unprepared to offer workplace interventions to improve the wellbeing of their staff and were left to their own devices in dealing with employees who experience a mental health problem.

The opinion that many of the gatekeepers, such as GPs and EAs, lack confidence in the other's area of competence was widespread among interviewees. It was commonly held that the identification of people with mental health problems and the assessment of their needs (be it employment or mental health related) were most problematic. As a result, many clients who needed support have slipped through the net of services and providers.

¹⁶ The *Working for Wellbeing* toolkit was developed by a group of Prime and specialist providers to be used by the employment advisers in the Work Programme with support from specialists. A similar JCP toolkit has recently been launched.

¹⁷ Most WP providers have signed up to the pledge to support people with mental health problems.

A strong theme from the interviews was that for those who are eventually identified as having mental health problems and employment needs, support often comes late (if at all), as the referral pathways and signposting are not as clear and direct as they could (or should) be. This increased the risk of further deterioration of their mental condition and skills and competencies becoming more obsolete with time.

Too little, too late

As mentioned earlier, interviewees agreed that people with mental health problems who were struggling to maintain their job or who were out of work, received insufficient and/or inadequate support and that, if provided at all, support usually came late. This is particularly evident for the clients of the WP (who usually stayed without work for at least 12 months).¹⁸

Some interviewees emphasised that clients referred to the WP form a very difficult group: they lack motivation to work and confidence that they can gain employment, they have often been without work for a long period of time, and usually have multiple needs that must be addressed before they are 'job ready'. Less widespread but a recurring view was that the incentives for WP providers to provide tailored support for people with mental health problems are insufficient and that the targets for the WP are overly optimistic. The WP distinguishes nine payment groups defined by the category of benefits claimed by the clients, rather than their conditions.¹⁹

Many interviewees mentioned several challenges related to the IAPT programme. These included capacity issues (i.e. long waiting times) in comparison to demand for talking therapies, consistency of services provided, diverse intensity and quality of employment advice offered by various locations, as well as the fact that support is time-limited. Also, there was a commonly held opinion that the referral routes could be further improved.²⁰

3.3.2. Possible solutions to the problems

Need for culture shift in awareness

The majority of the informants believed there was a need for a culture shift through awareness-raising and educational campaigns targeted at various audiences, including the gatekeepers, people with mental health problems, their families, and the general public. Such campaigns might address the stigma related to mental health and make people more sensitive to mental health problems, help people to recognise the symptoms, and draw attention to various treatment options. It was commonly held that these activities are essential for improving identification and assessments of people with mental health problems so they could be picked up

¹⁸ The design of the intervention is that most people are not offered the Work Programme before 12 months.

¹⁹ People with mental health problems do not form a separate category and many of them go unreported, unless their mental health problem was identified as a primary condition.

²⁰ For example, 'tickets to recovery' or 'referral cards' are used in some localities to facilitate referrals between employment and health services.

faster without the risk of medicalising the problem (and potentially stigmatising those people).

Early interventions are important to prevent people from falling out of work

Generally, interviewees felt it was necessary to focus on prevention and promotion programmes in order to keep people at work during the difficult time when they are unwell. According to some interviewees, this would also require additional support and incentives for employers, especially small and medium-sized enterprises. Others mentioned the Health and Work Service as having a potential role to play for employees with mental health problems. The point most commonly made by interviewees was a call for early interventions, that is, interventions before people lose their job and start claiming benefits.

Integration of health and employment services is critical to shorten client journey and offer more complex and adequate support

Another clear message from the interviews was the call for the integration at policy and service delivery levels. Many informants thought that employment should feature more prominently in the outcome framework of IAPT and the NHS mandate. This in turn should help healthcare and employment services work towards the same objectives. The majority of the interviewees agreed that there was a need for creating a more coherent system and 'connecting the dots' among various actors (starting with better linking of primary and secondary care, as well as healthcare and employment services). Some interviewees suggested here that referrals to IAPT should be made easier for GPs and that the option of referral be extended to employers, WP providers, JCP and potentially other actors – either for free or (for some) on a commercial basis. This would, in the view of these interviewees, help to boost the market for IAPT services and, if IAPT services were provided on a commercial basis, they would provide an additional (to the NHS) funding stream helping to address some of the capacity issues faced at the moment.

Modifying existing interventions

In terms of specific ideas for improvements of existing (or future) programmes many interviewees suggested opening up the black box approach of the WP. Some interviewees thought that soft outcomes and distance travelled should also be rewarded. Others suggested a revision of WP pricing and a premium for achieving successful outcomes among 'hard-to-reach' groups (in addition to payments for the final outcome). Less widespread suggestions included introducing minimum standards for providers when supporting people with mental health problems, or more radical solutions, for example removing individuals with mental health problems from the WP and directing them to a separate intervention.

4. Developing Policy Options

4.1. Longlist of policy options

Based on consultation with stakeholders and findings from the review of the evidence, we drew up a longlist of policy options (these are set out in Appendix B). While this list is not intended as exhaustive, it includes all policy options identified in the literature or during consultations that aim to improve employment outcomes of those with common mental health problems. We categorised these policy options into ten broad themes:

- I. Focus on workplace interventions
- II. Build capability and influence the behaviour of key gatekeepers
- III. Strengthen the employment focus of IAPT and GPs
- IV. Improve assessments in the benefit system
- V. Introduce greater integration between services
- VI. Encourage higher ratios of EAs to therapists in IAPT
- VII. Promote the role of the Work Programme
- VIII. Set minimum standards in service provision
- IX. Test new interventions
- X. Incentivise longer-term outcomes.

These categories map onto the possible client journey from being in work to falling out of work and returning to work as depicted in Figure 2. It is clear that these interventions have different aims and target audiences. Some focus more on the in-work group while others focus more on benefit claimants, placing individuals into work or providing health treatments or support. In all cases, we have tried to look at interventions that incorporate both treatment for a mental health problem and an employment focus. It is important to point out that some of the options are not mutually exclusive – adopting some of them in a package of interventions could increase effectiveness and also coverage. Some of the policy options were refined in discussions with our project partners for this study.

Below we provide a high level description of the ten sets of policy options that we looked at. Appendix B provides the long list of policy options with information on how we assessed each.

Figure 2: Potential client journey from ‘at work’ to ‘gaining’ and ‘maintaining’ work



Source: RAND Europe

4.1.1. Focus on workplace interventions

The first set of interventions focus on the in-work group. These interventions mostly aim to prevent the development of mental health problems or else to more effectively manage a mental health condition when it first arises. Previous research by RAND Europe suggests that employers in the UK can do more to manage psychosocial risks for employees (van Stolk et al., 2012). As touched upon in the evidence review approaches could involve raising employers’ and employees’ awareness of IAPT or incentivising employers (eg through tax incentives) to refer employees on to specialist providers for mental health support (Knapp et al., 2011).

The Health and Work Service to be introduced in 2014 may also have a role to play. In addition to its central role of assessing employees, the service will promote employer awareness of potential support services, good practice in managing employees mental health, signpost where adequate service provision is available, and function as a local broker between employers and services. For anyone who needs general health and work advice, the Service will provide information and support via the telephone and internet. The benefit of this approach is that it is an early intervention and should assist in maintaining individuals in employment.

4.1.2. Build capability and influence the behaviour of key gatekeepers (health professionals, staff in the benefit system and WP providers)

This set of options primarily aims to address challenges around diagnosis and referral by GPs. It focuses predominantly on strengthening the training and development of gatekeepers and issuing better guidance. Some of our stakeholders have mentioned that currently in some GP practices up to 60 per cent of patients present with a mental health problem. However, we have heard extensively from the stakeholders interviewed that GPs have no training requirement in mental health, might not engage with mental health in continuous professional development, nor have their mental health proficiency tested in appraisals and revalidation. Policy interventions would focus on strengthening training, development and guidance for GPs.

Similarly, we found in our interviews that Jobcentre Plus and WP advisers lack the skills and time needed to identify claimants with mental health problems and assess

their employment-related needs. The quality of service provided by EAs was also raised by the House of Commons (HoC) Work and Pension Committee (2013).²¹ Lack of awareness of how mental health needs affect employment also influences how they refer onwards to both internal and external specialist support. Some Jobcentres are more proactive in training staff and some WP prime providers have built mental health and employment assessment and support more explicitly into their service provision model. We identified some policy interventions that aim to share good practice in this area, by building on the mental health toolkit designed by the DWP for use in Jobcentres, engaging specialist providers in training of Jobcentre staff and disseminating good practice more systematically (between Jobcentres and between WP primes). It is possible that such training could be funded from budgets in Jobcentres for multi-professional education and training that, according to one of our interviewees, are currently underspent.

Interviewees mentioned a number of challenges related to this set of options. Firstly, creating awareness may not necessarily lead to behaviour change. There is some evidence on the effectiveness of training but it is not systematic. In addition, there can be substantial costs involved in training or retraining advisers and healthcare professionals. Some professional associations may not support such initiatives. The competitive nature of the WP contracts might pose another barrier to sharing good practice among the providers. It would be important to carefully consider the appropriate incentives in this area.

4.1.3. Strengthen the employment focus of IAPT and GPs within the current policy/service environment (NHS Mandate, GP contract, NHS outcomes framework, CCGs) and influence health and wellbeing boards

Our consultations suggested that typically health services have not engaged directly with employment outcomes. Many stakeholders felt that strengthening employment targets in the health domain would help services speak with one voice. It might be possible for the Government to signpost the importance of employment as an outcome even more in mandates, outcomes frameworks, and interactions with Clinical Commissioning Groups (CCGs). More concretely, IAPT could collect more information on employment outcomes.²² It would be worth considering outcomes at different points in the employment process (eg entering and staying in employment, and potentially an indicator of work readiness for those who are still out of work).

²¹ The HoC report pointed to caseloads per adviser in the WP (around 120–180 jobseekers) and considered it far too high for an effective service. The report further recommended that all frontline advisers should be professionally accredited and qualified through the Institute of Employability Professionals and other specialist organisations (p.7).

²² At the moment IAPT collates information on 'the number of people moving off sick pay or benefits during the reporting period' (KPI 7).

In terms of health and wellbeing boards,²³ there is an opportunity to influence the strategies of such bodies and build in a greater focus on mental health and employment.

Finally, several interviewees mentioned influencing how commissioners use NHS Commissioning for Quality and Innovation (CQUIN)²⁴ envelopes. Some of the targets attached to this funding could relate to improved mental health improvements or employment outcomes.

There is insufficient evidence on how effective these options would be in creating behaviour change.

4.1.4. Improve assessments in the benefit system

We know from our consultations that there are missed opportunities in the benefit system to identify those with mental health problems and assess their employment needs earlier. Providing further guidance on the assessment of mental health and wellbeing needs for employment in Jobcentres could be considered. The current DWP mental health toolkit for Jobcentres could be a central element in the training of Jobcentre staff.

The Work Capability Assessment (WCA) – a functional assessment of an individual’s capability for work – by its nature is geared mostly to allocating individuals to different benefit streams. The recent Harrington (2012) and Litchfield (2013) reviews have sought to improve the sensitivity of assessments of mental health conditions. The nature of the functional assessment means that it does not undertake a full assessment of the needs and potential support required. As a result, relevant information on the claimant is often not present in the system or passed between providers. We consider that there may be future opportunities to improve the WCA and also re-examine the viability of the Work-Focused Health Related Assessment (WFHRA), which was a supplement to the WCA and focused on what the individual was capable of doing and how to manage his/her condition at work.

It may also be beneficial to encourage online self-assessment of mental health and employment needs. As far as we are aware, this option is currently not offered in the benefit system. Claimants could be encouraged to engage in online assessments and subsequently provided with online, telephone or face-to-face support. The use of online platforms is increasing in health services provision (e.g. in the NHS) and it has the ability to provide interventions to people who may not be willing (or unable) to engage face-to-face. Given this, it may be that such approaches also hold promise in assessing people and promoting access to services available, although the evidence on online assessment tools points to some of their limitations (Buchanan, 2002). Such a platform could be used by those in contact with both the health and benefit

²³ Health and wellbeing boards were introduced as part of the Health and Social Care Act 2012. According to the act, they are statutory bodies at local authority level that aim to improve joined-up working between local health, social care, public health and other public service practitioners.

²⁴ The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

systems and also be made more widely available (e.g. to employers and perhaps to the general public).

4.1.5. Enhance/improve greater integration between IAPT, Jobcentre Plus and the Work Programme

These policy interventions focus on the joint working of services. By greater integration we mean strengthening the referral routes between various providers including Jobcentre Plus, IAPT and perhaps WP providers. Expectations could be set by commissioners of services on referring benefit claimants from Jobcentre Plus to IAPT. One interviewee talked about referring all JSA claimants to IAPT, which would then raise questions about the appropriateness of treatment and referral.

Similarly, WP providers could be encouraged (through influencing or setting expectations) to engage with IAPT services and to refer claimants to IAPT. There are some challenges. Some claimants (mainly from the Employment and Support Allowance group) may be on treatment plans already and it may be inappropriate to refer to IAPT. Furthermore, according to one of our interviewees, one of the key challenges in IAPT has been managing the demand for services and ensuring good completion rates. As such, increased referral to IAPT requires coordination with local CCGs. To replicate this at a national level would require negotiations as part of the refresh of the mandate to NHS England in the context of wider prioritisation of future NHS resources.

Our consultations revealed some interest in a paid-for IAPT service (as a way of expediting access) that could be accessed by employers and/or WP providers who would pay for IAPT services. The underlying logic in requiring employers and WP providers to pay is that a market for IAPT services would develop and as such capacity issues could be more readily resolved.

Other integration options include providing ring-fenced budgets to be spent on dedicated support in Jobcentre Plus offices to refer those with mental health problems to specialist providers. At a minimum, this requires Jobcentre advisers being aware of, and able to identify, employment and wellbeing needs of claimants with mental health problems. There may also be issues around creating incentives for staff to make appropriate referrals.

Furthermore, some of the consulted stakeholders mentioned examples of EAs placed in GP practices.

Finally, we know from our interviews that certain localities have created communities of providers working together to improve employment outcomes for people with mental health conditions (for example in Sunderland). The Government could play a coordinating role to map the geography of local services and encourage them to meet and set local strategies. The challenge is how the Government can coordinate local providers effectively and influence them, although local authorities may already have some knowledge of local networks and could have a role in this coordination. Joint commissioning frameworks may provide an answer to support more coordination of different public sector providers.

4.1.6. Encourage higher ratios of employment advisers to therapists in IAPT

Another type of integration is the offering of employment advice and treatment of mental health problems as part of the same intervention. In the original design of the IAPT programme, it was envisioned that there would be one employment adviser for every eight therapists. This aspiration has not been realised in the implementation of IAPT, and our interviewees mentioned that some IAPT services have no EAs at all. Increasing the number of EAs will in turn increase the number of individuals with mental health problems who engage with their employment-related issues. One challenge to this is that Clinical Commissioning Groups (CCGs) are responsible for contracting IAPT services and there are limits on the influence the central Government can exert in their priority setting.

4.1.7. Promote the role of the Work Programme in securing specialist help for people with mental health conditions

In the WP, the Government could consider incentivising a wider set of outcomes. We know from our evidence review in Chapter 2 that cross-incentivising outcomes may be effective. In the WP, this requires devising a measurement that captures distance travelled or progress towards employment (rather than incentivising just an employment outcome). We understand that the future of the WP (post 2016) is now being discussed and while the models of prime providers and payment by result are likely to stay, the remaining elements are under consideration. This provides a good opportunity to consider the following options.

If the aim is to incentivise primes to provide more tailored services to those with mental health problems, an option is to create a mental health payment group. This requires better identification of those who should be assigned to such a group. Also, this group could be large as many benefit claimants report a mental health issue as a primary or secondary condition. A final risk is that designation to a mental health group may medicalise (and potentially stigmatise) those with common mental health problems.

Another option is to introduce a mental health-related premium to recognise poorer outcomes for people with mental health problems and cross-incentivise across payment categories (as mentioned above). This can be done on the basis of assessments of self-efficacy or distance travelled. An example from Australia shows that when the jobseeker caseload is more skewed towards the most disadvantaged, a dedicated assessment instrument can help EAs allocate claimants to a relevant 'stream' based on their distance from the labour market. Claimants who report serious health or other personal barriers are referred to an additional assessment, which may lead to referral to a dedicated 'stream' offering specialised support and higher premium for providers (OECD 2012).

A final option is to trial the removal of specific 'hard to place' groups from the WP and place them in an intervention where they are more likely to receive appropriate and specialist support. This could be funded by on a payment by results basis, including possibly a social impact bond, or it could be part of existing government programmes (eg an enlarged Work Choice programme). As before, it may be difficult to identify the target group.

4.1.8. Set minimum standards in service provision

There are some areas where the Government could consider policy interventions to try to influence service delivery. There has been discussion among those administering IAPT services about specifying waiting time standards in IAPT. Interviewees indicated that the NHS England Mandate for 2014–2015 aims to develop a range of costed options for funding and implementing new access and/or waiting time standards for mental health and IAPT services by the end of March 2015. According to one interviewee, the challenge with this is the capacity of IAPT, in particular in recruiting sufficient therapists or EAs to the programme, as introducing waiting time standards must not jeopardise the quality of service. To mitigate this risk, further fidelity measures could be introduced to monitor programme quality and adherence to the expected standards. Similar scales have been developed for specific supported employment programme models, assessing fidelity on dimensions such as staff caseloads, integration with mental health services, contact with clients and so forth (eg Becker et al., 2001; Bond et al., 2012).

In the WP on the other hand, the Government could consider influencing the 'black box' and set minimum service standards for providers on how to support clients with mental health conditions (WP providers are already required to meet some minimum service standards). Such standards may include referral routes and sourcing of basic evidence-based treatment that follows NICE guidelines. We could not find evidence on the effectiveness of setting minimum standards in 'black box' type interventions.

4.1.9. Test new interventions

We discussed a range of options in the evidence review in Chapter 2 that could be tested as part of a pilot:

- Give all benefit claimants (or the general public) access to online or telephone CBT or develop relevant mobile applications: This could be a cost-effective way to make assistance available to a large group of claimants.
- Offer group therapy to selected benefit claimants in selected localities: as mentioned in Chapter 2 there is an evidence-base around JOBS II showing effectiveness over time (Price, 2012). Group therapy could be used alongside other approaches.
- Widen the provision of IPS to those with common mental health issues: there is a growing evidence-base on the effectiveness of IPS and a pilot could test how effective it is for those with common mental health problems in the benefit

system. Stakeholders pointed out some initiatives already being tried in Scotland and Wales (eg IPS programme Cardiff and Vale UHB) but there is no evidence available as to their effectiveness at the time of writing.

4.1.10. Incentivise longer-term outcomes

An option would be to incentivise the employer (eg through tax breaks) to offer longer-term support in terms of accredited programmes to an individual after their return to work. Some employers support staff through Employee Assistance Programmes (EAP) or occupational health schemes to combat the impacts of presenteeism and absenteeism. This is not always consistent or does not always utilise robust mental health protocols or providers. In practice, employers could be incentivised via tax breaks to facilitate the funding of specialist interventions outside of welfare programmes to prevent returns to benefits. This is already part of government policy. To help employers, the Budget 2013 announced a tax exemption of up to £500 per person per year for employers who fund health interventions recommended by employer arranged occupational health services and the Health and Work Service. In addition, IAPT providers could commercially sell their offer or services outside to enable employers to spot purchase support for employees at the right time, that is, before their needs become greater and Step 3 IAPT²⁵ interventions are required. This would offer brief and timely interventions to help those at work maintaining their employment and wellbeing benefits.

4.2. From a longlist to a shortlist of policy options

We developed the selection criteria to arrive at a shortlist in meetings with stakeholders and policy makers in the DH and DWP. Two aspects of the review seemed especially important in selecting policy options. Firstly, the evidence is limited in general when looking at effective interventions to improve the employment outcomes of those on out of work benefits with common mental health problems. As such, there is a need to build an evidence base. This finding confirms the need to pilot interventions as was envisioned at the outset of this project. Secondly, we were also informed by the two consistent themes from the evidence review and consultations, that efforts towards supporting and gaining employment for people with mental health problems in employment are more likely to be effective if they:

- provide early access to evidence-based treatment and/or employment support for a greater number of individuals with common mental health problems

²⁵ Step 3 IAPT services offer Cognitive Behavioural Therapy (CBT) for more severe mental health problems through IAPT High Intensity therapists. Steps 1 and 2 will typically use low intensity therapy workers trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression.

- encourage the co-location or integration of employment advice and mental health treatment services in order to provide employment advice as early as possible.

Our meetings also highlighted the need to focus on proposing options that entail structural change in the delivery of local services. We took structural change to mean: the introduction of new evidence-based models of service delivery that could combine employment advice and mental health treatment and could be used in the UK context; more integration between existing mental health treatment and employment services; new applications of existing evidence-based models that focus on employment advice and mental health treatment; or a combination of all three.

The RAND Europe project team then developed six policy options from our longlist. In selecting options, we only looked at those that apply approaches which have an established evidence base in a different context, or propose the use of approaches with an emerging evidence base. Furthermore, the project team looked at interventions that made specialist services available earlier than is currently the case in most locations. Finally, in making this selection, the project team also looked at interventions that:

- implied ‘structural change’ in service delivery;
- could potentially be piloted; and
- were judged to be acceptable, feasible and suitable according to our assessment criteria.

These policy options were tested at a workshop. At this workshop, we asked participants (mostly those involved in service delivery) to judge the acceptability, feasibility and suitability of these interventions to validate or challenge the assessments made by the research team (see Appendix B). We also asked participants to consider the additionality of each option: whether the option provided services in addition to current provision. We then facilitated a general discussion on each option. On the basis of the workshop we reduced the policy options to four. The input we received from the participants in the workshop and from wider stakeholders who often had many years of experience of implementing employment, disability or mental health policy, helped us to further outline and refine the policy options. The four remaining options were (we discuss these in more detail in Chapter 5):

1. Embed vocational support based on the Individual Placement and Support (IPS) model in IAPT or psychological therapy services.
2. Use group work in employment services to build self-efficacy and resilience to setbacks that benefit claimants face when job seeking.
3. Provide access to online mental health and work assessments and support.
4. Jobcentre Plus commissions third parties to provide a telephone-based specialist psychological and employment-related support.

In the workshop, we identified two themes around the development of an assessment tool that measures claimant self efficacy and wellbeing, and joint

commissioning models. We did not see these as separate policy options but they could underpin or enable the four proposed policy options as they are further developed.

- An employment-focused assessment tool looking at claimant self-efficacy and wellbeing that could create a gateway to specialist help, particularly in Jobcentres. This would be a pre-requisite for understanding when specific interventions (over and above usual service provision) would be appropriate. The tool might be used in employment services or by health services, e.g. therapists. This assessment tool may need to be developed separately for some policy options or an assessment tool may be part of the policy option proposed.
- Joint Clinical Commissioning Group/local authority/local DWP commissioning of employment support. This could be integral to a programme of piloting to make the mutual benefits of joint working transparent and increase incentives for integration of health and employment services. The aim would be to provide a commissioning and/or outcomes framework to promote support for people in employment as well as out of work groups.

The four proposed policy options are not mutually exclusive. Indeed, they are complementary. They have slightly different aims and potentially target different population groups. Furthermore, our shortlist does not mean other policy options in the longlist are not worth pursuing. We would like to see a wider set of actions to tackle the issue of mental health and employment that incorporate a wide range of stakeholders. However, the challenge of the project was to make sense of a limited evidence base. Therefore, the aim of the project was to propose a number of policy interventions that appear promising in improving the employment outcomes of those with mental health problems and that could be piloted. This in turn would help to build the evidence base in this area.

5. Proposed policy options

5.1. Introduction

In this chapter, we provide more detail on the shortlisted policy options. For each of these policy options, we have provided a general business case, including:

- an overview of the intervention: details on the approach, location and client group;
- the journey the customer takes: referral, core service provision, supplementary service provision, and exit from the service; and
- business case: the benefit-cost ratio of introducing the intervention.

In terms of the business case, it is important to note that we looked at specific costs and benefits only. We included the direct (e.g. salary) and indirect (e.g. overheads and training) costs of running the service. For some policy options, we used a RAND Europe model on the cost of employment to public sector to calculate these costs. In terms of benefits, we look at the benefits of a person achieving an employment outcome. These benefits include tax revenue increases and benefit savings for the Exchequer, the direct cost savings to employers in terms of statutory sickness pay (SSP) savings, and reduced primary care healthcare utilisation. We used the DWP TAXBEN model to calculate benefit and tax savings of achieving an employment outcome. For savings in healthcare utilisation, we used data provided in Lord Layard's business case for the Improving Access to Psychological Therapies (IAPT) service.²⁶

We see an employment outcome as a person moving from sickness or unemployment benefits into employment for a period of six months. We also assume that for each employment outcome in a given year the savings to the Government will accrue for a period of six months taking into account the time required to provide treatment or advice and for the client to transition into employment. There is also the potential of a person leaving employment again relatively quickly after starting employment. We only include costs and benefits of an option for a given year of running the intervention and have not made allowances in our business case for a start-up phase wherein costs are likely to be higher compared to benefits than estimated.

We cannot always be sure of the counterfactual and the additional value of the service compared to what would have happened in the absence of the intervention.

²⁶ For TAXBEN model see

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214613/dwp-worklessness-codesign-ir.pdf [accessed December, 2013], pp. 29–30. Lord Layard's business case is available at <http://www.iapt.nhs.uk/silo/files/building-a-business-case-for-employment-advice-and-support-in-iapt.pdf> (accessed December, 2013).

However, in three of the options we look at net employment effects on the basis of best available evidence on the intervention, thus taking into account that some people will find employment regardless of the intervention.

We have not monetised additional positive outcomes such as improvements in health and wellbeing and greater job readiness. In this way, we believe that the actual benefit estimates of running the interventions may be conservative. The interventions are likely to have a wider range of positive benefits to individuals and the society than we represent here. We have used the best assumptions available from earlier reports, specific locations and the literature to arrive at these estimates. When we had to rely on anecdotal information and small data sets, the assumptions and data can be improved. However, it would be part of the pilot(s) to test whether these assumptions hold and make a business case for wider roll-out of any or more of the four policy options. In all cases, we propose a robust evaluation (randomised controlled trial [RCT] or similar approach with control and treatment groups) to test the cost-effectiveness of the proposed option.

Please note that more detailed information on the underlying logic of these pilots, possible funding and implementation models, risks and challenges related to their implementation are presented in Appendix E.

5.2. Description of policy options

5.2.1. Policy option 1: Embed vocational support based on the principles of IPS in local IAPT or psychological therapy services

Proposition

To pilot an approach which places dedicated vocational specialists in local IAPT services in England (or their equivalent for Scotland and Wales). The aim is to improve employment support in primary care for people with common mental health problems. As the key principles of the Individual Placement and Support (IPS) model are specified, this approach could help to understand the key ingredients of effective employment support for people with common mental health problems. We have situated IPS support in IAPT services in this option as there are examples of IPS services being offered in IAPT. However, other primary care locations such as GP practices could be considered.

IPS is widely recognised as a good rehabilitation programme for those with severe mental health problems, and a considerable development on earlier interventions. There is a developing evidence base around the effectiveness of IPS in Europe (see Burns et al., 2007; Bond et al., 2008; Howard et al., 2010). Appendix D provides additional information on the evidence. Many of the principles of the model could

also work for people with common mental health problems who are out of work and need vocational support, or for those who are in work who but struggling.

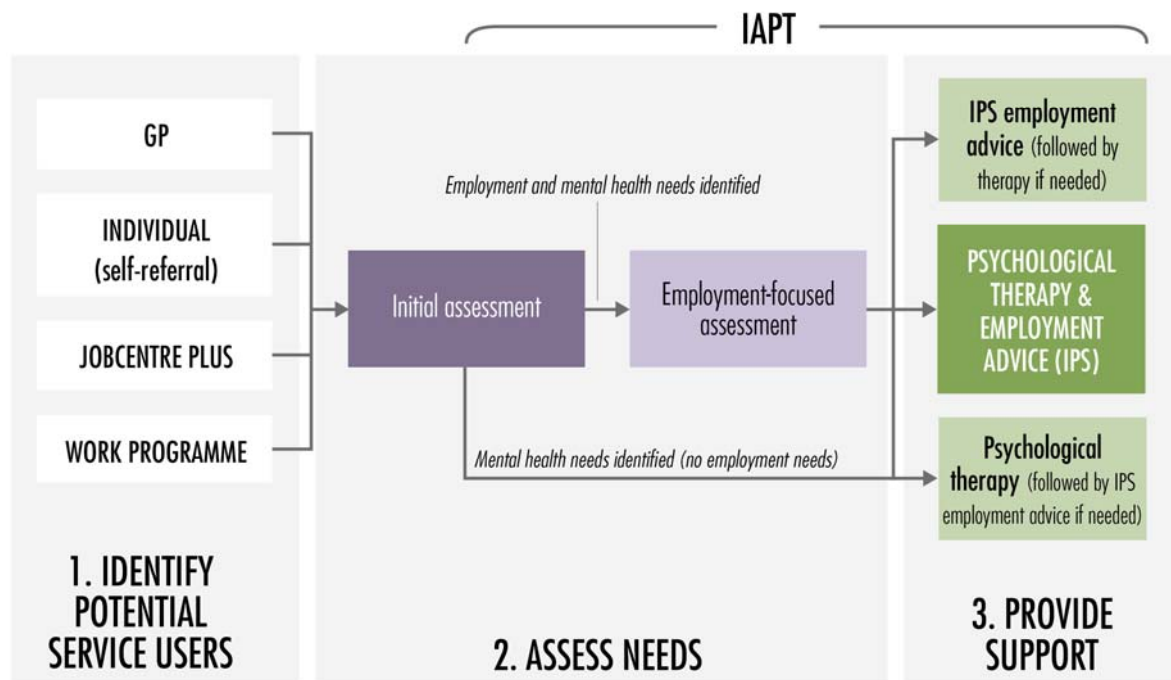
IPS is normally used in secondary care settings generally for people who have severe mental illness. Delivering IPS through IAPT in England or equivalent primary care services in Scotland and Wales would help the large group of people with common problems who do not generally need secondary care services. The target audience is any individual presenting to a talking therapy primary mental healthcare service with a common mental health problem and employment-related needs. They will likely have greater functionality compared to the patients in a secondary care IPS service.

The service would require some awareness-raising of the service among local GPs and Jobcentre Plus staff as they might refer a considerable number of users to psychological therapy services. The gateway to vocational support would be via an initial screening questionnaire, undertaken for all users referred to IAPT services. If employment issues were identified, individuals would then have a more detailed assessment with an employment support specialist. Individuals may also receive additional support (eg normal IAPT treatments or complementary services) as deemed necessary by the IAPT therapist and vocational specialist who would consult each other. The presupposition in IPS is that mental health treatment takes place. Services could be provided at the location of IAPT services (or equivalent for Scotland and Wales), in GP practices, and possibly even Jobcentres.

Customer journey

The service would be located primarily at IAPT premises. Individuals would be able to enter through four different pathways (Figure 3). This requires good awareness of the service among those who refer, and clarity around referral pathways at local level. Once individuals enter the service, they are initially assessed for mental health problems by a therapist. If the therapist determines that an individual only has mental health problems and no employment needs, this individual will receive the usual psychological therapy. If during treatment this individual is assessed as having employment needs, they can be offered IPS-style employment advice.

Figure 3: IPS in IAPT customer journey



Source: RAND Europe/DWP

Business case

This is an investment model whereby the Government would need to invest in vocational specialists to save money (in terms of benefits).

In developing the business case, we look at tax revenue increases and benefit savings for the treasury as a result of additional people in work, the direct cost savings to employers in terms of statutory sickness pay (SSP) benefits, and benefits in terms of reduced primary care healthcare utilisation that initially would occur within one year. We have not monetised additional positive outcomes such as improvements in health and wellbeing and greater job readiness. We use 2011 data for benefits and have not adjusted those for inflation. In a conservative approach, we have used lower-end estimates for benefits and higher-end estimates for costs.

Below is the outline of a simple cost-benefit calculation. It demonstrates the net employment effect of vocational specialists embedded in IAPT services and the corresponding costs and potential savings of this intervention (policy option).

- **Net Employment Effect of Intervention**
 - **Total estimated employment outcomes per vocational specialist: 35 p.a.**²⁷

²⁷ Based on management information on caseloads, type of cases (benefit claimant, employed, etc) and outcomes per case provided for this study by the providers in a small number of local areas (Wolverhampton and Wandsworth IAPT Services), we assume 120 referrals a year of which 100 start treatment, which results in 70 estimated completed contacts per vocational specialist for a year, and

- **Employment outcomes, JSA claimants: 24.5 p.a.;** it is assumed that 70 per cent of those achieving an employment outcome are on JSA.
- **Employment outcomes, SSP recipients: 10.5 p.a.;** it is assumed that 30 per cent of those achieving an employment outcome are on SSP.
- **Costs of Intervention**
 - **Cost of Vocational Specialist:** assumed to be **£75,000 p.a in 2013.**²⁸ (A); includes salary, pension and benefits (£40,000) and estimated indirect costs such as overheads (£35,000).
- **Potential Savings of Intervention**
 - **Estimated savings to the Exchequer from a person transitioning from JSA into employment: £3,900 p.a.**²⁹ (B); it is assumed that employment is additional.
 - **Estimated savings from a person transitioning from SSP into employment: £1,225 p.a.**³⁰ (C)
 - **Estimated savings from healthcare utilisation costs per employment outcome: £300 p.a.**³¹ (D); includes savings in form of fewer GP visits and limited use of secondary care.

that of these 40 would move off sickness benefits and enter employment, while about 5 of these would have moved off benefits without the intervention. The net employment effect is 50 per cent. We looked at each stage of the treatment along with success rates and assume that these locations are typical.

²⁸ We estimate these costs to be higher than Lord Layard's business case as we assume that employment of advisers will also entail indirect costs such as overheads. These overheads include costs such as building, support staff, IT, training, sickness and maternity cover. We have based our estimate on RAND models estimating costs of public sector employment. An application of this model for Ministry of Defence capacity and skills planning can be found at <http://www.rand.org/pubs/monographs/MG1023.html> (accessed December 2013).

²⁹ Estimate based on DWP's TAXBEN model and includes benefit savings and additional tax income for a person transitioning from JSA into employment for a year, taking into account that only 50 per cent of JSA claimants will find sustained employment. We have taken the JSA cost saving to provide a conservative estimate. But it is likely that a wider group of benefit claimants (eg ESA) will benefit from the intervention. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214613/dwp-worklessness-codesign-ir.pdf (accessed December, 2013), pp. 29–30.

³⁰ In terms of those on statutory sickness pay, we assume a cost of £2,450 (sick pay for 28 weeks).³⁰ Given that many individuals will not take up the full period of statutory sickness pay, we assume that the average saving will be half.

³¹ It is estimated that the cost saving of keeping one person in employment to primary care is a minimum of about £600 using 2011 data, see Lord Layard's business case for the introduction of IAPT services in England available at <http://www.iapt.nhs.uk/silo/files/building-a-business-case-for-employment-advice-and-support-in-iapt.pdf> (accessed December, 2013). We assume only 50 per cent of the outcomes are sustained averaging the cost saving to £300.

Table 1: Cost Benefit Calculation of IPS employment advice in primary care

Costs	(A): Vocational Specialist (including overhead costs) each	75,000
Potential Savings	(B): JSA claimants into employment (24.5 x £3,900)	95,550
	(C): SSP claimants into employment (10.5 x £1,225)	12,863
	(D): Healthcare Utilisation Cost (35 x £300)	10,500
	(E): Total Savings	118,913
Net benefit (overall)	(E)-(A): Net benefit per vocational specialist	43,913
Benefit/cost ratio (overall)	(E)/(A): Potential saving per £ spent for each employment outcome	1.59
Net benefit (gov.)	(B+D)-(A): Net benefit per vocational specialist	31,050
Benefit/cost ratio (gov.)	(B+D)/(A): Potential saving per £ spent for each employment outcome	1.41

Source: RAND Europe calculations

As shown in Table 1, if the experience of the IAPT locations that provide IPS services is typical, this leaves a net annual benefit of £43,913 per vocational specialist (E-A).

If we define savings to the Exchequer and savings to the NHS as savings to the Government, then the net benefit per vocational specialist to the Government is £31,050 per vocational specialist (B+D –A). The total savings for the Government are £106,050 (B + D).

This means a net annual benefit of £887 per employment outcome (£31,050 divided by 35).

The total benefit-cost ratio of 1.59 means that for each £1 the Government would spend to achieve an employment outcome with this intervention, in return it would save £1.59 in total.

Considering the savings to the Government only (£106,050), the benefit-cost ratio for the Government is 1.41. The benefit-cost ratio of 1.41 means that for each £1 spent to achieve an employment outcome, the Government would save £1.41.³²

³² In this benefit- cost ratio, we do not take into account broader improvements in health and wellbeing, self-efficacy, and job readiness in the wider population receiving the intervention.

5.2.2. Policy option 2: Introduce group work approaches based on JOBS II in Jobcentre Plus

Proposition

To pilot a group work approach based on JOBS II in Jobcentre Plus to ascertain the extent to which it improves the employment and health and wellbeing outcomes of people with common mental health problems.³³

JOBS II is a peer-led group programme for 12–20 individuals who are unemployed which is run for around four hours a day, four days a week over six weeks. Fundamental to the design is the principle that successful behavioural outcomes are achieved through the combination of techniques that build up relevant skills and the motivation to use them. The JOBS II programme has therefore been designed to increase the participant's sense of job search self-efficacy and their ability to manage the setbacks they may encounter in the job search process. It has proved to be effective in different contexts. Appendix D has more information on evidence base behind the JOBS II programme.

While the JOBS II trainers would work with Jobcentre Plus staff to screen participants, the actual assessment of benefit claimants will be carried out by Jobcentre Plus advisers. This would require the development of a screening/assessment tool. The screening tool will look at levels a client's self-efficacy and assess whether a claimant has, or is at risk of developing mental health problems. The target group are JSA claimants with common mental health problems, or at significant risk of developing these problems, who are also less likely to enter employment.³⁴ Trainers will be conversant in group facilitation skills, mental health problems and job search skills. Counselling sessions facilitated with Personal Advisers will dovetail with the training programme in order to ensure consistency in the experience of the jobseeker and adequate follow-up.

It is likely that the JOBS II programme implemented in this policy option may be slightly modified in terms of sessions and duration. An option could be a programme lasting a total of 20 hours delivered over the course of four days. The pilot could run for twelve months with regular follow-ups with participants over two years to monitor outcomes.

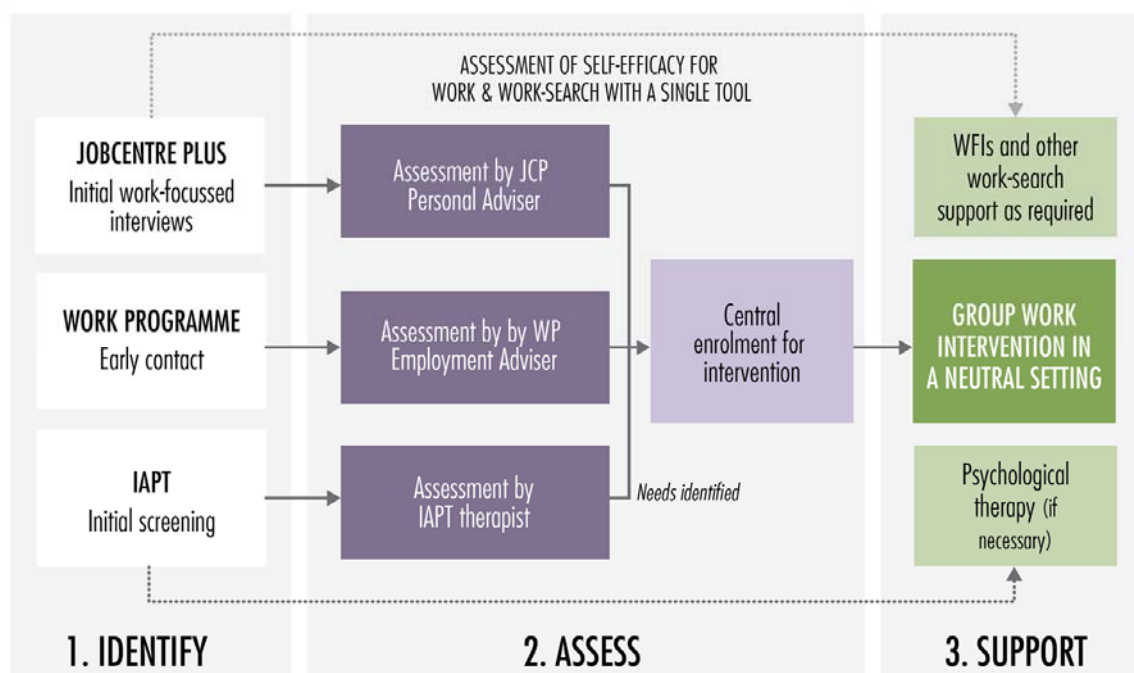
³³ The pilot could also look at how the JOBS II programme could be integrated in the future as an option for employment advice in the Improving Access to Psychological Therapies (IAPT) services (or equivalent in Scotland and Wales).

³⁴ It has also been suggested in discussions with stakeholders that a JOBS II type intervention could also target the ESA claimant group and potentially the in-work group.

Customer journey

The service would be provided in a neutral setting at local level (eg mirroring Jobcentre locations). It is envisaged that the main referral pathways into the service would be through Jobcentre Plus in the initial pilot, but IAPT and Work Programme providers (at early contact stage) could also refer if the service is rolled out. JSA claimants and those flowing onto ESA (initial Work Focused Interview) are initially assessed for self-efficacy and job readiness by Jobcentre Plus advisers using an assessment tool. To account for the fluctuating nature of mental health problems, a JSA claimant could be assessed for the intervention in every Work Focused Interview to identify any mental health problems which may emerge during the claim. This assessment tool could also be used in other potential referral settings such as Work Programme providers and IAPT. In time, the service could take referrals from IAPT and the Work Programme. Once needs have been identified and claimants are assessed as suitable to enter the intervention, they are referred to a central enrolment service that allocates them to a provider at local level. This could run in parallel to other interventions such as psychological support and Jobcentre Plus work search support.

Figure 4: Customer journey for JOBS II intervention



Source: RAND Europe/DWP

Business case

Evidence (Vuori and Silvonen, 2005) suggests that the intervention significantly decreases depression, improves emotional functioning and also increases rates and quality of re-employment which, in turn, had major impacts on decreasing financial strain. These effects incorporate hard employment outcomes and also softer health and wellbeing outcomes that may impact healthcare utilisation. They also appear to be sustained. This is a model whereby the Government would need to invest first to save money later.

In developing the business case, we look at tax revenue increases and benefit savings for the Exchequer and benefits in terms of reduced primary care healthcare utilisation that initially would occur within one year. We have not monetised additional positive outcomes such as improvements in health and wellbeing and greater job readiness. We use 2011 data for benefits and 2007 data for costs and have not adjusted those for inflation. In a conservative approach, we have used lower-end estimates for benefits and higher-end estimates for costs.

Below is the outline of a simple cost-benefit calculation. It demonstrates the net employment effect of JOBS II and the corresponding costs and potential savings of the intervention (policy option).

- **Net Employment Effect of Intervention**
 - **Net Employment effect: 25-30 per cent**³⁵; it is assumed that the drop-out rate is about 12 per cent.³⁶
 - **Estimated participants per employment outcome: 4.48**
- **Costs of Intervention**
 - **Costs per participant:** assumed to be **£875**³⁷ (A).
- **Potential Savings of Intervention**
 - **Estimated savings to the Exchequer from a person transitioning into employment: £3,900 p.a.**³⁸ (B); it is assumed that employment is additional.

³⁵ The net employment rate is the difference between the employment rates of control and treatment groups. A net employment effect of 25 per cent means that the intervention generates 1 employment outcome per 4 participants. Taking into account the potential drop-out rate of 12 per cent, the ratio is 4.48 per outcome.

³⁶ We have assumed a drop-out rate of 12 per cent on the basis of the "From the Ground Up" programme of the Department of Social Services of Baltimore County, Maryland as reported in an effectiveness trial document made available to this study.

³⁷ These costs per person were estimated previously by the DWP (in 2007 £). We have taken this number as it represents the likely long-term cost. It may be that in a pilot additional overheads and design costs need to be taken into account. Our estimation based on the DWP business case is that Jobs II may cost £1,250 per participant. However, it seems obvious that some of these indirect costs will decrease as the intervention is scaled up. We have taken the £875 to reflect a truer estimate of average cost.

- **Estimated savings from healthcare utilisation costs per employment outcome: £300 p.a.**³⁹ (C); includes savings in form of fewer GP visits and limited use of secondary care.

Table 2: Cost Benefit Calculation of JOBS II intervention

Costs	(A): Per employment outcome (£875 x 4.48)	3,920
Potential Savings	(B): Per employment outcome	3,900
	(C): Healthcare utilisation cost per employment outcome	300
	(D): Total savings per employment outcome	4,200
Net benefit	(D)-(A): Net benefit per employment outcome	280
Benefit/cost ratio	(D)/(A): Potential saving per £ spend for each employment outcome	1.07

Note: the estimates are sensitive to the reported net employment effect in JOBS II and the average cost of delivering the programme.

Source: RAND Europe calculations

Table 2 illustrates that for each hard employment outcome, the Government spends about £3,920 (using the lower end 25 per cent net employment outcome rate). The potential savings for each hard employment outcome are £4,200.

If we define savings to the Exchequer and savings to the NHS as savings to the Government, then the annual net benefit to the Government would be about £280 per employment outcome.

The benefit-cost ratio of 1.07 means that for each £1 spent to achieve an employment outcome, the Government would save £1.07.⁴⁰

³⁸ Estimate based on DWP's TAXBEN model and includes benefit savings and additional tax income for a person transitioning from JSA into employment for a year, taking into account that only 50 per cent of JSA claimants will find sustained employment. We have taken the JSA cost saving to provide a conservative estimate. But it is likely that a wider group of benefit claimants (eg ESA) will benefit from the intervention. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214613/dwp-worklessness-codesign-ir.pdf (accessed December, 2013), pp. 29-30.

³⁹ It is estimated that the cost saving of keeping one person in employment to primary care is a minimum of about £600 using 2011 data, see Lord Layard's business case for the introduction of IAPT services in England available at <http://www.iapt.nhs.uk/silo/files/building-a-business-case-for-employment-advice-and-support-in-iapt.pdf> (accessed December, 2013). We assume only 50 per cent of the outcomes are sustained averaging the cost saving to £300.

⁴⁰ In this benefit- cost ratio, we do not take into account broader improvements in health and wellbeing, self-efficacy, and job readiness in the wider population receiving the intervention.

5.2.3. Policy option 3: Improving access to online assessments and interventions for common mental health problems

Proposition

To pilot an innovative use of online tools that assess for mental health problems and vocational needs and signpost to specialised services. The purpose of this option is to build the evidence base on the efficacy and cost-effectiveness of online tools in terms of improving both health and employment-related outcomes for people with common mental health problems. It is important to note that this pilot would not be limited to any benefit claimant groups, but it would provide mental health support for the general population.

Rationale and overview of the current landscape

Internet-based tools and interventions can be delivered widely, efficiently and at relatively low cost. More importantly, they can target people who do not actively seek help elsewhere or prefer using a computer rather than talking to a therapist. Such tools could therefore offer people with common mental health problems early support and reduce costs of developing more significant mental health problems (Knapp et al., 2011). It is important to note here that online tools that include an assessment or screening component (such as electronic chat, eCHAT), are valuable only if they lead to increased uptake of appropriate interventions (Goodyear-Smith, 2013a).

Existing online platforms provide therapies and offer meditation techniques and interactive applications, such as games to improve wellbeing or address a specific condition (eg sleep disorder, stress, anxiety disorders, and more). They offer a wide spectrum of treatment options from self-help groups to talking therapies, including **computerised CBT (cCBT)** such as:

- Beating the Blues (BtB, Ultrasis Plc),⁴¹ which is approved by the National Institute for Health and Care Excellence (NICE) for treating depression, anxiety and phobias⁴². It offers a course made up of eight online sessions (each lesson lasts approximately an hour) teaching practical, lifelong skills to help people feel and stay better.
- FearFighter (FF, CCBT Ltd),⁴³ which is approved by NICE for use by people with phobias and those who experience panic attacks. The programme consists of nine steps with sets of activities to complete between the steps

⁴¹ www.beatingtheblues.co.uk [accessed in December 2013]

⁴² Please note that NICE states in its guidance about depression in that other, similar cCBT packages may also be effective – see NICE (2010) Depression. The NICE Guideline on the Treatment and Management of Depression in Adults, The British Psychological Society and The Royal College of Psychiatrists, available at <http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf> [accessed in December 2013]

⁴³ <http://www.fearfighter.com> [accessed in December 2013].

(these activities help build on topics covered in sessions and they are important to make progress). Most sessions last about 30 minutes. It is recommended to take one step a week.

- Living Life to the Full (LLTTF, Glasgow, UK).⁴⁴ The course uses a self-help format and the CBT model; it offers 2 to 9 hours of online treatment time and patient support options (email, telephone and face-to-face).
- MoodGYM (MGYM, Canberra, Australia).⁴⁵ The programme consists of five modules, an interactive game, anxiety and depression assessments, downloadable relaxation audio, a workbook and feedback assessment.
- BT Steps (Pfizer, Inc.).⁴⁶ The programme is divided into nine steps and aims to help people with obsessive-compulsive disorder; it uses a telephone interactive voice response system, workbook and helpline support.

Outcomes measured focus on improvements in mental health conditions⁴⁷ and, for cost-effectiveness models, the effects of cCBT were measured in terms of quality-adjusted life-years (QALY). There is evidence for the effectiveness of several different online interventions including Beating the Blues (see Kalenthaler et al., 2006), a web-based application for chronic insomnia disorder (see Krusche et al., 2012), an online course for stress reduction (Espie et al., 2012) and more. There are emerging systematic and meta-reviews of cCBT for symptoms of depression and anxiety (Spek et al., 2006; Kalenthaler et al., 2006). Some of them also indicate that long-term effects achieved were not significant – this may suggest that the effectiveness of cCBT for adult depression may need to be re-considered (Yamaguchi, 2013). In addition, more recent publications suggest that, although composite screening tools may not be effective in reducing the burden of health problems, they were not tested for employment outcomes (Goodyear-Smith, 2013a).

However, there is, as yet, little evidence that assessment and support/treatment interventions alone improve employment outcomes for people with mental health problems. The pilot will aim to test this link.

Structure and content of the proposed platform

1. Assessment

At first, the new online application would enable an individual to assess their mental health generally or assess for a specific condition, and determine their employment status. The mental health assessment would be adapted from the PHQ-9, GAD-7 tools, which are used to measure the scale of anxiety disorders and the level of depression and offer concise, self-administered screening and diagnostic tools for mental health disorders. It is also assumed that the mental health assessment would build on NHS Direct applications or various initiatives developed under Improving

⁴⁴ <http://www.lltff.com/> [accessed in December 2013].

⁴⁵ www.moodgym.anu.edu.au [accessed in December 2013].

⁴⁶ <http://www.healthtechsys.com/ivr/btsteps/btsteps.html> [accessed in December 2013].

⁴⁷ Improvements were measured on clinical scales (eg the Yale–Brown Obsessive Compulsive Scale was used for the Beating the Blues).

Access to Psychological Therapies (IAPT). The vocational assessment element of the application will have to be specified beyond determining the employment status and whether or not mental health problems are work-related. This assessment could potentially build on lessons from IPS or JOBS II concerning what an effective employment assessment would look at.

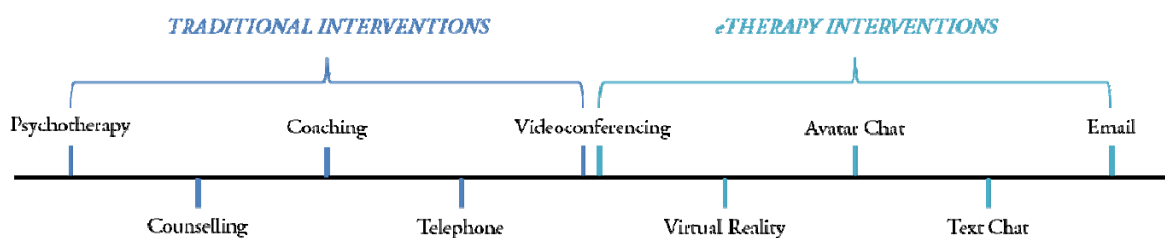
2. Signposting

The application would then signpost the individual to a relevant therapy or specialised service from the main two types of support (Figure 5):

- **Existing, more traditional interventions.** These could include:
 - primary and secondary healthcare services providing mental health support such as exercise, self-help groups, talking therapies, medication, combination therapy, specialised treatment
 - employment services such as EAs at IAPT (or their equivalent in Scotland and Wales) and Jobcentre Plus offices (possible also future Health and Work Service) or third party providers.
- **eTherapy interventions**, such as online counselling, cCBT and other methods. These would include:
 - existing interventions focused on health and wellbeing outcomes but not offering vocational support
 - the new application with a vocational element.

The presumption is that some people might be suitable for just an employment advice element. In such instance mental health support would not be provided (either in traditional or online format). It is important to note that for some individuals the best approach would combine traditional and online elements in order to ensure effective support, be it for a mental health problem, employments needs, or both.

Figure 5: eTherapy interventions Lie on a Continuum



Source: J. M. Grohol, Psy.D., Best Practices in eTherapy. Definition & Scope of eTherapy, May 14, 1999 cited in J Sarasohn-Kahn (2012)

3. Treatment and support

Finally, the application would test the effectiveness of online assessment and interventions, not only for health and wellbeing outcomes, but also in relation to

employment outcomes. Therefore, the application would need to screen users and randomly offer them online therapies with (or without) a vocational element.

It is important that a vocational element is added to or built into the recommended online interventions so they could help to:

- prevent people from falling out of work; and/or
- help people improve their mental health and job searching skills

by providing them rapid access to support and advice or job offers in their proximity, for example. The new application could build on existing therapies modified for the purpose of the pilot, for example developing beta versions of Beating the Blues or FearFighter with a vocational component incorporated into their design.

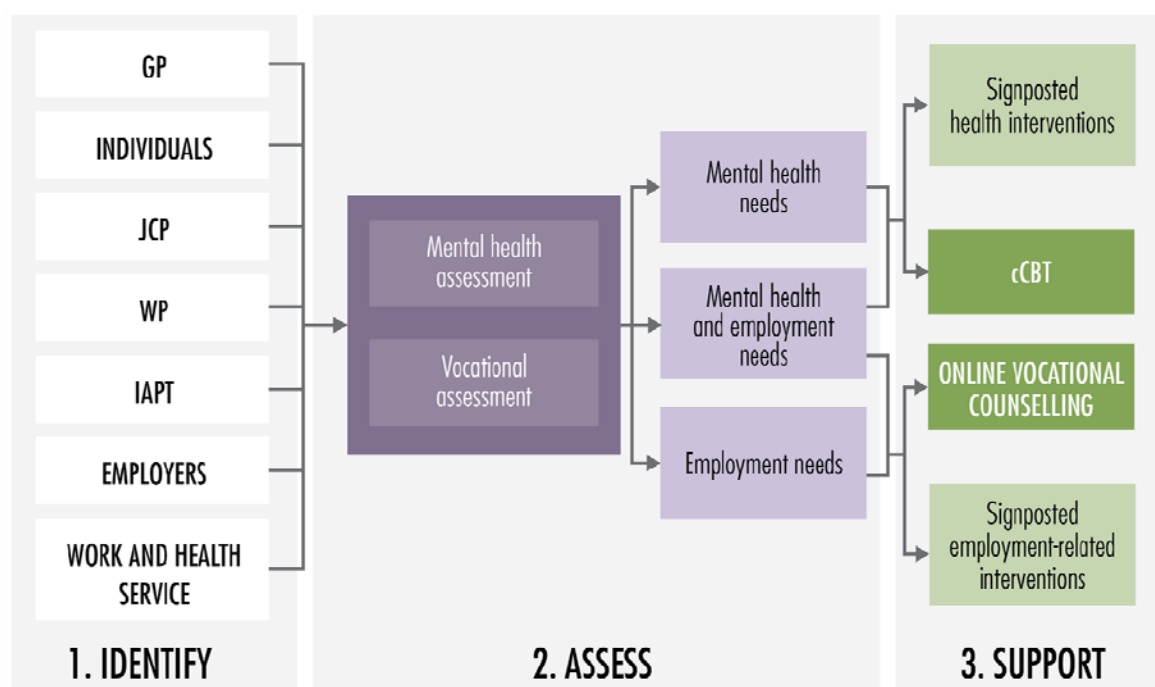
Development and accreditation of the application

The application could be developed/accredited jointly by the DH and DWP or provided by third sector and/or private providers. It could be promoted at GP practices, by NHS and IAPT services, and Jobcentre Plus alike.

Customer journey

The service would be hosted by the NHS, the new Health and Work Service or both. As the online intervention is aimed at the general population, there are more ways to enter the service. People can access the service themselves, as well as through signposting by primary care services and those services providing employment support. In terms of primary care, this tool may be appropriate for those assessed as being able to self-manage their condition or requiring some additional support next to normal/regular treatment. In terms of employment support, the intervention largely complements existing services. For the Work Programme, this intervention could also support those who recently entered work and who are struggling. The intervention could also be useful for the in-work group. The online assessment tool would determine both the mental health and employment needs of the user. The service will then signpost users to services as well as offer rapid access to cCBT and online vocational counselling where appropriate. The tool will tailor this signposting to the specific needs which have been identified during the assessment. This may require some additional support by qualified professionals who support the service (either online or on the telephone).

Figure 6: Customer journey for online intervention



Source: RAND Europe/DWP

Business case

As there are several unknown elements of the approach to the application, and we have little data on employment outcomes in this new field, it is difficult to develop a business case for this policy option at the moment. The costs for developing the platform would have to be further scoped with specialised IT providers. Calculating potential benefits of such an intervention pose additional challenges – the evidence in this area is limited to health outcomes and it is patchy in that it is related to specific disorders: depression, sleep disorder, for example. We would have to rely on some very crude assumptions to capture both health and employment benefits.

As such, our best evidence on likely costs comes from the results of a systematic review and economic evaluation of cCBT carried out in 2006 for the treatment of anxiety, depression, phobias, panic and obsessive-compulsive behaviour (Kalenthaler et al., 2006). A variety of software packages were considered in this study included Beating the Blues and FearFighter.

According to Kaltenthaler et al. (2006), there is some evidence that cCBT is as effective as therapist-led CBT for the treatment of depression/anxiety and phobia/panic attacks. It is also more effective than treatment as usual in the treatment of depression/anxiety. cCBT also appeared to reduce therapist time compared with therapist-led CBT.

Health impacts

Only one published economic evaluation of cCBT was identified at the time: an economic evaluation of the depression software Beating the Blues alongside a RCT. The study found that Beating the Blues was cost-effective against treatment as usual in terms of cost per QALY (less than £2,000).

The results of the model for the depression software packages in terms of incremental cost per QALY gained compared were £1,801 for Beating the Blues, £7,139 for Cope, and £5,391 for Overcoming Depression £5,391.⁴⁸

For phobia/panic software, the model showed an incremental cost per QALY of FearFighter over relaxation was £2,380. Its position compared with therapist-led CBT is less clear. When modelling obsessive-compulsive behaviour packages, using the practice-level licence cost meant that BT Steps was dominated by therapist-led CBT, which had significantly better outcomes and was cheaper. However, the cheaper primary care trust licence resulted in the incremental cost-effectiveness of BT Steps over relaxation being £15,581 and therapist-led CBT over BT Steps being £22,484 (Kalenthaler et al., 2006).

Employment impacts

We have little evidence on actual costs and employment effects. Beating the Blues was estimated to cost approximately £397 (in 2000). That is slightly more than treatment as usual (£357) over an eight-month treatment period (McRone et al., 2004). The 'net employment effect' of Beating the Blues is four percentage points (where the employment effect is measured as proportion of participants that stay at work, rather than go back to work). Taking into account the costs for lost employment, Beating the Blues has on average a positive net effect of £367 per participant (in 2000).

5.2.4. Policy option 4: Commission third-party organisations to provide a combination of psychological and employment related support to claimants

Proposition

To pilot an approach in which Jobcentre Plus commissions specialist psychological and employment-related support from specialist and third party providers to test whether it improves the employment and health and wellbeing outcomes of benefit claimants with common mental health problems.

This pilot will aim to involve suitable specialist providers and other third parties more directly in offering specialist support to Jobcentre Plus. Other third parties already

⁴⁸ The chance of being cost-effective at £30,000 per QALY were 86.8 per cent for Beating the Blues, 62.6 per cent for Cope and 54.4 per cent for Overcoming Depression.

provide information sessions and training on mental health and employment to Jobcentre Plus staff and benefit claimants. However, this intervention would give benefit claimants more *direct* access to the specialist services offered by the third parties. Many of these interventions were designed for use in the Work Programme and/or to support those in work with mental health problems under employment assistance programmes paid for by employers. The intervention is mostly telephone-based.

The target group are JSA claimants with common mental health problems, potentially ESA claimants with mental health problems (before they become eligible for the Work Programme), and potentially those claimants who are assessed as being at significant risk of developing mental health problems. The third party organisation will develop referral criteria for Jobcentre Plus advisers to make appropriate referrals to the commissioned service. This could involve an assessment tool. The quality of referrals will be monitored by the third party provider. A point to consider is whether one assessment tool will be developed across Jobcentre Plus sites or whether customised assessment guidance will be used in different locations.

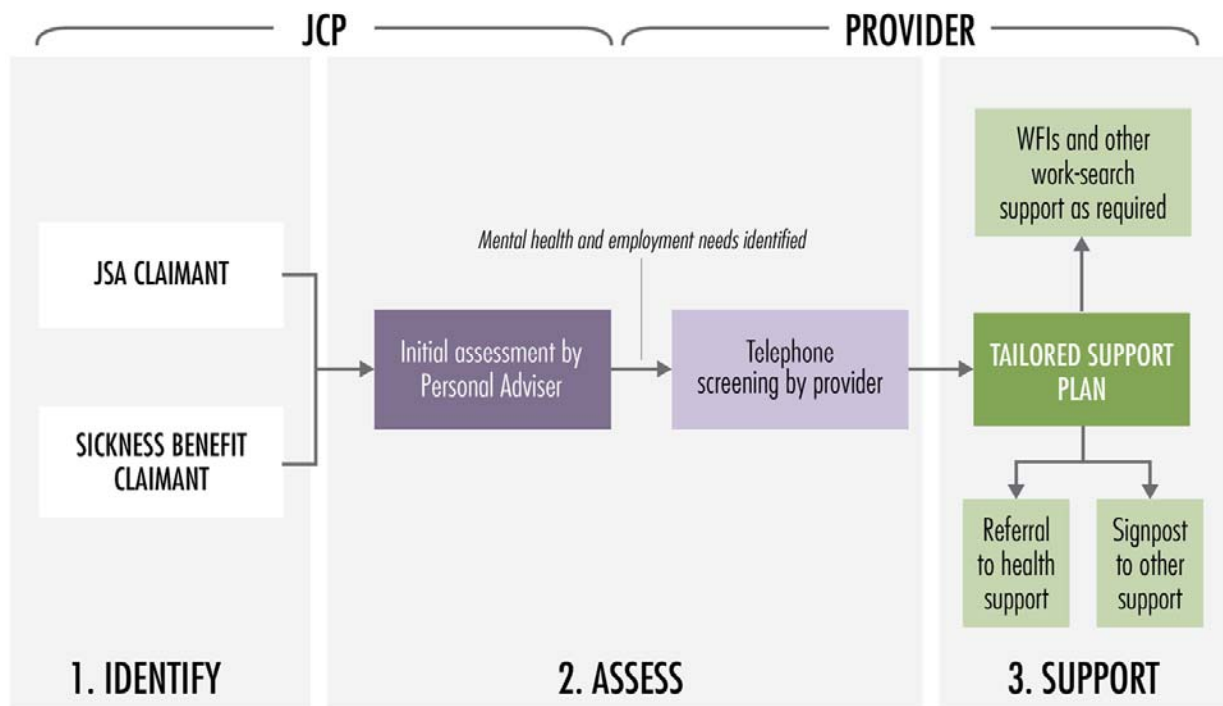
The intervention will most likely involve several steps. Initially, we expect the intervention to be telephone-based: a third party adviser will assess the participant and check the participant's suitability for services. The participant will then be enrolled in a service provision plan, if appropriate. In many cases, the engagement with the participant will remain telephone-based. However, the adviser may refer the participant to additional services. The services available to the participant could include, but are not limited to: computerised CBT; counselling; and complementary services (eg IAPT services). Typically, these programmes aim to improve the health and wellbeing of a participant by providing specialist support, which will enable participants to cope with emotional problems that affect employment. Services also typically follow up progress with the participant. The intervention signposts complementary services but does not assist in job search (CV production) or job placement activities. Progress is measured on clinical scales such as PHQ-9, GAD-7, Phobia Scale and Work and Social Adjustment. Job readiness is assessed on the basis of improvements on the scales. Most interventions use a case management approach.

Customer journey

This intervention would be mostly telephone-based and provided by a third party. The assessment will be undertaken at Jobcentre Plus by a personal adviser. This adviser will assess the mental health and employment needs of JSA claimants and those at an early stage in the ESA claim. We expect the advisers to assess JSA claimants at every Work Focused Interview (WFI). The ESA claimants could be assessed in the initial WFI. The adviser will use a bespoke tool. The third party providers will also screen those referred to assess their needs and suitability for participating in the intervention. The intervention will need a Service Level Agreement to ensure good coordination between Jobcentres and third parties and to govern the assignment to the intervention. The person referred will then enter the

telephone-based intervention, they may be referred to other services such as IAPT, or may be signposted to other services provided locally or by other third parties (not paid for under this intervention). The telephone-based intervention may also incorporate broader support for those with specific needs such as computerised CBT and in a small number of cases face-to-face meetings.

Figure 7: Customer journey in the telephone-based intervention



Source: RAND Europe/DWP

Business case

Based on management information from a small number of local areas, participants in such interventions are more likely to engage in work-related activity or seek further assistance. This is probably due to increased confidence and motivation. In most cases, the health and wellbeing of participants improves. The interventions are sometimes less specific on hard employment outcomes.⁴⁹

In developing the business case, we look at tax revenue increases and benefit savings for the Exchequer and benefits in terms of reduced primary care healthcare utilisation that initially would occur within one year. We have not monetised additional positive outcomes such as improvements in health and wellbeing and

⁴⁹ There are commercial sensitivities around several of these models. We therefore do not directly reference particular models. We have made the description of a service and the results more generic. The assumptions underlying the effectiveness of an intervention are based on our analysis and interpretation of actual numbers provided to us in confidence.

greater job readiness. We use 2011 data and have not adjusted these for inflation. In a conservative approach, we have used lower end estimates for benefits and higher end estimates for costs.

Below is the outline of a simple cost-benefit calculation. It demonstrates the net employment effect for the intervention and the corresponding costs and potential savings.

- **Net Employment Effect of Intervention**
 - **Net Employment effect: 10 per cent.**⁵⁰ It is assumed that the drop-out rate is about 33 per cent.⁵¹
 - **Estimated participants per employment outcome: 15.**⁵²
- **Costs of Intervention**
 - **Costs per participant:** assumed to be **£250.**⁵³ (A).
- **Potential Savings of Intervention**
 - **Estimated savings to the Exchequer from a person transitioning into employment: £3,900 p.a.**⁵⁴ (B). It is assumed that employment is additional.
 - **Estimated savings from healthcare utilisation costs per employment outcome: £300 p.a.**⁵⁵ (C). Includes savings in form of fewer GP visits and limited use of secondary care.

⁵⁰ The net employment effect is the difference in employment effect between treatment and control groups. Across those participating between 50–60 per cent of participants had positive outcomes. Of these positive results, about 10 per cent are employment-related. Given that these interventions often target groups of individuals who have been unemployed longer and can have more complex needs, we assume that opening up these interventions to a wider group who are more job ready would double the employment effect of interventions to 20 per cent. We cannot be sure of the counterfactual and assume that the net employment effect is about 10 per cent of those participating (assuming 10 per cent would have achieved an employment outcome without intervention). These are assumptions that have been tested with some providers.

⁵¹ In many cases, we only have evidence on particular groups using the intervention (eg ESA group or in-work group). We often have less information on the JSA target group. Management information from a small number of local areas suggests that the drop-out rate is about 33 per cent. For every 150 participants, 50 will drop out. We have assumed that 50 will still represent a cost to the programme (we have calculated them at full cost in this model).

⁵² A net employment effect of 10 per cent means that the intervention generates 10 employment outcomes per 100 participants, or 10 participants per employment outcome (100/10). Taking into account the potential drop-out rate of 33 per cent, the ratio is 15 participants per outcome.

⁵³ The service is estimated to cost roughly £150–250 per participant depending on the service arrangement. We assume a cost of £250.

⁵⁴ Estimate based on DWP's TAXBEN model and includes benefit savings and additional tax income for a person transitioning from JSA into employment for a year, taking into account that only 50 per cent of JSA claimants will find sustained employment. We have taken the JSA cost saving to provide a conservative estimate. But it is likely that a wider group of benefit claimants (eg ESA) will benefit from the intervention. See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214613/dwp-worklessness-codesign-ir.pdf [accessed December, 2013], pp. 29-30.

⁵⁵ It is estimated that the cost saving of keeping one person in employment to primary care is a minimum of about £600 using 2011 data, see Lord Layard's business case for the introduction of IAPT

Table 3: Cost Benefit Calculation of telephone-based intervention delivered by third parties

Costs	(A): Per Employment Outcome (£250 x 15)	3,750
Potential Savings	(B): Per Employment Outcome	3,900
	(C): Healthcare Utilisation Cost per employment outcome	300
	(D): Total Savings	4,200
Net benefit	(D)-(A): Net benefit per employment outcome	450
Benefit/cost ratio	(D)/(A): Potential saving per £ spent for each employment outcome	1.12

Note: the estimates are highly sensitive to the reported net employment effect and the average cost of delivering the programme.

Source: RAND Europe calculations.

Table 3 illustrates that for each hard employment outcome, the Government spends about £3,750. The potential savings for each hard employment outcome are £4,200.

If we define savings to the Exchequer and savings to the NHS as savings to the Government, then the annual net benefit to the Government would be about £450 per outcome.

The benefit-cost ratio of 1.12 means that for each £1 spent to achieve an employment outcome, the Government would save £1.12.⁵⁶

services in England available at <http://www.iapt.nhs.uk/silo/files/building-a-business-case-for-employment-advice-and-support-in-iapt.pdf> [accessed December, 2013]. We assume only 50 per cent of the outcomes are sustained averaging the cost saving to £300.

⁵⁶ In this benefit-cost ratio, we do not take into account broader improvements in health and wellbeing, self-efficacy, and job readiness in the wider population receiving the intervention.

5.3. Comparing the options

Each of these options implies new applications of existing evidence-based models that focus on employment advice and mental health treatment. The strength of the evidence base is not the same for all policy options. IPS has a strong evidence base in a secondary care setting for patients with complex mental health needs but it has not been tested in primary care settings. The evidence base on JOBS II is exclusively situated in different contexts outside the UK. Evidence surrounding telephone-based interventions is emergent, while there is some, at times mixed, evidence on specific online interventions. We have found no evidence concerning the effectiveness of introducing a vocational element in an online mental health assessment tool.

When thinking through these options, our aim was to embed them in existing service provision. To make the options more feasible and acceptable to design and implement, they are located within primary care settings (IPS in IAPT) or accessed through employment offices (JOBS II or telephone-based service provision). In some cases, they are based on examples of service delivery that are already used in some locations: we found that IPS in IAPT is used in a small number of locations. Telephone-based services accessed through Jobcentres are also in use. The only option that is perhaps not as strongly linked up to existing service provision is the online option. However, providing online resources is not without precedent. The NHS has a mental health assessment tool and online cCBTs are provided in some localities. The service could sit within the NHS or new Health and Work Service to be launched in 2014.

Though the options can reach a wider target group (including the in-work group), the client group of each option is likely to be slightly different. It is likely that options offered through Jobcentres will reach more benefit claimants than perhaps providing IPS through IAPT or through online interventions. Looking at client groups for each option in this way assumes that current client journeys remain the same. However, it could be the case that new referral pathways or ways of signposting are created that result in a broader coverage of clients in specific options.

The aims of these options are also slightly different. On the one hand, our work placed a lot of emphasis on hard employment outcomes, which in turn produce savings in benefit expenditure, gains in tax revenue, reduced costs to employers through lower sickness absence and potentially lower healthcare utilisation. However, as mentioned in the introduction of this chapter, options could have wider benefits. Most of the options involve trying to improve job readiness, health and wellbeing and self-efficacy. They also involve attempts to raise awareness and reduce the stigma of mental health. Some options focus more on this than others as explained in the descriptions of the policy options above. Such attempts all have beneficial value, which we do not incorporate in this analysis. On the other, the intensity of the treatment also varies. IPS is an intensive treatment model that requires the person giving advice to engage in depth with the situation of the client. It

also requires the person giving advice to support the client in employment over time. The telephone-based or online options are less intensive. As a result, the cost per person treated/given advice to vary. Online options are likely to reach a greater number of individuals than IPS. At the same time, effectiveness of the interventions differs. Hard employment outcomes are bound to be fewer in less intensive interventions. In this way, policymakers need to make some strategic choices around client groups, models of integration, commissioning and funding, and outcomes (employment outcomes gained and coverage) inherent in the policy options when deciding which of these policy options they would consider for piloting. However, in at least three of the four policy options⁵⁷ put forward the estimated benefits to the Government exceed the costs of running the service, making the case for investment more compelling.

Table 4: Brief overview of four proposed policy options

	Option 1	Option 2	Option 3	Option 4
Benefit-cost ratio	1.41	1.07	?	1.12

Source: RAND Europe calculations

⁵⁷ We do not have benefit information for the online policy option.

6. Concluding comments

The aim of this Contestable Policy Fund study is to develop new, innovative or adapted approaches that will improve the alignment of health and employment services for those with common mental health problems.

Our review of the evidence and consultations led to three main findings, which also form our recommendations to the Government:

- Earlier access to specialist services will improve the employment and wellbeing outcomes of people with common mental problems and employment needs.
- Co-location or integration of employment advice and mental health treatment is likely to improve outcomes.
- Given the limitations in the evidence base for improving employment outcomes of people with common mental health problems the evidence base should be improved through for instance piloting and social experimentation.

We have proposed four policy options out of a longlist of over 30 options. The options were identified through a review of the evidence and consultations with stakeholders. Our shortlist is not exhaustive and other policy options could be considered. The options are also complementary and could potentially be used as a package of support.

In essence, our work identified four options that appear acceptable to stakeholders, feasible to implement, have grounding in the evidence, and give an increased likelihood of a successful outcome. The options also importantly call for structural change or increased integration in terms of how employment and health services are delivered (eg by offering access to specialist mental health and employment support in employment services or placing employment advice in primary care). Furthermore, the policy options aim to provide earlier access to specialist services than is the case now in many locations. Finally, each of these policy options could be piloted.

Our concluding thoughts pertain to the enablers of these policy options. As mentioned in Chapter 5, we identified two main enablers when drawing up the shortlist of four policy options.

More effective referrals to specialist services through a single assessment

The development of an assessment tool that measures claimant self-efficacy and wellbeing could potentially create a gateway to specialist help. This has also been proposed in the recent Disability and Health Employment Strategy (DWP, 2013). The formulation of a specialist tool that identifies mental health and employment needs could enable all four policy options to improve targeting and service provision. It

could also be used in other interventions and by other stakeholders such as Work Programme providers and third parties providing services for those with mental health problems.

Currently, there is no accepted way, nor 'off the shelf' instrument, to assess self-efficacy for work. In the current system clients undergo a range of assessments for particular problems and needs, but no assessment looks at employment needs and mental health in the round. Even if such an assessment were devised, challenges might be experienced in encouraging different services to adopt the tool and use it in the way intended. For instance, personal advisers in Jobcentre Plus locations only have a short amount of time with a benefit claimant and it may be difficult to perform an effective assessment. Rollout may require an incentive for service providers to use the tool (eg by setting minimum standards for public sector providers), guidance and training for staff and line managers. This may also need to be extended to a wider number of gatekeepers such as GPs who could more effectively refer individuals to specialist services and whose referrals may impact the success of a pilot. Clearly, a pilot of the four policy options would need to incorporate the design of the tool and determine the effectiveness of the tool in referring the appropriate individuals to specialist services. The DWP could build on the *Employment and Wellbeing* toolkit which was launched in January 2014 or the Work Programme employment advice toolkit (*Working for Wellbeing*) which is now widely used by Work Programme providers.

Incentivising service providers

Some form of joint commissioning may be needed to incentivise service providers to work across health and employment spheres. Those responsible for commissioning health services have not systematically focused on employment outcomes. Similarly, employment services commissioners have not focused explicitly on improving mental wellbeing. In the course of this study, we found examples of more integrated service delivery. Our consultations also revealed more willingness among health officials to engage with employment as a clinical outcome. A joint commissioning model may be part of piloting.

There are some risks in such joint commissioning. Integration of services may become the objective itself rather than the outcome the integrated service is trying to achieve. A further risk is that in times of economic and fiscal constraints commissioners often make savings in areas of joint funding rather than core areas. As a result, funding set aside for joint commissioning may be vulnerable. In addition, a more scaled up service after the conclusion of the pilot underpinned by joint commissioning may displace or disrupt initiatives that exist at local level and focus on integrated service delivery.

We have encountered some initiatives that brought together Jobcentres, local mental health services, IAPT and at times Work Programme providers. Some of these initiatives may be quite effective on the basis of some anecdotal evidence that we collected as part of this study. Finally, it is unlikely that joint commissioning will be widely taken up without funding being made available by the departments involved

and clear expectations set in operational plans such as the NHS Mandate and NHS Outcomes Framework. For instance, in the health sector, the Government may emphasise the importance of employment outcomes. Here, the DWP may have an advantage over DH in setting expectations for local Jobcentres due to its relatively centralised delivery structure. DH will need to rely more on influencing and incentivising its local commissioners.

Designing robust pilots

Our work has focused mostly on proposing a number of policy options that appear promising in improving the employment outcomes of those with mental health problems. The descriptions of the policy options in Chapter 5 provide suggestions for how the policy options could be piloted. A robust pilot design is essential because one of the aims of piloting is to improve the evidence base. We have proposed the use of RCTs, since pilots that randomly assign participants to treatment and control groups would be preferable in terms of generating robust evidence of effectiveness. However, we note that there are challenges in implementing RCTs. If an RCT is not possible, those designing the pilots should attempt to build comparable treatment and control groups. This comparability should not just incorporate demographic factors but also motivations, relative wellbeing and job readiness. These are key aspects to consider in the facilitation of people with mental health problems gaining and sustaining employment. The pilot design would preferably also aim to understand how the intervention can be scaled up and as such the intervention should be piloted in different geographies and contexts to draw out wider lessons for scaling up the intervention. In this way, it is hoped that the pilot will have a demonstration effect for commissioners at all levels.

A case for investment

In Chapter 5, we have provided some conservative benefit-cost ratios for each policy option (except online). In each case, the benefits are likely to exceed the costs of the service, especially when taking into account wider benefits to individuals treated, society and the economy that this study could not monetise. This study puts forward a case for investment by the Government. Our work has provided some strategic options for policymakers. However, this study has not set out in detail how the implementation and piloting would occur.

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APPENDICES

Appendix A: Interview topic guide

Interviewee name	
Position & institution	
Date & mode	
Interviewer(s)	

Introduction:

- Summary of the key objectives of this study
- Brief overview of the main research methods
- Reporting and next steps
- Aims of this interview.

Confidentiality:

- Check whether the respondent agrees to have the interview recorded for note taking purposes [if so, turn on].

General questions

1. Can you explain your role and responsibilities, and what your engagement with the DWP and DH was on this subject so far?
2. What do you consider as the main issues in gaining and maintaining employment for people with mental health problems? *Prompt, if necessary:*
 - a. To what extent do you think these issues have been addressed so far by current policies?
 - b. Are these issues the same or dissimilar for different groups of people with common mental health problems (in/out of work, (un)diagnosed, with mild/moderate mental health problems)?
3. Gaining and maintaining employment for those with mental health problems:
 - a) What approaches/interventions do you believe are helpful and what is the evidence for these?
 - b) What, if any, is the evidence on the existing programmes and interventions?
Prompt, if necessary:
 - active labour market programmes / universal services / payment for results programmes?
 - occupational health programmes / work place interventions?

- what kind of evidence?
- c) To your knowledge, what interventions / provisions work (and what are unhelpful) for people with mental health problems? *Prompt, if necessary:*
 - What is the evidence behind these?
- d) What specific policy action would you propose to the UK Government that would make a substantial difference in this area? *Prompt if necessary:*
 - quick wins? (ie could be introduced before the next election in 2015)
 - longer-term strategic options?
 - type of innovative approaches?
- e) What potential problems or difficulties can you envisage in relation to your suggestions?

Specific issues

Health service

4. How, if at all, could current provisions and services be made more effective?
Prompt, if necessary:
- GP and clinical involvement:
 - addressing the ‘treatment gap’ – diagnosis and treatment methods
 - considering employment as a clinical outcome
 - referral to other services (IAPT, Jobcentre Plus, Work Programme, Work Choice)
 - incentives and barriers for working with other services
 - commissioning of health services.
 - IAPT:
 - referral to IAPT (and from IAPT to other services)
 - capacities to meet demand (waiting times, treatment options)
 - employment component of IAPT (employment advisors)
 - measuring and monitoring KPIs and employment outcomes
 - incentives and barriers for working with other services (GPs, Jobcentre Plus, Work Programme, Work Choice)
 - maintaining the momentum.

Probe:

How they might work in practice? What would the barriers to successful implementation be? How likely is it that any changes could be introduced successfully?

Benefits and payments

5. How, if at all, could the welfare provision system support employment outcomes for claimants with mild or moderate mental health problems? *Prompt, if necessary:*

- data on mental health of benefit claimants
- early identification and support
- referral to other services
- sanctions for non-compliance for people with mental health problems
- introduction of the Universal Credit.

Probe:

How they might work in practice? What would the barriers to successful implementation be? How likely is it that any changes could be introduced successfully?

In work services

6. The Government has announced that an independent occupational health service will be introduced in 2014 to provide advice for people off sick from work for four weeks or more. What role do you think this service could play in maintaining people with mental health problems in employment?
7. What other services might be needed?
8. What conditions have to be met for these services to be effective?

Employment services

9. How could the current employment services be improved for people with mental health problems? *Prompt, if necessary:*

- Work Programme/ Work Choice/Access to Work:
 - incentives for providers
 - payment structure
 - outcome measures for providers [GAD, etc]
 - scaling up effective services
 - capacities to meet demand (waiting times)

- referral to other services / provision of relevant support (IAPT, specialist support)
- data on mental health of the beneficiaries.

Probe:

How they might work in practice? What would the barriers to successful implementation be? How likely is it that any changes could be introduced successfully?

Potential solutions to be tested

10. Please tell us what you think about the following ideas how to address the problem and improve employment outcomes for people with mental health problems:

- **Measurements:** who benefits from extra support
- **Strategic:** using the new local health and wellbeing boards
- **Joint working models:** co-commissioning / colocation of services provided at a local level
- **Work Programme:** a) introducing contractual arrangements requiring WP providers to describe how they plan to help people with mental health problems; b) introducing a requirement to report on how the providers help improve wellbeing c) changing the incentives for the service providers.

11. What are your thoughts on Individual Placement and Support (IPS) and Jobs II?

Appendix B: Longlist of policy options assessed against criteria

We made a preliminary assessment of each of the options using three criteria: feasibility, acceptability and suitability:

- **Acceptability** looks at the extent to which proposed action can secure buy-in from political decision-makers, administrators, and wider stakeholders.
- **Feasibility** refers to whether the proposed action fits within the institutional set-up, organisational processes and policy framework.
- **Suitability** refers to 'value for money'. Value for money (VfM) refers to the economy, effectiveness, and efficiency of a proposed action. These three E's effectively refer to whether the initiative allows you to do less (spend less), do more with the same, or do the same with less.

We scored each policy option against each of these criteria as follows:

+: There is evidence confirming the criterion will be met.

=: There is mixed or anecdotal evidence.

?: There is no evidence.

This assessment was initially undertaken by the project team at RAND Europe in a workshop format whereby each policy option was discussed and assessed by the project team. We then validated these judgments in a workshop with our project partners. The workshop was facilitated by RAND Europe staff. We discussed and assessed each policy option in turn. The evidence in this area is often limited, variable and anecdotal as explained in Chapter 2, which made arriving at judgments in some cases difficult.

Identifying and assessing the needs of those with mental health problems

Policy option	Specific action	A	F	S	Comment
1. Focus on workplace interventions: work with employers to promote effective ways to retain employers with common mental health problems in employment and prevent development of mental health problems					
1.1. Encourage line manager training to recognise health conditions in employees and how to manage conditions.	1.1.1. The public sector could adopt some line manager training as a trial.	+	=	+	The attractiveness of workplace interventions is that they come earlier and as such are likely to be more effective – many respondents mentioned line manager training.
1.2. Emphasise the merits of evidence-based treatment and early intervention for mental health problems among employers.	1.2.1. Incentivise employers to buy services from IAPT or other specialised providers (eg tax incentives).	+	+	?	The aim here is to create a market for IAPT or IAPT type services to provide help for employees with mental health issues and offer continued support to sustain the outcomes.
1.3. Set minimum standards for the new Health and Work Service (HWS) to engage with specialist mental health services and employment advisers.	1.3.1. Create clear referral paths for the HWS to assist those with mental health issues most effectively.	+	+	?	It seems obvious that HWS provides an early intervention but without proper integration into other services (eg IAPT) it may not be that effective in assisting those with mental health issues. Removing tax disincentive to fund services that the employee needs can help improve effectiveness.

Policy option	Specific action	A	F	S	Comment
2. Build capability and influence behaviour of key gatekeepers (health professionals, staff in the benefit system and WP providers)					
2.1. Raise awareness among GPs of the needs of people with mental health problems and employment benefits (all GPs).	2.1.1. Introduce e-learning modules with GPs or other approaches trialled in London to create awareness around employment and mental health and referral options (eg IAPT, specialist providers, NHS, etc).	+	+	=	If early intervention is important for those with mental health problems, than targeting GPs could be critical. It is not certain, if awareness raising will lead to behaviour change. The challenge is how to incentivise them to do so.
	2.1.2. Embed mental health into the system to make it easier for GPs to make referrals (introduce it in the electronic system to reduce workload for GPs).	+	+	?	There appear to be practical barriers to why GPs do not refer on – apparently the electronic system is one of them.

Policy option	Specific action	A	F	S	Comment
2.2. Influence the training and development of health professionals to improve their contribution to achieving successful employment outcomes for patients with mental health conditions (mainly GPs and nurses).	2.2.1. Revise education curricula of healthcare professionals to engage more with employment and social outcomes when undertaking case management.	+/=	+	?	<p>Some Royal Colleges appear quite open to this but the role of the Government in this is more indirect.</p> <p>Some of these options could be linked to initiatives proposed by PH England:</p> <ol style="list-style-type: none"> 1) mandatory postgraduate training for GPs on MH and paediatric health 2) train the trainers / create champions by getting some GPs to have regular updates on MH developments 3) pre-registration and post-registration training requirements. <p>The levers include:</p> <ol style="list-style-type: none"> 1) annual appraisals (CQC registration) 2) renewal/revalidation of registration 3) on-going inspections – if a practice is focused on employment outcomes, etc.
	2.2.2. Encourage the royal colleges to produce guidance on employment and mental health issues	+/=	+	?	
	2.2.3. Revise continuous professional development (CPD) to emphasise employment and social outcomes when undertaking case management	+/=	+	?	

Policy option	Specific action	A	F	S	Comment
2.3. Raise awareness among health professionals, employers and Jobcentre Plus advisers of a. mental health b. services available and local options for referral for people with MH conditions (eg IAPT, NHS services and specialist providers at workplaces etc.).	2.3.1. Provide general information on services available and the issue of mental health and employment in GP surgeries, workplaces and NHS organisations.	+	+	=	The aim of this intervention is to create more awareness of services currently offered and encourage patients to self-refer or ask system gatekeepers to refer them on.
	2.3.2. Continue rolling out the MH Toolkit in Jobcentre Plus, achieve buy-in from local managers, and map local MH services available to provide support for people with MH problems.	+	+	=	The aim here is to improve assessment of those with mental health issues and speed up referral to specialist support.
2.4. Work with WP providers to create more awareness among employment advisers with regards to employment and mental health issues and look at referral options.	2.4.1. Build on the WP toolkit and disseminate good practice more systematically (through platforms, meetings, and online resources) between WP providers.	=	+	?	Most of the WP providers have signed up to the pledge to support those with mental health issues – though there may be issues around WP providers sharing their practice with competitors.

Policy option	Specific action	A	F	S	Comment
3. Strengthen employment focus of IAPT and GPs with the current policy/service environment (NHS Mandate, GP contract, NHS outcomes framework, CCGs) and influence health and wellbeing boards					
3.1. Influence / mandate CCGs to provide adequate and timely IAPT services	3.1.1. Set minimum requirements in IAPT commissioning on waiting times and treatment standards (case load and number of sessions, number therapists)	+	=	?	IAPT service provision is variable across England and explicitly re-emphasising service standards may create more capacity and reduce variability of provision This option requires engagement with all the CCGs
3.2. Influence/mandate GPs to engage more proactively with mental health issues and employment.	3.2.1. DH and NHS England to introduce focus on mental health issues and employment in next GP contract.	=	+	?	If we believe that employment is generally associated with better health and wellbeing it seems logical to have GPs engage with employment as an outcome. Changing the contract may be possible but could face some resistance from professional associations.
3.3. Engage with local health and wellbeing boards to have a local focus on health and employment.	3.3.1. Try a targeted approach in some localities to see if local priorities can be influenced.	+	+	?	The DWP has not been overly successful so far in engaging with them.
3.4. Promote a greater focus in IAPT services on employment outcomes.	3.4.1. Build in/mandate employment outcomes in the next round of IAPT commissioning (with CCGs).	=	+	?	
	3.4.2. Build in an employment outcome in the planned IAPT P4P pilot and monitor performance on this measure.	+	+	?	Our impression is that this could be discussed given the pilot is still at the design stage.

Policy option	Specific action	A	F	S	Comment
4. Improve assessments in the benefit system					
4.1. Improve the identification of those with mental health problems in the benefit system (and the assessment of employment-related needs of these people)	4.1.1. Design guidance, require Jobcentre Plus staff to assess benefit claimants more systematically for health conditions including mental health, and ensure they communicate observations when referring onto other services	+	+	?	We know assessment in Jobcentres is patchy, does not necessarily lead to referrals for support, and when referrals are made information on pre-existing conditions is often lacking
4.2. Engage services that Jobcentres may refer to (IAPT and WP providers) in the training of Jobcentre Plus staff.	4.2.1. Trial in certain areas whether involving specialist providers in assisting Jobcentre Plus staff in identifying candidates for referral is effective.	+	+	?	
4.3. Strengthen the approach used to identify sickness benefit claimants' health and work needs.	4.3.1. Improve existing assessment process for sickness benefit (WCA) to collect more information on health condition and potential specialist support required – maybe reintroduce an improved version of the Work Focused Health Related Assessment (WFHRA) for these purposes.	+	+	?	Better information from the various assessments could lead to claimants being directed to adequate/specialist support quicker – the DWP is currently looking into improving the quality of the WCA. The assessors and end-users of the assessments outputs should be involved in the development of a new/revised tool to avoid shortcomings of WFHRA.

Policy option	Specific action	A	F	S	Comment
4.4. Promote self-assessment among benefit claimants.	4.4.1. Promote methods and tools for self-assessment and provide clear signposting for treatment options and further consultations, when necessary.	+	?	?	This could help increase awareness of those accessing Jobcentres on their health conditions. Everyone entering Jobcentres should be offered this choice.

Referring those with mental health problems to appropriate support

Policy option	Specific action	A	F	S	Comment
5. Introduce greater integration between services (IAPT, Jobcentre Plus and the WP)					
5.1. Promote greater/automatic referral of those with mental health issues seen in Jobcentre Plus (JSA claimants) to IAPT.	5.1.1. Pilot the automatic referral of those with mental health issues from Jobcentre Plus to IAPT in a locality.	+/=	+/=	=	This would need involvement of the CCG given their role in commissioning local services and setting local priorities – capacity in IAPT may be an issue and variability in service provision. It also assumes that those with common MH problems can be identified.
5.2. Promote greater/automatic referral of those with mental health issues seen in WP (JSA claimants entering the WP and ESA) to IAPT or other available psychological therapy services.	5.2.1. Pilot the automatic referral of those with mental health issues from WP prime to IAPT or mental health services in a locality.	+	+	=	This may be especially relevant if primes or partners do not offer evidence-based treatment for those with MH problems. Capacity in IAPT may be an issue and variability in service provision. WP providers seem to have an incentive to use those services (given that currently they are free and that after the treatment clients may be 'easier' to place. It also assumes that those with common MH problems can be identified.

Policy option	Specific action	A	F	S	Comment
5.3. Require WP providers to refer benefit claimants with mental health problems (JSA claimants entering the WP and ESA) to IAPT and pay for services.	5.3.1. Pilot an automatic referral and payment scheme in a locality.	?	=	?	<p>The assumption is that IAPT services would create capacity, if they received additional payment for services.</p> <p>The issue would be how to incentivise WP providers to do this, though using the pledge they all signed up to might be the way forward.</p> <p>There is also an assumption that claimants with MH conditions could be identified appropriately within the WP.</p> <p>Self-referral may make creating a market for IAPT more difficult as it offers a free route into the system that providers could exploit.</p>
5.4. Introduce ring-fenced budgets in local Jobcentre Plus offices to pay for referral of JSA claimants with mental health conditions to specialist support services.	5.4.1. Pilot whether the use of such budgets leads to better outcomes for claimants involved in selected local Jobcentre Plus offices.	+	+	=	<p>The aim is to link up Jobcentre Plus more directly to local specialist services – Turning Point has successfully done this in Manchester.</p> <p>The advantage is that it is an early intervention but what incentives are there for Jobcentre Plus to be proactive in referring people to providers (these providers could also be local IPS services).</p>
5.5. Create local communities of service providers that cover employment advice and mental health services.	5.5.1. Encourage regular meetings between local providers to set a common strategy.	+	+	?	<p>We know that in certain localities this is happening – a main question is how the central Government can encourage such meetings to occur.</p>

Policy option	Specific action	A	F	S	Comment
5.6. Create dedicated support offered by specialist staff (healthcare professionals, Jobcentre Plus staff, or WP provider) for 'hard to place groups' in the benefit system (mostly ESA).	5.6.1. This option is similar to the pilots announced by Mark Hoban on July 8	+	+	=	This dedicated support would sit next to existing channels – the pilot takes three years and runs to 2016. The assumption is that an appropriate mental health group could be identified
6. Encourage higher ratios of employment advisers to therapists in IAPT					
6.1. Influence / mandate CCGs (through the NHS mandate and/or IAPT outcomes framework) to provide IAPT services as it was initially intended and perhaps make additional funding available for employment advice	6.1.1. Pilot the added value of greater number of employment advisers in selected IAPT services	+	=	=	The assumption is that a combination of therapists and employment advisers could produce better (employment) outcomes for those with mental health problems
7. Promote the role of the Work Programme in securing specialist help for people with mental health conditions					
7.1. Introduce a distance travelled measure and link payment to job readiness	7.1.1. Pilot a scheme with selected WP providers whereby they receive incentives on the basis of improving the health and wellbeing of individuals next to employment outcomes	+	=	+/=	The design of a measure may not fit well in the current outcome-focused design of the WP but it could result in improving the mental health of individuals without an employment outcome per se

Policy option	Specific action	A	F	S	Comment
7.2. Create a 'mental health payment group' in the Work Programme rather than (or next to) the current benefit groups.	7.2.1. Pilot a scheme whereby a greater number of JSA claimants with perceived mental health issues are referred at an early stage to WP providers for a higher pay for performance (similar to ESA group).	+	=	?	This option may undermine the generalist nature of the WP as a large number of individuals have mental health issues – but it may create more focus in the WP on mental health as more claimants would likely be referred and be eligible for higher payment.
7.3. Revise the payment structure within the WP.	7.3.1. Introduce premium payments for achieving outcomes for people with mental health problems (or for improvement in mental health).	=	=	?	This option may undermine the generalist nature of the WP as a large number of individuals have mental health issues. This option is just about increasing the premium for those currently identified as difficult to place.
7.4. Exploit the potential of existing specialist programmes and interventions to re-direct some claimants with MH conditions from the WP (mostly ESA).	7.4.1. Trial referring a greater number of benefit claimants into Work Choice or Access to Work and see how those programmes could support people with mental health conditions.	+	+	?	This was frequently mentioned by stakeholders but we have not looked in detail how this would work for those with common mental health issues. An alternative would be to adopt the Work Choice mechanism (that provides ongoing support during an initial period at work) rather than push more people into it.
7.5. Design a social impact bond for certain 'hard to place groups' currently in the WP.	7.5.1. Pilot the approach on a selected group (eg ESA) in selected localities.	?	?	?	The aim is to create more dedicated specialist and adequate support away from the more generalist WP (this option is similar to Option 19). It may be difficult to identify the target group if we go outside of the benefit system (eg ESA).

Policy option	Specific action	A	F	S	Comment
8. Set minimum standards in service provision					
8.1. Work with the DH and other stakeholders to develop a range of costed options for funding and implementing new access and/or waiting time standards for mental health services and be prepared and committed to introducing those standards as they are agreed.	8.1.1. A fidelity measure could be introduced to monitor programme quality and adherence to the expected standards.	+	+	?	The challenge is capacity of IAPT, as introducing waiting times cannot put at risk the quality of service.
8.2. Influence the black box of the WP to force primes to provide evidence-based mental health services.	8.2.1. Pilot with WP primes the use of interventions that follow the NICE guidelines.	=	=	?	Most of the WP providers have signed up to the pledge to support those with mental health issues – this approach may be similar to the pilots announced by Mark Hoban on July 8 (Option 12).
9. Pursue options currently not in use in the UK health and welfare sectors					
9.1. Widen the provision of IPS to include those with common mental health issues (general population).	9.1.1. Pilot the use of IPS for a wider range of individuals with mental health problems in selected localities.	+	+	?	IPS may only be suitable for particular groups of claimants.

Policy option	Specific action	A	F	S	Comment
9.2. Give all benefit claimants (JSA claimants) access to online CBT.	9.2.1. Pilot in selected Jobcentre Plus locations the use of such platforms.	+	+	?	<p>We know that online applications can be effective in treating individuals with low level mental health problems at an early stage.</p> <p>While they not focus on work readiness, they include relevant skills (confidence building, resilience, self-regulation).</p> <p>Dedicated computer games or programmes that would aim to increase work readiness could also be developed and evaluated.</p>
9.3. Provide targeted intervention for a group of benefit claimants.	9.3.1. Pilot the use of group therapy (eg Jobs II) approach on a selected group of benefit claimants in certain localities.	+	?	=	We have only anecdotal evidence on this approach and it may only be suitable for particular groups of claimants.
10. Incentivising long-term outcomes					
10.1. Incentivise WP providers to capture longer-term outcomes.	10.1.1. Encourage WP providers to offer on-going support to claimants <u>after</u> they get a job offer.	=	=	?	We know that employment services in Australia monitor the employment outcomes up to 26 weeks (in comparison to 12 weeks for the EAS claimants in the UK).
10.2. Incentivise employers to maintain people in employment.	10.2.1. Provide tax incentives for accredited programmes for employees after they return to work.	+	=	?	

Appendix C: Overview of the four shortlisted policy options

Policy option / Pilot	Description	Implementation	Business Case
<p>Embed vocational support based on the principles of IPS in local IAPT or psychological therapy services</p>	<p><u>Proposition</u></p> <p>To pilot whether offering specialist vocational support based on the IPS model is effective and cost-effective in achieving employment outcomes for those with common mental health problems.</p> <p><u>Approach</u></p> <p>The proposed pilot approach is a randomised control trial (RCT) whereby those referred to IAPT with employment needs are randomly assigned to IPS (treatment) and more 'standard' IAPT service (control).</p>	<p><u>Target group</u></p> <p>Any individual presenting to IAPT with a mental health problem and employment-related needs (with likely greater functionality compared to the patients in a secondary care IPS service). May include the 'in work' group</p> <p><u>Location</u></p> <p>Services could be provided at the location of IAPT services (or equivalent for Scotland and Wales), or in GP practices.</p>	<p><u>Funding</u></p> <p>Funding could be made available through normal IAPT budgets, a joint commissioning model between Clinical Commissioning Groups (CCGs) and the DWP, or additional top-ups provided by the DWP or DH to IAPT funding.</p> <p><u>Effectiveness</u></p> <p>For each £1 spent, the Government would save £1.41 in return with this intervention.</p> <p><u>Cost</u></p> <p>Scaling up the intervention to 83,916 participants would cost £62.9 million.</p>

Policy option / Pilot	Description	Implementation	Business Case
<p>Introduce group work approaches based on JOBS II in Jobcentre Plus</p>	<p><u>Proposition</u></p> <p>To pilot a group work approach based on JOBS II in current provision of services to see how it improves the employment and health and wellbeing outcomes of those with common mental health problems.</p> <p><u>Approach</u></p> <p>The proposed pilot approach is a randomised control trial (RCT). It will compare the additionality of the JOBS II treatment (treatment group) to normal treatment of benefit claimants seen in Jobcentre Plus.</p>	<p><u>Target group</u></p> <p>JSA claimants who have been assessed by the screening tool as having (or being at risk of developing) a mental health problems and who are also less likely to enter employment.</p> <p><u>Location</u></p> <p>The aim is to make the JOBS II programme at a neutral venue close to Jobcentre Plus offices.</p>	<p><u>Funding</u></p> <p>Pilots would need to be funded in Jobcentre Plus districts and any other locations (eg IAPT or equivalent). Potential longer-term funding from Jobcentre Plus budgets, a joint commissioning model between CCGs and the DWP for employment advice, or additional top-ups provided by the DWP to Jobcentres.</p> <p><u>Effectiveness</u></p> <p>For each £1 spent, the Government would save £1.07 in return with this intervention.</p> <p><u>Cost</u></p> <p>If the intervention is offered to a good proportion of ESA and JSA claimants with mental health problems the cost would be 130.7 million for 149,432 participants.</p>

Policy option / Pilot	Description	Implementation	Business Case
<p>Providing access to online mental health and work assessments and interventions</p>	<p><u>Proposition</u></p> <p>To pilot the use of online tools that assess for mental health problems and signpost individuals to specialised services/support.</p> <p><u>Approach</u></p> <p>The pilot would randomly assign individuals to:</p> <ul style="list-style-type: none"> • traditional interventions (treatment as usual – TAU); • eTherapy interventions not offering vocational support; • eTherapy interventions with a vocational element. 	<p><u>Target group</u></p> <p>The general population. May include the ‘in work’ group.</p> <p><u>Location</u></p> <p>The application could be developed/accredited jointly by the DH and DWP or provided by third sector and/or private providers. It could be promoted at GP practices, by NHS and IAPT services, and Jobcentre Plus alike.</p>	<p><u>Funding</u></p> <p>Pilots would need to be funded and run in selected localities or populations.</p> <p><u>Effectiveness</u></p> <p>We have little evidence on actual costs and employment effects. Certain interventions appear cost-effective in terms of normal treatment per QALY.</p> <p>We estimate the cost of the service for about 100,000 participants at between £20–40 million.</p>
<p>Use Jobcentre Plus budgets to commission third-party organisations to provide a combination of psychological</p>	<p><u>Proposition</u></p> <p>This pilot aims to involve specialist providers such as Turning Point, MIND and other third parties more directly in offering specialist support to Jobcentre Plus.</p>	<p><u>Target group</u></p> <p>JSA claimants with mild to moderate mental health problems, potentially ESA claimants with mental health problems, and possibly those claimants seen at significant risk of developing mental</p>	<p><u>Funding</u></p> <p>This option would mean pilots funded in Jobcentre Plus districts. Potential longer-term funding from Jobcentre Plus budgets under the Freedom and Flexibilities delegation, a joint commissioning model between CCGs and the DWP for employment advice,</p>

Policy option / Pilot	Description	Implementation	Business Case
<p>and employment related support to claimants</p>	<p><u>Approach</u></p> <p>We will compare the additionality of the telephone-based treatment (treatment group) to normal treatment of benefit claimants seen in Jobcentre Plus. In other words, the treatment group will receive the intervention in addition to the normal offering in Jobcentres.</p>	<p>health problems.</p> <p><u>Location</u></p> <p>Service provided through Jobcentres by third parties.</p>	<p>or additional top-ups provided by the DWP to Jobcentres.</p> <p><u>Effectiveness</u></p> <p>For each £1 spent, the Government would save £1.12 in return</p> <p><u>Cost</u></p> <p>Providing the intervention to a good proportion of JSA and ESA claimants with mental health problems would cost £37.4 million for 149,432 participants.</p>

Appendix D: Additional information on IPS and JOBS II

Individual Placement Support (IPS)

IPS targets individuals with severe and enduring mental health conditions. IPS services are delivered by supported employment teams that operate within community mental health centres in close collaboration with clinical staff. Individuals who express interest in working will be referred to an employment specialist on the IPS team for an initial meeting. The employment specialist works with the service user to learn about his or her goals and preferences and provides information about how IPS works. Right after the decision to start in IPS, the individual and the employment specialist make a plan together and begin to look for regular jobs in the community as soon as the client expresses interest in doing so. Employment specialists are trained to provide people with support, coaching, resume development, interview training, and on-the-job support. IPS puts the service user's preferences at the centre of attention, as the service user decides whether or not employers and potential employers know about their mental illness and whether or not their employment advisor contacts the employer on his or her behalf. The service user also decides which jobs to apply for and how much he or she wants to work. The decision about how much to work is often influenced by a desire to transition to a working life while minimising the risk of being both out of work and without disability benefits.

The IPS model includes seven elements:

1. Primary goal is to achieve competitive employment with central focus to support job seekers gaining paid employment
2. Everyone is eligible with free service user decision of when to start return to work process
3. Job search is consistent with individual preferences
4. Job search is rapid
5. Joint location of employment specialists and clinical
6. Information about benefits is provided to help
7. Support is time unlimited and customised, to both the employee and the employer.

IPS was initiated in the US, which has a very different initial setup in terms of public mental health and employment services compared to the UK. For instance elements 1, 3, 4 and 6 are provided in the UK on a national basis and for instance everyone is eligible but jobseekers cannot choose independently when and how to engage with adjunct employment support. There is a broad literature showing that IPS is effective

(Bond et al., 2008; Knapp et al., 2013; Marshall et al., 2013). However, the majority of the evidence is for the US and almost all research on IPS is based on a comparison of IPS with vocational rehabilitation (VR) models but there is some evidence that VR has not produced good data on employment outcomes. Furthermore in IPS employment for more than three hours a week is classed as an outcome in research on IPS.

The evidence base for IPS in the European context shows ambiguous effects. Burns et al. (2008) study the effectiveness of IPS for six European centres (London, Ulm, Rimini, Zurich, Groningen and Sofia). A total of 312 patients with severe mental illness were randomly assigned to receive IPS or vocational services (status quo). Patients were followed up for 18 months, with the primary outcome observed the difference between the proportions of people entering competitive employment in the two groups. IPS has shown to be more effective than vocational services for every vocational outcome, with 55 per cent of patients assigned to IPS working for at least one day compared to 28 per cent patients assigned to vocational services. Patients assigned to vocational services were significantly more likely to drop out of the service and to be readmitted to hospital. The study concluded that IPS is effective approach for vocational rehabilitation in mental health that deserves investment. Bond et al. (2008) conducted comprehensive literature review for RCTs of IPS, limited to programmes with high fidelity IPS programmes. The competitive employment outcomes the examined are employment rates, days to first job, annualised weeks worked and job tenure in longest job held during the follow-up period. Across 11 studies, the competitive employment rate was 61 per cent for IPS compared to 23 per cent for controls. About two-thirds of those obtained competitive employment worked 10 hours or more per week, while among those who obtained a competitive job, IPS participants obtained their first job nearly 10 weeks earlier. Among IPS participants who obtained competitive work, duration of employment after the start of the first job averaged 24.2 weeks. Note that the follow-up periods differ in the studies explored from one year to two years, with the majority of follow-ups after 18 to 24 months.

Howard et al. (2010) test the hypothesis that support employment using IPS is effective in helping individuals to gain employment in the UK context. Individuals with severe mental illness in South London were randomised to IPS or local traditional vocational services with 219 individuals were randomised and 90 per cent assessed one year later. The study shows no significant differences between the treatment as usual group and intervention groups in obtaining competitive employment (13 per cent in intervention and 7 per cent in controls), with no evidence that IPS was of significant benefit in achieving competitive employment for individuals in South London at a one-year follow-up. The authors explain the different outcomes with the specific nature of the labour market compared to the US, a lack of employer incentives in employing individuals with severe mental illness, but also the payment for healthcare in the US, which may increase incentive for individuals to find work faster. Another explanation is that IPS programme in the trial was not structurally and managerially integrated with community mental health services (CMHS), which determines the effectiveness of IPS programmes. Studies have shown that

integration of IPS with CMHS is crucial for success. And furthermore, the relatively high proportion of participants from ethnic groups other than White (62 per cent in the study) could limit the success of IPS in the UK, as they are more likely to have lower labour market attachment and are more likely to be unemployed.

Kinoshita (2013) shows that in terms of employment (days in competitive employment, over one-year follow-up), supported employment seems to significantly increase levels of any employment obtained during the course of studies. Supported employment also seems to increase length of competitive employment when compared with other vocational approaches.

JOBS II

The JOBS model was developed as an intervention programme to help unemployed workers seek a way back to the marketplace and at the same time protect their mental health. The programme's focus is on currently unemployed individuals. The programme is delivered through a workshop that allows for intensive interaction between participants and two group facilitators (one male and one female coming from diverse backgrounds to provide role model similarity for participants) with a dual goal of: (1) creating effective job search, (2) addressing emotional needs of unemployed job seekers (preventive measure for those at risk for depression as a result of job loss). These two goals are addressed by a combination of techniques that build up relevant skills and enhance and maintain motivation of job seekers. In summary, the JOBS II is a peer-led group programme with the intention to group therapy for about 12 to 20 individuals who are unemployed, and takes place for around four hours a day, four days a week over six weeks. The idea behind JOBS II is that behavioural outcomes can be achieved through the combination of techniques that build up relevant skills and the motivation to use them. The JOBS II programme was designed to increase the participant's sense of job search self-efficacy and improve their ability to manage the setbacks they may encounter in the job search process. Vinokur et al. (1995) show that the JOBS group intervention significantly decrease depression, improve emotional functioning and also increased rates and quality of reemployment which, in turn, had major impact on decreasing financial strain. Vuori and Silvonen (2005) highlight that the programme's beneficial effects were still present at a two year follow-up of participants, including those who were long-term unemployed, which shows a rather long-term positive impact of the intervention. JOBS II field experiments also demonstrated that the intervention primarily improved the mental health and the reemployment outcomes of high risk respondents. A two-year follow-up of the JOBS II randomised trials demonstrated that programme has an impact on a wide range of psychosocial outcomes including motivation, mental health, psychical health, and provided economic benefits through higher paying and higher quality jobs (Vinokur, Schul, Vuori and Price, 2000). The individual trainer skills have shown to be particularly important in reducing depressive symptoms and in producing higher levels of reemployment. Overall, the research on JOBS II illustrates the importance of self-efficacy, building on strengths, active learning and group attention to preparation for setbacks on having an

important impact by reducing distress and depression and was particularly powerful in helping those at highest risk for depression. The value of attending to issues that individuals predict will be potential setbacks or will cause them difficulties in the workplace has been supported by other research (Blonk, Brenninkmeijer, Lagerveld, and Houtman, 2006).

Appendix E: Additional information on pilot design and implementation

Below, we provide more detail on the shortlisted policy options. For each of these policy options, we have present:

- the experimental design of the pilot: the comparison of the treatment versus the control group and outcomes monitored
- hypotheses: the underlying logic of putting this intervention in place
- funding and implementation: models of commissioning and specific implementation requirements
- risks and challenges: known and envisioned barriers to implementation
- scaling up the intervention: the cost to the taxpayer of rolling out the intervention more widely on the basis of the likely client population.

Policy option 1: Embed vocational support based on the principles of IPS in local IAPT or psychological therapy services

Pilot design

The intention is to test whether offering specialist vocational support based on the IPS model is effective and cost-effective in achieving employment outcomes for those with common mental health problems in a primary setting.

The proposed pilot approach is an RCT or a similar robust evaluation with control and treatment groups. People referred to IAPT with employment needs would be randomly assigned to one of three groups:

- 'standard' IAPT treatment, the NICE approved therapy alone (control group)
- IPS (employment support)
- IPS and standard treatment offered in combination.

Anyone assessed as reaching the threshold for IAPT treatment would be offered therapy. It is important to note that IAPT treatment may not be suitable for everyone with a common mental health problem. The trial could exploit natural waiting times for therapy with precipitated (day one) access to employment advice if needed, while the individual awaits treatment. The outcomes considered will align with the current IAPT employment outcome, individuals moving off sick pay or sickness benefits. However, the aim will also be to capture other employment outcomes such as net employment (eg work entry rates) and sustained employment as well as outcomes such as improvements in health and wellbeing. Capturing a wider set of employment

outcomes is also helpful for monitoring the progress of the in-work group or the group not on sickness and unemployment benefits. There may be challenges in undertaking an RCT as outlined in the risk section later on.

Hypotheses

Individuals with common mental health problems often find it difficult to obtain specialist employment advice early on. Providing access to vocational specialists in a primary care setting will enable greater access for people with common mental health problems to those specialist services. This in turn should lead to better health and employment outcomes for those treated.

Integration of mental health treatment and employment advice through co-location of services and the introduction of a treatment pathway appears a logical way to address the needs of people with common mental health problems and employment-related needs.

This pilot is largely about testing whether fidelity to a specific model offers better results than other models of specialist employment support or no specialist employment support. As a result, the pilot could also strengthen the provision of employment advice in IAPT, which arguably has not been delivered to the extent that was originally envisioned when IAPT was introduced. The value of this pilot is mainly to local strategy and commissioning.

Funding and implementation

This approach would mean paying for trained vocational specialists delivering employment support in the pilot phase. In England (longer-term) funding for specialist support could be made available through IAPT budgets (which incorporate funding for employment advice), a joint commissioning model between local partners or additional top-ups provided by the DWP or DH to IAPT funding. The latter may be an appropriate route given that IPS is a specified model, and could be offered through existing IAPT services.

The pilot may also benefit from a joint commissioning approach to reflect the integration of services proposed. There are no set definitions of what joint commissioning is⁵⁸ and there is no fixed model of practices and processes associated with joint commissioning. Rather, it sets out an intention of integrating services in a way that brings together a range of funders and stakeholders. In this pilot, we will have to guard against integration becoming the objective itself. There is limited evidence on the impact of joint commissioning. As such, we will need to carefully track the progress against the ultimate objectives of the pilot (eg improving employment outcomes). Moreover, new commissioning arrangements may disrupt local integration models. With safeguards in place, any disruptive aspects of the pilot should be apprehended early and their detrimental effects avoided or diminished.

⁵⁸ See the recent SDO-funded report at http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1806-260_V02.pdf (accessed December 2013).

Finally, joint commissioning is likely to be more difficult given budgetary constraints in the public sector with services retrenching to core business and services.

Risks/challenges

While IPS has been effective for people with severe mental illness in a secondary health setting, it has not been systematically used or evaluated for people with common mental health problems in a primary care setting. IPS is a fidelity model meaning the key principles of service delivery are specified. There is a need to understand the appropriateness of making such a model available in such a setting.

IPS often has a low threshold for defining successful employment outcomes. Studies of IPS can count three hours of work per week as a successful outcome. This raises the question of what is seen as a successful employment outcome.

IPS can be expensive. Unit costs for IPS services in England range from about £1,800 to £7,100 per person per year, though the locations that use IPS report much lower costs (see business case below). The level of one-to-one support to achieve and maintain employment outcomes in the IPS model can be offered on a time unlimited basis. This raises issues around feasibility of general provision, though some localities in England have started to adopt the proposed approach as part of IAPT provision.

IPS is a voluntary/opt-in model. Candidates are mostly committed and motivated. In existing IAPT services in England, as reported by one of our interviewees, there are significant problems with patients not showing up for appointments and completing treatment. This means that specific population groups who are hard to engage in services may not receive support.

IAPT services aim to treat about 15 per cent of the anticipated need in England. As such, offering IPS in IAPT services could mean that services may not serve all populations.

There are some indications that IPS may not work as well for minority groups. Minority groups are less likely to have a positive outcome (Howard et al., 2010). This will need to be taken into account in service design.

There are challenges in conducting an RCT on this policy option, which rests on an assumption that there would be a waiting time for psychological therapy. It would also be important to establish whether those in the treatment and control groups have similar levels of motivation.

Finally, CCGs commission IAPT services in England. Different delivery models are in place across England, and therefore the quality and nature of employment advice varies across IAPT services. On the one hand, we know that several IAPT services provide employment advice based on IPS. On the other, we know that the type and quality of employment advice is variable and often poorly resourced.

Scotland and Wales have different institutional arrangements. There may not be clear mechanisms in the current institutional arrangements to incentivise the funding of specialist vocational support in the middle to longer-term.

Policy option 2: Introduce group work approaches based on JOBS II in Jobcentre Plus

Pilot design

The proposed pilot approach is a randomised controlled trial (RCT). The intention is to assign participants randomly to control and treatment groups and look at sustained employment effects, the speed with which those participating find work, changes in the flows on to other benefits, and wider benefits such as changes in psychological health and wellbeing and job readiness.

The pilot would compare the additionality of the intervention based on JOBS II (treatment group) to normal treatment of benefit claimants seen in Jobcentre Plus. In other words, the treatment group will receive the intervention in addition to the normal offering in Jobcentres.

If the intervention was to be made available to different groups of benefit claimants (eg ESA and JSA), there would also be a need to control for benefit type.

Hypothesis

Individuals with common mental health problems (eg JSA claimants with mental health problems) often do not receive much psychological support to address their mental health problems. Evidence suggests that an 'early' intervention should lead to better health and employment outcomes for those treated (British Society of Rehabilitation Medicine, 2003).

The group approach is primarily designed to enable the development of self-efficacy. It will also involve one to one work to develop work self-efficacy. Traditional UK approaches have relied mainly on self-managing the return to work and building motivation. The hypothesis is that group work builds self-efficacy for a group that, due to the combination of unemployment and a mental health problem, are likely to struggle to do so (Vuori and Silvonen, 2005). The focus in JOBS II is to build up resilience and to inoculate the participant against setbacks.

There is international evidence that suggests that providing an intervention which builds self-efficacy and teaches job search skills, in combination with group and individual work, can lead to increases in re-employment rates (Vuori and Silvonen, 2005).

The combination of psychological and employment-related support appears to be a logical way to address the needs of those with common mental health problems and employment-related needs.

Funding and implementation

The Government would commit itself to funding the pilot in Jobcentre Plus districts and any other locations (eg IAPT or equivalent). Longer-term funding could come from Jobcentre Plus budgets under the Freedom and Flexibilities delegation, a joint commissioning model between Clinical Commissioning Groups (CCGs) and the

DWP for employment advice, or additional top-ups provided by the DWP to Jobcentres.

JOBS II provides a structured model of delivering employment. We believe that the specification for the JOBS II pilot should be relatively straightforward to design because it has already been used in a number of different contexts.

It is the intention in the pilot also to trial a joint commissioning model to reflect the integration of services proposed. The previous section on IPS in IAPT comments on aspects of joint commissioning.

Risks/challenges

Evidence on JOBS II has shown that the quality of the trainer is particularly important in achieving outcomes. As such, a critical component is creating a cohort of qualified trainers (for more evidence see Appendix D).

JOBS II has been used in a variety of settings including the US, China and Ireland but it has never been used in the UK context.

There could be questions around scalability of JOBS II, though some trials included up to 6,500 individuals (Price et al, 1998). There are some concerns around acceptability given group work is commissioned by several Jobcentre Plus districts.

JOBS II is relatively expensive with costs up to an estimated £875 per participant (previous DWP estimate).⁵⁹ The cost of training the trainers where JOBS II has been used has been significant, though the costs may reduce as the intervention scales up and fixed costs decrease.

Randomisation in an experiment may be problematic if enrolment in JOBS II is voluntary (on an opt-in basis). It may be difficult to find a control group with the same motivations and profile as the group who have voluntarily selected into the intervention. If enrolment is made mandatory (or it replaces the work activity requirement), randomisation should be more straightforward.

Policy option 3: Improving access to online assessments and interventions for common mental health problems

Pilot design

The intention is to test whether offering an online assessment and support application is effective and cost-effective in improving health and employment outcomes for people with common mental health problems. The pilot would randomly assign individuals to one of three groups:

- traditional interventions (treatment as usual)

⁵⁹ DWP Jobs II business case (2007), 'Business Case For A Pilot To Support People On JSA Who Have Or Are At Risk Of Developing A Mental Health Condition', unpublished.

- eTherapy interventions not offering vocational support
- eTherapy interventions with a vocational element.

The pilot would aim to assess the sustained health and employment effects for each group.

Hypothesis

Many people with common mental health problems do not actively seek support to address their mental health and work needs. Providing an online tool will allow more people to assess themselves for common mental health problems and it will provide a greater number of people with specialist mental health services with an inbuilt vocational element. This in turn should lead to better health and employment outcomes for these individuals. The application could serve a wider population including in-work and out of work groups.

Outcomes for traditional and online interventions are comparable between control and treatment groups with lower costs per individual for the latter. The effectiveness of online therapies with and without a vocational element will be tested. There might be individuals with specific characteristics or certain conditions for whom online interventions would be more or less suitable. The pilot will aim to establish for whom eTherapy works well and under what conditions.

Funding and implementation

In the short term, funding is required to develop the application and pilot it in selected localities (IAPT, Jobcentres or equivalent). In the longer-term, there would need to be consideration about funding for maintenance and monitoring of the application and where this would come from.

The application could be hosted by NHS Choices and made available to GPs, IAPT therapists and employment advisers, Jobcentre Plus advisers, as well as open for self-referrals (after piloting it with selected audiences).

Risks/challenges

The main difficulty may be related to developing an online tool that includes a vocational element. We have not identified an off-the-shelf example. Further, potential issues with this pilot also include practical implications for hosting, maintaining and the accreditation of the application, as well as its promotion among a specific target group or the general public.

Relying on online interventions also presents some challenges. Potential limitations of using the internet to deliver psychological interventions are:⁶⁰

- Correct diagnosis may be more difficult because of lack of visual and auditory cues.

⁶⁰ Please note this section relies heavily on Childress (1998) available at: http://www.ismho.org/potential_risks_and_benefits.asp [accessed in December 2013]

- Ensuring confidentiality can be more problematic, as risks occur during a transmission of online data, and when storing data at both the therapist- and client-end.
- Computer literacy of therapists determines the quality of support provided, while computer literacy and general characteristics (such as age) of potential users determine their access to the application. As a result, some groups may be somewhat disadvantaged which poses risks to equality issues.
- Anonymity of the service may not allow therapists to provide an adequate response in crisis situations.
- Given the trans-border nature of the internet, there might be legal issues related to using the application by non-UK residents.

Challenges with this option are also related to the feasibility of an RCT for an online health intervention, particularly the question of what outcomes might be measured if people drop out of the programme, which may be more likely for a group with mental health problems.

Perhaps a more significant issue is that approach raises some ethical questions about appropriate responses to addressing mental health needs. As the application would assess people who may be unable or unwilling to seek help from face-to-face healthcare services, the intervention would probably play a role in identifying new, undiagnosed cases of mental health problems. If uncovered, this need would be addressed but online support may be inappropriate or insufficient in some instances, for example, people in crisis. On the other hand, it can also over-medicalise mental health problems that are already heavily stigmatised.

The costs of using existing cCBT packages vary from free applications, such as MoodGYM, to £149.95 (Beating the Blues). If the new application is offered on a paid for basis (includes licence fees for using it) it may create additional barriers for people to access the services.⁶¹

Policy option 4: Commission third-party organisations to provide a combination of psychological and employment related support to claimants

Pilot design

The intention is to randomly assign participants to control and treatment groups and look at sustained employment effects, the speed by which those participating find work, changes in the flows on to other benefits, and wider benefits such as changes in psychological health and wellbeing.

⁶¹ The Government could explore different offerings. The intervention could be offered by the NHS for free. The Government could also make a paid offering available to employers or Work Programme providers.

We will compare the additionality of the telephone-based treatment (treatment group) to normal treatment of benefit claimants seen in Jobcentre Plus. In other words, the treatment group will receive the intervention in addition to the normal offering in Jobcentres.

Hypothesis

Individuals with common mental health problems (eg JSA claimants with common mental health problems) often do not receive much psychological support to address their mental health problems. Evidence suggests that an 'early' intervention should lead to better health and employment outcomes for those receiving support (British Society of Rehabilitation Medicine, 2003).

It also seems logical that specialist providers who work specifically with the target group will be able to achieve better outcomes.

Many of these specialist providers are sub-primes in the Work Programme. They receive fewer referrals than expected under the Programme and this initiative may create additional demand for specialist services and make such services available to a larger group.

Evidence from some locations suggests that providing access to specialist psychological services (which is part of the proposed intervention) to support the provision of employment advice can be effective in addressing the needs of those with common mental health problems and employment-related needs.⁶²

Funding and implementation

The Government would need to fund this pilot in Jobcentre Plus districts. Longer-term funding could come from Jobcentre Plus budgets under the Freedom and Flexibilities delegation, a joint commissioning model between Clinical Commissioning Groups (CCGs) and the DWP for employment advice, or additional top-ups provided by the DWP to Jobcentres.

This pilot will require a Service Level Agreement between provider and Jobcentre Plus detailing payment by participant and service provided.

The specification of the pilot delivery model may require some thought. Minimum service standards would need to be developed. Implementation should be acceptable as strong links between third party providers and Jobcentres exist in a number of locations. We would also expect the specification to be developed with the measurement of outcomes in mind.

It is the intention in the intervention to trial a joint commissioning model to reflect the integration of services proposed. Previous sections comment on some

⁶² See for instance the experience of Newham in integrating services, Newham CCG Mental Health Programme Board (2013), available at: <http://share.pdfonline.com/481f2d7464dd42cfa152835be27d7835/Mental%20Health%20Programme%20Board%20TOR%20FINAL%20Jan%202013.pdf> [Accessed December, 2013].

considerations policy makers need to make when implementing joint commissioning models.

Risks/challenges

Third parties are likely to have different delivery models and offer different services. It is not clear whether a set model for delivery or a model with basic minimum standards could be identified. Though many of the models make reference to an evidence base (eg using IAPT standards), that evidence base should be evaluated and assessed at the outset.

Services provided by third party providers have mostly focused on ESA and Incapacity Benefit claimants and the in-work group. There is less evidence on how suitable they would be for a more JSA-focussed population, though their current use across differing populations gives some confidence on wider applicability.

These specialist services focus mostly on removing barriers to employment and may fall short of achieving the 'hard' employment outcomes that the DWP is mainly interested in. In this case, the self-efficacy assessment could function as a benchmark and distance travelled proxy.

Current budgeting rules at Jobcentre Plus may make it difficult to fund providers situated outside of the Jobcentre Plus locality.

Randomisation in an experiment may be problematic if enrolment is voluntary. It may be difficult to find a control group with the same motivations and profile as those who have volunteered into the intervention. If enrolment is made mandatory (or fulfils, for instance, the JSA activity requirement), randomisation could be more straightforward. However, there may be ethical issues around mandating health treatment.

Beyond the pilot, there may not be clear mechanisms in the current institutional arrangements to incentivise the funding of this intervention in the middle to longer-term. The main aim of the current pilot is to encourage Jobcentres to prioritise discretionary spending on those with mental health problems.