Research report

Mental health in context: the national study of work-search and wellbeing

By Sally McManus, Alice Mowlam, Richard Dorsett, Stephen Stansfeld, Charlotte Clark, Victoria Brown, Ivonne Wollny, Nilufer Rahim, Gareth Morrell, Jenny Graham, Rachel Whalley, Lucy Lee and Howard Meltzer

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- Dr Richard Dorsett, at the National Institute of Economic and Social Research.

Abbreviations

APMS 2007	Adult Psychiatric Morbidity Survey 2007
CATI	Computer Assisted Telephone Interview
CIS-R	Clinical Interview Schedule – Revised
CMD	Common mental disorder
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
HSE	Health Survey for England
GAD	Generalised Anxiety Disorder
GOR	Government Office Region
GHQ	General Health Questionnaire
IB	Incapacity Benefit
IMD	Index of Multiple Deprivation
JSA	Jobseeker's Allowance
MHC	Mental health condition
NatCen	NatCen Social Research
NIESR	National Institute for Economic and Social Research
OCD	Obsessive-compulsive disorder
ONS	Office for National Statistics
PA	Personal Adviser
SES	Socio-Economic Status
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
WCA	Work Capability Assessment
WSWBS	Work-search and Wellbeing Study

Glossary

Adults

Adults were defined as people of statutory working age (men aged 16 to 64 and women aged 16 to 59).

Anxiety disorders

Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive-compulsive disorder (OCD). See also the individual disorders.

Clinical Interview Schedule – Revised

The Clinical Interview Schedule – Revised (CIS-R) is an interview instrument designed to measure neurotic symptoms and disorders, such as anxiety and depression. It comprises of 14 sections each covering a particular type of neurotic symptom. Scores are obtained for each symptom based on frequency, duration and severity in the last week. Individual symptoms scores can be summed to provide an overall score for the level of neurotic symptoms.

A CIS-R score of 12 of more indicates the presence of significant neurotic symptoms of a level likely to impact on day-to-day functioning, cause distress, and be responsive to treatment.

A CIS-R score of 18 or more indicates a level of symptoms that are more severe and almost certain to warrant treatment, such as medication or talking therapy.

Common mental disorders (CMD)

Diagnoses of six specific neurotic disorders were obtained by looking at answers to the various sections of the CIS-R and applying algorithms based on the International Classification of Diseases and Related Health Problems 10th Revision (ICD-10) diagnostic criteria for research. The six categories of neurotic disorder are:

- GAD;
- mixed anxiety and depressive disorder;
- depressive episode (mild, moderate and severe);
- phobias;
- OCD;
- panic disorder.

See also **CIS-R, neurotic psychopathology** and the individual disorders.

Community care services

Community care services were defined as use of the following in the past year: a psychiatrist, psychologist, community psychiatric nurse, community learning difficulty nurse, other nursing services, social worker, self help/support group, home help/homecare worker or outreach worker.

Current treatment for a mental or emotional problem	Current treatment for a mental or emotional problem included currently receiving any medication, counselling or therapy, or both medication and counselling.
Day care services	Day care services were defined as including use of a community mental health centre, day activity centre, sheltered workshop or other nursing services in the past year.
Depressive episode	The diagnostic category of depressive episode used in this report combined people identified by their responses to the CIS-R as having either a mild, moderate or severe depressive episode. Depressive episodes are characterised by various combinations of low mood, loss of interest, sleep disturbance, fatigue, change in appetite or weight, low self-worth, problems with concentration, or thoughts of death.
Depressive symptoms	Depressive symptoms include low mood and loss of interest and enjoyment in ordinary things and experiences.
Educational level	Educational level was based on the highest educational qualification reported. These were grouped into: Degree or equivalent; Teaching, HND, Nursing or equivalent; A Levels or equivalent; GCSE or equivalent; Foreign or other; and no qualification. The measure used was comparable with that used on APMS 2007.
Employment and Support Allowance	A Government benefit introduced in 2008 to replace Incapacity Benefit (IB) and Income Support (IS) (see below) for new claimants. Eligibility for Employment and Support Allowance (ESA) is based on an assessment of what individuals are capable of (the Work Capability Assessment (WCA)).
Fit note	Common name for the Statement of Fitness for Work.
Framework	Framework is a matrix-based approach to qualitative data management and analysis originally developed by NatCen Social Research.[1] The approach was recently developed into a software programme in collaboration with NVivo, to combine both approaches to qualitative data analysis in one qualitative package.
Generalised Anxiety Disorder	GAD is an anxiety disorder characterised by persistent and free-floating anxiety that is disproportionate to the source of worry. The worrying interferes with daily functioning and is usually associated with physical symptoms.
Health care services	The definition of health care service use included an inpatient stay or outpatient visit in the past quarter, or spoken with a GP in the past year, for a mental or emotional reason. The time frame varied between different types of health service and so this variable does not represent all health care services used in the past year.

1 Ritchie, J. and Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. Sage: London.

ICD-10	The ICD-10 is a classification system for diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organisation (WHO).
Incapacity Benefit	IB was a weekly payment for people under State Pension age who were incapable of work because of illness or disability. Since January 2011, claimants of this benefit have been assessed to decide whether they should receive ESA or Jobseeker's Allowance (JSA).
Jobcentre Plus	Jobcentre Plus is part of the Department for Work and Pensions (DWP). It provides services that support people of working age progress from welfare into work, and helps employers to fill their vacancies.
Jobseeker's Allowance	JSA is paid to people of working age who are unemployed and actively looking for work, or working fewer than 16 hours a week and seeking work.
Life events	A modified version of the Life of Threatening Experiences Scale was used. See Appendix C for a list of life events asked about.
Marital status	Participants were categorised according to their self-reported legal marital status, this included a code for whether the respondent was in a legally recognised Civil Partnership with someone of the same sex. The derived marital status variable incorporates cohabitation, but analysis is also presented with cohabitation shown separately from married. Participants who initially reported not cohabiting but did report being in a partnership with another household member were subsequently recoded as cohabiting.
Mixed anxiety and depression	People were assigned to the category of 'mixed anxiety and depression' when their CIS-R responses indicated a significant level of neurotic symptoms (a score of 12 or more), but did not meet the specific criteria required for diagnosis of one of the five types of CMD assessed. The category is, therefore, mutually exclusive of the other CMDs assessed by the CIS-R, and people in this group generally have less severe neurotic symptoms that those assigned to the other five diagnostic categories.
Morbidity	Morbidity refers to the rate at which an illness or condition occurs in a particular area or population.
Mortality	A mortality rate is a measure of the number of deaths in a given population over a particular period of time, either in general or due to a specific cause.

Neurotic psychopathology	This is characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which present to such a degree that they cause problems with daily activities and distress. The prevalence of neurotic symptoms in the week prior to interview was assessed using the revised version of the CIS-R. A score of 12 or more indicates the presence of significant neurotic symptoms while a score of 18 or more indicates symptoms of a level likely to require treatment (see CIS-R for more details of these thresholds).
Obsessive-compulsive disorder	OCD is an anxiety disorder characterised by recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images, or impulses that enter the person's mind again and again and are distressing. Compulsive acts or rituals are stereotyped behaviours that are also repeated again and again and cause distress. Anxiety is almost invariably present.
Panic disorder	Panic disorder is an anxiety disorder where the essential feature is recurrent attacks of severe anxiety (panic), which are not restricted to a particular situation and are, therefore unpredictable. As with other anxiety disorders, the dominant symptoms include sudden onset of palpitations, chest pain, choking sensations, dizziness and feelings of unreality.
Percentile	The value of a distribution which partitions the cases into groups of a specified size. For example, the 20th percentile is the value of the distribution where 20 per cent of the cases have values below the 20th percentile and 80 per cent have values above it. The 50th percentile is the median.
Personal Adviser	Jobcentre Plus Personal Advisers (PA) help people find work. They also have a responsibility to protect the integrity of the benefits system by ensuring those who should be doing so are actively seeking work.
Phobias	Phobic anxiety disorders are a group of disorders in which anxiety is mainly evoked in certain well-defined situations that are not dangerous. As a result these situations tend to be avoided or endured with dread. The person's concern may be focused on symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad.
Psychiatric morbidity	Psychiatric morbidity refers to the extent of mental health conditions or disorder in a population.

P value	A p value is the probability of the observed result occurring due to chance alone. A p value of less than five per cent is conventionally taken to indicate a statistically significant result ($p<0.05$). The p value is dependent on the sample size, so that the large sample differences or associations which are very small may still be statistically significant. Results should, therefore, be assessed for their importance on the magnitude of the differences or associations as well as the p value itself.
Suicidal thoughts and attempts	In this study, suicidal thoughts were defined as thinking about taking one's own life. Suicidal attempts refer to an attempt to take one's life. They were asked about in this study because they are part of the diagnostic criteria for depression.
Wellbeing	Subjective wellbeing is generally regarded as consisting of at least two factors. Broadly, these are 'hedonic' wellbeing (happiness, pleasure, enjoyment) and 'eudaimonic' wellbeing (purpose, meaning, fulfilment). This study used two key measures of subjective wellbeing: the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and the four questions developed by Office for National Statistics (ONS) as part of their programme to measure national wellbeing. See Appendix C for more detail about these measures.

Notes to tables

1 The survey data used in this report have been weighted using wave-specific weighting variables. The base sizes are always shown unweighted, at the foot of each table or in a column adjacent to the variable. These show the numbers of people each estimate is based on. The base is always in italics.

2 The following conventions have been used in tables:

- – no observations (zero value);
- 0 non-zero values of less than 0.5 per cent and, therefore, rounded to zero;
- .. data not collected (e.g. the question was not asked in that wave);
- [ ] used to warn of small sample bases, usually where the unweighted base is less than 40 people.

3 Because of rounding, row or column percentages may not add exactly to 100 per cent.

4 A percentage may be quoted in the text for a single category that aggregates two or more of the percentages shown in a table. The percentage for the single category may, because of rounding, differ from the sum of the percentages in the table.

5 In this report percentages are generally given to one decimal place.

6 'Missing values' occur for several reasons, including refusal or inability to answer a particular question; refusal to co-operate to an entire section of the study (for example, to the second survey wave); and cases where a question is not applicable to the respondent. In general, missing values have been omitted.

7 The group to whom each table refers is stated at the upper left corner of the table.

8 The term 'significant' refers to statistical significance (at the 95 per cent level) and is not intended to imply substantive importance. Unless otherwise stated, differences mentioned in the text have been found to be statistically significant at the 95 per cent confidence level. Standard errors that reflect the complex sampling design and weighting procedures used in the survey have been calculated and used in tests of statistical significance.

Summary

Background and study design

When people start a claim for Jobseeker's Allowance (JSA), what is the state of their mental health and wellbeing? And what happens to them in the months that follow? To examine these questions, a two-wave telephone cohort survey was conducted with a sample of people who began a JSA claim in the first quarter of 2011. Wave 1 fieldwork was conducted between March and May (2,079 people interviewed) with participants followed up for a second interview approximately four months later (July to August, 1,279 people interviewed). An assessment of common mental disorder (CMD) was carried out at both waves. Comparisons were made with the general population, using data from other surveys. Qualitative interviews were conducted with participants identified with symptoms of stress, anxiety or depression during Wave 1 survey interviews. Qualitative fieldwork was conducted in June and July 2011.

Health and wellbeing among recent JSA claimants

People who started a JSA claim in the first quarter of 2011 had worse mental health than people of working age in the population as a whole. After standardising the JSA claimant cohort to the age and sex profile of the general population, 14.7 per cent were found to have severe neurotic symptoms, that is, a Clinical Interview Schedule – Revised (CIS-R) score of 18 or more – a level of symptoms almost certain to warrant treatment. This is nearly twice the rate for the general population (8.5 per cent).

More than a fifth (22.6 per cent) of the cohort had a CMD like anxiety or depression. In the months after a claim commenced the average mental health of men in this cohort remained poor, while that of women improved.

Overall, two-thirds of JSA claimants believed that working leads to better health. Very few felt that working leads to worse health (0.9 per cent). JSA claimants with a CMD held more negative views about work. They had less self-confidence about their work-search abilities than claimants without a CMD and had generally much lower levels of optimism about the future.

Socio-economic circumstances of recent JSA claimants

Recent experience of adverse life events, such as a major financial crisis or a relationship breakdown, was relatively common among the recent JSA claimants in the cohort. For example, one in ten had been homeless or living in temporary accommodation in the previous 12 months. They were more likely to be young, male and single than the rest of the working age population. Among both JSA claimants and the rest of the population, mental health was worse among women, people aged 25 to 49, and those who were divorced or separated.

People with a CMD were more likely than those without to have been dismissed from their last job. They were also more likely to give a personal or health related reason for leaving their last employment.

Work-search activity, support and outcomes

Job search activity varied with mental health. Overall people with CMD had less confidence in their job search abilities and sent out somewhat fewer job applications.

Discussion of health and wellbeing in work-focused interviews with Jobcentre Plus Personal Advisers was not widespread, but was found to be helpful when it happened. One in six of the JSA claimants who had had a Personal Adviser (PA) interview reported that their health or wellbeing had been discussed. By comparison the vast majority reported that they had discussed strategies for finding work. Women with a CMD were much more likely to have discussed their health and wellbeing with a PA than men with a CMD. Women were also more likely to have found the discussion helpful. It seems, however, that discussion about health and wellbeing with a PA was more likely when the claimant had poor physical health, rather than poor mental health.

Satisfaction with support from Jobcentre Plus was lower among people with CMD than among those without, although a symptom of CMD is to tend towards more negative views. In particular, they were less likely to feel that Jobcentre Plus support had increased their work-search self-confidence. Claimants transitioning to JSA from a sickness benefit also reported lower levels of satisfaction with support.

About four in ten of the cohort was still in receipt of JSA at the Wave 2 survey interview. People who had CMD at Wave 1 were less likely to enter jobs over the study period. Wave 1 characteristics that predicted being in employment at Wave 2 also included socio-demographic factors (being female; married; not having children in the household; and younger, below the age of 55); employment history and qualifications (being employed by Wave 1; not having claimed Employment and Support Allowance (ESA)/Incapacity Benefit (IB) in the previous year; having a driver's licence); and related to neighbourhood deprivation (less deprived). The Wave 1 characteristics that predicted remaining on JSA for longer were similar but reversed.

The stresses of unemployment among people with CMD

Qualitative interviews were carried out with people whose survey responses indicated the presence of symptoms of anxiety and depression.

Two groups of claimants were identified: those facing multiple and longstanding challenges in their lives and those dealing primarily with recent experiences of adversity. The group with multiple and ongoing problems tended to have broken or limited work histories, while those with mainly recent experiences of adversity had more stable and long-term employment histories.

A range of factors affected the experience of unemployment and people's expectations of finding work. These included the local labour market conditions where people live; their age; finance and housing situation; the social support systems around them and their individual psychological factors. The ways in which these factors manifested in people's lives was complex and dynamic, making trajectories of mental health conditions and labour market outcomes difficult to predict.

Experience of Jobcentre Plus and work-search among people with CMD

The experience of claiming JSA was associated with feelings of shame and the stigma of being on benefits. Personalised support and being treated respectfully were important to people.

PAs and claimants alike could be reluctant to discuss mental health. Some claimants did not see themselves as having a mental health problem; others acknowledged a problem but preferred not to talk about their health and wellbeing.

Where movement towards the labour market was evident, Jobcentre Plus had in some cases supported this progress in the form of specialist support, such as Lone Parent support or a Disability Employment Adviser.

Some particular mental health problems made it difficult for people to adhere to the requirements of the JSA regime and some raised concerned about moving into work. This included people experiencing panic attacks and feelings of paranoia or agoraphobia.

Predictors of change in mental health

New JSA claimants started a JSA claim with worse mental health than that of the rest of the working age population. In the four months that followed, about a third of them experienced a recovery or improvement in their mental health, a third experienced little or no change, and a third experienced deterioration.

The initial (Wave 1) circumstances that predicted a future deterioration in mental health after the start of a JSA claim included: health and wellbeing (having a longstanding illness, an anxiety disorder, or low subjective wellbeing), the quality and number of social relationships, the ongoing experience of traumatic events, and the characteristics of the local area. Fewer factors significantly predicted an improvement in mental health, but anxiety disorders were prominent for making recovery less likely. Entering work supported mental health recovery.

Before adjustment for explanatory factors, men and women were equally likely to experience a decline in mental health between the survey waves. While women were more likely to show signs of recovery, men were more likely to experience no change. However, after adjustment for other factors the association between sex and change in mental health was no longer significant. Other demographic factors, such as age and ethnic group, also did not influence what happens to someone's mental health after starting a JSA claim.

Conclusion

The findings indicate that CMDs contribute to poorer employment outcomes, because by their nature, they erode beliefs about abilities and optimism about the future. But entering employment can support recovery.

More broadly, the study has shown that mental health is rooted in the context of people's lives. Poor physical health, low levels of social support, neighbourhood context and adverse life events all play a role in whether or not someone will experience a decline in mental health during a period of unemployment. However, there is an important distinction for policy-makers to consider between people who arrive on JSA with relatively stable employment histories having developed symptoms of distress as a result of recent life events, and those for whom a mental health condition is one issue among an array of longstanding life adversities.

1 Background and study design

1.1 Overview

This study was funded by the Department for Work and Pensions (DWP). It examined the nature and extent of common mental disorder (CMD) among people entering unemployment (as represented by starting a Jobseeker's Allowance (JSA) claim) and provides insight into the dynamic relationship between mental health and labour market outcomes. The results have relevance for policy on supporting unemployed people with different levels of psychological distress to access services, seek jobs and return to work.

This study goes beyond much of the current research literature in this area by extending the substantive scope to include:

- The wider circumstances of unemployed people's lives, bridging areas of policy interest to both health and employment.
- A validated and detailed assessment of CMD.
- Measures of positive attributes, such as subjective wellbeing.
- Measures of psychological factors and beliefs, like self-efficacy.

The longitudinal and mixed method design means that this study also extends the scope of some of the current research in this area methodologically.

1.2 Background

In Dame Carol Black's Review of the health of Britain's working age population, the importance of work for wellbeing was emphasised.[2] In the review it was argued that while good health improves an individual's chances of finding and staying in work, there is also compelling evidence that paid work has a beneficial impact on an individual's state of health. Based on a review of scientific literature, Waddell and Burton have also concluded that work is generally good for both physical and mental health and wellbeing.[3] Specific calls were made in Dame Black's Review to fully integrate the option of specialist mental health provision into employment support programmes, not just for people on incapacity benefits, but for all those who are workless, including job seekers.

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2 Black, Dame C. (2008). *Review of the health of Britain's working age population: Working for a healthier tomorrow*. London: TSO.

3 Waddell, G. and Burton, A.K. (2006). *Is work good for your health and well-being?* London: TSO.

The link between mental health and unemployment is widely recognised. Unemployed people have, on average, worse mental health than employed people.[4, 5, 6, 7,8, 9, 10] There are a number of reasons for this: sustained periods out of work are associated with increased risk of developing mental health problems; unemployed people with mental health problems are less likely to re-enter employment; and employed people with mental health problems are more likely to lose their jobs.

There is mixed evidence on the impact of the duration of unemployment on mental health, with some research suggesting that mental health stabilises after around six months of being out of work.[11] Other research has found that poor mental health is associated with length of time unemployed, with rates highest among those out of work for several years as well as among those who became unemployed recently. Work by economists such as Andrew Clark and Richard Lucas has found that prolonged unemployment is a shock that, unlike other life events such as bereavement and divorce, individuals tend not to adjust to.[12]

The transition into unemployment can be stressful, particularly when accompanied by a sudden drop in income.[13] Job loss can also be stressful when anticipated, for example when preceded by longer-term job insecurity.[14, 15] Socioeconomic context is thought to influence whether such transitions contribute to the onset of depression or anxiety related disorders. People moving from

4 Waddell, G. and Burton, A. (2006). *Is work good for your health and well-being?* London: TSO.

5 Stankunas, M., Kalediene, R., Starkuviene, S. and Kapustinskiene, V. (2006). Duration of unemployment and depression: a cross-sectional survey in Lithuania. *BMC Public Health*. 6: 174.

6 Honkonen, T., Virtanen, M., Ahola, K., Kivimaki, M., Pirkola, S., Isometsa, E., Aromaa, A. and Lonnqvist, J. (2007). Employment status, mental disorders and service use in the working age population. *Scandinavian Journal of Work Environment and Health*. 33(1): 29-36.

7 Alavinia, S.M. and Burdorf, A. (2008). Unemployment and retirement and ill-health: a cross sectional analysis across European countries. *International Archives of Occupational & Environmental Health*. 82: 39-45.

8 Lelliott, P., Tulloch, S., Boardman, J., Harvey, S., Henderson, M. and Knapp, M. (2008). *Mental health and work*. London: The Royal College of Psychiatrists.

9 Perkins, P., Farmer, P. and Litchfield, P. (2009). *Realising ambitions: better employment support for people with a mental health condition*. London: TSO.

10 Ford, E., Clark, C., McManus, S., Harris, J., Jenkins, R., Bebbington, P., Brugha, T., Meltzer, H. and Stansfeld S. (2010). 'Common mental disorder, unemployment and welfare benefits in England'. *Public Health* 2010;124(12):675-81.

11 Thomas, C., Benzeval, M. and Stansfeld, S. (2005). Employment transitions and mental health: an analysis from the British household panel survey. *Journal of Epidemiology and Community Health*. 59: 243-9.

12 Lucas, R.E., Clark, A.E., Georgellis, Y. and Diener, E. (2004). Unemployment alters the set point for life satisfaction. *Psychological Science*. 2004;15(1):8-13.

13 Thomas, C., Benzeval, M. and Stansfeld, S. (2007). Psychological distress after employment transitions, the role of subjective financial position as a mediator. *Journal of Epidemiology and Community Health*. 61: 48-52.

14 Ferrie, J.E., Shipley, M.J., Newman, K., Stansfeld, S. and Marmot, M. (2005). Self-reported job insecurity and health in the Whitehall II study, potential explanations of the relationship. *Soc Sci.Med* 60, 1593-1602.

15 Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S. and Stansfeld, S. (2010). Job insecurity, socio-economic circumstances and depression. *Psychological Medicine*. 2010;40(8):1401-7.

a benefit regime such as Employment and Support Allowance (ESA)/Incapacity Benefit (IB) to a supported, but more labour market intensive benefit that requires greater jobsearch activities (such as JSA) may also experience impacts on their psychological wellbeing. Research is needed to understand the extent of anxiety and depression among people entering unemployment, and predictors of change in mental health among this group over time.

1.3 Study aims

The primary aims of this study were to:

- contribute to an evidence-base on customers receiving JSA (including those in the fit for work category following a Work Capability Assessment (WCA)) but who have mild to moderate CMD and need some focused support;
- complement research into support for people in receipt of IB/ESA;
- provide insights that could inform programmes of support: including the type and scale of any support services needed, the timing of their offer, and efficient ways of targeting this support at the right customer groups; and
- provide information to help DWP staff be aware of potential triggers for mental distress.

1.4 Research questions

This study considers a wide range of research questions:

- What factors in the transitions around unemployment contribute most to or trigger the onset of poor mental health?
- How does individuals' job search activity vary with their mental health?
- How does individuals' job search success vary with their mental health?
- What experiences in the claims process and which individual characteristics and circumstances make people more vulnerable to the development of mental disorder and mental distress?
- What factors exacerbate existing mental health problems in people made unemployed?
- What factors protect people who become unemployed from developing poor mental health.
- What are the additional support needs of people with mental disorders who are seeking re-employment?

1.5 Overview of study design

The study as a whole comprised:

- **An initial review** with a brief summary of recent policy and research and secondary analyses of two existing datasets:
  - the Adult Psychiatric Morbidity Survey 2007; and
  - the Health Survey for England (HSE) 1998-2008.
- **A two wave telephone cohort survey** with a stratified sample of recent JSA claimants drawn from DWP administrative databases (General Matching Service scans for three consecutive months). Mental disorders were identified using the Clinical Interview Scheduled – Revised (CIS-R), which enabled identification of those who may require clinical treatment as well as those with subthreshold neurotic symptoms. Specifically, data were collected on:

  - the nature, severity and prevalence of CMD about two to four and six to eight months after signing on to JSA; and
  - personal, social, economic, employment, service use and other factors that might independently predict poor mental health among JSA claimants.
- **Multivariate modelling** of the factors predicting:
  - being in receipt of JSA at the Wave 2 interview;
  - being in employment at the Wave 2 interview;
  - being economically inactive at the Wave 2 interview;
  - a decline in neurotic symptoms between survey waves;
  - an increase in neurotic symptoms between survey waves.
- **Qualitative interviews** with survey participants whose results were indicative of CMD (although they may not perceive themselves as having any mental health problems). The interviews explored the experience of unemployment and what effect this has had on their lives as well as their experiences of Jobcentre Plus and searching for work. Half of the interviews were with people coming from recent job loss and half were with people moving from a less labour market intensive benefit.

1.6 Methods

Methodological details are provided in the appendices and summarised below.

1.6.1 Survey sample

The sample was drawn from people identified through DWP administrative databases as having started a JSA claim in the first quarter of 2011. The primary stratification variable for the sample was whether or not a recipient was in receipt of long-term sickness benefits – ESA or IB – prior to claiming JSA. This ensured that sufficient recipients with experience of poor mental health would be included in the survey sample selected. While not all ESA recipients have a history of mental health symptoms, they will all have had experience of benefit transitions, another area of interest to the research. Owing to complexity in benefit pathways and in the data collected, those selected with a history of sickness benefit receipt may not have transitioned directly from sickness benefit to JSA. Sickness benefit history was defined as receipt in the past year.

The sample was further stratified by region, age and sex. Age and sex are factors known to influence mental health, and employment context varies with region. Recipients without an apparently valid telephone number and address were excluded from the sample. The pilot sample was examined to ensure that this did not introduce bias. The first criteria for inclusion in the sample was that a claim for JSA had been initiated in the previous three months. 4,400 recipients were selected for the survey sample, half of whom had been in receipt of sickness benefit within the past year and half of whom had not. Within the two groups (sickness benefit and non-sickness benefit) the recipients were sorted by Government Office Region (GOR), then by sex and finally by age.

We considered whether the sickness benefit group should be stratified by whether or not the claim was primarily for a mental health problem. However, this was decided against owing to questions about the usefulness of this variable as mental disorders could often be a claimant's secondary health condition (which is not recorded on DWP administrative databases).

Letters were sent to all selected participants in advance of contact from the Telephone Unit. Information was provided to enable people to opt out of the study. Contacts details were provided at both DWP and NatCen Social Research and people could opt-out to either.

1.6.2 Survey methods

Computer assisted telephone interviewing (CATI) took place with the same sample of people at two points in time and allowed for measurement of:

- Nature, severity and prevalence of CMD at about two to four and six to eight months after signing on to JSA, and change between these points.
- Identification of personal, social, economic, employment, service related and other factors that predict presence and change in mental health among recent JSA recipients.

The telephone survey consisted of two waves:

- Wave 1: the initial baseline prevalence survey, comprising a 35 minute telephone interview to assess work history, mental wellbeing and contextual factors.
- Wave 2: a follow-up 25 minute interview four months later to assess change in employment status, mental wellbeing and wider circumstances.

Thank you letters were sent with a small token of appreciation after each survey wave.

1.6.3 Survey data analysis

All survey data presented in this report are weighted unless specified otherwise. The weighting strategy is described in Appendix A. Analyses were carried out using SPSS and consist of the following approaches:

- prevalence rates and cross-tabulations;
- age-standardised rates, controlling for age and sex;
- multivariate regressions, controlling for a wide range of factors.

1.6.4 Qualitative study sample

Wave 1 survey participants agreeing to further contact constituted the sample frame for the qualitative study. Participants were purposively selected according to various sampling criteria. Purposive sampling involves symbolic rather than statistical representation to ensure that range and diversity of relevant characteristics are represented within the sample.

The key aim of the in-depth interviews was to explore the experience of becoming unemployed (as represented by starting a JSA claim, either in transition from another benefit or from work) with people showing symptoms of anxiety or depression. Therefore, the primary sampling criteria for the qualitative work was the presence of mental health symptoms as assessed at the Wave 1 survey interview, with an even split between those with a CIS-R score of 12-17 and those with a score of 18 or more.

Although the qualitative participants had all been found by the CIS-R to have symptoms of a CMD, such as anxiety or depression, they would not necessarily define themselves as having a ‘mental health condition’, particularly those with a score of 12-17. Therefore, recruitment for the qualitative interviews was framed in terms of participant’s survey scores indicating that the recent JSA claims process might have been a stressful time for them.

The other primary sampling criteria for the qualitative sample were:

- Route onto JSA: about half of the participants had transitioned to JSA from a sickness benefit and half had transitioned from job loss or some other activity.
- Demographic information: the sample was selected to ensure representation of both men and women and different age and ethnic groups.

Due to the anticipated diversity of the JSA population, it was decided that the age range would start at 21 rather than 18 (when people can start claiming JSA). This was because many younger people (aged 18 to 20) would have specific experiences involving living with parents and transitioning between training and further education which were likely to differ from the rest of the population. Likewise, the upper age limit for the qualitative sample was set at 60, to avoid issues related specifically to the transition to retirement.

Given the relatively small sample size for the qualitative study, it was felt that capturing regional variation across England was more feasible than attempting to cover the rest of Great Britain. The survey data were examined for identification of geographical clusters of potential qualitative participants (reflecting regional and economic variation across England). The final sample matrix of 28 achieved interviews is provided in Table 1.1.

Table 1.1 Qualitative sampling matrix

Sampling characteristics	Range	Number of participants
CIS-R score	12-17	12
	18 or more	16
Sex	Men	16
	Women	12
Age	21-35	11
	36-49	7
	50-60	10
Transitioned to JSA from...	ESA or IB	16
	Elsewhere	12
Employed at time of interview	Yes	7
	No	21
All qualitative participants		28

A limitation of the qualitative element of this research is the small size of the sample, this has particularly limited scope for analysis given the wide range of characteristics that impact on the experience of unemployment.

1.6.5 Qualitative study methods

To recruit the sample, an initial approach letter was sent providing information about what participation in this part of the study would involve, in particular how the qualitative interview would differ from the survey interview and what it would add to the value of the research overall. We included details about what participants could expect in terms of anonymity and confidentiality and offered participants £20 as a token of appreciation for taking part.

The research was made as accessible as possible. Interviews were carried out in a venue of the respondent's choice, and breaks were offered during the interview as required. Interviews, generally, lasted 1-1.5 hours, and were all carried out by members of the research team. The qualitative study participants were asked at the end of the interview whether they would like to withdraw from taking part in Wave 2, to minimise participation burden.

1.6.6 Qualitative study analysis

As expected, the sampling criteria yielded an extremely diverse sample. While some very clear themes were identified, the small sample did result in some limitations in coverage. For example, there were no participants in the qualitative study who had returned to very unstable or insecure employment.

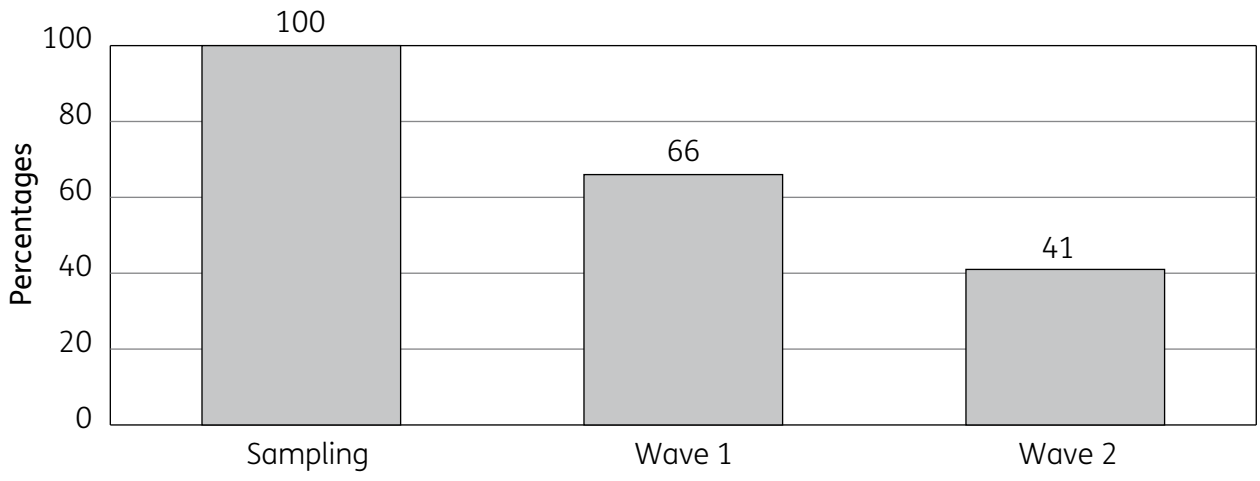
The interviews were transcribed verbatim and analysed using the Framework method, developed by NatCen. Framework is a qualitative data analysis method, which uses a 'matrix' approach to conduct theme and case based analysis. Using Framework, we adopted a comprehensive approach to the data analysis ensuring systematic and consistent treatment of every piece of data collected to ensure reliable and valid interpretation. In carrying out analysis of qualitative data, we ensured that the analytical framework was grounded in the data and not imposed by the research team, and was one which met the study objectives.

1.7 Recent JSA claimants: the study population

The term 'recent JSA claimants' is used in this report to refer to the cohort of people who began a JSA claim around the first quarter of 2011. This cohort was the sampling frame for the study. Some of the study participants were no longer JSA claimants at the time of the Wave 1 interview. However, they all started a claim at around the same time and for the purposes of this report, they are collectively referred to as 'recent JSA claimants'.

All of the sample had started a JSA claim. By the time of the Wave 1 interview – about two to four months later – 66 per cent of the sample were still JSA claimants. By Wave 2, about four months later, this was the case for 41 per cent of the cohort.

Figure 1.1 Whether on JSA at each stage of the survey



Base: WSWB Wave 1 and Wave 2.

Some of the sample (61 people) were not JSA recipients at Wave 1, but had become so again at Wave 2. Table 1.2 shows the weighted proportion of the longitudinal sample (those who took part in both Waves 1 and 2), by whether or not they were JSA recipients at each survey wave.

Table 1.2 JSA status at Wave 1 and 2

JSA status	Weighted proportion	Unweighted cases
	%	Bases
On JSA at Waves 1 and 2	37.2	483
On JSA at Wave 1 only	27.2	346
On JSA at Wave 2 only	5.8	61
Not on JSA at Waves 1 or 2	29.9	389
All	100	1,279

Base: Work-search and Wellbeing Study (WSWB) survey participants at Wave 1 and Wave 2.

The characteristics of the JSA population are not fixed. In 2011, the JSA claimant count was about twice the size it was in 2008.[16] The profile of the JSA population that participants for this study were sampled from also reflected other changes in the benefits system. Since the cessation of new claims to IB, IB claimants have undergone reassessment to decide whether they should be referred to ESA or JSA. From the start of this study, it was recognised that this particular cohort of JSA claimants was likely to include a higher proportion of people with recent experience of sickness benefit than would be the case with most other cohorts of JSA claimants. People with a history of sickness benefit receipt are known to have higher rates of mental health conditions than other unemployment benefit recipients.[17] Route onto JSA was also a key factor in the subsequent experience of unemployment, as this report explores.

1.8 Mental health: conditions, assessment and terminology

1.8.1 Common mental disorders

CMDs, also known as neurotic disorders, are mental conditions that cause marked emotional distress and interfere with daily function, although they do not usually affect insight or cognition.[18] CMDs comprise different types of depression and anxiety. Symptoms of depressive episodes include low mood and a loss of interest and enjoyment in ordinary things and experiences. They impair emotional and physical wellbeing and behaviour. Anxiety disorders covered by this study include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive-compulsive disorder (OCD). Symptoms of depression and anxiety frequently co-exist, demonstrated for example by the high proportion meeting the criteria for more than one CMD or for mixed anxiety and depressive disorder. OCD is characterised by obsessive thoughts, impulses or images, with or without compulsive behaviours. Obsessions are defined as recurrent and persistent thoughts, impulses or images that are intrusive and inappropriate and cause anxiety or distress. Compulsions are repetitive, purposeful and ritualistic behaviours or mental acts, performed in response to obsessive intrusion and to a set of rigidly prescribed rules.

16 For discussion of trends in claimant count, see: http://statistics.dwp.gov.uk/asd/asd1/stats_summary/stats_summary_nov11.pdf

17 Ford, E., Stansfeld, S., McManus, S., Harris, J. and Clark, C. (2010). Common mental disorder, unemployment and welfare benefits in England. *Journal of Public Health* 2010; 124(12):675-81.

18 McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey*. Leeds: NHS Information Centre.

1.8.2 Survey assessment for CMD

The CIS-R is a structured mental health assessment tool that can be administered by a lay interviewer. It was developed by Lewis *et al.* in the nineties and has been used extensively since then, both in clinic based and survey research.[19] Most notably, it is used on the Psychiatric Morbidity Survey programme to generate the community rates of CMD and neurotic symptoms used to monitor the nation's mental health. It allows for mental health to be considered from both a dimensional perspective (with a severity score) and a categorical perspective (with diagnostic measures of disorder).

The CIS-R collects detailed information about non-psychotic symptoms focusing mainly on the week prior to interview. It can be used to generate prevalence estimates for 14 types of neurotic symptoms, a continuous scale that reflects the overall severity of neurotic psychopathology, and six types of CMD. The algorithms applied to generate these are described in detail in Appendix B, and the approach is summarised below.

Neurotic symptoms: include experiencing things like fatigue, sleep problems, and panic. Each of the 14 types of neurotic symptom are scored according to frequency, duration and severity. The separate neurotic symptom scores are not reported on in this report.

Overall severity score: is generated by adding up the scores for each of the different types of neurotic symptom. Broadly, a CIS-R score of:

- 18 or more indicates someone with severe morbidity who would almost certainly benefit from a programme of treatment, such as psychoactive medication or a programme of counselling. They are probably experiencing a very high level of psychological distress and impact on day-to-day functioning.
- 12 to 17 indicates 'caseness' – that is, presence of 'a clinically significant level of symptoms of anxiety and depression'. It is expected that anyone with a score of 12 or more experiences psychological distress, some impairment to functioning, and would benefit from discussing their mental health with a GP or other another medical or social support professional. Those with a score of less than 18 may not require a programme of treatment such as medication or counselling, although this may well be necessary and appropriate.
- 6 to 11 has been used to indicate a 'sub-clinical' level of neurotic symptoms.[20, 21] It is possible that high levels of symptoms that do not quite meet case criteria may reflect the prodrome (or early indications) of an episode of disorder about to onset or the consequences of previous episodes.[22]
- 0 to 5 is the score band into which the majority of the population falls. It indicates the presence of no (or very few) neurotic symptoms.

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19 Lewis, G., Pelosi, A.J., Araya, R. and Dunn, G. (1992). Measuring psychiatric disorder in the community; a standardised assessment for use by lay interviewers. *Psychological Medicine*, 22, 465-486.

20 Singleton, N. and Lewis. G. (2003). *Better or Worse: A Longitudinal Study of the Mental Health of Adults Living in Private Households 2000*. London: TSO (The Stationery Office).

21 For example: Magklara, K., Skapinakis, P., Gkatsa, T., Bellos, S., Araya, R., Stylianidis, S. and Vavreas, V. Bullying behaviour in schools, socioeconomic position and psychiatric morbidity: a cross-sectional study in late adolescents in Greece. Child and Adolescent Psychiatry and Mental Health 2012, 6:8.

22 Kendler, K.S., Thornton, L.M. and Gardner, C.O. Stressful life events and previous episodes in the etiology of major depression in women: an evaluation of the 'kindling' hypothesis. *American Journal of Psychiatry* 2000:157, 1243–51.

CMDs: algorithms are applied to the CIS-R data to identify people who have the precise symptoms indicative of a particular diagnostic category of mental disorder. Five primary diagnostic categories are produced: depressive episode, GAD, OCD, phobias, and panic disorder. There are very exacting criteria that have to be met for any of these to be diagnosed. These are drawn from the International Classification of Disease (version 10).[23] Not all of the disorders require the overall severity score to be 12 or more. It is technically possible, for example, for someone to be diagnosed with a phobia and not to have an overall severity score of 12 or more. However, this only occurs very rarely: having a CMD and having a score of 12 or more are treated as essentially synonymous. Mixed anxiety and depression was diagnosed when someone had an overall CIS-R score of 12 or more, but did not meet the precise criteria for the diagnostic disorders included. People in this category averaged a lower CIS-R score than those identified with the other diagnostic disorders (see Section 2.2.2).

Appendix B describes the CIS-R assessment process and outputs in more detail.

When considering the survey data on mental health it is important to note that:

- They provide a snapshot of symptoms during the week prior to interview. Conditions such as anxiety and depression can fluctuate.
- They cover only CMD and not, for example, psychotic symptoms, dependencies, personality disorders, or conditions such as attention deficient hyperactivity disorder (ADHD) or eating disorders. The CIS-R will not have identified everyone in the sample who has any 'mental health condition' (MHC). Someone with a severe MHC, such as psychosis, could have a low CIS-R score if they did not have neurotic symptoms at the time of the interview.

1.8.3 The approach to mental health in the qualitative interviews

The qualitative interviews were not intended to be used to validate the CIS-R score. They often provided a very different perspective on a participant's mental health from the survey interview because:

- Mental health had sometimes changed in the months between the survey and qualitative interviews.
- The qualitative interviews were inclusive of a wider range of mental conditions, including psychotic conditions, alcohol and drug dependence, and general feelings of stress and distress.
- The nature of questioning, and the relationship between interviewer and participant, was so different that the two approaches generated different insights. The survey interview asked about a wide range of specific clinical symptoms, while the qualitative interview explored the lived experience of mental health more broadly, for example in terms of perceived stigma.

1.8.4 Mental health terminology used in this report

In this report the presence of 'CMD' and 'symptoms of anxiety and depression' are referred to in relation to the survey data. A related term used is 'neurotic symptoms'. These terms are used because these were the specific aspects of mental health that were measured by the survey questionnaire. Other mental health conditions, such as psychosis and dependencies, were not assessed by the survey and so can not be reported on using the survey data.

The qualitative sample as a whole are described as people identified by the survey as having had a stressful experience transitioning onto JSA. In the qualitative interviews a wider range of mental health conditions and stresses and strains were explored, and the language used reflects this.

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[23] World Health Organisation (2010). International Classification of Diseases and Related Health Problems 10th Revision. Geneva.

1.8.5 Interpreting associations with neurotic symptoms

It is always important to avoid making causal inferences from observed associations. This is particularly pertinent in a survey that explores associations with mental health. Symptoms of CMD include having a generally negative view of the world and of interactions with it. In cross-sectional analyses this should be borne in mind as a factor confounding the association between presence of CMD and other self-reported outcomes. Health selection is also likely to have played a part in the associations identified in this study – in other words, people with poor health may be more likely to end up in certain social positions.

1.9 Report structure

This report is made up of six substantive chapters, plus a discussion chapter and six appendices with further technical detail.

In **Chapter 2** the survey data are used to describe the mental and physical health, subjective wellbeing and health and community service use of people who become unemployed. Psychological factors and beliefs are also considered.

In **Chapter 3** the survey data are used to describe the social and economic circumstances of recent JSA claimants, and to examine how these circumstances are associated with mental health.

In **Chapter 4** the survey data are used to examine work-search activity and views of Jobcentre Plus. Regression analyses are used to identify what predicts the different labour market outcomes of JSA claimants in the cohort, and the role that mental health plays in this.

In **Chapter 5** findings from the qualitative interviews are used to explore the experiences of unemployment and looking for work, from the perspective of claimants with symptoms of anxiety or depression.

In **Chapter 6** the focus is on the impact of unemployment on the mental health of JSA claimants with anxiety and depression. This chapter also draws on findings from the qualitative strand of the study.

In **Chapter 7** regression analyses are used to identify what factors predict either a decline in mental health between the two survey waves, or a recovery.

Chapter 8 provides a discussion of the main findings.

2 Health, mental health and wellbeing among recent JSA claimants

Key findings

- People who started a Jobseeker's Allowance (JSA) claim in the first quarter of 2011 had worse mental health than people of working age in the population as a whole.
- After standardising the JSA claimant cohort to the age and sex profile of the general population, 14.7 per cent were found to have severe neurotic symptoms. This is nearly twice the rate for the general population (8.5 per cent).
- More than a fifth (22.6 per cent) of the cohort had a common mental disorder (CMD) like anxiety or depression.
- In the months after a claim commenced the mental health of men in this cohort remained poor, while that of women improved. This association is explored further in Chapter 7, in analyses that control for other factors.
- Overall, two-thirds of JSA claimants believed that working leads to better health. Very few felt that working leads to worse health (0.9 per cent).
- JSA claimants with CMD held more negative views about work. They had less self-confidence about their work-search abilities than claimants without CMD and had generally much lower levels of optimism about the future.

In this chapter the physical and mental health and wellbeing of a cohort of recent JSA claimants are described. Psychological factors and beliefs are also considered. Some comparisons are made with the general population of working age, using data from other national surveys. Change over time is examined.

The chapter includes sections on:

- Severity of neurotic symptoms.
- CMDs.
- General health.
- Subjective wellbeing and life satisfaction.
- Psychological factors and beliefs.
- Treatment and service use.

Context is provided and comparisons are made with the general population using publicly available survey datasets such as the Adult Psychiatric Morbidity Survey (APMS), the Health Survey for England (HSE), the Office for National Statistics (ONS) Opinions Survey, and Understanding Society (USoc). While the comparison rates presented here are based on general population participants aged 16 to 64, it is key to note that the JSA population and the wider working age population have very different

demographic profiles. For example, the JSA population is more likely to be young, male and single (these differences in profile are examined in Chapter 3). CMDs are more common among women than men and peak in middle age. To control for this, an age-standardised rate has also been generated for comparing CMD rates (see Table 2.2 and Figure 2.4). It should be noted however that the age-standardised rate is an artificial construct produced to enable meaningful comparisons with the general population, and does not represent the actual prevalence of CMD in the JSA population.

2.1 Mental health

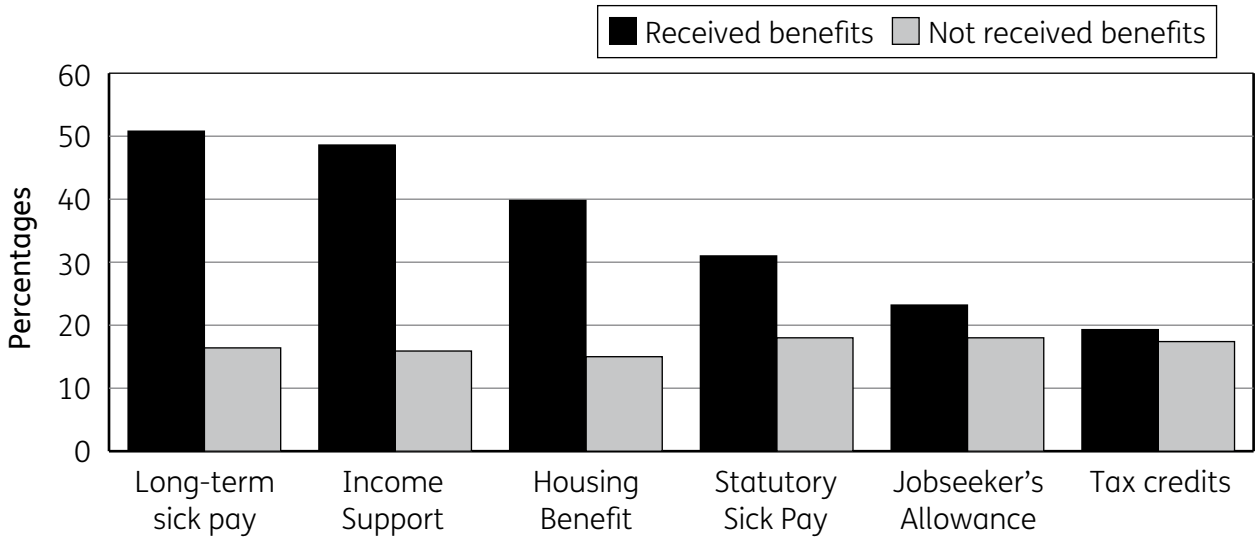
2.1.1 Context on mental health in job-seeking populations

There is a well established link between mental health and economic activity status. Data from the 2007 APMS has shown that people without a job are more likely to have CMD than people who are in employment.[24] Mental health is worse both among those who are unemployed and among those whose are economically inactive.

The likelihood of having a CMD also differs by benefit recipient group. This is not unexpected, given that the eligibility criteria for some benefits include having a health condition or being out of employment. In APMS 2007 data, people in receipt of long-term sickness benefits – for whatever reason – were particularly likely to have a CMD.[25] This was also true of benefits designed to supplement very low incomes, such as housing benefits.

In this same 2007 dataset, the JSA population was found to have a mental health profile that was not significantly different from that of the rest of the population, and was better than that for people receiving most other types of benefit. It is important to note, however, that these data are based on a general population sample of about 7,400 respondents. The numbers in receipt of each type of benefit were too small for robust assessment.

Figure 2.1 CMD by whether or not in receipt of different types of benefit



Base: All APMS 2007 respondents of normal working age.

[24] Ford, E., Stansfeld, S., McManus, S., Harris, J. and Clark, C. Common mental disorder, unemployment and welfare benefits in England. *Journal of Public Health* 2010; 124(12):675-81.

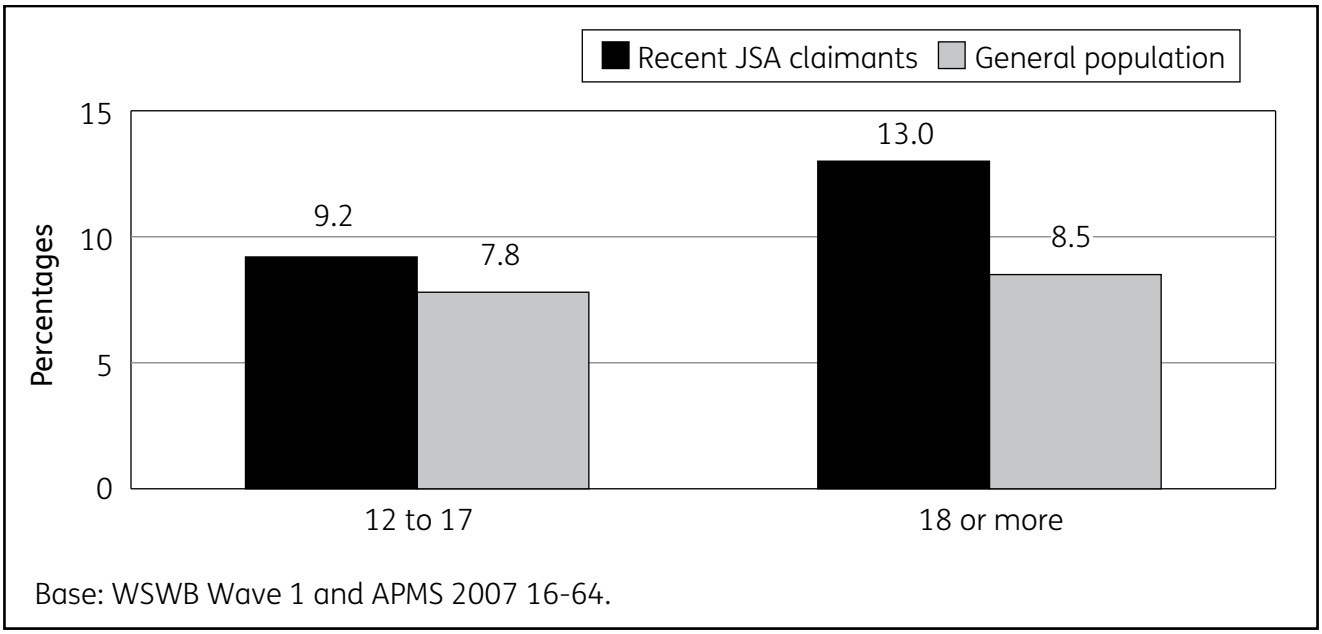
[25] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey*. The NHS Information Centre.

2.1.2 Severity of neurotic symptoms

Comparisons of recent JSA claimants with the general population

This study – the National Study of Work-search and Wellbeing (WSWB) – followed a cohort of people who started a JSA claim in the first quarter of 2011. People in this cohort were more likely to have clinically significant levels of anxiety and depression than people in the working-age population as a whole (using APMS 2007 for general population comparisons). While one person in six (16.4 per cent) in the general population had a Clinical Interview Schedule – Revised (CIS-R) score of 12 or more, the proportion among recent JSA claimants at the Wave 1 interview was between one in four and one in five (22.1 per cent). This prevalence of CMD among JSA claimants was very similar to that found among the JSA claimants who took part in APMS 2007.

Figure 2.2 CIS-R score among recent JSA claimants at Wave 1 and the working-age general population



Base: WSWB Wave 1 and APMS 2007 16-64.

The difference in rate was particularly pronounced among people with a more severe level of neurotic symptoms (a CIS-R score of 18 or more). These are people for whom a programme of treatment for anxiety and depression would almost certainly be warranted. Recent JSA claimants were about 50 per cent more likely than people in the general population to be in this most adversely affected group (13.0 per cent compared with 8.5 per cent).

Table 2.1 CIS-R score among recent JSA claimants and the general population, by sex

CIS-R score	Recent JSA claimants[a] (WSWB Wave 1) %	General population[b] (APMS 2007) %
Men		
Under 12	**81.3**	**87.4**
0-5	69.0	73.2
6-11	12.3	14.2
12 or more	**18.7**	**12.6**
12-17	8.7	6.2
18 or more	10.1	6.4
Bases	*1,247*	*2,366*
Women		
Under 12	**71.4**	**79.9**
0-5	53.7	60.1
6-11	17.8	19.8
12 or more	**28.6**	**20.1**
12-17	10.2	9.4
18 or more	18.4	10.7
Bases	*832*	*3,059*
All		
Under 12	**77.9**	**83.6**
0-5	63.7	66.6
6-11	14.2	17.0
12 or more	**22.1**	**16.4**
12-17	9.2	7.8
18 or more	13.0	8.5
Bases	*2,079*	*5,425*

Base: APMS 2007 general population sample aged 16-64.
WSWB – Wave 1, started a JSA claim around Q1 2011 aged 16-64.

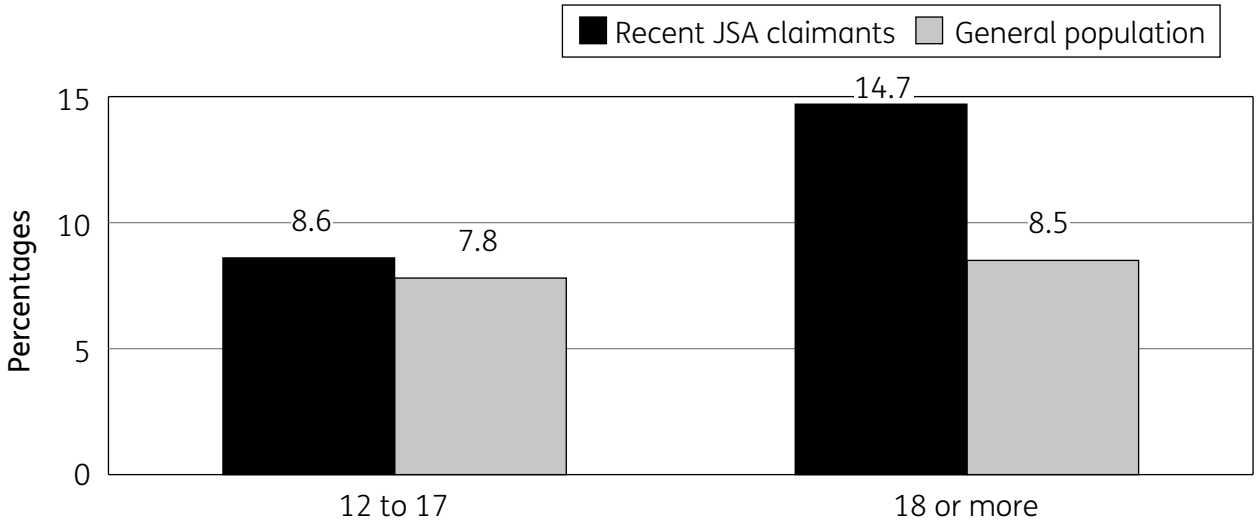
[a] People who started a JSA claim around the first quarter of 2011. They may not have still been claiming at the point of interview.

[b] The general population sample covers England only and includes some JSA claimants, but too few to impact on estimates. APMS was conducted in 2007. At a population level, CIS-R score has remained quite stable over the past fifteen years. However, it is plausible that the recent recession may have contributed to a decline since the survey was carried out.

Age and sex standardised comparisons in CMD

The higher rates of CMD among recent JSA claimants are all the more noteworthy given the age and sex profile of the claimant population. As discussed in the Introduction and in Chapter 3, recent JSA claimants are more likely to be young and male than the general population, while CIS-R scores tend to be highest among middle aged women (aged 45 to 54).[26] JSA claimants were also more likely than the general population to be single, and single people have higher rates of CMD than married people. As such, comparisons were made that took into account some of these differences between the characteristics of the JSA population and the general population by presenting CIS-R scores for the population of recent JSA claimants that have been weighted to match the age, sex and region profile of the working-age population as a whole.[27]

Figure 2.3 Age-standardised CIS-R score among recent JSA claimants at Wave 1 and the working-age general population



Base: WSWB Wave 1 and APMS 2007 16-64.

After adjusting for the fact that JSA claimants are more likely to be male and young, the difference in rate of severe neurotic symptoms (a CIS-R score of 18 or more) between recent JSA claimants and the working-age population as a whole increased (14.7 per cent compared with 8.5 per cent). However, after standardisation JSA claimants were not significantly more likely than the rest of the working-age population to have a less severe level of neurotic symptoms (a CIS-R score of 12-17).

26 Spiers, N., Bebbington, P., McManus, S., Brugha, T.S., Jenkins, R. and Meltzer, H. Age and birth cohort differences in the prevalence of common mental disorder in England: the National Psychiatric Morbidity Surveys, 1993 to 2007. *British Journal of Psychiatry*. 2011: 198: 479-484.

27 2010 Mid-Year Population estimates were used to create household population figures (ONS 2011). The Wave 1 selection and non-response weights were then calibrated to this in order to represent the age (16-64), sex and region distribution of the general household population.

Table 2.2 CIS-R score among recent JSA claimants and the general population, standardised rate

CIS-R score	Recent JSA claimants %	JSA claimants: standardised to profile of general population[a] %	General population %
All			
Under 12	77.9	76.8	83.6
0-5	63.7	61.2	66.6
6-11	14.2	15.5	17.0
12 or more	22.1	23.2	16.4
12-17	9.2	8.6	7.8
18 or more	13.0	14.7	8.5
Bases	*2,079*	*2,079*	*5,425*

Base: APMS 2007 general population sample aged 16-64.
WSWB – Wave 1.
[a] Rate standardised to that of the working-age general population in terms of age, sex and region.

Mental health by whether or not claiming JSA at Wave 1

The recent JSA claimants interviewed at Wave 1 included people (38 per cent of the cohort) who had found work soon after their claim started. A comparison of CIS-R score by whether people were still in receipt of JSA at the Wave 1 interview, shows that the rate of severe neurotic symptoms was higher among people who were still claiming JSA. Recent JSA claimants who were no longer on JSA had a mental health profile more similar to that of the general population, especially among women. In particular, those who were no longer JSA claimants were less likely to have a severe level of neurotic symptoms. The likely causal pathways operating here – that people with better mental health may have been more likely to have found work, as well as that finding work may have improved people's mental health – are explored in Chapters 4 and 7.

Table 2.3 CIS-R score among recent JSA claimants by whether on JSA at the Wave 1 interview

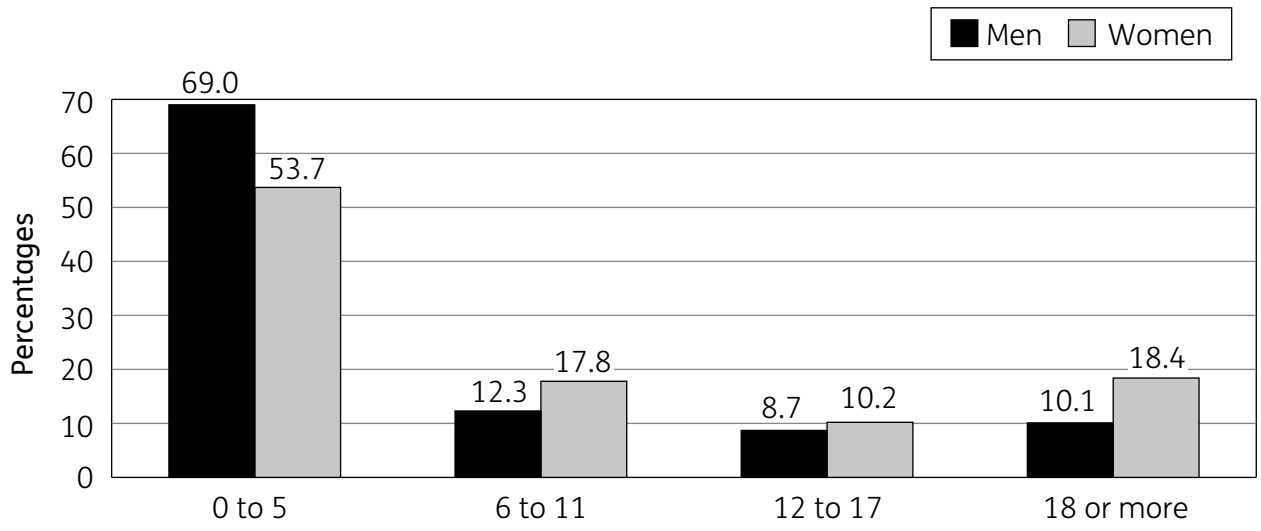
CIS-R score	On JSA at Wave 1 %	Not on JSA at Wave 1 %	General population %
Men			
Under 12	**81.1**	**81.6**	**87.4**
0-5	68.2	70.3	73.2
6-11	12.9	11.3	14.2
12 or more	**18.9**	**18.4**	**12.6**
12-17	7.6	10.5	6.2
18 or more	11.3	7.9	6.4
Bases	833	414	2,366
Women			
Under 12	**68.4**	**75.8**	**79.9**
0-5	51.3	56.9	60.1
6-11	17.0	18.8	19.8
12 or more	**31.6**	**24.2**	**20.1**
12-17	11.3	8.6	9.4
18 or more	20.3	15.7	10.7
Bases	*424*	*299*	*3,059*
All			
Under 12	**76.9**	**79.4**	**83.6**
0-5	62.6	65.3	66.6
6-11	14.2	14.1	17.0
12 or more	**23.1**	**20.6**	**16.4**
12-17	8.8	9.8	7.8
18 or more	14.3	10.8	8.5
Bases	*1,343*	*736*	*5,425*

Base: APMS 2007 general population sample aged 16-64.
WSWB – Wave 1, started a JSA claim around Q1 2011 aged 16-64.

Severity of neurotic symptoms: associations with age and sex

At Wave 1, both male and female JSA claimants had worse mental health than men and women in the general population. And as is also the case in the general population, female claimants at Wave 1 were more likely to have a CIS-R score of 12 or more than male claimants (28.6 per cent compared with 18.7 per cent).

Figure 2.4 CIS-R score by sex, among recent JSA claimants

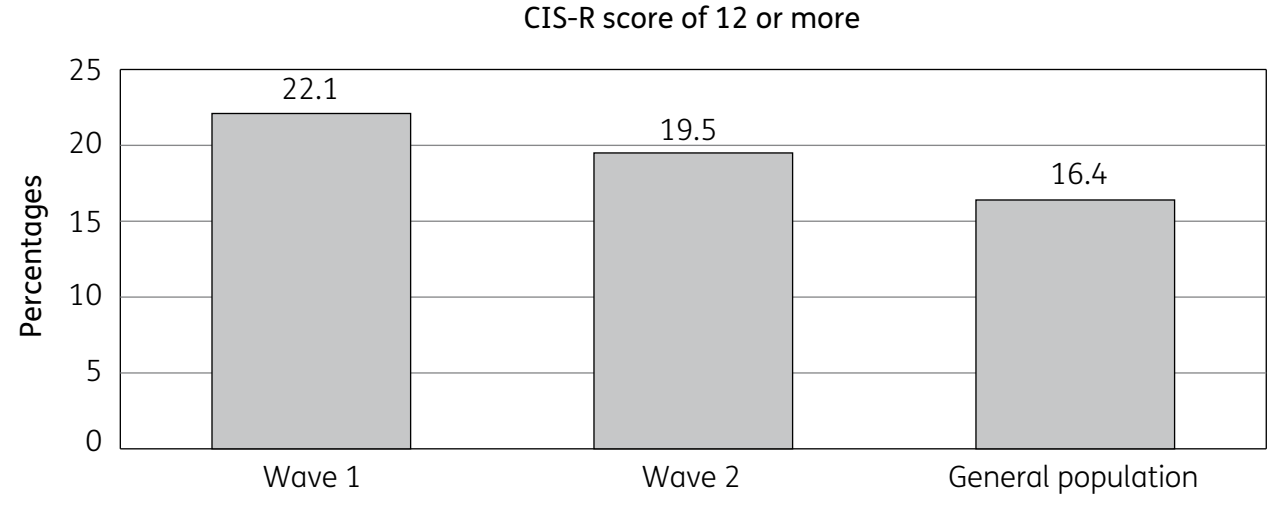


Base: WSWB Wave 1.

Severity of neurotic symptoms: change over time

By Wave 2 – about four months later – the proportion of the whole claimant cohort with a CIS-R score of 12 or more had declined. It was not as low as the rate for the working-age population as a whole, but it had moved in that direction. This was not unexpected given that most of the cohort was no longer on JSA, including many who had entered the workforce (these issues are explored further in Chapter 7).

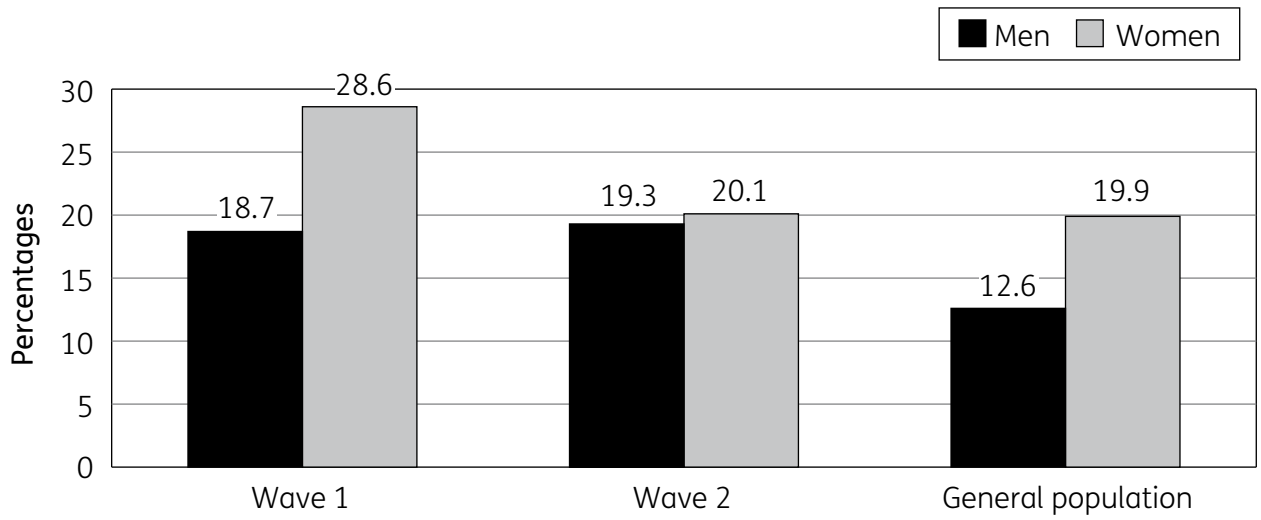
Figure 2.5 CIS-R score of 12 or more, among recent JSA claimants at Waves 1 and 2 and the working-age general population



Base: APMS 2007 16-64, WSWB Wave 1 and Wave 2.

The gap in CIS-R scores between men and women (which was pronounced at Wave 1) was no longer evident by Wave 2. Overall, the average mental health of men in the cohort changed little between Waves 1 and 2. It remained worse than that of men in the working age population, despite the fact that many in the cohort had entered the workforce by Wave 2. Meanwhile, the average mental health of women in the cohort improved between Waves 1 and 2, reaching a level comparable with that found among women in the general population. This is despite the fact that many women in the cohort were still JSA claimants and that women in the general population are older (and therefore, might be expected to be have somewhat higher rates of CMD).

Figure 2.6 CIS-R score of 12 or more by sex, among recent JSA claimants at Waves 1 and 2 and the working-age general population



Base: APMS 2007 16-64, WSWB W1 and W2.

Results presented in Chapter 4 show that for this cohort, women were more likely than men to enter work. After controlling for this and other factors, sex no longer seemed to predict how mental health changed in the months after starting a claim. However, a large body of previous research has also suggested that unemployment has a greater impact on men's mental health than on women's.[28, 29]

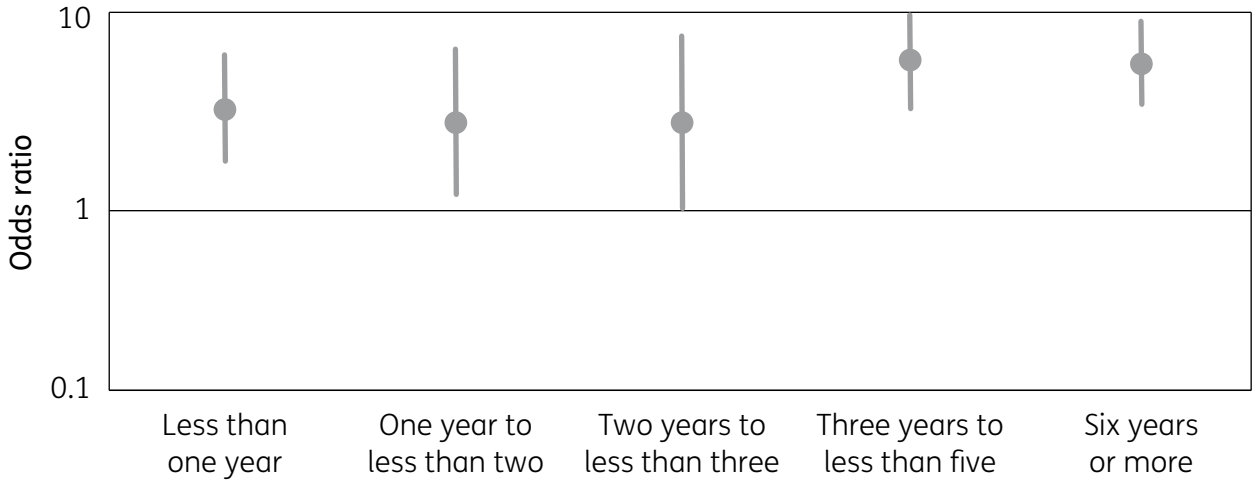
[28] Warr, P. (1985). Twelve questions about unemployment and health. In: Roberts, B., Finnegan, R., Gallie, D., editors. *New Approaches to Economic Life*. Manchester University Press: p302-18.

[29] Rodgers, B. (1991). Socio-economic status, employment and neurosis. *Social Psychiatry and Psychiatric Epidemiology*. 26: 104-14.

There are various hypotheses for why this might be, including gender traditionalism in family roles of care giving and being a provider.[30] [31] Other researchers have found that where the woman is single or the main wage earner, the impact of unemployment on mental health is similar for men and women.[32, 33]

Other data sources shed light on the association between longer durations of unemployment and mental health. Figures 2.7 and 2.8, using data from APMS show that the odds of having a CMD (after controlling for socio-demographic factors) increased with length of time not in employment. Being out of work was always significantly associated with higher rates of CMD among men, but among women this was only significant after three years of unemployment or economic inactivity.

Figure 2.7 Adjusted odds of CMD by length of time since last employed among men, with those in employment as the reference category



Base: Male APMS 2007 respondents of normal working age.

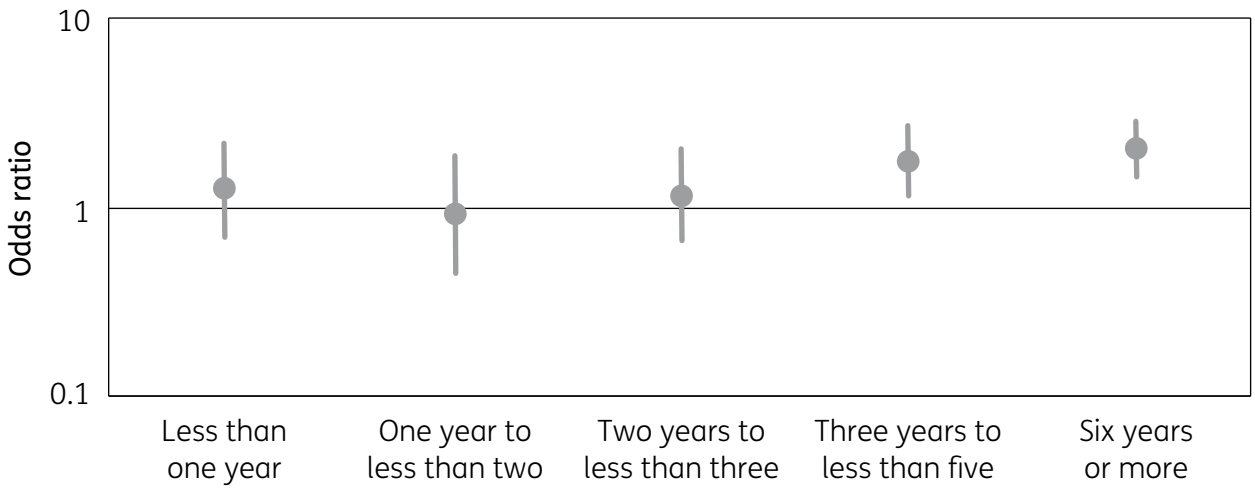
30 Artazcoz, L., Benach, J., Borrell, C. and Cortes, I. (2004). Unemployment and Mental Health: Understanding the Interactions Among Gender, Family Roles, and Social Class. *American Journal of Public Health*. 94(1): 82-8.

31 Warr, P. (1984). Job Loss, Unemployment and Psychological Well-Being. In: Allen, V.L., van der Vliert, E., editors. *Role Transitions: Explorations and Explanations*. (New York: Plenum Press) p263-85.

32 Fryer, D. (1992). Psychological or Material Deprivation: Why does unemployment have mental health consequences. In: McLaughlin E, (ed). *Understanding Unemployment: New perspectives on active labour market policies* (Routledge).

33 Leeflang, R., Klein-Hesselink, D. and Spruit, I. Health Effects of Unemployment – II. Men and Women. *Social Science & Medicine* 1992.34(4): 351-63.

Figure 2.8 Adjusted odds of CMD by length of time since last employed among women, with those in employment as the reference category



Base: Female APMS 2007 respondents of normal working age.

Chapter 7 explores the factors influencing trajectories in mental health over a shorter period of time, using multivariate analyses. Several of these issues are explored further there.

Table 2.4 CIS-R score at Wave 1 and 2

CIS-R score	Wave 1 %	Wave 2 %
Men		
Under 12	**81.3**	**80.7**
0-5	69.0	70.0
6-11	12.3	10.7
12 or more	**18.7**	**19.3**
12-17	8.7	7.8
18 or more	10.1	11.5
Bases	*1,247*	*747*
Women		
Under 12	**71.4**	**80.1**
0-5	53.7	61.6
6-11	17.8	18.5
12 or more	**28.6**	**19.9**
12-17	10.2	6.3
18 or more	18.4	13.6
Bases	*832*	*532*
All		
Under 12	**77.9**	**80.5**
0-5	63.7	66.9
6-11	14.2	13.6
12 or more	**22.1**	**19.5**
12-17	9.2	7.2
18 or more	13.0	12.3
Bases	*2,079*	*1,279*

Base: WSWB – Wave 1.

Mental health by whether or not claiming JSA at Wave 2

CIS-R score at Wave 2 was related to whether or not the respondent was still claiming JSA at Wave 2. Among people who were still JSA claimants at Wave 2, 15.7 per cent had a severe level of neurotic symptoms (CIS-R score of 18 or more), compared with 9.9 per cent of the cohort who were no longer JSA claimants by Wave 2. As mentioned previously, the causal pathway could be in both directions: that people with fewer neurotic symptoms were more likely to find work and that those who remained out of work experienced deterioration in mental health as a consequence.

Table 2.5 CIS-R score among recent JSA claimants at Wave 2, by whether still on JSA at Wave 2

CIS-R score	Still on JSA at Wave 2 %	Not on JSA at Wave 2 %	General population %
Men			
Under 12	78.7	82.3	87.4
0-5	66.1	73.2	73.2
6-11	12.7	9.1	14.2
12 or more	21.3	17.7	12.6
12-17	6.4	8.9	6.2
18 or more	14.9	8.8	6.4
Bases	*345*	*402*	*2,366*
Women			
Under 12	75.0	83.1	79.9
0-5	55.2	65.4	60.1
6-11	19.8	17.7	19.8
12 or more	25.0	16.9	20.1
12-17	7.8	5.4	9.4
18 or more	17.2	11.5	10.7
Bases	*283*	*468*	*3,059*
All			
Under 12	77.5	82.6	83.6
0-5	62.4	70.1	66.6
6-11	15.1	12.6	17.0
12 or more	22.5	17.4	16.4
12-17	6.9	7.5	7.8
18 or more	15.7	9.9	8.5
Bases	*544*	*735*	*5,425*

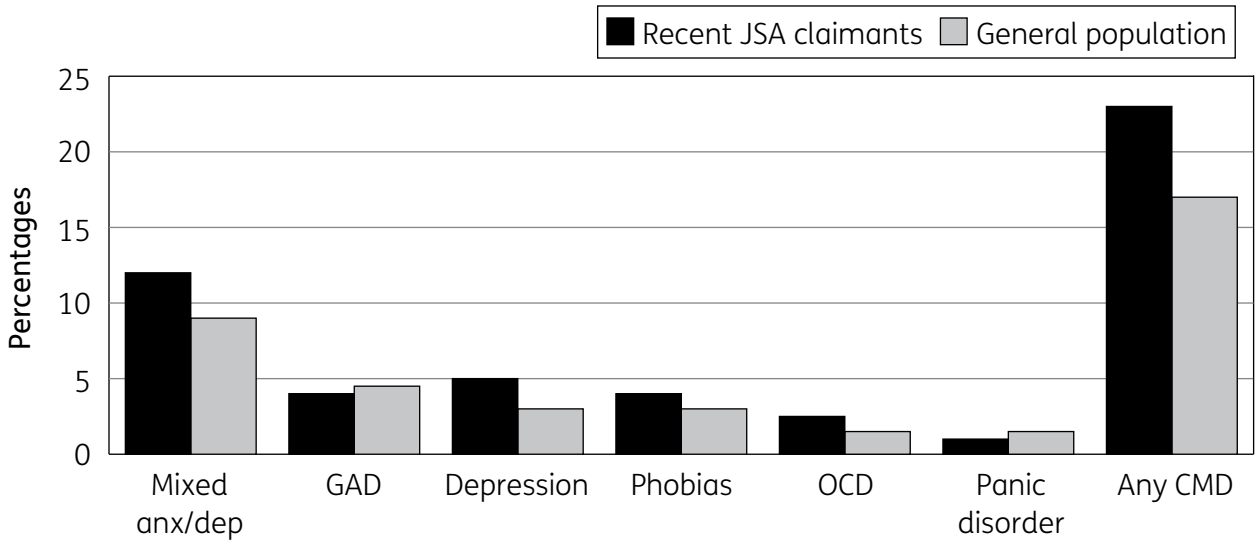
Base: APMS 2007 general population sample aged 16-64.
WSWB – Wave 2, started a JSA claim around Q1 2011 aged 16-64.

2.1.3 Common mental disorders

Comparison with the general population

Consistent with the pattern for severity score, recent JSA claimants were more likely than the rest of the working age population to have a CMD (22.6 per cent, compared with 17.6 per cent). Differences in individual disorders were evident for depressive episode, phobia and obsessive-compulsive disorder.

Figure 2.9 CIS-R score of 12 or more among recent JSA claimants at Wave 1 and the working-age general population



Base: WSWB W1; APMS 2007.

It is important to note that people identified with mixed anxiety and depression made up a group with a lower average level of neurotic symptoms than the people diagnosed with other CMDs. Thirty-eight per cent of those with mixed anxiety and depression had a CIS-R score of 18 or more. However, the proportion of people with a CIS-R score of 18 or more was 66 per cent for panic disorder, 82 per cent for GAD, 88 per cent for phobias, 89 per cent for depressive episode, and 91 per cent for OCD. That is, 91 per cent of people identified with OCD had a severe level of overall neurotic symptoms.

Table 2.6 CMD in past week among recent JSA claimants and the general population

Type of common mental disorder (CMD)[a]	Recent JSA claimants (WSWB Wave 1) %	General population (APMS 2007) %
All		
Mixed anxiety and depression	11.9	9.1
Generalised anxiety disorder	4.6	4.7
Depressive episode	5.0	3.3
Phobia	4.4	2.4
Obsessive-compulsive disorder	3.3	1.3
Panic disorder	1.3	1.2
Any CMD	22.6	17.6
Bases	*2,079*	*5,425*

Base: WSWB – Wave 1. APMS 2007 aged 16-64.

[a] An individual could have more than one type of CMD.

Table 2.7 CMDs in past week among recent JSA claimants and the general population, by sex

Type of common mental disorder (CMD)[a]	Recent JSA claimants (WSWB Wave 1) %	General population (APMS 2007) %
Men		
Mixed anxiety and depression	10.3	7.1
Generalised anxiety disorder	3.4	3.6
Depressive episode	5.0	2.7
Phobia	4.2	1.5
Obsessive-compulsive disorder	2.7	1.1
Panic disorder	1.1	1.1
Any CMD	19.2	13.7
Bases	*1,247*	*2,366*
Women		
Mixed anxiety and depression	14.9	11.0
Generalised anxiety disorder	6.8	5.8
Depressive episode	5.0	3.8
Phobia	4.8	3.3
Obsessive-compulsive disorder	4.4	1.5
Panic disorder	1.7	1.4
Any CMD	29.0	21.5
Bases	*832*	*3,059*

Base: WSWB – Wave 1; APMS 2007 aged 16 to 64.
[a] An individual may have more than one type of CMD.

Types of CMD: change over time

The pattern of change in CMD between Waves 1 and 2 was very similar to that for the overall CIS-R score, with a general trend of stability in rates among men (19.2 per cent with any CMD at Wave 1, 20.4 per cent at Wave 2); and improvement in mental health among women (29.0 per cent with any CMD at Wave 1, 20.6 per cent at Wave 2). Much of the overall decline in CMD was accounted for by the change in rate of mixed anxiety and depression. 14.9 per cent of women were identified with mixed anxiety and depression at Wave 1, and 10.1 per cent at Wave 2.

Table 2.8 CMDs in past week at Wave 1 and Wave 2

Type of common mental disorder (CMD)[a]	Wave 1 %	Wave 2 %
Men		
Mixed anxiety and depression	10.3	9.2
Generalised anxiety disorder	3.4	4.0
Depressive episode	5.0	2.9
Phobia	4.2	5.3
Obsessive-compulsive disorder	2.7	2.4
Panic disorder	1.1	1.3
Any CMD	19.2	20.4
Bases	*1,247*	*747*
Women		
Mixed anxiety and depression	14.9	10.1
Generalised anxiety disorder	6.8	3.9
Depressive episode	5.0	5.2
Phobia	4.8	5.8
Obsessive-compulsive disorder	4.4	4.4
Panic disorder	1.7	0.5
Any CMD	29.0	20.6
Bases	*832*	*532*
All		
Mixed anxiety and depression	11.9	9.5
Generalised anxiety disorder	4.6	4.0
Depressive episode	5.0	3.8
Phobia	4.4	5.5
Obsessive-compulsive disorder	3.3	3.2
Panic disorder	1.3	1.0
Any CMD	22.6	20.5
Bases	*2,079*	*1,279*

Base: WSWB – Wave 1 and Wave 2.

[a] An individual could be diagnosed with more than one type of CMD.

2.2 General health and wellbeing

2.2.1 General health

Not everyone who described their general health as poor would necessarily have a diagnosed health condition, and many people with a health condition would not describe their general health as poor. However, people who self-report poor general health do tend to have worse health than people who self-report their general health more positively.[34] The measure is also a good predictor of mortality.[35] In both Waves 1 and 2 a standard question, taken from the Short Form (SF) 12, was asked about 'health in general'. The same question was also in APMS 2007, allowing for comparison with the wider working age population.

Table 2.9 Self-reported general health among recent JSA claimants and the general population

	Wave 1 %	Wave 2 %	General population %
'How is your health in general, is it...'			
Men			
Excellent/very good	56.7	59.5	58.2
Good	28.6	26.6	27
Fair/poor	14.7	13.9	14.7
Bases	*1,245*	*747*	*2,366*
Women			
Excellent/very good	53.5	51.7	56.6
Good	27.6	31.0	27.8
Fair/poor	18.8	17.3	15.6
Bases	*830*	*532*	*3,059*
All			
Excellent/very good	55.6	56.5	57.4
Good	28.3	28.3	27.4
Fair/poor	16.1	15.2	15.2
Bases	*2,075*	*1,279*	*5,425*

Base: WSWB – Wave 1 and Wave 2.
APMS 2007 aged 16-64.

The distribution of general health categories (from excellent/very good to fair/poor) was similar at Waves 1 and 2. It was also similar among recent JSA claimants and the working age population. It has been noted that questions like these are subject to reporting biases, which can tend to overstate poor health in more advantaged socio-economic groups.[36]

[34] Moller, L., Kristensen, T. and Hollnagel, H. (1996). Self rated health as a predictor of coronary heart disease in Copenhagen, Denmark. *J Epidemiol Community Health* 1996, 50:423-428.

[35] Kaplan, G.A., Camacho, T. (1983). Perceived health and mortality: a nine-year follow-up of the Human Population Laboratory cohort. *Am J Epidemiol*. 1983; 117:292-304.

[36] Krause, N.M. and Jay, G.M. *What do global self-rated health items measure?* Medical Care 1994; 32:930-942.

Recent JSA claimants were also asked about whether or not they had any limiting, longstanding illness, disability or infirmity which impacted on the amount or type of work that they can do. Generally, people refer to physical health problems in response to this question, rather than mental health problems.[37] A fifth of the sample (20.7 per cent Wave 1, 21.6 per cent Wave 2) reported such an illness, disability or infirmity. This rate is broadly similar to that identified in surveys that use a similar question with the general population.

Table 2.10 Limiting longstanding illness, disability or infirmity, at Wave 1 and Wave 2

	Wave 1 %	Wave 2 %
Limiting longstanding illness, disability or infirmity	20.7	21.6
Bases	*2,079*	*1,279*

Base: WSWB – Wave 1.

2.2.2 Subjective wellbeing

Two different approaches to assessing subjective wellbeing were included on the Wave 1 interview: measures developed by ONS to inform the measurement of national wellbeing and the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS).

ONS subjective wellbeing items

ONS has developed four questions designed to utilise different approaches to the assessment of subjective wellbeing. The items include:

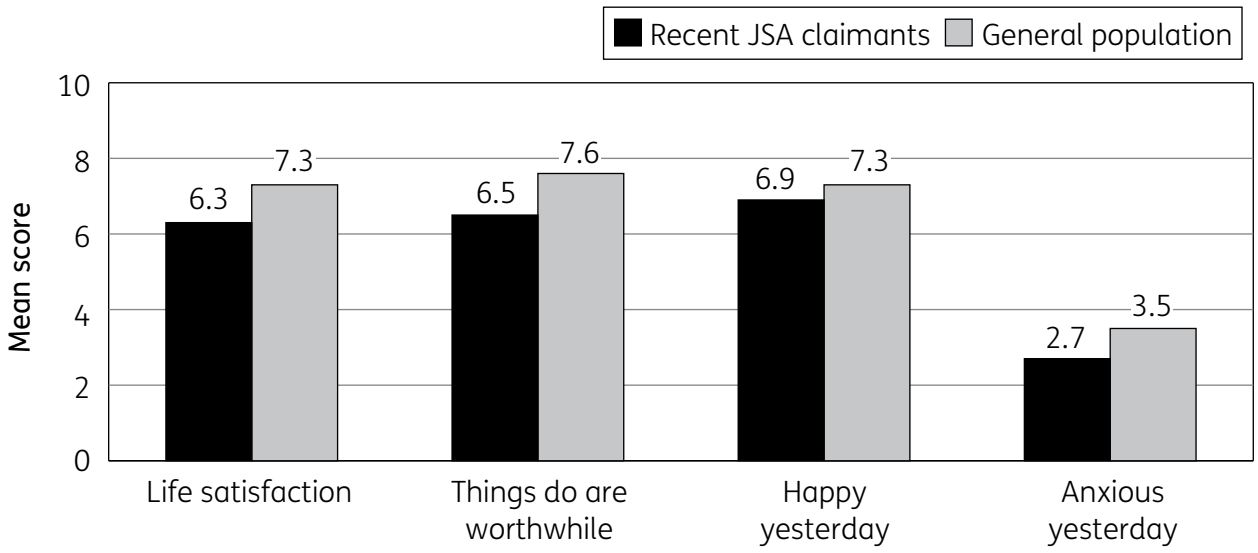
- an evaluative measure which asks people to rate how satisfied they are with their life overall;
- measures of positive (feeling happy) and negative affect (feeling anxious) related to how they felt yesterday; and
- a question informed by a eudaimonic perspective on wellbeing, about how worthwhile people feel the things that they do are.

It has been recommended that the items are used separately as a 'dashboard', rather than being combined to form a single scale or score.[38] More detail is given in Appendix C.

[37] Cohen, G., Forbes, J. and Garraway, M. Interpreting self reported limiting long-term illness. *BMJ* 1995;311:722.

[38] Measuring Subjective Wellbeing in the UK, Analysis of experimental subjective well-being data from the Annual Population Survey, April – September 2011. http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/analysis-of-experimental-subjective-well-being-data-from-the-annual-population-survey--april---september-2011/index.html

Figure 2.10 ONS subjective wellbeing measures, recent JSA and general population



Base: WSWB W1 and ONS Opinions Survey.

Subjective wellbeing tended to be lower among JSA claimants than among the general population. The apparently higher rate of anxiety reported by the general population may be because anxiety is more commonly reported by women, while the JSA claimant group is more likely to include men.

ONS administered these questions to a general population sample using their Opinions Survey. They found a similar pattern of association when they looked at the relationship between subjective wellbeing and economic activity.[39] Unemployed participants provided lower average ratings for the first three measures of subjective wellbeing than employed respondents. Life satisfaction had a mean score of 6.3 for unemployed people compared with 7.5 for those in employment; for the 'worthwhile' question 7.0 compared with 7.8, and for 'happy yesterday' 6.8 compared with 7.5. Unemployed participants gave higher ratings for the anxiety question than employed participants (4.0 compared with 3.3) but this difference was not significant.

[39] ONS (2011). 'Comparison of the mean rating for overall subjective well-being questions by economic activity, April to August 2011', in Initial investigation into Subjective Well-being from the Opinions Survey. http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/investigation-of-subjective-well-being-data-from-the-ons-opinions-survey/initial-investigation-into-subjective-well-being-from-the-opinions-survey.html#tab-Section-4--Factors-associated-with-the-four-overall-subjective-well-being-questions

Table 2.11 ONS measures of subjective wellbeing, recent JSA and general population

ONS subjective wellbeing indicators[a]	Wave 1, Q1 2011 Mean score	General population Mean score
Life satisfaction[b]	6.3	7.3
Things you do are worthwhile[b]	6.5	7.6
Happy yesterday[b]	6.9	7.3
Anxious yesterday[c]	2.7	3.5
Bases	*2,021*	*3,800[d]*

Base: WSWB Q1 2011 – Wave 1. ONS Opinions Survey Q2 2011 – aged 16-64.

[a] Experimental questions included on the Opinions Survey module of the ONS Integrated Household Survey.

[b] A higher value indicates better SWB. Highest score 10.

[c] A lower value indicates better SWB. Lowest score 0.

[d] This figure is an estimate, as the base was not presented by age in the source material.

SWEMWBS

The 14-item Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) was developed in recent years for assessing positive mental health (mental wellbeing). The short version (SWEMWBS), used in both Waves 1 and 2 of the survey, consists of a seven positively-worded item scale with five response categories (see Appendix C). It covers most aspects of positive mental health (positive thoughts and feelings) discussed in existing literature, including both hedonic and eudaimonic perspectives. Hedonic wellbeing includes happiness and pleasure, while eudaimonic wellbeing focuses more on value, meaning and purpose in life. The mean SWEMWBS item score remained stable, at around 25 at both Waves 1 and 2.

Table 2.12 Mean SWEMWBS score, at Waves 1 and 2

Understanding Society (USoc) Wave 2 – 16 to 64 year olds	Wave 1	Wave 2	General population
SWEMWBS score			
Mean	25.06	25.20	25.05
Bases	*2,028*	*1,273*	*30,140*

Base: WSWB – Wave 1 and Wave 2.

The SWEMWBS was also asked on Wave 2 of the Understanding Society survey, a large general population survey that covers Britain. The mean SWEMWBS score for people aged 16-64 was 25.05, almost identical to the mean score among JSA claimants. However, the SWEMWBS was administered by self-completion on Understanding Society, and self-completion is known to encourage higher reporting of stigmatised responses.[40] It is likely that if the SWEMWBS had been administered in the same way on both surveys, that the JSA claimant sample would have had an average score that indicated lower subjective wellbeing than the general population.

[40] Tourangeau, R., Rips, L.J. and Rasinski, K. (2000). The Psychology of Survey Response. Cambridge University Press: Cambridge.

2.3 Psychological factors and beliefs

Survey data on some psychological factors and beliefs related to health and work among recent JSA claimants was also collected. These are drawn on in the multivariate analyses in Chapters 4 and 7. The areas covered in the survey included:

- Coping strategies:
  - Dealing with problems well.
  - Able to make up own mind about things.
  - Thinking clearly.
- Beliefs:
  - Self-efficacy – belief in job-search abilities.
  - Attitudes towards work.
  - Optimism about the future.

Coping strategies were covered as part of the SWEMWBS. Beliefs among JSA claimants are explored in more detail below.

2.3.1 Self-efficacy

Self-efficacy is a concept used widely in psychology to refer to people's beliefs in their capabilities to produce given outcomes.[41] Levels of self-efficacy are thought to influence people's motivation, choices about actions, productivity, and social interactions.

Self-efficacy and job search behaviour

Studies examining self-efficacy in the context of work-search have found that higher levels have a positive impact on job search outcomes.[42] Training unemployed people to increase their level of self-efficacy has resulted in increased job search activity and greater re-employment.[43] It has also been found that people with higher job search self-efficacy reported more frequent job search activity, had lower levels of anxiety, and had a higher number of job offers.[44]

To measure job search self-efficacy, people who were still in receipt of JSA at the Wave 1 interview were asked to rate how confident they felt about each of five different work-search activities or skills.

41 Bandura, A. (1977). Self-Efficacy: Towards a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.

42 Trougakos, J.P., Green, S.G., Bull, R.A., MacDermid, S.M. and Weiss, H.M. (2003). Influences on Job Search Self-Efficacy of Spouses of Enlisted Military Personnel. http://www.mfri.purdue.edu/content/reports/Influences%20on%20Job%20Search%20Self.pdf

43 Eden, D. and Aviram, A. (1993). Self-efficacy training to speed reemployment: Helping people to help themselves. *Journal of Applied Psychology*, 78, 352-360.

44 Saks, A.M. and Ashforth, B.E. (2000). Change in job search behavior and employment outcomes. *Journal of Vocational Behavior*, 56, 277-287.

The Job Search Self-Efficacy (JSSE) scale

How confident do you feel about...

- Making the best impression in an interview
- Talking to others to get job openings
- Talking to others about potential employers
- Making a list of your skills
- Completing an application and résumé
- Persuading potential employers.

A score of 0 indicated 'not confident at all' and 5 indicated 'very confident'. See Appendix C for more details.

Job search self efficacy among JSA claimants

Overall, quite a high level of confidence in abilities was reported for most work-search items. These ranged from a mean score of 3.7 for being able to persuade employers, to 4.2 for being able to complete an application form or CV. There was some evidence to suggest that confidence in abilities was lowest for tasks involving interpersonal skills, and that this (therefore) would be an aspect for further support and training to focus on.

Job search self-efficacy among JSA claimants with CMD

As expected, job search self-efficacy declined with worsening mental health. For every item, the mean score appeared to be lower for those with CMD than for those without CMD, and was always below 4. The lower rates of self-efficacy applied both to written and interpersonal work-search skills.

Table 2.13 Job search self-efficacy scale mean scores for each item, by grouped CIS-R score

	CIS-R score			
How confident do you feel about...[a]	**0-11**	**12+**	**18+**	**All**
Making the best impression at an interview	4.0	3.7	3.6	3.9
Talking to others to get job openings	4.1	3.9	3.8	4.1
Talking to others about potential employers	4.1	3.9	3.9	4.1
Making a list of your skills	4.1	3.9	3.7	4.1
Completing an application or CV	4.3	3.9	3.7	4.2
Persuading potential employers	3.8	3.5	3.4	3.7
Bases[b]	*878*	*453*	*304*	*1,279*

Base: WSWB Wave 1 – those still claiming JSA at Wave 1.

[a] Each item was scored 0 to 5, where 0 indicated 'not at all' confident and 5 'very confident'.

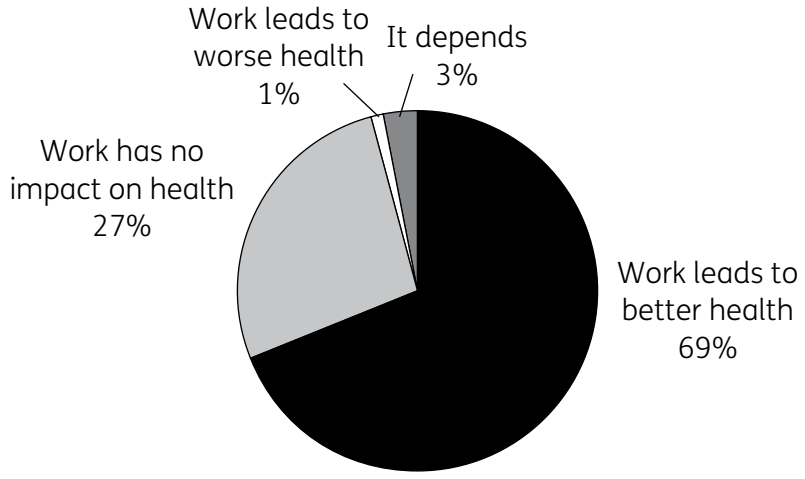
[b] Base size shown is for 'making the best impression at an interview'. Base sizes for the other variables were similar.

People with a CIS-R score of 12-17 (indicating clinically significant levels of symptoms) and those with a higher score, of 18 or more (a very high level psychological distress), reported similar levels of confidence in their job-seeking abilities. This suggests that people with a moderate level of neurotic symptoms also need to be targeted with interventions designed to improve their perception of their own abilities, alongside those with severe symptoms.

2.3.2 Attitudes towards work

People were asked to rate the impact that they felt that paid work has on health. The findings were clear: there is a strong and widely held belief among recent JSA claimants in the positive health benefits of employment. Of participants receiving JSA at the time of the first survey interview, two-thirds (68.6 per cent) agreed that working would lead to better health. Just over a quarter (27.1 per cent) reported that working has no impact on health, and very few reported that it either depends on the job (3.4 per cent) or that it leads to worse health (0.9 per cent).

Figure 2.11 Perceived impact of work on health



Base: WSWB Wave 1.

Collingwood, in a recent Department for Work and Pensions (DWP) report on attitudes to health among the working age population,[45] found even higher rates (over 80 per cent) across the population as a whole regarding work as beneficial for mental and physical health. However, in line with the results from this study, Collingwood identified people who were not in employment as less likely to agree that work was good for mental health.

There was an association between CIS-R score and perception of the health impacts of employment. People with a higher score were less likely than those with a low score to feel neutrally about the impact of work on health. Although this view was held by a small minority, people with a score of 18 or more were the most likely to regard work as damaging to health. However, they were also somewhat more likely to view it as beneficial.

[45] Collingwood, S. (2011). *Attitudes to Health and Work amongst the working-age population*. DWP Research Report No 763. DWP: Sheffield.

Table 2.14 Perceived impact of work on health, by grouped CIS-R score

	CIS-R score			
	0-11 %	12+ %	18+ %	All %
Yes – work leads to better health	66.2	76.8	78.3	68.6
Yes – work leads to worse health	0.6	1.9	2.8	0.9
Work has no impact on health	30.6	15.6	13.2	27.1
'It depends'	2.6	5.7	5.7	3.4
Bases	*815*	*431*	*290*	*1,246*

Base: WSWB Wave 1 – those still claiming JSA at Wave 1.

These results are interesting given that the qualitative interviews with people selected because of their symptoms of anxiety and depression, identified health problems and work related stress as factors that could contribute to job loss among this group.

2.3.3 Optimism about the future

One of the SWEMWBS items asks about how much of the time people feel optimistic about the future. Around a third (36.0 per cent) of recent JSA claimants reported feeling optimistic either most or all of the time. However, just over a quarter (26.1 per cent) felt this way rarely or none of the time. Optimism was strongly associated with the presence of neurotic symptoms. While a fifth of people with a CIS-R score of between 0 and 11 reported rarely or never feeling optimistic about the future, these views were expressed by more than half (56.1 per cent) of those with a score of 18 or more.

Table 2.15 Proportion of time feel optimistic about the future, by grouped CIS-R score

	CIS-R score			
Optimistic about the future	0-11 %	12+ %	18+ %	All %
Most/all of the time	40.5	20.3	15.3	36.0
Some of the time	39.4	32.5	28.6	37.9
Rarely/none of the time	20.1	47.1	56.1	26.1
Bases	*1,365*	*655*	*437*	*2,020*

WSWB Wave 1.

2.4 Treatment and use of health and community services

2.4.1 Treatment and service use

Treatment for a mental health reason

Various types of treatment and service use for a mental health related reason were asked about at both the Wave 1 and the Wave 2 interviews. The proportion of recent JSA claimants who had discussed mental health issues such as feelings of anxiety and stress with their GP (12.3 per cent)

was much lower than the proportion with clinically significant symptoms (22.1 per cent). Such a pattern is also evident in the general population. As is also the case for the general population,[46] recent JSA claimants were more likely to be in receipt of psychoactive medication (8.6 per cent) than in talking therapy (4.2 per cent).

Table 2.16 Treatment and service use for a mental, emotional or stress related reason

	Wave 1 %	Wave 2 %
GP consult for mental health reason[a]	12.3	16.3
Counselling or therapy[a]	4.2	5.5
Medication for a mental health reason[b]	8.6	9.8
Bases	*2,071*	*1,281*

Base: WSWB – Wave 1 and Wave 2.

[a] For Wave 1, reference period was 'past three months'. For Wave 2, reference period was 'since last interview' (about four months).

[b] This relates to 'current' medication prescribed for mental health or stress related reason.

At Wave 1, treatment and service use was asked about in relation to the past three months. At Wave 2, treatment and service use was asked about in relation to the time since the last survey interview. This was usually about four months. Therefore, the rates reported for Waves 1 and 2 are not strictly comparable, as the reference period at Wave 2 was slightly longer.

The proportion of claimants reporting treatment for a mental health related reason was either similar or higher in Wave 2, suggesting that there was at least stability in access to treatment in the months following the start of a JSA claim.

Recent JSA claimants were asked whether they had ever been treated in a hospital or ward specialising in mental health. The study did not assess claimants for psychoses, such as bipolar disorder or schizophrenia (which are rare and severe mental illnesses), and a question of this kind can help identify people with experience of such conditions. The proportion of JSA claimants reporting this (1.9 per cent) was not significantly different from the proportion reporting this in the wider working-age general population (2.2 per cent).

Table 2.17 Ever treated in a specialist mental health hospital or ward

	Wave 1 %	General population %
Ever treated in specialist mental health hospital/ward	1.9	2.2
Bases	*2,071*	*5,425*

Base: WSWB – Wave 1. APMS 2007 aged 16-64.

[46] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey*. The NHS Information Centre.

Use of health services

Survey participants were asked about their use of secondary health care, specifically in-patient and out-patient hospital visits. Again, at Wave 1 this related to the past three months and at Wave 2, to the time since the last survey interview (about four months). Broadly, hospital use was similar in the recent JSA and general working age populations.

Table 2.18 Hospital visits among recent JSA claimants and the general population

	Wave 1 %	Wave 2 %	General population %
In-patient stay	3.6	4.2	2.4
Out-patient visit	14.3	17.2	17.8
Bases	*2,071*	*1,281*	*5,425*

Base: WSWB – Wave 1 and Wave 2. APMS 2007 aged 16-64.

[a] For Wave 1, reference period was 'past three months'. For Wave 2, reference period was 'since last interview' (about four months).

Use of community services

People were asked whether or not they used each of a wide range of different types of community services. While use for a mental health reason was not specified in the question, the types of community services asked about are relevant to supporting people with mental health conditions. As mentioned previously, at Wave 1 the reference period referred to the past three months, at Wave 2 it related to the period between the first and second interview – usually about four months. Despite the Wave 2 questions relating to a slightly longer time period, the reported use of community services remained very stable between the two survey waves.

Table 2.19 Use of community services at Waves 1 and 2

	Wave 1 %	Wave 2 %
Psychiatrist, psychologist or community psychiatric nurse[a]	2.6	2.3
Social worker, outreach worker or family support[a]	3.6	3.3
Used a self-help or support group[a]	2.6	3.6
Used a home help or home care worker[a]	0.6	0.9
Bases	2,079	1,283

Base: WSWB – Wave 1 and Wave 2.

[a] For Wave 1, reference period was 'past three months'. For Wave 2, reference period was 'since last interview' (about four months).

3 The social and economic circumstances of recent JSA claimants

Key findings

- Recent Jobseeker's Allowance (JSA) claimants are more likely to be young, male and single than the rest of the working age population. Among both JSA claimants and the rest of the population, mental health is worse among women, people aged 25-49, and those who are divorced or separated.
- Recent experience of adverse life events, such as experiencing a financial crisis and living in temporary housing, were relatively common among recent JSA claimants.
- People who had previously been in receipt of sickness benefit were more likely to have a common mental disorder (CMD) like anxiety or depression.
- People with a CMD were more likely than those without to have been dismissed from their last job. This could be because their poor mental health contributed to their being dismissed, or because being dismissed contributed to the onset of poor mental health.
- People with a CMD were also more likely to give a personal or health related reason for leaving their last employment.

In this chapter, data from the Wave 1 survey are used to profile the social and economic characteristics of people who start a JSA claim. The associations between these characteristics and claimants' mental health are also examined. The chapter includes sections on:

- socio-demographic characteristics;
- social relationships, support and caring;
- recent experience of adverse life events;
- financial and economic circumstances;
- education, employment, and benefit history.

Within each section, survey data are presented that:

- profile the recent JSA population as a whole;
- compare JSA claimants with and without symptoms of anxiety and depression.

3.1 Socio-demographic characteristics

3.1.1 Socio-demographics: profile of recent JSA claimants

The unweighted proportions in Table 3.1 represent the socio-demographic profile of the raw achieved Wave 1 survey sample. The column with weighted percentages represents the achieved sample weighted to match the profile of the JSA claimant population that the sample was drawn from. The weighted base differs greatly in size from the unweighted base. This is because the sample design involved over-sampling people who had been in receipt of sickness benefit Employment and Support Allowance (ESA) or Incapacity Benefit (IB)) in the past year. This highlights the importance of focusing only on the weighted data, which corrects for this sampling bias in addition to non-response to the survey. All the data in this report are presented weighted, unless explicitly stated otherwise. The weighted profile represents the profile of the whole JSA cohort population; it is not a profile of the study sample.

The JSA claimant population that this study sample was drawn from was mostly male (65.2 per cent) and mostly single (63.9 per cent). Young people (17 to 24 years of age at the time of the Wave 1 interview) made up more than a third (37.2 per cent) of recent JSA claimants. People from minority ethnic groups were also overrepresented among JSA claimants, making up 17.3 per cent of this cohort. In contrast, ethnic minorities make up less than ten per cent of the general population aged 16 to 64.[47]

[47] ONS (2005). Focus on Ethnicity and Identity. National Statistics. http://www.ons.gov.uk/ons/rel/ethnicity/focus-on-ethnicity-and-identity/focus-on-ethnicity-and-identity-summary-report/index.html

Table 3.1 Socio-demographic profile of recent JSA claimants (unweighted and weighted), at Wave 1

	Bases	Unweighted %	Weighted %
Sex			
Men	*1,247*	60.0	65.2
Women	*832*	40.0	34.8
Age[a]			
17-24	*589*	28.3	37.2
25-44	*856*	41.2	42.5
45-64	*634*	30.5	20.3
Marital status			
Single	*1,239*	59.6	63.9
Married/cohabitating	*553*	26.6	27.3
Divorced/separated/widowed	*287*	13.8	8.9
Ethnic group			
White	*1,676*	84.5	82.7
Black	*122*	6.1	7.2
Asian	*100*	5	5.9
Mixed/other	*86*	4.3	4.2
Country			
England	*1,721*	82.8	83.9
Scotland	*245*	11.8	11.0
Wales	*113*	5.4	5.1

Base: Work-search and Wellbeing Study (WSWB) Wave 1.

[a] Age at Wave 1 interview. Where age at interview was missing, age at the point of sample selection was used instead.

3.1.2 Socio-demographics: associations with mental health

Mental health among recent JSA claimants, by sex

As described in Chapter 2 (and as is also the case in the general population) CMD was more common among female JSA claimants than in males.[48] While one in ten (10.1 per cent) male claimants had a Clinical Interview Schedule – Revised (CIS-R) score of 18 or more, the rate was closer to one in five among women (18.4 per cent). The difference was also evident at the lower severity threshold. More than a quarter (28.6 per cent) of female JSA claimants had a score of 12 or more (indicative of a clinically significant level of symptoms) compared with 18.7 per cent of male claimants.

[48] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey*. The NHS Information Centre.

Table 3.2 CIS-R score, by sex

CIS-R score	Men %	Women %	All %
0-11	81.3	71.4	77.9
12+	18.7	28.6	22.1
18+	10.1	18.4	13.0
Bases	*1,247*	*832*	*2,079*

Base: WSWB Wave 1.

3.1.3 Mental health among recent JSA claimants, by age

Associations between mental health and age are not straightforward.[49] In the general population there is evidence of a 'hill' shape in rates of mental disorder, with rates highest among people around middle age.[50] This pattern was also evident among the JSA population, with evidence to suggest that CMD was most common among people aged in the 25 to 49 year age group. About a quarter (25.2 per cent) of people in this group had a CIS-R score of 12 or more, compared with around a fifth of those in the other age groups.

Table 3.3 CIS-R score, by age group

CIS-R score	17-24 %	25-49 %	50-64 %
0-11	80.2	74.8	82.9
12+	19.8	25.2	17.0
18+	10.6	14.9	12.2
Bases	*589*	*1,071*	*419*

Base: WSWB Wave 1.

Mental health among recent JSA claimants, by country

The prevalence of having a very high CIS-R score (18 or more) is similar among recent JSA claimants living in Scotland (13.2 per cent) and England (13.3 per cent). However, in Wales the proportion of new JSA claimants with a CIS-R score of 18 or more was lower (6.6 per cent). Recent JSA claimants living in Wales were also less likely than those living in England or Scotland to have a CIS-R score of 12 or more. The sample size for Wales is small so caution is required in interpreting these results.

49 McManus, S. General health and mental well-being. Chapter in Bromley, C .and Given, L. (eds) The Scottish Health Survey 2011. 2012: Scottish Government: Edinburgh.

50 Spiers, N., Bebbington, P., McManus, S., Brugha, T.S., Jenkins, R. and Meltzer, H. Age and birth cohort differences in the prevalence of common mental disorder in England: the National Psychiatric Morbidity Surveys, 1993 to 2007. *British Journal of Psychiatry*. 2011: 198: 479-484.

Table 3.4 CIS-R score, by country

CIS-R score	England %	Scotland %	Wales %
0 – 11	78.2	74.1	81.1
12+	21.9	25.9	18.8
18+	13.3	13.2	6.6
Bases	*1,721*	*245*	*113*

Base: WSWB Wave 1.

3.2 Social relationships, support and caring

3.2.1 Relationships: profile of recent JSA claimants

Cohabitation

At the Wave 1 interview, almost three-quarters (72.7 per cent) of recent JSA claimants were not living with a partner. This is higher than the proportion of the wider working-age population who do not live with a partner, although this is likely to reflect the younger age profile of JSA claimants.[51] At Wave 2 – around six months after starting a JSA claim – the proportion not living with a partner appeared to increase very slightly (74.7 per cent).

Table 3.5 Whether living with a partner, at Waves 1 and 2

	Wave 1 %	Wave 2 %
Living with a partner or spouse	27.3	25.3
Not living with a partner or spouse	72.7	74.7
Bases	*2,079*	*1,279*

Base: WSWB Wave 1 and Wave 2.

Elsewhere, it has been suggested that unemployment transitions can have an adverse impact on sustaining relationships.[52] In the Wave 2 sample, 34 per cent of participants had changed their marital or cohabitation status since the last interview. However, roughly similar numbers had entered a cohabitation or marriage as had experienced a divorce or separation (data not shown due to small numbers).

Among recent JSA claimants living with a partner, nearly a third (31.3 per cent, Wave 1) were living in a partnership with someone who was also not employed. This proportion fell slightly by Wave 2 (27.1 per cent). It is possible that partners entered work in an attempt to meet the household income gap. It is also possible that relationship breakdown occurred more often when neither partner was employed.

51 ONS Statistical Bulletin. *Families and households, 2001 to 2011*. ONS 2012.

52 Lester, D. The Impact of Unemployment on Marriage and Divorce. *Journal of Divorce & Remarriage*. 25:3-4:1996. 151-154.

Table 3.6 Employment status of the respondent's spouse/cohabiting partner, at Waves 1 and 2

	Wave 1 %	Wave 2 %
Partner/spouse is employed	68.7	72.9
Partner/spouse is not employed	31.3	27.1
Bases	*529*	*336*

Base: WSWB Wave 1 and Wave 2: those with a spouse or living with a partner.

Household members, social support and caring

Around two-thirds (69.1 per cent) of recent JSA claimants lived in households without any children. Over a quarter (26.3 per cent) lived in households with two or more adults and children, and one in twenty (4.6 per cent) were lone parent households. One in twenty households had three or more children aged less than 18 (4.6 per cent). Child care was not the only caring responsibilities that JSA claimants had. More than a quarter (28.7 per cent) reported providing care to someone such as a family member, friend or neighbour, because of disability or problems related to health or age.

Table 3.7 Household characteristics, social support and provision of care

	Wave 1 %
Number of children (aged 18 or under) in household	
0	69.1
1 or 2	26.4
3 or more	4.6
Base	*2,070*
Household type	
Two or more adults, children	26.3
One adult, children	4.6
No children	69.1
Base	*2,070*
Provides care to someone because they have a disability or problem related to health or age	
Yes	28.7
No	71.3
Base	*2,000*

Base: WSWB Wave 1.

3.2.2 Relationships: associations with mental health

Mental health among recent JSA claimants, by marital status

Recent JSA claimants who were married or in a cohabiting relationship were much less likely to have symptoms of anxiety and depression than those who had previously been in a relationship (that is, those who were separated, divorced or widowed). Again, this same pattern of association is also found in the wider working-age population.[53]

Table 3.8 CIS-R score by marital status

CIS-R score	Single %	Married %	Cohabiting %	Divorced/ separated/ widowed %	All %
0-11	78.2	81.5	79.0	66.7	77.9
12+	21.8	18.5	21.0	33.3	22.1
18+	12.6	11.0	8.8	23.8	13.0
Bases	*1,239*	*363*	*190*	*287*	*2,079*

Base: WSWB Wave 1.

3.3 Recent experience of adverse life events

3.3.1 Adverse life events: profile of recent JSA claimants

A number of different types of life experiences were asked about in the Wave 1 survey interview, and whether or not each had occurred in the past 12 months. Financial crisis (43.5 per cent), loss of possessions (13.2 per cent), and insecure housing (11.9 per cent) were all relatively common occurrences among recent JSA claimants. Personal crises, such as relationship breakdown (11.2 per cent) and illness or assault of a close family member or friend (20.3 per cent) were also widespread. Experience of bullying, violence and abuse of various kinds were also reported by recent JSA claimants, with somewhat higher rates in women than men.

3.3.2 Adverse life events: associations with mental health

Nearly every type of adverse life event asked about was more prevalent among people with symptoms of anxiety or depression than among people without such symptoms. This could be because:

- the event had a negative impact on mental health;
- the presence of mental illness contributed to the event taking place in the first place (for example, mental illness might have caused or contributed to a relationship breaking down); and
- those with poor mental health may be more likely to state that they have experienced these events, as they may reinterpret previous events more negatively than if they were not anxious or depressed.

[53] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey*. The NHS Information Centre.

There are some striking differences between people with and without symptoms of anxiety and depression in their likelihood of experiencing adverse life events. For example, JSA claimants with CMD (a CIS-R score of 12 or more) were nearly twice as likely as claimants without CMD (a score of 11 or less) to live in insecure housing (22.7 per cent compared with 11.9 per cent).

A major financial crisis was reported by 39.3 per cent of people with a CIS-R score of less than 12, but 58.1 per cent of those with a score of 12 or more. Rates were higher still when focusing on people with even higher levels of neurotic symptoms. People with a CIS-R score of 18 or more were four times more likely than those with a score of 0-11 to report a serious problem with a friend or neighbour (25.6 per cent, compared with 6.4 per cent).

Table 3.9 Adverse life events in past six months, by CIS-R score

	CIS-R score			
Traumatic life events[a]	**0-11 %**	**12+ %**	**18+ %**	**All %**
All				
Looking for work for more than one month	86.7	91.6	92.8	87.8
Major financial crisis	39.3	58.1	61.9	43.5
Problem with police	6.2	8.2	9.0	6.7
Something lost or stolen	9.6	25.7	26.3	13.2
Unfair treatment in the workplace	5.2	13.6	13.5	7.1
Bullying or violence in the workplace	4.0	14.0	15.1	6.2
Bullying or violence from spouse or partner	1.6	6.3	7.7	2.7
Bullying or violence from anyone else	2.9	11.6	16.7	4.8
Sexual abuse or violence from a spouse or partner	0.5	3.2	4.5	1.1
Sexual abuse or violence from anyone else	0.6	2.0	2.3	0.9
Being homeless/insecure or temporary housing	8.9	22.7	24.8	11.9
Serious illness, injury or assault to yourself	4.2	14.1	16.3	6.4
Death, serious illness, injury or assault of a someone close	16.5	33.2	39.4	20.3
Relationship broken down	8.9	19.5	17.3	11.2
Serious problem with a friend, neighbour, relative	6.4	20.5	25.6	9.5
Bases	*1,406*	*673*	*447*	*2,079*

Base: WSWB Wave 1.

Table 3.10 Adverse life events in past 12 months among men, by CIS-R score and sex

	CIS-R score			
Traumatic Life Events[a]	**0-11 %**	**12+ %**	**18+ %**	**All %**
Men				
Looking for work for more than one month	86.5	93.0	96.3	87.7
Major financial crisis	38.5	59.2	61.5	42.5
Problem with police	7.2	8.3	7.2	7.4
Something lost or stolen	8.3	30.1	32.2	12.5
Unfair treatment in the workplace	5.3	14.6	14.9	7.1
Bullying or violence in the workplace	3.6	12.9	13.1	5.4
Bullying or violence from spouse or partner	1.2	4.9	5.7	1.9
Bullying or violence from anyone else	3.3	11.7	17.2	4.9
Sexual abuse or violence from a spouse or partner	0.1	1.7	1.3	0.4
Sexual abuse or violence from anyone else	0.2	2.8	3.1	0.7
Being homeless/insecure or temporary housing	9.7	26.8	29.8	13.0
Serious illness, injury or assault to yourself	4.0	16.3	21.2	6.3
Death, serious illness, injury or assault of a someone close	13.1	31.8	41.2	16.7
Relationship broken down	8.9	17.8	14.7	10.6
Serious problem with a friend, neighbour, relative	5.9	19.8	27.8	8.5
Bases	*900*	*347*	*226*	*1,247*

Base: WSWB Wave 1.

Table 3.11 Adverse life events in past 12 months among women, by CIS-R score and sex

	CIS-R score			
Traumatic Life Events[a]	**0-11 %**	**12+ %**	**18+ %**	**All %**
Women				
Looking for work for more than one month	87.1	89.9	89.1	87.9
Major financial crisis	41.0	56.7	62.4	45.5
Problem with police	4.2	8.1	10.9	5.3
Something lost or stolen	12.3	20.2	20.0	14.6
Unfair treatment in the workplace	5.1	12.3	12.1	7.1
Bullying or violence in the workplace	4.8	15.3	17.2	7.8
Bullying or violence from spouse or partner	2.5	8.1	10.0	4.1
Bullying or violence from anyone else	1.9	11.6	16.2	4.7
Sexual abuse or violence from a spouse or partner	1.4	5.2	7.9	2.5
Sexual abuse or violence from anyone else	1.3	1.1	1.5	1.2
Being homeless/insecure or temporary housing	7.0	17.6	19.4	10.0
Serious illness, injury or assault to yourself	4.5	11.2	11.0	6.4
Death, serious illness, injury or assault of a someone close	23.9	35.0	37.5	27.0
Relationship broken down	8.9	21.7	20.1	12.5
Serious problem with a friend, neighbour, relative	7.3	21.3	23.2	11.3
Bases	*506*	*326*	*221*	*832*

Base: WSWB Wave 1.

3.4 Financial and economic circumstances

3.4.1 Financial and economic circumstances: profile of recent JSA claimants

Housing tenure

Owner-occupiers made up a sizeable minority (42.7 per cent) of recent JSA claimants, although among the population as a whole about 70 per cent of people live in owner-occupier households (according to APMS 2007). Just over half (51.2 per cent) of recent JSA claimants rented their home. Renters were somewhat more likely to rent from the social, rather than the private, sector. This is also the case for the general population. One in seventeen (6.1 per cent) recent claimants either had no fixed address (including sleeping rough) or was staying in temporary accommodation such as a bed and breakfast or a hostel at the time of the interview.

Table 3.12 Housing tenure and rental status

	Bases	Wave 1 %	Wave 2 %
Tenure			
Owner occupied	*778*	42.7	43.5
Rent	*1,113*	51.2	50.7
No fixed address/temporary	*110*	6.1	5.7
Rental sector (among renters)			
Social	*658*	56.9	57.7
Private	*450*	43.1	42.3

Base: WSWB Wave 1 and Wave 2.

Across the sample as a whole, there was little change in tenure status between survey Waves 1 and 2.

Problem debt

Problem debt was defined in terms of being seriously behind in paying for bills. The types of debt asked about included rent, gas, water, council tax and credit card repayments. Most JSA claimants (59.7 per cent) managed to avoid getting into problem debt. However, four in ten had at least one type of problem debt. And overall, a fifth of recent JSA claimants were seriously behind in paying for three or more different types of debt over the past 12 months.

Table 3.13 Number of types of problem debt in the past 12 months

	Wave 1 %
Problem debt in the past 12 months	
0	59.7
1 or 2	21.3
3 or 4	9.7
5 or more	9.3
Base	*1,992*

Base: WSWB Wave 1.

How household is managing financially

Recent JSA claimants experienced a range of different financial circumstances; from 'managing very well' to being 'in deep financial trouble'. This spectrum was also evident in the qualitative sample. A quarter (26.1 per cent) of recent JSA claimants at Wave 1 reported being either in financial difficulties or 'deep financial trouble'.

Table 3.14 Financial situation at Waves 1 and 2

How household is managing financially	Wave 1 %	Wave 2 %
Managing very well	10.5	9.8
Managing quite well	20.0	24.6
Getting by alright	43.4	38.2
Having some financial difficulties	20.7	21.7
In deep financial trouble	5.4	5.7
Bases	*1,981*	*1,265*

Base: WSWB Wave 1 and Wave 2.

The main change between Wave 1 and Wave 2 appears to be that some people moved from the 'getting by' category up into the 'managing quite well' group. It is likely that these are people who moved off JSA and into secure employment by Wave 2. Table 3.15 shows that people who were still on JSA at Wave 2 were more likely to be having financial difficulties or be in deep financial trouble than those who were no longer claiming JSA (35.7 per cent compared with 26.0 per cent).

Table 3.15 Financial situation at Wave 2 by whether or not claiming JSA at Wave 2

How household is managing financially	JSA claimant at Wave 2 %	Not JSA claimant at Wave 2 %
Managing very well	10.7	14.0
Managing quite well	20.9	25.1
Getting by alright	32.7	34.9
Having some financial difficulties	28.8	22.1
In deep financial trouble	6.8	4.0
Bases	*536*	*721*

Base: WSWB Wave 1 and Wave 2.

3.4.2 Financial and economic circumstances: associations with mental health

Mental health by financial circumstances

Problem debt is a well-established predictor of poor mental health.[54] Problem debt was also found to be strongly associated with mental health among recent JSA claimants. A fifth of people with CMD (20.6 per cent of those with CIS-R score of 12+) reported five or more different types of debt. Among people without CMD, the rate was closer to one in seventeen (6.1 per cent).

[54] Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S. and Dennis, M.S. Debt and suicidal ideation. *Psychological Medicine*. 2010 16:1-8.

Table 3.16 CIS-R score, by number of types of problem debt

Problem debt in the past 12 months	CIS-R score of 0-11 %	CIS-R score of 12+ %	CIS-R score of 18+ %	All %
0	67.5	31.8	31.3	59.7
1 or 2	19.0	29.8	28.4	21.3
3 or 4	7.4	17.8	18.1	9.7
5 or more	6.1	20.6	22.2	9.3
Bases	*1,347*	*645*	*430*	*1,992*

Base: WSWB Wave 1.

Participants' views of how well their household was coping financially were very strongly associated with the presence of symptoms of anxiety and depression. People with a CIS-R score of 12 or more were five times more likely (15.0 per cent) than those with a lower score (2.7 per cent) to report being 'in deep financial trouble'.

As mentioned previously, these associations may be confounded by the negative world view that can sometimes be a symptom of CMD. We also cannot infer causality from these associations: it is both possible that poor mental health makes coping financially more difficult and that problem debt causes or exacerbates symptoms of poor mental health.

Table 3.17 CIS-R score, by how well household is managing financially

Managing financially	CIS-R score of 0-11 %	CIS-R score of 12+ %	CIS-R score of 18+ %	All %
Managing very well	12.6	3.1	3.0	10.5
Managing quite well	23.0	9.4	8.8	20.0
Getting by alright	46.4	33.0	27.5	43.4
Having some financial difficulties	15.3	39.6	44.5	20.7
In deep financial trouble	2.7	15.0	16.2	5.4
Bases	*1,339*	*642*	*428*	*1,981*

Base: WSWB Wave 1.

3.5 Education, employment, and benefit history

3.5.1 Education, employment and benefit history: profile of recent JSA claimants

Highest educational qualification

JSA claimants are less well qualified than the general population. A fifth (20.6 per cent) of recent JSA claimants have no educational qualifications, and a further one in ten (10.6 per cent) reported educational qualifications that were not classifiable (and so may confer less benefit in a work application context). At the other end of the spectrum, a fifth (19.6 per cent) of recent JSA claimants had either a degree or degree level vocational qualification. Nearly a third of the general population of working age (30.5 per cent) have such a qualification.

Table 3.18 Highest educational qualification

Highest educational qualification	Wave 1 %	APMS %
Degree	14.2	23.0
Teaching, HND, Nursing	5.4	7.6
A Level	11.7	17.6
GCSE or equivalent	37.4	31.5
Other or foreign/unclassifiable	10.6	2.5
No qualifications	20.6	17.9
Bases	*1,976*	*5,425*

Base: WSWB Wave 1 and APMS 2007 (aged 16-64).

Participants at Wave 2 were asked whether or not they had acquired any new qualifications since the Wave 1 interview. One in ten (11 per cent) reported having gained another qualification between the survey waves (data not shown).

Employment and ESA history

Overall, nearly a tenth (9.1 per cent) of this JSA cohort had been in receipt of IB or ESA in the previous 12 months. Not all of these people had transitioned directly from a sickness benefit to JSA, although many did come via a Work Capability Assessment (WCA). This route was considered in the qualitative interviews and is described in Chapter 5.[55]

Table 3.19 Receipt of sickness benefit in the past year among recent JSA claimants

Receipt of ESA/IB in the past year	*Bases*	Unweighted %	Weighted %
Yes	*965*	46.4	9.1
No	*1,114*	53.6	90.9

Base: WSWB Wave 1.

More than half (54 per cent) of those who had ever had a job, were last employed in semi-routine or routine employment. For about one in seven (15.0 per cent) recent JSA claimants, their most recent employment had been in a managerial or professional level job.

[55] Table 3.19 shows both the weighted and unweighted distributed for this variable. This shows that people who had transitioned from a sickness benefit were deliberately oversampled, and that the weighted data corrects for this.

Table 3.20 Socio-economic position of recent JSA claimants' most recent job

NS-SEC[a] of most recent job	*Bases*	%
Managerial/professional	*238*	15.0
Intermediate occupations	*249*	14.1
Small employers/own account	*135*	7.3
Lower supervisory and technical	*181*	9.5
Semi-routine and routine	*1,011*	54.0

Base: WSWB Wave 1.

[a] The National Statistics Socio-economic Classification (NS-SEC): Office for National Statistics. http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html

3.5.2 Education, employment and benefit history: associations with mental health

Mental health among recent JSA claimants, by educational qualification

JSA claimants with a CIS-R score of 12 or more were more likely to have no qualifications (27.5 per cent) than claimants without CMD (18.6 per cent). This was even more pronounced among claimants with more severe symptoms (30.7 per cent among those with a CIS-R score of 18 or more).

Table 3.21 CIS-R score, by highest qualification

Highest educational qualification	CIS-R score of 0-11 %	CIS-R score of 12+ %	CIS-R score of 18+ %	All %
Degree	15.0	11.2	10.0	14.2
Teaching, HND, nursing	4.9	7.5	7.5	5.4
A Level	12.2	9.9	8.6	11.7
GCSE or equivalent	38.0	35.4	34.7	37.4
Foreign or other	11.3	8.5	8.6	10.6
No qualifications	18.6	27.5	30.7	20.6
Bases	*1,333*	*643*	*429*	*1,976*

Base: WSWB Wave 1.

Mental health among recent JSA claimants, by recent history of ESA/IB

JSA claimants who had been in receipt of sickness benefits in the previous year had far worse mental health than those who had not. This finding is not unexpected given that mental health conditions are a common reason for claiming sickness benefit, and that mental health conditions are widespread even among people claiming sickness benefit for a physical health related reason.[56] This difference was evident among both men and women. JSA claimants who had been in receipt of ESA or IB were twice as likely to have a CIS-R score of 12 or more than those who had not been in receipt of sickness benefit in the past year (41.8 per cent, compared with 19.6 per cent).

[56] Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707. Department for Work and Pensions.

Table 3.22 CIS-R score, by whether been in receipt of ESA/IB in past year and sex

	ESA or IB in past year		
CIS-R score	Yes %	No %	All %
Men			
0-5	51.8	71.0	69
6-11	10.6	12.1	12.3
Under 12	**62.5**	**83.1**	**81.3**
12-17	14.4	7.9	8.7
18 or more	23.2	8.9	10.1
12 or more	**37.5**	**16.9**	**18.7**
Bases	372	815	1,247
Women			
0-5	36.8	57.4	53.7
6-11	15.1	17.8	17.8
Under 12	**51.9**	**75.2**	**71.4**
12-17	15.3	9.3	10.2
18 or more	32.7	15.6	18.4
12 or more	**48.1**	**24.8**	**28.6**
Bases	294	504	832
All			
0-5	45.7	66.4	63.7
6-11	12.5	14	14.2
Under 12	**58.2**	**80.4**	**77.9**
12-17	14.8	8.4	9.2
18 or more	27.1	11.2	13
12 or more	**41.8**	**19.6**	**22.1**
Bases	666	1,319	2,079

Base: WSWB Wave 1.

Mental health among recent JSA claimants by reason for leaving last job

Recent JSA claimants who had ever had a job were asked for the reasons why their last employment had come to an end. The question was asked in an open-ended way, so participants were not prompted with reasons. For the majority of people, leaving employment had not been something that they had actively chosen. Rather, it had been because temporary or contract work had come to an end (36 per cent) or else they had been made redundant (28 per cent). One person in eleven (8.5 per cent) had been dismissed from their last job.

Table 3.23 Reason left last job by CIS-R score

	CIS-R score		
Reason left last job	**0-11 %**	**12+ %**	**All %**
Temporary job, contract ended	37.9	29.5	35.8
Made redundant	28.4	27.0	28.0
Resigned	15.7	14.7	15.5
Dismissed	7.7	10.9	8.5
Family or personal reasons	7.3	9.8	7.9
Accident, physical illness, disability	2.8	5.3	3.4
Mental health reason	0.2	2.9	0.9
Bases	*801*	*474*	*1,275*

Base: WSWB Wave 1 people who have ever been employed.

People with CMD (10.9 per cent) were more likely than those without CMD (7.7 per cent) to have been dismissed from their last job. This could be because their poor mental health contributed to their being dismissed, or because being dismissed contributed to the onset or exacerbation of poor mental health.

People with CMD were also more likely than those without CMD to give a personal (9.8 per cent) or a mental or physical health related (8.2 per cent) reason for leaving their last job. Overall, very few participants (0.9 per cent) volunteered 'mental health' as a reason for leaving their last job.

4 Work-search activity, support and outcomes

Key findings

- While discussion of strategies for finding work was common, discussion of health and wellbeing in work-focused interviews with Jobcentre Plus Personal Advisers (PAs) was not widespread, but was generally found to be helpful when it happened.
- Among people with a common mental disorder (CMD), women were much more likely to have discussed their health and wellbeing with a PA than men. Women were also more likely to find the discussion helpful.
- There are indications that physical health conditions are more commonly addressed in interviews than mental health conditions.
- Satisfaction with support from Jobcentre Plus was lower among people with CMD, although having a generally more negative world view can be a symptom of CMD. In particular, they were less likely to feel that Jobcentre Plus support had increased their belief in their ability to find a job. Claimants transitioning to Jobseeker's Allowance (JSA) from a sickness benefit also reported lower levels of satisfaction with the support.
- Less than half of the cohort was still in receipt of JSA at Wave 2, six to eight months after starting a JSA claim. People who had been in receipt of sickness benefit were significantly less likely to have entered jobs over the study period. Other Wave 1 characteristics that predicted being in employment at Wave 2 included socio-demographic factors, indicators of employment history and qualifications, work-search self-confidence, and level of neighbourhood deprivation.

In this chapter data from Waves 1 and 2 of the survey are used to describe the nature and extent of JSA claimants' contact with Jobcentre Plus and their engagement in work-search activities. The information relates to claimants' perceptions of their contact with Jobcentre Plus. The Wave 1 factors predicting labour market outcomes at Wave 2 are examined. The chapter consists of sections on:

- nature and extent of contact with Jobcentre Plus;
- satisfaction with Jobcentre Plus;
- work-search activities and outcomes;
- multivariate analyses of what factors predict remaining on JSA;
- multivariate analyses of what factors predict entering employment.

4.1 Contact with Jobcentre Plus: Personal Advisers

4.1.1 Number of PA interviews

The Wave 1 survey interviews mostly took place two to four months after a JSA claim was started. At that point, about two-thirds (68.4 per cent) of recent JSA claimants reported having had an interview with a PA in the previous 12 months. A quarter (24.6 per cent) had just the one interview, nearly a third (30.5 per cent) had two or three, and a smaller proportion reported (13.3 per cent) four or more interviews with a PA. Despite the question specifying that Jobcentre contact for the purpose of 'signing on' should be excluded, it is possible that some participants included such contact at this question.

Table 4.1 Number of interviews with a PA in the 12 months prior to Wave 1

	Bases	%
Whether had an interview with a PA in past 12 months [a]		
Yes	*1,386*	68.4
No	*640*	31.6
Number of interviews with PA		
0	*640*	31.6
1	*498*	24.6
2 or 3	*618*	30.5
4 or more	*270*	13.3

Base: Work-search and Wellbeing Study (WSWB) Wave 1.

[a] Defined as 'an interview at a Jobcentre with a PA, other than for signing on.'

Contact with Jobcentre staff was identified in the qualitative interviews with claimants with symptoms of anxiety and depression as impacting on claimants' experience of Jobcentres. Howat and Pickering[57], in analysis of the 2011 Jobcentre Plus Customer Survey, also identified staff contact as an important and memorable aspect of the service, regarded as both the best and the worst aspect of Jobcentres. The nature and extent of contact with staff, particularly in PA interviews, could, therefore, be expected to have an association with mental health. This emerged as important in the qualitative interviews and is explored in Chapters 5 and 6.

Overall, a third (31.6 per cent) of recent JSA claimants reported having had no interview with a PA in the previous 12 months. As one would expect, this was associated with whether or not the person was claiming JSA at the time of the Wave 1 interview. Among those who were still JSA claimants, just over a quarter (26.7 per cent) reported that they had not had an interview with a PA in the past 12 months. It is worth noting that the survey questionnaire captured claimants perceptions of what had happened. It is possible that some claimants who had an interview with a PA did not realise that they had, or else had forgotten that it had happened.

[57] Howat, N. and Pickering, E. (2011). *Jobcentre Plus Customer Survey 2011*. DWP Research Report No 775. Department for Work and Pensions (DWP): Sheffield.

Table 4.2 Interviews with PAs in 12 months prior to Wave 1, by whether or not still a JSA claimant at Wave 1

	JSA claimant at Wave 1			
		Yes		No
	Bases	%	*Bases*	%
Whether had an interview with a PA in past 12 months				
Yes	*913*	73.3	*468*	60.9
No	*333*	26.7	*300*	39.1
Number of interviews with PA				
0	*333*	26.7	*300*	39.1
1	*325*	26.1	*173*	22.5
2 or 3	*408*	32.7	*206*	26.8
4 or more	*180*	14.4	*89*	11.6

Base: WSWB Wave 1.

4.1.2 Topics covered at PA interviews (Wave 1)

The purpose of having an interview with a PA is to give advice and support to JSA claimants that are based on their personal circumstances.[58] This is intended to help those on JSA move closer to the labour market and should include addressing any issues that might help them look for work.

Table 4.3 Discussion of work plan and health at PA interviews in the 12 months prior to Wave 1

	Bases	%
Work plan discussed		
Discussed – very/fairly helpful	*1,080*	72.2
Discussed – not helpful	*315*	21.3
Not discussed at interview	*87*	6.5
Health or wellbeing discussed		
Discussed – very/fairly helpful	*345*	17.2
Discussed – not helpful	*97*	3.5
Not discussed at interview	*1,024*	79.3

Base: WSWB Wave 1.

Discussion of work plans

The overwhelming majority (94.5 per cent) of recent JSA claimants who had had a interview with a PA reported that they had discussed their plans for finding work. Nearly three-quarters (72.2 per cent) of those who had an interview, had discussed this topic and found the discussion to be helpful. About a fifth (21.3 per cent) discussed their work plan with a PA, but reported that they felt that the conversation was not helpful to them. One explanation for this is that some people had already found work, perhaps without Jobcentre Plus input. People who were still claiming JSA at Wave 1 were more likely than those who were no longer claiming JSA to have found the work-search discussion helpful.

[58] Directgov (2011) Helping you into work. http://www.direct.gov.uk/en/Employment/Jobseekers/LookingForWork/DG_10033052

Table 4.4 Discussion of work plan and health at PA interviews in past 12 months, by whether or not still a JSA claimant at Wave 1

	JSA claimant at Wave 1			
		Yes		No
	Bases	%	*Bases*	%
Work plan discussed				
Discussed – helpful[a]	*710*	75.1	*317*	66.3
Discussed – not helpful	*174*	18.4	*130*	27.2
Not discussed at interview[b]	*62*	6.6	*31*	[6.5]
Health or wellbeing discussed				
Discussed – helpful	*164*	17.5	*78*	17.2
Discussed – not helpful[b]	*28*	[3.0]	*21*	[3.5]
Not discussed at interview	*743*	79.5	*372*	79.4

Base: WSWB Wave 1 claimants who have had an interview.

[a] Very helpful and fairly helpful combined.

[b] Note small base sizes.

Discussion of health and wellbeing

While discussion of strategies for finding work was common, only one in six (17.2 per cent) of the JSA claimants who had had a PA interview reported that their health or wellbeing had been discussed. People who had claimed JSA for longer were no more likely to report having discussed their health and wellbeing than those who left JSA before the Wave 1 interview. Men and women were equally likely to have discussed their health and wellbeing with an adviser.

It is noteworthy that when health and wellbeing were discussed, most people found the discussion to be helpful. There also was evidence to suggest that discussion of health related topics is being targeted appropriately at the claimants for whom this was most relevant. One in three (31.8 per cent) recent JSA claimants with a longstanding illness or disability discussed their health with the PA, compared with one in six (17.2 per cent) claimants without a longstanding condition.

Table 4.5 Discussed health/wellbeing during PA interview, by whether have a longstanding illness, disability or infirmity

	Whether have any longstanding 'illness, disability or infirmity'	
How useful was discussion of health and wellbeing	Yes %	No %
Men		
Discussed – helpful	20.9	16.7
Discussed – not helpful	7.4	2.9
Not discussed at interview	71.8	80.4
Bases	*320*	*570*
Women		
Discussed – helpful	29.3	11.3
Discussed – not helpful	8.0	0.6
Not discussed at interview	62.6	88.1
Bases	*246*	*324*
All		
Discussed – helpful	24.2	15.0
Discussed – not helpful	7.6	2.2
Not discussed at interview	68.2	82.8
Bases	*566*	*894*

Base: WSWB Wave 1 – claimants who had had a PA interview in the past 12 months.

However, it appears that physical health conditions may be more likely to be discussed in PA interviews than mental health conditions. Overall, recent JSA claimants with symptoms of anxiety and depression were only slightly more likely than JSA claimants without symptoms to have discussed their health and wellbeing with a PA (24.3 per cent compared with 19.5 per cent).

It also appears that health and wellbeing was less likely to be discussed in interviews with male claimants with poor mental health than in interviews with female claimants with poor mental health. Women with CMD were more likely to have discussed their health and wellbeing and, furthermore, among those that did discuss health and wellbeing, female claimants were more likely than male claimants to have found the discussion useful. This suggests there may be a role for interventions or training that supports situations where men feel encouraged to talk about their health.

Table 4.6 Discussed health/wellbeing during PA interview, by Clinical Interview Schedule – Revised (CIS-R) score

	CIS-R score	
How useful was discussion of health and wellbeing	0-11 %	12+ %
Men		
Discussed – helpful	18.3	15.0
Discussed – not helpful	3.6	4.7
Not discussed at interview	78.1	80.3
Bases	*625*	*271*
Women		
Discussed – helpful	12.0	25.1
Discussed – not helpful	1.5	5.0
Not discussed at interview	86.5	69.8
Bases	*328*	*242*
All		
Discussed – helpful	16.5	19.5
Discussed – not helpful	3.0	4.9
Not discussed at interview	80.5	75.7
Bases	*953*	*513*

Base: WSWB Wave 1 – claimants who had a PA interview in the past 12 months.

4.1.3 PA interviews later in the JSA claim (Wave 2)

Number of PA interviews

The second survey interview (Wave 2) took place about three to four months after the first. This was around five to eight months after participants commenced a JSA claim. Just under half (44.8 per cent) of the sample reported that they had had at least one interview with a PA during this time. And most of these people had had more than one interview.

Table 4.7 Number of PA interviews between Waves 1 and 2

	Bases	%
Whether had an interview with a PA (since Wave 1)		
Yes	624	44.8
No	649	55.2
Number of interviews with PA (since Wave 1)		
0	649	54.8
1	226	16.5
2 or 3	287	19.8
4 or more	102	7.6

Base: WSWB Wave 2.

Topic coverage

The likelihood of having discussed plans for finding work did not differ between Waves 1 and 2. However, the likelihood of having discussed health and wellbeing increased. Around a quarter (26.4 per cent) of those who reported an interview with a PA between Waves 1 and 2 of the survey had discussed their health and wellbeing. The great majority (four-fifths) found this discussion to be helpful.

Table 4.8 Topic coverage in PA interviews between Waves 1 and 2

	Bases	%
Work plan discussion		
Discussed – helpful	*476*	75.3
Discussed – not helpful	*110*	18.3
Not discussed	*37*	6.4
Health discussion		
Discussed – helpful	*200*	21.9
Discussed – not helpful	*38*	4.5
Not discussed	*381*	73.6

Base: WSWB Wave 2.

4.2 Perceptions of Jobcentre Plus support

Everyone in the Wave 2 sample – whether or not they were still JSA claimants – was asked about what they thought of the service they had received from Jobcentre Plus. While Jobcentre Plus can refer claimants to support provided by other suppliers, the question requested 'general views on the service that you have received from Jobcentre Plus'.

4.2.1 Suitability of support from Jobcentre Plus

Overall suitability of support

Overall, a majority of recent JSA claimants (61.3 per cent) felt that the support that they had received from Jobcentre Plus had been appropriate for their needs. Nearly two-thirds (64.2 per cent) felt that they were not pressured to take up inappropriate activities. However, half (50.9 per cent) did report feeling pressurised to take up a job that they felt was not suitable for them.

Table 4.9 Suitability of Jobcentre Plus support, during current/most recent claim

Agreement that during current or most recent claim...	*Bases*	%
Jobcentre Plus offered support that matched your needs		
Agree	*799*	61.3
Disagree	*471*	38.7
You felt under pressure to take up a job that didn't match your needs		
Agree	*657*	50.9
Disagree	*614*	49.1
You felt under pressure to take up other activities that didn't match your needs		
Agree	*454*	34.3
Disagree	*807*	64.2

Base: WSWB Wave 2[a].

[a] Excludes 3 people who stated that they had not been a JSA claimant.

Perceived suitability of support among people with CMD

People who had transitioned from a sickness related benefit – less conditional on work-search activity – were more likely to perceive pressure to undertake activities or employment that they felt were inappropriate to their needs. Likewise, mental health was associated with perceptions of the suitability of Jobcentre Plus support, although this may partly reflect the more negative world view that can be a symptom of CMD. People with symptoms of anxiety and depression were less likely then those without such symptoms to feel that the support that they received from Jobcentre Plus matched their needs (52.3 per cent compared with 63.5 per cent). They were also more likely to report feeling pressurised to take up inappropriate work (44.7 per cent compared with 32.4 per cent) and other activities (69.3 per cent compared with 46.4 per cent).

Table 4.10 Suitability of Jobcentre Plus support during current/most recent claim, by CIS-R score at Wave 2

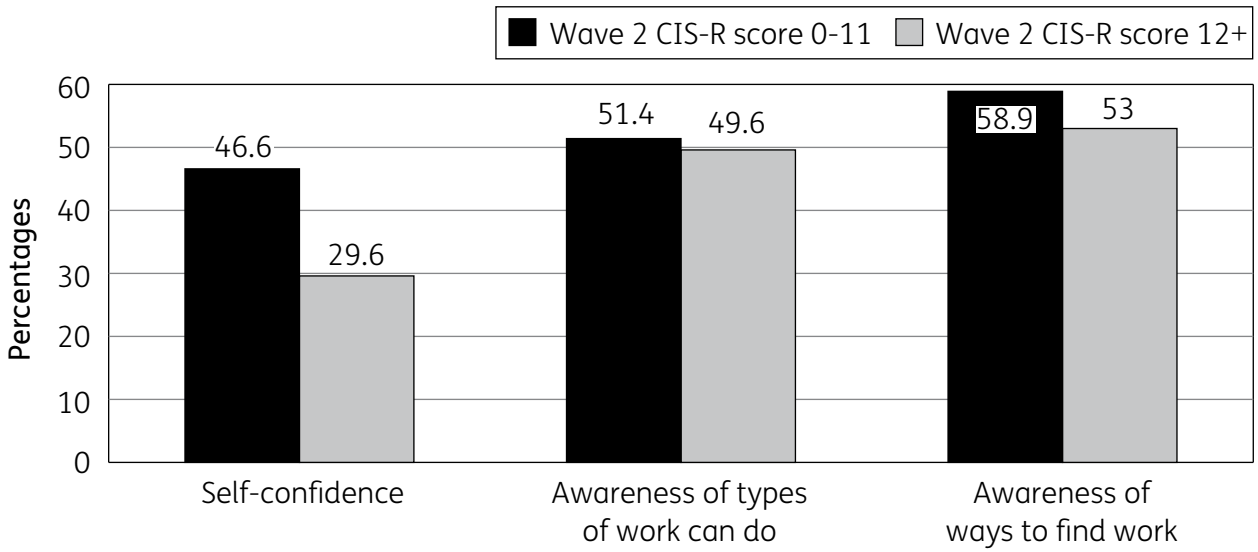
	CIS-R score	
Agreement that during current or most recent claim...	0-11 %	12+ %
Jobcentre Plus offered support that matched your needs		
Agree	63.5	52.3
Disagree	36.5	47.7
You felt under pressure to take up a job that didn't match your needs		
Agree	32.4	44.7
Disagree	67.6	55.3
You felt under pressure to take up other activities that didn't match your needs		
Agree	46.4	69.3
Disagree	53.6	30.7
Bases	*911*	*359*

Base: WSWB Wave 2.

4.2.2 Perceived impact of Jobcentre Plus support

Overall, new JSA claimants reported that their work-search skills and knowledge increased as a result of support provided or arranged by Jobcentre Plus. However, this was not a universally held view. In particular, Jobcentre Plus support was less likely to be perceived by people with symptoms of anxiety and depression as conferring such benefits. For example, while nearly half (46.6 per cent) of people with a CIS-R score of 0-11 reported that their self-confidence improved as a result of Jobcentre Plus support, this was reported by less than a third (29.9 per cent) of JSA claimants with scores of 12 or more.

Figure 4.1 As a result of Jobcentre Plus support, perceived an increase in:



Base: WSWB Wave 2.

4.2.3 Overall satisfaction with support from Jobcentre Plus

At the Wave 2 interview all participants were asked to think about their most recent JSA claim, still current for some of them, and to rate their overall level of satisfaction with the support that they received from Jobcentre Plus. Six in ten (59.0 per cent) claimants were either fairly or very satisfied with the support that they received. This is much lower than the levels of satisfaction reported in the 2011 Jobcentre Plus Customer Survey.[59] Howat and Pickering (2011) found 88 per cent of Jobcentre customers were satisfied with the service, and that levels of satisfaction were lowest among ESA claimants. Disabled claimants, including people with 'psychological or behavioural problems', also had lower levels of satisfaction that other claimants.

[59] Howat, N. and Pickering, E. (2011). *Jobcentre Plus Customer Survey 2011*. DWP Research Report No 775. DWP: Sheffield.

Table 4.11 Satisfaction with Jobcentre Plus support during current/most recent claim, CIS-R score at Wave 2

	CIS-R score at Wave 2		
Overall satisfaction with support	**0-11 %**	**12+ %**	**All %**
Very or fairly satisfied	61.7	48.0	59.0
Neither satisfied nor dissatisfied	17.0	19.4	17.5
Very or fairly dissatisfied	21.3	32.6	23.5
Bases	*916*	*362*	*1,278*

Base: WSWB Wave 2.

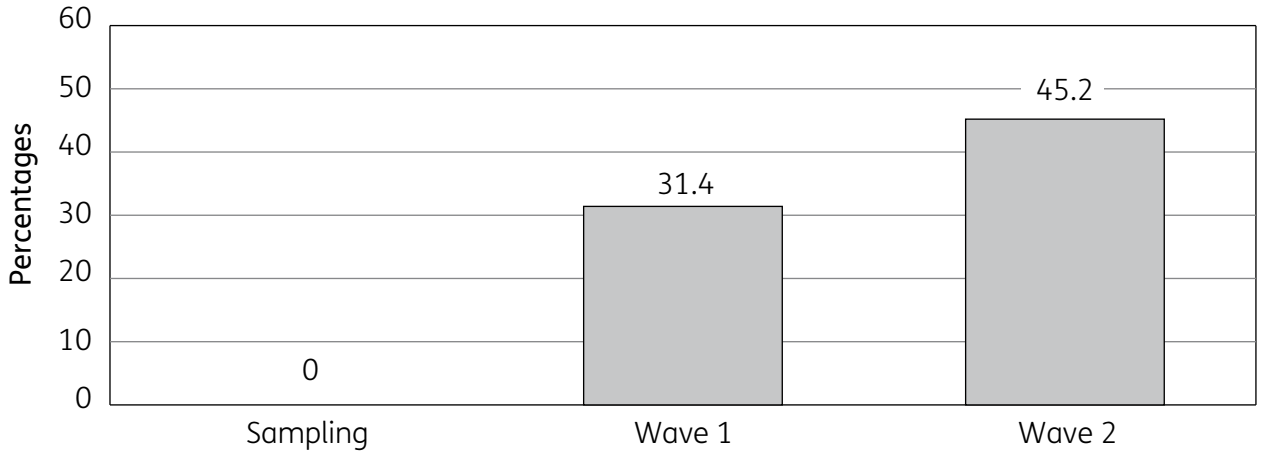
Like Howat and Pickering (2011), we also found reported satisfaction to be associated with mental health status, with half (48.0 per cent) of claimants with symptoms of anxiety and depression at Wave 2 reporting being satisfied with the service. Our levels of reported satisfaction among this group were much lower than those found in the Jobcentre Plus Customer Survey. It is possible that context effects, in particular the fact that the overall satisfaction question was asked directly after questions about whether or not health and wellbeing had been discussed, might have contributed to increased levels of reported dissatisfaction.

4.3 Work-search activity and outcomes

4.3.1 Work-search activity and outcomes

At the Wave 1 interview – usually around two to four months after starting a JSA claim – almost a third (31.4 per cent) of recent JSA claimants had found work. By Wave 2, about six to eight months after making a claim for JSA, nearly half (45.2 per cent) were in employment.

Figure 4.2 Proportion of recent JSA claimants in employment



Base: WSWB Wave 1 and Wave 2.

Among those not in employment the overall level of job-search activity remained fairly stable over time. About a third (32.4 per cent of those not in employment at Wave 1; 37.1 per cent of those not in employment at Wave 2) reported applying for at least 20 jobs in the previous four weeks. However, a fifth (20.8 per cent at Wave 1; 20.7 per cent at Wave 2) reported having applied for less than five jobs over the past four weeks.

Table 4.12 Employment status and work-search activity at Waves 1 and 2

	Wave 1 %	Wave 2 %
Employment status		
Employed	31.4	45.2
Not employed	68.6	54.8
Bases	*2,079*	*1,283*
Work-search activity (among JSA clients without a job lined up)		
0 applications in past 4 weeks	4.1	3.9
1-4 applications in past 4 weeks	16.7	16.8
5-19 applications in past 4 weeks	46.8	42.2
20+ applications in past 4 weeks	32.4	37.1
Bases	*1,145*	*568*

Base: WSWB Wave 1 and Wave 2

4.3.2 Work-search activity and outcomes: associations with mental health

Mental health by work-search activity

There was some evidence to suggest that people with CMD tended to make fewer job applications. About a fifth (19.4 per cent) of claimants without CMD made fewer than five applications in the past four weeks. Among people with CMD, more than a quarter (28.6 per cent) had made fewer than five applications.

Table 4.13 CIS-R score, by number of job applications made in the past four weeks

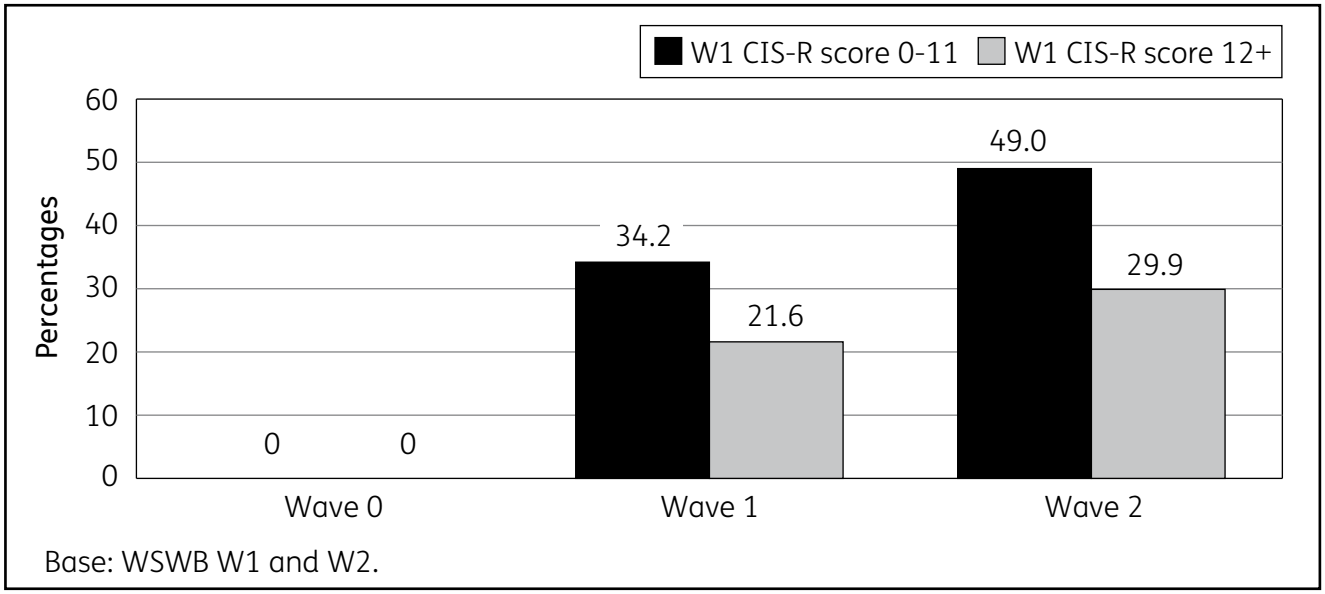
	CIS-R score			
Number of applications made in past four weeks	0 – 11 %	12+ %	18+ %	All %
No applications	3.4	6.1	7.7	4.1
1 to 4	16.0	19.1	20.9	16.7
5 to 19	48.1	42.7	39.1	46.8
20+ applications	32.5	32.0	32.3	32.4
Bases	*736*	*409*	*276*	*1,145*

Base: WSWB Wave 1.

Mental health by employment status at Wave 1

Mental health was also associated the length of time someone remained on JSA. A third (34.2 per cent) of JSA claimants without CMD at Wave 1 had found work by the time of the Wave 1 interview. This compared with a fifth (21.6 per cent) of people with a CIS-R score of 12 or more, and about a sixth (17.5 per cent) of those with a score of 18 or more. The gap in employment rate between people with and without CMD had increased by Wave 2. As mentioned previously, it could be that people without CMD found work more quickly, or that people who found work quickly then experienced an improvement in their mental health.

Figure 4.3 Proportion of recent JSA claimants in employment, by mental health status at Wave 1



Base: WSWB W1 and W2.

Table 4.14 CIS-R score, by current employment status

	CIS-R score			
Employment status	**0 – 11 %**	**12+ %**	**18+ %**	**All %**
In paid work	34.2	21.6	17.5	31.4
Not in paid work	65.8	78.4	82.5	68.6
Bases	*1,406*	*673*	*447*	*2,079*

Base: WSWB Wave 1.

4.4 Predictors of economic activity outcomes at Wave 2

Three multivariable regression models were run to examine what factors predicted:

- being in receipt of JSA at Wave 2;
- being in employment at Wave 2;
- being neither on JSA nor in employment at Wave 2.

For each model, the reference category was a combination of all the other possible economic activity outcomes. Nine broad topic areas were defined, drawing on the themes that emerged in the qualitative analysis (see Chapters 5 and 6) or which have been identified in previous research. Wave 1 variables relevant to each block were listed. Priority was given to variables with data for all or most of the sample (for example, some of the questions about attitudes and work-search were asked only of people claiming JSA at the time of the Wave 1 interview).

The association between each predictor variable identified (for example, age group, sex, benefit history) and the outcome variable (economic activity at Wave 2) was tested in isolation to establish whether or not they had a basic association. If the p-value was greater than about 0.15 (taken to indicate that associations would not be statistically significant in the final analysis), variables were excluded from the next stage of the analysis, unless there was a hypothesis-driven reason for retaining them or for reintroducing them again at a later stage.[60] Retained variables were then entered into multivariable regressions in thematic blocks. The variables that remained significant after the other variables in the block were controlled for were entered into the next stage of the modelling. While a stepwise-type approach was used, this was not automated and the process remained subject to interpretation. Odds ratios are presented for the variables retained in the final combined multivariate model. Final retained values required a p value of about 0.05 or less to be considered significant.

Appendix D describes the different stages of this analysis in more detail, including listing all the variables that were tested at each stage, and whether or not they were significant at each stage. The results are also presented in full in the Appendix, and only summarised here.

4.4.1 Predictors of being on JSA at Wave 2

By the time of the Wave 2 interview, 41 per cent of the cohort were still claiming JSA and most of the rest had entered the workforce. The whole sample were retained in this model, and being employed at Wave 1 was one of the variables controlled for. To test the stability of the findings, this model was also run based only on participants who were JSA claimants at Wave 1, with very similar results.

60 An example is that sex was not initially found to predict being on JSA at Wave 2. However, it was retained in subsequent stages of the modelling given its known association with other predictor variables, including with mental health.

Table 4.15 Adjusted odds for being on JSA at Wave 2[61]

Wave 1 predictors	Odds ratios	Significance
Sex		p = 0.013
Men	1.557	
Women	1	
Cold home		p = 0.026
No	0.569	
Yes	1	
Financial crisis		p = 0.001
No	0.551	
Yes	1	
Driver's license		p = 0.031
Yes	0.672	
No	1	
CIS-R[a]		p = 0.108
0-11	0.714	
12+	1	
Marital status		p <0.001
Single	0.927	
Married or cohabitating	0.351	
Separated, divorced or widowed	1	
Index of Multiple Deprivation (IMD)		p <0.001
IMD – least deprived	0.251	
IMD – 2	0.372	
IMD – 3	0.544	
IMD – 4	0.881	
IMD – 5	0.828	
IMD – 6	1.170	
IMD – most deprived	1	
'People accept me for who I am'		p = 0.009
Not true	0.496	
Partly true	1.948	
Certainly true	1	

Base: WSWB Wave 1 and Wave 2: participants to both waves only.
[a] Note non-significant p value.

Interpretation of factors predicting remaining on JSA

Wave 1 characteristics that predicted remaining on JSA for longer related to:

- Socio-demographics (being male, non-married).
- Social support (not fully accepted by others).
- Socio-economics (experienced a financial crisis, living in a cold home).

[61] Detailed results are provided in Appendix D.

- Experience (not having a driver's license).
- Mental health (having a CMD).
- Neighbourhood (living in deprived area).

Socio-demographics: Men were more likely than women to still be on JSA at the Wave 2 survey interview, but other demographic factors like age and ethnic group were not found to be significant predictors once other factors were controlled for.

Social support: Social support, here captured by whether or not the claimant felt that other people accepted them for who they were, was a strong predictor of remaining on JSA for longer. Marital status was also independently significant. People who were single or previously married were more likely than married people to still be on JSA at Wave 2, and it is likely that other aspects of social support and household stability plays a role in this association.

Socio-economic factors: Two socio-economic factors remained significant in the final model. Having experienced a major financial crisis in the 12 months prior to the Wave 1 interview predicted still being on JSA at Wave 2. Living in a cold home is indicative of poor housing quality and of being in fuel poverty. People living in such conditions were also more likely to still be on JSA at the Wave 2 interview, even after the experience of financial crisis was controlled for.

Work-search beliefs and experience: Not having a driver's license strongly predicted remaining on JSA. Making fewer job applications had predicted remaining on JSA for longer until other factors were controlled for. Likewise, lacking confidence in work-search abilities was associated with increased odds of being on JSA at Wave 2, until other variables were controlled for.

Health: After controlling for other factors, people with CMD were more likely to remain on JSA than people without CMD, although after other factors were controlled for this was only borderline significant ($p = 0.108$). Interestingly, the other health related variables – like general health or having a longstanding illness or disability – also did not predict remaining on JSA. The absence of subjective wellbeing – like a lack of optimism or not feeling relaxed – strongly predicted remaining on JSA in the initial analyses, but not once other factors were controlled for.

Neighbourhood: The Index of Multiple Deprivation (IMD) is an area level variable. It collates data from a number of different domains, including the employment rate in the local area. The more deprived the area in which a claimant lived, the more likely it was that they were still claiming JSA at Wave 2.

4.4.2 Predictors of being in employment at Wave 2

By the Wave 2 interview, 45 per cent of the sample were no longer in receipt of JSA and had entered employment or self-employment. The model presented in Table 4.16 is based only on people who were JSA claimants at Wave 1.

Table 4.16 Adjusted odds for being employed at Wave 2[62]

Wave 1 predictors	Odds ratios	Significance
Sex[a]		p = 0.081
Men	0.662	
Women	1	
Age group[a]		p = 0.157
16-24	2.905	
25-34	1.612	
35-44	2.658	
45-54	2.538	
55-64	1	
ESA/IB in 12 months prior to Wave 1		p = 0.003
Yes	0.556	
No	1	
Drivers licence		p = 0.026
Yes	1.801	
No	1	
Unfair treatment at work in 12 months prior to Wave 1		p = 0.008
Yes	3.111	
No	1	
Self-confidence in job interview[a]		p = 0.052
Not at all confident	0.498	
Quite confident	0.666	
Very confident	1	
CIS-R score at Wave 1[a]		p = 0.075
0-11	1.657	
12 or more	1	.
Marital status[a]		p = 0.297
Single	0.893	
Married or cohabitating	1.472	
Separated, divorced or widowed		
Any children in the household		p = 0.010
Yes	0.477	
No	1	
IMD		p = 0.012
IMD – least deprived	3.181	
IMD – 2	1.848	
IMD – 3	2.229	
IMD – 4	1.269	
IMD – 5	0.994	
IMD – 6	0.494	
IMD – most deprived	1	

Base: WSWB Wave 1 and Wave 2: people claiming JSA at Wave 1.

[a] Note non-significant p values.

[62] Detailed results are provided in Appendix D.

Interpretation of factors that predict entering employment

As expected, the variables that predicted whether Wave 1 JSA claimants were in employment at Wave 2 were broadly similar to the variables that predicted remaining on JSA, except in the opposite direction. The predictors of job entry were:

- socio-demographic (being female, not aged 55-64 –both only borderline significant);
- household (not having children in the household);
- work-search beliefs and experience (not transitioning from a sickness benefit, having a driver's license, self-confident about job interviews);
- mental health (not having a CMD);
- neighbourhood (not living in a deprived area).

Socio-demographic and household: Several social demographic factors appeared to play a role, but were only of borderline statistical significance in predicting a return to work when other factors were controlled for. Women appeared to be more likely to enter work than men (p=0.081) and people aged 55 to 64 appeared to have especially low rates of re-employment (p=0.157). Presence of children in the household had not predicted remaining on JSA, but it was significant in making entry into the labour market less likely.

Work-search beliefs and experience: Employment related variables played a greater role in predicting a return to work then in predicting remaining on JSA. Obviously, being in employment at Wave 1 predicted being employed at Wave 2, to avoid this dominating the multivariate model the sample was restricted to those on JSA at Wave 1. Having transitioned from a sickness related benefit was also a strong predictor: people without a recent history of Employment and Support Allowance/ Incapacity Benefit (ESA/IB) having almost twice the odds of finding work quickly compared with those without a recent history of sickness benefit receipt. Having a driver's licence was again a key factor associated with people getting into work, as was self-confidence in work-search abilities. People who reported self-confidence in their ability to present themselves well in an interview had higher odds of subsequently getting a job than those who lacked confidence in this skill. People who reported that they had been unfairly treated at work in the 12 months prior to Wave 1 were more likely to find new work quickly. This is likely to be because they were all people who had had recent employment experience.

Health: Claimants with a CIS-R score of less than 12 were more likely to be employed at Wave 2 than those with a higher CIS-R score, although this association just missed being significant after other variables were controlled for (p=0.075). Other health variables – such as having a longstanding health condition or disability, even one considered to impact on the ability to work – did not appear to impact on the odds of being employed at Wave 2.

Neighbourhood: Neighbourhood remained an important factor predicting whether or not a JSA claimant found work by the Wave 2 interview. People living in the least deprived areas were more likely to find work quickly than those living in the most deprived areas.

4.4.3 Predictors of being economically inactive at Wave 2

By the Wave 2 interview, nine in ten of the cohort were either in employment or still on JSA. The survey did not establish destinations for the remaining tenth of the sample, who were assumed to be economically inactive. A third regression analysis was undertaken to examine what factors predicted being in this group.

Table 4.17 Adjusted odds for being economically inactive at Wave 2 (not employed or on JSA)[63]

Wave 1 predictors	Odds ratios	Significance
In receipt of Disability Living Allowance (DLA) at Wave 1		p = 0.018
No	0.300	
Yes	1	
Carer		p = 0.025
Yes	0.592	
No	1	
Sex[a]		p = 0.266
Men	1.290	
Women	1	
Age group		p = 0.001
16-24	4.560	
25-34	3.310	
35-44	3.654	
45-54	3.237	
55-64	1	
Employment status at Wave 1		p < 0.001
In paid work	4.992	
Not in paid work	1	
Drivers licence		p < 0.016
Yes	1.735	
No	1	
Marital status		p < 0.001
Single	0.635	
Married or cohabitating	0.274	
Separated, divorced or widowed	1	

Base: WSWB Wave 1 and Wave 2: participants to both waves only.
[a] Note non-significant p values.

Interpretation

The factors that predicted who from the cohort would be neither on JSA nor in employment at Wave 2 included: age (particularly being 16-24), being in receipt of DLA at Wave 1, marital status (not being married), and not providing care for others. Having been employed at Wave 1 strongly predicted membership of this group (OR 4.99). This suggests that some of the people who found work by the time of the Wave 1 interview had soon lost those jobs, perhaps because the work they had found was short-term or insecure.

[63] Detailed results are provided in Appendix D.

5 Qualitative exploration of the stresses of unemployment

Key findings

- Qualitative interviews were carried out with people whose Wave 1 survey responses indicated the presence of symptoms of anxiety and depression.
- Two groups were identified: people facing multiple and longstanding challenges in their lives and those dealing primarily with more recent experiences of adversity. The group with multiple and ongoing problems had broken or limited work histories, while those with recent experiences of adversity had stable and long-term employment histories.
- A range of factors affected claimants' experience of unemployment and their expectations of finding work. These included the claimant's age; finance and housing situation; their support systems, individual psychological factors and local labour market conditions.
- The way in which these factors manifested in people's lives was complex and dynamic, making trajectories of mental health conditions and labour market outcomes difficult to predict.

The next two chapters report findings from the qualitative part of the Work-search and Wellbeing Study. This chapter (Chapter 5) explores how mental health manifested in the qualitative sample, and identifies factors in claimants' lives that mediate between unemployment and mental health. The next chapter (Chapter 6) examines contact with Jobcentre Plus and considers issues that are salient for people with mental health conditions seeking work.

Qualitative (in-depth) interviews were conducted with people whose Clinical Interview Schedule – Revised (CIS-R) scores on the Wave 1 survey were 12 or above. This indicated that at that point in time, they were experiencing clinically significant symptoms of anxiety and depression. As outlined in Chapter 1, the other sampling criteria informing the selection of respondents for the qualitative study were: age, gender, and route onto Jobseeker's Allowance (JSA). About half of the qualitative interviews were with people who had transitioned to JSA from work. During recruitment to the qualitative study, people were asked whether they were back in work, to ensure that this group was also represented in the sample.

The aims of the qualitative part of the study were to explore in-depth the experiences of living through a period of unemployment among people at risk of or experiencing mental health problems. Although the CIS-R scores of these people indicated poor mental health, it is important to point out that this inclusion criterion was not made explicit when participants were being recruited. Participants were informed that their survey scores indicated that they had recently experienced a stressful time, and that it was important to explore the reasons for this and any impact that this had had on their lives.

The achieved sample was very diverse, including recent JSA claimants with:

- few or no skills and qualifications through to highly trained and educated people;
- very stable family backgrounds through to people who had experienced a wide range of difficulties in their family lives;
- lots of social support through to individuals who were very isolated;
- long and stable employment histories through to those with limited experience of working.

Without also interviewing people with lower CIS-R scores, it is not possible to comment on how similar or different the experiences of people with mental health symptoms are compared with people without. However, the survey results discussed in Chapter 7 show that there was a lot of fluctuation in mental health symptoms among the wider JSA cohort. Some claimants experienced improvements in mental health during the study period, and a similar proportion experienced deterioration. Reasons for this are explored in Chapter 7. Given that unemployment was widely experienced as stressful and that mental health symptoms fluctuated within individuals, distinguishing the experiences of those with mental health problems and those without may not always be straightforward.

5.1 The nature of mental health

Perceptions and experiences of mental health among the group of JSA claimants with symptoms of anxiety and depression were wide ranging but broadly differed between two key groups:

- people with experience of recent adversity;
- people with experience of multiple and longstanding problems.

5.1.1 Experience of recent adversity

The stressful experiences described by people primarily experiencing only recent adversity were linked to job loss either directly or indirectly. Claimants either felt that job loss itself was the main driver of stress in their lives, or they felt that job loss was experienced alongside other adverse life events, such as relationship breakdown, bankruptcy, or physical ill health.

Job loss occurred either through redundancy (including the end of temporary or contract work), resignation, or dismissal. Common to claimants experiencing recent adversity was the fact that their previous employment experiences had been relatively stable (discussed in more detail in the next section) and their experience of being unemployed was associated with a new sense of shame, stigma and sudden social isolation. Within this group, three broad experiences can be identified.

Firstly, experience of stress was closely linked to individuals' experience of their local labour market. One man in his late 50s who had worked in the textile industry all his life was made redundant. He was finding it very difficult to find work due to a lack of jobs in his industry and area and described the shame he felt at not being able to provide for his family. This importance of local area context also emerged in the survey data (see Chapter 4), Neighbourhood deprivation – which includes the level of unemployment in the area where claimants live – was one of the strongest predictors of labour market outcomes. People living in the most deprived areas were far less likely to find work during the study period.

Secondly, there was a very strong link between the onset of physical ill health and job loss. For example, one man in his forties who had worked all his life developed a knee injury which left him unable to continue working. He was finding it very difficult to deal with being unemployed, particularly the isolation, as his social life had revolved around his job.

> *'When you're not part of something, you just feel on the outside ... life's like looking through a window: everything's just passing you by at the moment, and you just don't feel you've got the confidence to even step into that world and, and do things.'*
>
> (Male, 36-49 years, CIS-R >=18)

A third factor for claimants with poor mental health and recent adversity revolved around the breadth of other adverse life events that they were experiencing in tandem with job loss. One female participant in her fifties had also been in stable employment all her life. Her recent problems started when she moved to a different city to live with her partner. The relationship broke down and she found herself both homeless and jobless on moving back to her home town.

> *'I've bounced back through my life many times. A divorce, losing my parents ... you come out of it and you think 'Okay, I'm all right now'. Then something else hits you, 'I'm all right now', you come out of it ... This one wasn't like any other, anything else I'd ever come across.'*
>
> (Female, 50-60 years, CIS-R >=18)

Other examples of participants in this group included a woman in her late 40s who was married, living with her husband and three children in their own home and who had worked in a school for 29 years. She then went through a divorce, experienced a series of physical health problems, and was made redundant all around the same time. She described herself as having a 'breakdown' through this period.

Among JSA claimants with symptoms of anxiety or depression, these three factors – the local environment, the individual's physical health, and the range of other adverse experiences that were taking place in their lives – varied to some extent. While claimants in this group understood that they were experiencing a particular time of recent difficulty and stress the way that they articulated and rationalised these experiences differed. Some people felt that their experiences had triggered an episode of depression that could be understood from medical perspective:

> *'I think it becomes like a tidal wave and you just ... shut your eyes ... not physically but mentally you shut your eyes and you think, "Maybe it will go away". So, depression is there. I would think up to the last three or four weeks I haven't accepted that. But I went to see the doctor and they've given me medication to try and make me sleep. I suppose I've got to accept it haven't I?*'
>
> (Male, 50-60 years, CIS-R >=18)

However, other people described the way they were feeling in terms of just having to 'cope' with the practical pressures they were experiencing.

> *'At the moment ... I only feel like I feel because of my situation at the moment. And I should ... be able to cope with that. I feel I should be able to cope with that.'*
>
> (Female, 50-60 years, CIS-R 12-17)

These participants talked about the difficulty that they had 'accepting' how they felt, and feeling that they 'should' be able to cope. These examples reflect the stigma associated with mental health problems and the complexities of identifying and dealing with mental health symptoms in the real world.

5.1.2 Multiple and longstanding difficulties

This group of JSA claimants with symptoms of anxiety and depression was characterised by the experience of multiple or longstanding challenges. There was a noticeable presence of learning difficulties and literacy problems in this group, with participants having struggled with reading and writing at school. Also evident was misuse of and addiction to drugs and alcohol. This section describes the types of difficulties experienced and considers the impact of these on people's mental health during periods of unemployment.

Claimants fell into two broad groups. Some people had long-term, often life-long, experience of multiple and diverse challenges; others were characterised by chronic mental health issues that had affected them for many years.

This first group of participants were facing issues that were not directly related either to mental health or to lack of work. These issues were multifaceted, complex and had occurred over the life course. They included traumatic experiences such as childhood sexual abuse, domestic violence, bereavement, and having been in care as a child. Poor mental health was not necessarily the primary problem faced, but was a compounding problem. For example, a young man in his twenties had been sexually abused as a child and had a number of physical health problems. He could not read or write very well, had no qualifications, and had been diagnosed with bipolar disorder and paranoia. To him, work did not seem like a realistic possibility.

The second group saw mental health problems as dominant. One woman in her thirties had a long history of mental health problems, including having been sectioned. She had had periods of employment in the past and was keen to get back to work after a long period of being ill with depression.

5.2 Employment and benefit history

The JSA claimants with anxiety and depression interviewed in the qualitative part of the study had employment and benefit histories that fell broadly into one of three categories.

- Claimants with long-term work histories: this group included people who had spent most of their lives working either in long-term and mostly skilled, stable jobs or in a string of shorter-term and usually low-skilled jobs. Some of the older people in this group had experienced unemployment much earlier in their lives, but their recent JSA claim was the first in a long time.
- Claimants with broken work histories: This group of people had spent much of their working lives moving repeatedly between work and benefits. This included a subgroup of young men in their twenties who appeared to be in a cycle of moving between short-term work, sickness benefits and JSA. Other participants who followed the pattern of moving between employment and out-of-work benefits did so due to their mental health condition or because of substance misuse and dependency. Periods of work were not always short-term; some had had long-term jobs with periods of unemployment in between.
- Claimants with limited or no work histories: this group consisted of claimants in their early and mid twenties who had either very little or no experience of work at all prior to claiming JSA. For example, a participant who had left university to enter work in order to pay off his student debts; another had had two short-term, low skilled jobs but was subsequently unable to find another. This group included participants who transitioned to JSA from education, as well as from short-term employment and other benefits.

5.3 Factors affecting the relationship between unemployment and mental health

A range of factors were identified as key in mediating the association between unemployment and mental health. Some of these have already been seen in the examples provided above and are explored in the following section:

- Local labour market.
- Age.
- Finance and housing.
- Support systems.
- Personality.

5.3.1 Local labour market

As mentioned above, analysis of the survey data found level of local area deprivation to predict whether or not participants had entered employment by the second survey interview (see Chapter 4). Participants had views about the availability of work in their local area, and these views impacted on how stressful they found their experience of unemployment. The challenging national economic climate and rising levels of unemployment were frequently raised themes in the qualitative interviews. People expressed worry about how they could apply for the number of jobs they were required to by the JSA regime if suitable work was not available.

> *'If there's jobs not out there they're not out there* [to apply for]*.'*
>
> (Male, 21-35 years, CIS-R 12-17)

Lack of employment opportunities was perceived to be more marked in some areas than others. Claimants living in rural areas or towns with a declining industry raised the local labour market as compounding their anxiety and leaving them feeling low about their prospects of finding work. Participants felt that living in an area with fewer job options placed particular stresses on them, because they had to consider work that did not match their skills and experience or did not fit with their complex needs.

5.3.2 Age

Survey data analysis reported in Chapter 4 found a strong association between age and economic activity at the Wave 2 interview. Older people, aged 55 and over, were the age group least likely to be employed by Wave 2. And the youngest age group, 16 to 24 year olds, were the most likely to be economically inactive. These two groups also emerged in the qualitative interviews as having a particular attitudes and experiences that impacted on their mental health and wellbeing while unemployed.

Over 50s

Older participants with symptoms of anxiety and depression cited age as a major barrier to finding employment. Age-related issues were regarded as impacting on their wellbeing while unemployed in two main ways.

Firstly, their perception of age-related disadvantage was particularly galling because they often had qualifications and long work histories, and felt that these were undervalued by potential employers. They also described being accustomed to a standard of living and surprised at their decline in status. Older claimants experienced stigma associated with this loss of social status and self-esteem.

> *'I've gone from being, I won't say well off, but comfortable, with a little bit of extra, to being not very well off. That's not the way it's meant to be, as you get older, is it? It's meant to get easier. It's getting harder. And any savings that I was hoping, you know, that is for my retirement, that's going out the window.'*
>
> (Female, 50-60 years, CIS-R 12-17)

Secondly, the onset of physical health limitations complicated future opportunities, particularly for claimants who had worked in manual occupations. For this age group, physical health conditions were not felt to be short-term barriers, but signified permanent shifts in capability. Older participants felt opportunities to retrain and find work in different sectors would be offered instead to younger people. This left older claimants feeling anxious about what their future would be.

> *'You feel as though you're on a scrap heap, let's put it that way. You think well if I can't get that* [job in a supermarket] *... where do I go from here? I honestly don't feel as though there is anywhere. I've applied for so many different types of jobs'.*
>
> (Female, 50-60 years, CIS-R 12-17)

Twenty somethings

Within the qualitative sample, this age group was populated entirely by participants with multiple and longstanding difficulties, including experience of sexual and emotional abuse, lack of parental contact during childhood, learning difficulties and literacy problems, drug and alcohol abuse, and bereavement. The sample was insufficient to draw conclusions about how age-related issues more generally impact on the experience of unemployment among young claimants with anxiety and depression.

The most obvious way in which the problems faced by these young people had impacted on their experience of unemployment was manifested in their lack of qualifications and work experience, which left them feeling that work search was hopeless.

> *'I like to be outside. It's been like that since I've left school, it's that same jobs what I've just told you, gardening, construction and packing. I haven't had not one job offer, not one. There were a gardening job on but you needed experience just with flowers and stuff. If you haven't got it on paper, you've got nothing, you know what I mean?'*
>
> (Male, 21-35 years, CIS-R >=18)

The analysis of survey data in Chapter 4 identifying factors that predicted a return to work by the second survey wave identified two areas where these younger claimants were disadvantaged. These were job search self-confidence and having a driver's license. Young claimants living in the parental home cited a lack accessible and affordable transport as a barrier. This meant that they were particularly vulnerable to feeling trapped and lacking a sense of efficacy or control over their situation.

5.3.3 Finance and housing

The quantitative analysis found that the experience of debt or financial crises were strong predictors of anxiety, depression and work-search failure. The struggle to manage financially on JSA was an issue for all participants in the qualitative interviews, mitigated to some extent for those with other sources of income, such as an employed spouse or for young people parents or other family members. Three key dimensions to this issue were identified as having an impact on the wellbeing of claimants with anxiety and depression while unemployed.

Firstly, the worry over being unable to pay for basic needs – such as housing, food, and other bills – was described as very stressful, particularly where people had dependents. Anxiety about avoiding or dealing with debt could be a major trigger to arguments and problems in relationships.

Secondly, having limited money was described as being very isolating because people could not afford to socialise. Feeling alone and isolated were seen to contribute to the loss of confidence and low self-esteem described as part of the general experience of unemployment. One young man talked about the impact of being unemployed on his social activity and horizons:

> *'P: It's had a big impact on my life. At the time, it, I'm going back a few years now. When I first started signing on at the age of 18 I was more confident and even just going to town like and having a little drink on Friday. I haven't been out now for the last six years, so I don't reckon I could go to socialise in town and all that. I just get to know the same faces like on me street and I don't like leaving the street now. It's like this is me comfort zone. I know it sounds stupid but ...*
>
> *I: WHAT IS IT ABOUT IT THAT YOU THINK HAS AFFECTED YOUR CONFIDENCE?*
>
> *'P: I don't know, just having no money. So, when you know you've got no money you don't think about doing nothing in life, just for instance going the pictures or something like that, you know you've got no money.'*
>
> (Male, 20-35 years, CIS-R 12-17)

A third dimension was housing. Where this was discussed in the qualitative interviews, it was described as being particularly stressful in different ways for different age groups. Among the young, multiplied disadvantaged participants in their twenties, not having a family home added another dimension to their vulnerability and stress. For older participants who had families and mortgages, the fear of losing their homes was a major cause of anxiety, mitigated if insurance policies to cover mortgage payments were set up.

For those who had succeeded in entering employment, there was evidence that their financial situations had improved when the job was sufficiently well-paid and secure.

5.3.4 Support systems

Claimants with anxiety and depression described the level and nature of social support that they had in their lives. Sometimes this referred to informal social support networks such as family and friends. Sometimes more formal types were described, such as church, health care professionals like GPs, or other professionals and organisations such as Citizens' Advice Bureau or the Samaritans. The nature of support took three different forms. Firstly, it was about just having people around to interact and communicate with (which could be a negative experience where those relationships were strained). Secondly, it could represent a therapeutic relationship, for example in the case of a health care professional treating a patient. Finally, support could also be practical in terms of accessing formal information and advice services.

Informal social support networks of family and friends were either absent, limited, or strong. Analysis of the survey data reported in Chapter 7 found that among JSA claimants, not having people who give 'support and encouragement', and having only a small social network, both strongly predicted a subsequent deterioration in mental health.

- Absence of social support: individuals in this group reported no close relationships with friends or family. Family relationships had typically broken down and friendships formed through work had been lost since becoming unemployed. The experience of unemployment was, therefore, particularly isolating for this group.
- Limited social support: this group included single parents, whose children provided company and social interaction, but with whom it was not considered appropriate to share problems. There were also people who had good friends, but chose to limit the extent to which they confided in them either because they did not want to burden them or because they felt ashamed.
- Strong social support networks: where warm and loving relationships with partners, family and friends were described, these were important in supporting people through the stresses of unemployment. However, support could operate in both a positive and a negative way. The stress and pressure of responsibility to provide for a family or deal with a partner or spouse's worry could heighten feelings of shame and guilt. One participant expressed his shame about the fact that he was unemployed while his wife was still working.

5.3.5 Acknowledging the problem

The stigma associated with mental health problems could be seen in relation to people accessing support, with some people describing reluctance to talk about how they were feeling. Reasons for not confiding in friends and family included not wanting to burden them, doubting that they would understand, and feeling shame and embarrassment about asking for the support of others, and about experiencing mental health problems at all.

Contrasting experiences can be identified between those who had sought professional help or advice and those who had not. Arguably, there were people who did not need professional input in order for their problems to be resolved. Others, however, were not moving forwards. Where this latter group had recognised and accepted that there was a problem, this admission took them a significant step forwards. The following quote is from a woman whose family and friends were very concerned about her mental health and were trying to convince her to go to the GP. It is a good example of how difficult it could be for people to ask for help.

> *'Like how do you go to someone and tell them that you always feel crap about yourself, and about what you're doing, and you don't wanna get up in the mornings and do anything. I just didn't feel like anyone would get it ... I was embarrassed of myself. Like I didn't wanna tell anyone that I was low and sad.'*
>
> (Female, 21-35 years, CIS-R >=18)

In such cases, their movement could, therefore, be as much about the individual's readiness to deal with their issues as about the nature of the support itself.

5.3.6 Psychological factors

The final factor identified related to individual psychological factors. Individual beliefs such as self-efficacy appeared to play an important part in how able people felt that they were to cope with periods of unemployment. This was particularly evident in relation to the job search process. Widely described as a demoralising experience due to the lack of response, some people seemed more

resilient than others to cope with job search. A man in his mid-40s with a history of alcoholism and depression describing a difficult experience looking for a job in the groundworks industry:

> *'Well,* [sighs] *sometimes it just gets to a point ... I don't wanna get out of bed. I just can't be bothered with it. And you just find yourself staring at the telly all day and that is really not the way it should be. You just have to do it, you have to force yourself and get up and go and do it. If you don't you just vegetate.'*
>
> (Male, 36-49 years, CIS-R >=18)

Conversely, there were participants who talked about themselves as lacking in confidence and self-esteem:

> *'Lack of confidence. I don't come across positive enough. I know that. Because I think I'm a very negative person, I'm not a positive person. I can't sell myself.'*
>
> (Female, 50-60 years, CIS-R 12-17)

Some, like the woman quoted above, were explicit about the negative impact psychological factors were likely to have on their job search success. In other cases, it was not explicitly articulated by participants, but could nevertheless be observed in the way people described themselves and their levels of confidence and motivation.

5.4 Associations between experience of unemployment and mental health

An individual's experience of unemployment was influenced by how the factors identified in the section above manifested in their lives. Because of the complex and changing nature of the interrelationships between these factors, predicting trajectories in mental health and labour market outcomes was difficult. If each of the factors are regarded as a spectrum running from negative to positive, someone on the negative end of a spectrum would be expected to be at higher risk of a poor outcome. However, the qualitative work also shows how individuals negotiate their journey through unemployment is a dynamic process, with some people moving forwards and others backwards.

As is reflected in the quantitative findings on the role of self-efficacy in predicting outcomes and in the associations with psychological factors, some people display particular tenacity and resilience in the face of challenge. The qualitative work has also shown that sometimes the same factors can work in both a positive and negative direction. For example, while the presence of social support can be positive, the guilt, shame and sense of responsibility to provide for others can also be a major source of anxiety.

In this section, three case studies are presented to demonstrate different relationships between mental health and experience of unemployment, highlighting the complex ways in which the mediating factors come into play for different individuals.

5.4.1 Case study 1

The first case study is an example of the impact of recent adversity on a woman with a stable history of employment. It shows how the experience of unemployment interacts with other types of adversity that either coincided with or were directly triggered by job loss, such as poor physical ill health and debt. Her feeling of shame and perceptions of stigma, and the complexity of her experience of social support (feeling both isolated and a burden) created a particular context for her experience of mental health while without work. It is notable how she felt her mental health issues resolved with a return to work.

Lisa, a 33 year old married woman from the Midlands, had a long, stable history of employment having always worked since leaving school. When made redundant from her job in office management, she did not plan on claiming benefits, expecting to find another job easily. However, she then became very ill with pneumonia and was unable to look for work for more than two months, which was then closely followed by the Christmas and New Year holidays. She started to claim JSA in the New Year and found work after several months.

Lisa found the experience of unemployment and claiming benefits extremely difficult. She quickly spent her savings on keeping up her mortgage payments and bills, after which she borrowed money from her parents and her husband. She was embarrassed about having to go to the Jobcentre and claim JSA, feeling herself to be 'different' from most of the people there. Although she described some of the Personal Adviser (PAs) in positive terms, she had also had some bad experiences, when she felt that she had been spoken to rudely and disrespectfully, which she found very upsetting.

Lisa began to avoid social contact for fear of being asked about her current circumstances. If someone came to her house, she would pretend that she had a day off work, rather than admit to being unemployed. She described this period as:

'*Really, really depressing ... I was at a very, very low point. If* [I hadn't found work] *I think I would have just kept going sort of deeper into the dark hole.*'

Although her parents and husband were very supportive, she felt a burden to them through this time. Since having been back in work, Lisa described feeling completely different 'literally back to normal,' and despite her wages being less than they were, she feels grateful to have a job.

5.4.2 Case study 2

In contrast, the following case study highlights the experience of someone facing multiple and longstanding issues with a limited employment history. Despite some of his problems originating in early life experiences, it is notable that current context had a clear impact on his mental health while unemployed. In particular, he felt that he gained confidence and self-esteem from participating in employment training, and cited the influence and role of social interaction at Jobcentres on how he felt.

Shaun is a 23 year old man from the North West of England. He had not been close to his mother while growing up, saying that no-one 'gave a damn' about him when he was young. Since leaving school, he had mostly been living with his uncle, which he said was 'OK'. Shaun had poor literacy and numeracy skills. His limited work experience had been a short contract at a call centre and a few months working in an old people's home, neither of which he had enjoyed. Since then, he has unsuccessfully been looking for an administrative role. He talked about what a difference it made when going to the Jobcentre to be greeted with a smile and a friendly face rather than someone who looked miserable.

Although he had a girlfriend, she lived in a different city and they could not afford to see each other often. Lack of money left him isolated because he could not afford to socialise and most of his friends were working. He talked openly about having experienced mental health problems in the past. At the time of the qualitative interview, Shaun was attending a literacy and numeracy course at an employment agency and had just completed Level One, which he was very proud of.

5.4.3 Case study 3

Age can be seen as a driving factor in this participant's experience as a JSA claimant. The anxieties and stresses she articulated were about immediate circumstances, but also rooted in fear of loss and vulnerability in the future. Again, in this case study, social relationships can be seen as a key component of the emotional experience of unemployment.

A 54 year old with a long working history at a range of retail outlets, Margaret was made redundant for the second time in two years several months before the qualitative interview took place. She lived in the south-east of England with her partner and 29-year-old son. Having worked all her life, she was finding the experience of unemployment very difficult. She described the negative impact it was having on her relationships with her son and partner, particularly in terms of money and contributions to the household, which she had always contributed to substantially before but was no longer able to. The lack of available jobs in her local area was making Margaret very anxious about her future and she feared losing her house and finding herself homeless as she approached old age. Margaret acknowledged that she found her situation depressing, but saw it as something she just had to get on with.

The qualitative findings provide insight into how a small group of people who had symptoms of poor mental health soon after becoming a JSA claimant experienced the stresses of unemployment. Although the factors identified in this chapter as shaping this experience could be important for all JSA claimants, further comparative research would be required to determine how generalisiable these dynamics are to the JSA population as a whole.

6 Qualitative exploration of experiences of Jobcentre Plus and work search

Key findings

- The experience of claiming Jobseeker's Allowance (JSA) was associated with feelings of shame and the perceived stigma of being on benefits.
- Personalised support and being treated respectfully by Jobcentre Plus Personal Advisers (PAs) were important to people.
- Claimants could be reluctant to raise mental health; some claimants also felt that PAs were reluctant to discuss such issues too. Some claimants did not regard themselves as having a mental health problem; while others recognised a mental health problem but did not want or feel able to talk about it.
- Where movement towards the labour market was evident, Jobcentre Plus had in some cases supported this progress in the form of specialist support, such as Lone Parent support or a Disability Employment Adviser.
- Some mental health problems were felt by participants to make adherence to the requirements of the JSA regime more difficult. Some claimants with poor mental health raised concerns about their ability to move into work or particular types of work. This included people experiencing panic attacks, paranoia, and agoraphobia.

Like Chapter 5, this chapter draws on findings from the qualitative interviews. The experiences of searching for work and of using Jobcentre Plus services are examined with participants whose survey scores indicated that they had symptoms of anxiety or depression a couple of months after starting a JSA claim. Throughout this chapter comparisons are made between the experiences of the two main groups identified in Chapter 5: claimants characterised either by experience of recent adversity or by with multiple and longer-term problems.

6.1 The experience of claiming JSA

The sense of shame and stigma associated with claiming benefits was predominant in claimants' descriptions of how it felt to be a JSA claimant. In particular, the physical act of attending the Jobcentre was discussed in negative terms:

> *'It's not nice to go there, you feel embarrassed and ashamed.'*
>
> (Female, 21-35 years, Clinical Interview Schedule – Revised (CIS-R) >=18)

People were keen to disassociate themselves from the image of being a 'benefit scrounger'. They did not want other people to see them as someone unwilling to work or happy to claim money from the state. Claimants were often keen to explain in the qualitative interviews why their specific situation made claiming benefits justifiable. Anger at feeling that others felt they were undeserving of help was also commonly expressed, particularly by people who had paid taxes for many years. One woman explained her first encounter with staff at the Jobcentre:

> '[They were] *making me feel that I was begging for money! I said 'I have worked all my working life. I've never had maternity. I couldn't have children, so we've had no free dental, never had anything off the government ever.' I said, 'Now I need help, I'm feeling as if I'm begging from you.' And that was the attitude they took.'*
>
> (Female, 50-60 years, CIS-R >=18)

6.2 Moving onto JSA

Transitioning onto JSA was broadly experienced as being a stressful time. However, the underlying reasons for this were quite varied. Two key groups were evident: those who felt job ready and those who did not feel job ready.

6.2.1 Claimants who felt 'job ready'

This group consisted of two subgroups. First, it included people who felt job ready and were urgently engaged in work-search activities. Their stress related to whether or not they would be able to find (suitable) work and how to cope both financially and psychologically with unemployment till they did. One man in this group, had lost his job due to his firm being closed down. His wife was physically disabled and his daughter had severe learning difficulties. He was the only one in the family capable of earning money. He described how the stress he felt while unemployed was different from the types of stress he had experienced before:

> *'There were occasions when you were stressed about* [work]*, but then you could go back the next day and deal with problems and get a sense of achievement, accomplishment even. You can't do that if you're on Jobseeker's because you've got nothing to achieve apart from getting a job, so ... there's no release for the stress. The only release is getting a job, so the longer it goes on the more that stress in some ways builds up ... The main thing is you feel that you're letting your family and yourself down.'*
>
> (Male, 36-49 years, CIS-R >=18)

Claimants who felt job ready and were urgently engaged in work-search activities consisted of people with recent experience adversity, all of whom had long-term work histories.

The second subgroup was populated by people with multiple and longstanding difficulties, but who had moved forwards to the point where they were ready to start looking for work. Interestingly, these were people who also acknowledged their mental health problems. Although describing themselves as ready to work, they also expressed fear and anxiety about how entering employment would affect their future mental health. As described in Section 6.3.1, the relationship with PAs at the Jobcentre could play a particularly important role for this group.

6.2.2 Claimants who did not feel 'job ready'

Another group of participants felt less ready to return to work. Two subgroups were evident: those who did not agree with a Work Capability Assessment (WCA) of their fitness to work and those for whom unemployment was one of multiple ongoing challenges.

Participants who did not feel job ready but had been found fit for work expressed feelings of anger and resentment with the system. Among this group were people who chose not to appeal against their WCA because they did not feel able to cope with the stress of an appeal process, and were worried that an unfavourable outcome could leave them without any benefits. It was beyond the scope of this study to examine outcomes for this group – that is, whether or not these people did find work, and where they did what the impact had been.

A second subgroup included people with multiple and ongoing issues who felt that they were a long way from the labour market because of the extent of other problems they were facing. For this group, the stresses associated with being unemployed were overshadowed by the impact that their wider set of life challenges had on their mental health. This subgroup included people who were unkempt in appearance; had ongoing problems with alcohol or drugs; and very poor communication and interpersonal skills.

6.3 Experiences at Jobcentre Plus

Three factors were identified as important to JSA claimants with symptoms of anxiety or depression during their visits to the Jobcentre:

1 Relationships with PAs.

2 Physical environment of the Jobcentre.

3 Support with job search.

6.3.1 Relationships with PAs

As noted above, the relationship with the PA was an important dimension of participants' experience of Jobcentre Plus. Three aspects of participants' relationships with Advisers at the Jobcentre were highlighted. Firstly, good communication skills were described by claimants as important. Attending the Jobcentre was not, nor was expected to be, an enjoyable experience, but could be much improved by being treated with respect by Jobcentre staff. A friendly manner and making eye contact could make a huge difference to a person's visit. However, if people felt that they had been treated disrespectfully, it seemed to be keenly remembered.

Secondly, personalised service which made people feel they were being treated as individual, was also highly valued by claimants. This related to Advisers checking customers' employment requirements, skills and experience and any restrictions on their job search (such as part-time or within specific locations) prior to or during the interview. While Advisers were not necessarily expected to take a personal interest in each claimant, this was much appreciated by participants when it did happen. This could be in the form of showing interest in some aspect of a claimant's life, being proactive and thinking laterally about ways to move an individual forwards, or using flexibility when applying guidelines to accommodate individual circumstances.

This kind of personalised service was particularly valued by claimants who felt job ready, but were easing themselves back into work as part of their mental health recovery. They felt that where their perceived needs for particular working conditions, for example with restricted hours or working close to home, were acknowledged this could have a major impact on their current mental wellbeing and their anticipated progress forwards. One example was a woman who was recovering from a breakdown during which she had been suicidal and sectioned. Claustrophobic and not able to use the underground, she described her experience with a PA:

> *'... I came away in tears, 'cause she was having a go at me because I wasn't looking for far enough afield for jobs. I was only looking within a five mile radius. She was pushing me, she was trying to get me to apply for a job in,* [name of area] *which I think is 12 or 15 miles away and you can only get to it on the tube. And I was saying to her, "I can't!".'*
>
> (Female, 21-35 years, CIS-R >=18)

Finally, the way in which mental health issues were dealt with was also raised by claimants. Work-focused discussions are designed to be tailored to each claimant's needs and focused on helping the claimant back to work. PAs exercise discretion as to whether to enquire or discuss the issue of mental health. This was reflected in the survey results, which found that health and wellbeing were not discussed in most interviews between JSA claimants and PAs. The qualitative interviews with claimants with mental health symptoms suggested that the reluctance to discuss mental health could come from the claimant or the Adviser. If a claimant had been found fit to work through the WCA process, Advisers could perceive that it would be unwise to consider health issues. The stigma associated with mental health could also play a part. Some participants described their reluctance to admit to experiencing mental health problems, particularly given some of the issues identified in the next section with the physical environment of the Jobcentre.

6.3.2 Physical environment of the Jobcentre

Issues relating to the physical environment of the Jobcentre were identified by some JSA claimants as affecting the quality of their experience of work-search support. Two aspects emerged for people experiencing mental health problems, or which affected the discussion of mental health.

Firstly, for people with mental health conditions like agoraphobia, panic attacks and paranoia, just getting to and being at a Jobcentre could be extremely challenging, particularly if the Jobcentre was big and busy. One young man who had been diagnosed with bipolar disorder described what going to the Jobcentre was like for him:

> *'The longer I end up standing in there I start sweating and everything, 'cause I just feel like everyone's staring at me and talking about me. I know that's paranoid ... but there's nothing I can do about that. I'd rather just walk out and not sign on ... I just start sweating you know.'*
>
> (Male, 21-35, CIS-R 12-17)

Secondly, a lack of private space in which to talk to the PA was felt by claimants to be problematic. Participants with mental health problems did not feel that the open plan layout encouraged them to share issues relating to their mental health, they were fearful of being overheard. One participant described being seen by her PA while sitting next to a woman she had been to school with, and feeling very compromised in terms of what she felt comfortable discussing with her Adviser.

6.3.3 Job search and return to work

The experience of looking for work and applying for jobs without success, or even feedback, was widely described as demoralising, as this quote illustrates:

> *'I don't get any response ... Say you do a hundred* [applications] *you might get two back that say, 'Unfortunately, this place has been filled', but other than that you don't hear anything from anybody.'*
>
> (Female, 50-60 years, CIS-R 12-17)

All participants still receiving JSA at the time of the qualitative interview described carrying out job search activities in accordance with the requirements of their benefit claim. However, the level of motivation, urgency and effectiveness with which this was being done with varied according to their perceived proximity to the labour market (as described in Section 6.2). People's approach to job search depended on their individual circumstances. Participants with a long, stable history of employment, a mortgage to pay, and a family to provide for tended to be more motivated to seek work than participants living with family, facing a range of personal problems, and with limited employment experience to draw on.

Job search on the internet, in newspapers, at the Jobcentre and through agencies were widely described. Participants also networked through friends and former colleagues, which resulted in a successful outcome for some. This shows that social support networks, and their lack, play an important role in both economic and mental health outcomes. Where specialist support at the Jobcentre was accessed, this was regarded by claimants as having been very effective. One example was a lone parent with a history of depression and weight problems. Dyslexic and with low self-esteem resulting from an abusive relationship, she had received a lot of support from a Lone Parent Adviser, resulting in her training and qualifying as a nursery nurse. She was in work at the time of the interview, and described how she was feeling:

> *'I think I've got a lot more confidence now than I had then. And I have got me self-esteem back.'*
>
> (Female, 36-49 years, CIS-R >=18)

Another example was a young man who had developed serious mental health problems subsequent to being made bankrupt in his early twenties. He had been referred to a Disability Employment Adviser who organised some volunteering experience. This represented his first experience in a workplace for several years and was a really valued step forwards for him, which he hoped would increase his chances of getting paid work.

There were several examples in the qualitative sample of people who had returned to work. These were people with long-term employment histories. For this group, the stresses experienced during unemployment had been significantly reduced, if not entirely eliminated, by being back at work. However, although this can be seen as a job ready group, the qualitative findings also provide evidence that even people who are apparently further from the labour market are capable of moving towards and into work.

6.3.4 Implications for Jobcentre Plus

Understanding people's experiences of Jobcentre Plus services while a JSA claimant has raised some important implications. The sense of shame and stigma felt about being unemployed and on benefits was widely expressed. However, shame and stigma were also felt about experiencing mental health problems, stress, and difficulties with coping. Some claimants were open about their problems with mental health. But others either did not regard themselves in this way, or admitted to it in the qualitative interview but said that they preferred not to or found it difficult to talk about. At the moment, mental health and wellbeing are not routinely raised in interviews with PA. If they were, some claimants reluctance to talk about it would present a challenge to PAs in providing assistance to this group, despite the fact that there was clear evidence that recognition and targeted support could be effective in moving people forwards.

7 Predicting change in mental health

Key findings

- New claimants tend to start a Jobseeker's Allowance (JSA) claim with worse mental health than that of the rest of the working age population. In the months that follow, about a third of them experienced an improvement in their mental health, a third experienced little or no change, and a third experienced deterioration.
- The circumstances that predicted a deterioration in mental health after the start of a JSA claim included: current health and wellbeing (having a longstanding illness, an anxiety disorder, or indication of low subjective wellbeing), the quality and number of social contacts, the number and type of traumatic events experienced, and the characteristics of the local area.
- Similar factors, operating in reverse, predicted an improvement in mental health. Entering work was of borderline significance as a predictor for improved mental health. Anxiety disorders were prominent for making recovery less likely.
- Before adjustment for explanatory factors, men and women were equally likely to experience a decline in mental health between the survey waves. But while women were more likely to show signs of recovery, men were more likely to experience no change.
- However, after adjustment for other factors there was no association between sex and change in mental health. Other demographic factors, such as age and ethnic group, also did not influence what happens to someone's mental health after starting a JSA claim.

In this chapter multivariate analyses identifying what predicts a change in mental health after the start of a JSA claim are presented. Information collected near the start of a JSA claim are used to examine what characteristics might identify people:

- at most risk of a deterioration in mental health (and who may, therefore, benefit from additional targeted support); and
- who are most likely to experience an improvement.

The impact of experiences that occurred during unemployment were also considered, specifically the number and types of traumatic event and whether or not the participant entered work between the Wave 1 and Wave 2 interviews.

The focus of this chapter is quite different from that of the other chapters in this report. It is not about whether people have 'good' or 'bad' mental health, rather it is about what factors predict whether, in the months after starting a JSA claim, people's mental health improves, stays the same, or deteriorates. Interpreting these findings can be complicated and even initially appear counter intuitive. For example, people who have neurotic symptoms will be more likely to experience an improvement in such symptoms. Controlling for Clinical Interview Schedule – Revised (CIS-R) score is, therefore, a key part of this analysis.

Variability in the direction and extent of change in neurotic symptoms between survey waves is also to be expected. There are two main reasons for this.

Firstly, the context in which people live and the labour market outcomes that they experience vary greatly from person to person. The qualitative analysis highlighted context to be a key driver in how people experience unemployment.

Secondly, the Wave 1 interview took place within a few months of a JSA claim commencing, and the Wave 2 interview a few months later. These could represent somewhat arbitrary points from the perspective of an individual's own mental health trajectory. For example, an adverse experience six months previously may be associated with an ongoing process of recovery between survey waves in one person, but with a continuation of poor mental health in another. The qualitative analysis highlighted that for some people starting a JSA claim was a major life event, while for others it was overshadowed by other events in their lives. However, these two points in the claims process are meaningful from the perspective of informing service contact at these stages, and for identifying what characteristics of recent claimants might indicate particular support needs in the coming months.

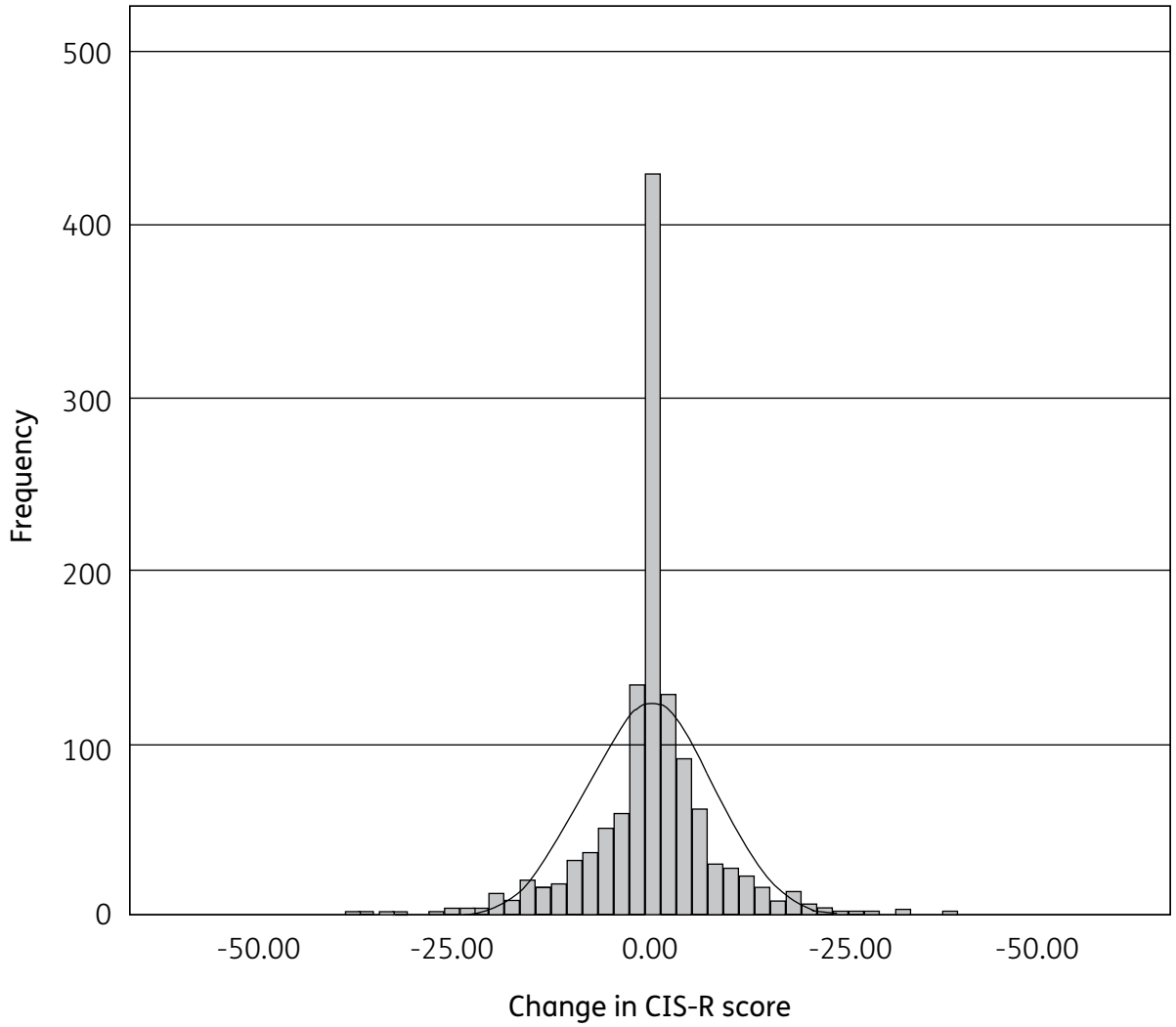
7.1 Change in mental health between survey waves

There was great variability in the mental health trajectories of recent JSA claimants in the months after starting a claim. That is, some people got better, some got worse, and others experienced little change or remained the same.

Overall, about a third (33.7 per cent) of people experienced a decline in their mental health between Waves 1 and 2; around another third (37.9 per cent) experienced an improvement, and the remainder (28.4 per cent) had exactly the same CIS-R score at both waves. Figure 7.1 is a weighted histogram of the frequency of each difference in scores between waves. The distribution is heavily centred around zero, with roughly symmetric variation either side. Most people experienced a small change in their level of neurotic symptoms, but some experienced a large change.

Stability in mental health can be positive – if initial mental health is good – but in the context of this study it is likely to be negative because the mental health of people who have recently become unemployed tends to be low. Many claimants at the time of the first interview, within a few months of starting a JSA claim, were likely to still be at a low ebb.

Figure 7.1 Histogram of change in CIS-R score between survey waves



Base: WSWB Wave 1 and Wave 2: participants at both waves.

7.2 Change in mental health, by sex and age group

While men and women were equally likely to experience a decline in mental health between the survey waves (both 33.7 per cent), women were more likely than men to show signs of improvement and recovery (44.0 per cent women, 34.1 per cent men). Conversely, men were more likely than women to experience no change in their mental health between the survey waves (32.2 per cent men, 22.3 per cent women). There was no clear pattern of association between age group and change in mental health between waves.

Table 7.1 Change in CIS-R score between waves, by age and sex

	Age group					
Change in CIS-R score	**16-24 %**	**25-34 %**	**35-44 %**	**45-54 %**	**55-64 %**	**All %**
Men						
Decline in mental health	28.7	39.6	34.3	32.8	37.6	33.7
Stayed the same	38.8	21.6	32.0	32.6	35.4	32.2
Improvement in mental health	32.5	38.8	33.7	34.6	27.1	34.1
Bases	*198*	*154*	*141*	*153*	*96*	*742*
Women						
Decline in mental health	32.8	31.8	44.6	23.9	30.7	33.7
Stayed the same	21.5	23.9	17.5	25.5	31.6	22.3
Improvement in mental health	45.7	44.3	37.9	50.6	37.7	44.0
Bases	*132*	*87*	*125*	*131*	*53*	*528*
All						
Decline in mental health	30.2	36.9	38.9	29.3	35.4	33.7
Stayed the same	32.4	22.4	25.5	29.8	34.2	28.4
Improvement in mental health	37.4	40.7	35.6	40.9	30.4	37.9
Bases	*330*	*241*	*266*	*284*	*149*	*1,270*

Base: WSWB Wave 1 and Wave 2 – participants in both waves.

7.3 Factors predicting change in mental health

Two multivariable regression models were run, to examine what factors predicted:

- An improvement in mental health between Waves 1 and 2.
- A deterioration in mental health between Waves 1 and 2.

Those whose score had not changed were included in the reference category for each regression, along with the rest of the sample. The same topic areas used in the multivariate analyses in Chapter 4 were used to structure the stages in which blocks of variables were tested. These blocks draw on the themes that emerged in the qualitative analysis or had been identified in the research literature. Wave 1 variables relevant to each topic were listed and priority was given to variables with data available for all or most of the sample. For example, some questions about attitudes towards and activities undertaken in searching for work were only asked of people who were not employed at Wave 1. An automated stepwise procedure was not used, instead the process was all handled manually, with flexibility to reintroduce variables back into the model if there was a theory informed rationale for doing so. The methodological approach is described in Chapter 4, and further details are provided in Appendix D.

7.3.1 Predictors of deterioration in mental health

The variables retained in the final multivariate model are summarised in Table 7.2, and detailed in Appendix D (along with the p values, odds ratios (OR) and the 95 per cent upper and lower confidence interval). The ORs show what the odds are for people in each category having experienced a decline in mental health, compared with people in the other categories.

Table 7.2 Adjusted odds for a decline in mental health (increase in CIS-R score) between waves

Characteristics at Wave 1	Odds ratios	Significance
Primary group size		p = 0.030
0 or 1	0.458	
2 or 3	2.349	
4 to 9	1.047	
10 or more	1	
People give me support and encouragement		p = 0.009
Not true	5.666	
Partly true	1.011	
Certainly true	1	
Number and types of trauma between Wave 1 and 2		p < 0.001
Financial crisis only	2.057	
Bullying only	3.794	
Serious illness only	2.431	
Illness/injury relative or friend	1.412	
2 or more traumatic events	2.465	
3 or more traumatic events	13.649	
No traumatic events	1	
Longstanding illness, disability or health condition		p < 0.001
Yes	1.986	
No	1	
Been able to think clearly		p = 0.013
None or rarely	1.453	
Some of the time	2.073	
Often	1.733	
All of the time	1	
CIS-R score		p < 0.001
12 or more	0.389	
0 to 11	1	
Depressive episode		p = 0.051
Present	0.379	
Not present	1	
OCD		p = 0.073
Present	0.313	
Not present	1	
Panic disorder		p = 0.046
Present	4.531	
Not present	1	
Urban/rural		p = 0.015
Rural	0.338	
Fringe and town	1.154	
Urban	1	

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

[a] Detailed results are provided in Appendix D. Reference category: mental health stayed the same or got better.

[b] Note that for these variables significance at the 95 per cent level was not reached.

Interpretation

When a Personal Adviser (PA) meets with a new JSA claimant to discuss their work plans, what characteristics might indicate that the claimant sitting in front of them is likely to experience a deterioration in their mental health over the coming months?

Firstly, it is interesting to note what factors, after adjustment for confounding, did not predict a future decline in mental health. Socio-demographic factors – like sex, age and ethnic group – did not increase the odds of a decline. And while attitudes towards and beliefs about work, and employment, benefit and training history played a role in initial analyses, they did not predict a decline in mental health after other factors were controlled for.

The areas that did predict that someone's mental health was going to get worse over the coming months were:

- initial health, mental health and wellbeing;
- quality and number of social relationships;
- ongoing experience of traumatic life events;
- neighbourhood characteristics.

Health, mental health and wellbeing: People who reported having a longstanding illness, disability or infirmity at Wave 1 had almost twice the odds of a deterioration in mental health by Wave 2, compared with people without a longstanding illness. This was a highly significant finding ($p<0.001$). Another highly significant finding was that having a high CIS-R score (12 or more) at Wave 1 predicted an improvement in mental health. Although initially counterintuitive, this finding is actually to be expected. Recovery in mental health is unlikely if symptoms do not already exist. Regression to the mean may also play a role in this.[64]

Depression behaved in a similar way to having a high CIS-R score: people diagnosed with a depressive episode at Wave 1 had high odds of an improvement in neurotic symptoms by Wave 2. This was not true, however, of people with panic disorder. The presence of panic disorder (and phobias too, although this did not reach significance) increased the odds of a deterioration in neurotic symptoms.

One item related to subjective wellbeing and functioning remained a significant predictor of a decline in mental health in the final model. People who reported not being able to think clearly at Wave 1 were more likely to experience a deterioration than people who did not report this problem.

Quality and number of social relationships: Two variables related to social dynamics remained independently significant in the final model. Reporting that one did not have people to provide support and encouragement was associated a six-fold increase in the odds of a deterioration in neurotic symptoms. Being close to a small number of people (just two or three) also predicted decline in mental health.

Although the variable did not reach statistical significance overall, there was a suggestion that lone parents were more likely to experience a deterioration in mental health during a JSA claim than people living in other types of household unit.

64 'Regression to the mean' refers to a statistical phenomenon where if a variable is extreme on the first measurement, it will tend to be closer to the average when it is measured a second time.

Threatening and traumatic life events: The strong predictive power that threatening and traumatic life events play in people's mental health trajectories highlights the critical role that home and other non-work contexts play in the wellbeing of unemployed people. Traumatic events include experiences such as:

- financial and housing crisis;
- violence and abuse;
- discrimination, difficulties with neighbours, friends, family and police.

Experience of different types of threatening and traumatic events were asked about in relation to the 12 months prior to the Wave 1 interview, and, in a reduce form, in relation to the four months between Waves 1 and 2. After the latter was controlled for, earlier experience of traumatic events did not reach significance in predicting a decline in mental health. However, the number of traumatic events experienced between the survey waves very strongly predicted deterioration in mental health. Having experienced three or more such events was associated with odds of a decline of 14. Experience of bullying was the type of event associated with the highest odds of a decline.

Neighbourhood characteristics: In the final model, people living in urban areas were more likely to experience a decline in mental health than people who live in rural areas. At earlier stages of the analysis the deprivation level of the area also was predictive, although it was no longer significant once other factors were controlled for.

7.3.2 Predictors of recovery in mental health

The variables retained in the final multivariate model are summarised below and detailed in Appendix D (along with the p values, odds ratios (OR) and the 95 per cent upper and lower confidence interval).

Table 7.3 Adjusted odds for an improvement in mental health[65] (decline in CIS-R score) between waves

Characteristics at Wave 1	Odds ratios	Significance
Number of trauma types in the 12 months prior to Wave 1		p = 0.003
5 or more	3.848	
3 or 4	4.808	
1 or 2	2.766	
0	1	
Number of types of trauma between Wave 1 and 2		p = 0.023
Financial crisis only	0.543	
Bullying only	0.867	
Serious illness only	1.121	
Illness/injury relative or friend	1.321	
2 or more traumatic events	0.634	
3 or more traumatic events	0.176	
No traumatic events	1	
Change in employment status between Wave 1 and 2		p = 0.132
Lost employment	0.662	
No change	0.659	
Entered employment	1	
CIS-R score		p < 0.001
12 or more	6.353	
0 to 11	1	
Depressive episode		p = 0.020
Present	2.984	
Not present	1	
Phobias		p = 0.035
Present	0.403	
Not present	1	
Panic disorder		p = 0.036
Present	0.238	
Not present	1	

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

Interpretation

The areas that predicted that someone's mental health was going to improve over the coming months were their:

- initial mental health;
- previous and ongoing experience of traumatic life events;
- finding work.

[65] Reference category= mental health stayed the same or deteriorated. Detailed results are provided in Appendix D.

Initial mental health: The strongest predictor (OR 6) of recovery was having had a CIS-R score of 12 or more at Wave 1. This is not surprising, because this group have the symptoms to improve. A similar pattern was observed for people meeting the criteria for a depressive episode. The prognosis for people presenting with depressive symptoms at the start of the claim appears quite positive – mental health changes with time and poor mental health is by no means necessarily a long-term sentence. People with depression at Wave 1 were more likely to experience an improvement than a deterioration in their mental health by Wave 2.

The same pattern, however, was not evident for anxiety disorders. Recent JSA claimants identified at Wave 1 with a phobia or panic disorder had much lower odds of experiencing improved neurotic symptoms than people without those disorders, even after their elevated CIS-R score was controlled for. Anxiety is clearly very damaging to mental health during a period of work search and labour market transition. Anxiety disorders are also less likely than general neurotic symptoms or depression to fluctuate over short time periods.

Threatening or traumatic events: Improvement in mental health was predicted by having experienced traumatic events before the Wave 1 interview. This suggests that people with such experiences tend to recover from them in time. However, if further traumatic events were experienced between Waves 1 and 2, then recovery became much less likely. People who had experienced three or more types of traumatic event between the Wave 1 and Wave 2 interview had very low odds (0.18) of an improvement in their mental health.

Entering employment: Overall, the change in employment variable did not quite reach statistical significance as a predictor of improvement in mental health ($p=0.132$). However, people who entered employment between Waves 1 and 2 did appear to have significantly higher odds for an improvement in mental health compared with those people who did not experience a change in their employment status.

8 Discussion

8.1 Revisiting the research questions

In Chapter 1, a number of research questions were set out. Drawing on the findings of this study, these questions are revisited here.

8.1.1 What factors in the transitions around unemployment contribute most to the onset of poor mental health?

The qualitive interviews identified that the transition into unemployment (which could happen at the same time as other adverse life events) was a major and damaging shift for people whose lives were generally stable, but another adversity among many for those had experienced multiple and longstanding problems over the course of their lives.

This study as a whole has shown that mental health is rooted in the context of people's wider lives. Home and other non-work factors are key predictors of whether or not someone will experience a decline in mental health after transitioning into unemployment. Poor physical health, low levels of social support, adverse life events, and neighbourhood context all play a role. However, entering employment again can support recovery.

8.1.2 How does individuals' job search activity and success vary with their mental health?

Job search activity did vary with mental health. Overall, people with a common mental disorder (CMD) had less confidence in their work-search abilities and sent out somewhat fewer job applications. The demands of work-search could be particularly challenging for people with anxiety disorders, such as phobias or panic disorder. However, generally people with CMD managed to tackle many of these issues, in part because employment was widely regarded by claimants as a way to improving mental health, especially for those with less entrenched problems. After other factors were controlled for mental health at status near the start of a Jobseeker's Allowance (JSA) claim did predict whether or not people managed to find work, although other factors were stronger predictors.

8.1.3 What experiences in the claims process and which individual characteristics and circumstances make people more vulnerable to the development of mental disorder and mental distress?

After starting a JSA claim, some people will go on to experience improvement or recovery in mental health and others will experience deterioration. Deterioration was most likely when people had little social support, where they continued to experience ongoing and multiple types of adversity in their lives, and when they lived in an urban environment. Feelings of stigma and shame about being unemployed and claiming benefits were widely described in the qualitative interviews. A reluctance to admit to mental health problems was also identified. However, claimants that managed to discuss their health with a Personal Adviser (PA) found this to be helpful.

People who started a JSA claim with an anxiety disorder were particularly likely to experience further deterioration in their general mental health while unemployed. In the qualitative interviews, specific cases were identified where a mental health condition affected a person's ability to adhere to the requirements of the benefit regime. More broadly, however, claimants reported the importance of being treated respectfully by staff at the Jobcentre and receiving personalised support.

8.1.4 What factors exacerbate existing mental health problems in people made unemployed?

Alongside the presence of anxiety disorders – which was prominent for predicting a deterioration in neurotic symptoms while experiencing the stresses and strains of unemployment – the other key factor exacerbating poor mental health was the continuing experience of traumatic events. In particular ongoing events such as bullying, financial crisis and serious physical illness were found to greatly reduce the likelihood of recovery.

8.1.5 What factors protect people who become unemployed from developing poor mental health?

Good quality social support and larger social networks were found to protect people from developing poor mental health. Being married or cohabitating with a partner was also a feature of this. However, the qualitiative findings also highlighted that while close relationships played a protective role, they could also trigger feelings of shame about the failure to provide and worry about being a burden. The presence of children in the household constituted a source of comfort and support, but made a return to work less likely and, for lone parents, also appeared to reduce the chances of mental health recovery,

8.1.6 What are the additional support needs of people with mental disorders who are seeking re-employment?

Claimants were generally very positive about any additional support, often informal, that they had received from PAs. It appears that, appropriately, PAs are more likely to discuss health and wellbeing where a claimant does indeed have a health problem.

Although the qualitative interviews were with people whose survey responses indicated that they may have mental health problems, this did not necessarily relate to individual's perceptions of themselves. This highlights that identifying claimants with mental health issues could be a challenge when attempting to target additional support.

People talked about the experience of being unemployed as a demoralising one which affected self-confidence and self-esteem. This study found that social support was key, both to re-employment and to mental health recovery. The face-to-face contact that claimants have at Jobcentres could, therefore, be of value in achieving both of these outcomes, particularly where people lack other sources of support.

8.2 Strengths and weaknesses of the study and issues of interpretation

8.2.1 Sample

This study relates to a specific cohort of JSA claimants: those who started a claim in the first quarter of 2011. Strengths include the fact that it is a probability sample, representative of Britain. This population, however, may become less generalisable to other job-seeking groups, especially at it is likely to have included more people with recent experience of sickness benefits (due to the introduction of Employment and Support Allowance (ESA)) and because of the introduction of the Work Programme.

The sample for qualitative interviewing was small, and this limited the scope of analysis due to the multiple factors identified which could mediate individual experiences of unemployment. Not having a comparison group of people without mental health problems restricted the ability to generalise from the findings.

8.2.2 Method

This study used a mixed method approach, benefiting from both two waves of interviews with a cohort representative of all recent JSA claimants and qualitative interviews with people identified with particular experience of stress. The survey questionnaires included a rigorous assessment of mental health, more detailed than that used on most general population surveys. It enables mental health to be examined both from a dimensional perspective (looking at severity of symptoms), and from a categorical approach (looking at different depressive and anxiety related disorders). This report has focused more on the measure of mental health severity. The survey questionnaire also covered many more aspects of claimants' lives than previous studies of this type have done.

The survey interviews were conducted by telephone. Strengths of this approach include having a non-clustered sample, but drawbacks include limitations on length and potential issues with comparing results from face-to-face surveys. The measures used in the questionnaire were selected so that comparisons could be made with data from other general population surveys, and this has enabled the study to situate the experience of recent JSA claimants into a wider context.

The qualitative sample was drawn from the survey participants, and so the sample selection could focus on people identified with symptoms of poor mental health and draw on detailed information about potential participants. Qualitative accounts explored experiences of unemployment in the context of other aspects of people's lives. It was not appropriate to recruit people on the premise that they had been diagnosed with a 'mental health disorder' – this was not how the Clinical Interview Schedule – Revised (CIS-R) score was intended to be used and could have misled or caused distress to participants.

8.2.3 Issues of interpretation

It is always important to avoid making causal inferences from observed associations. This is particularly pertinent in a survey that explores associations with mental health. Symptoms of CMD can include a generally negative view of the world and of interactions with it. This should be borne in mind as a factor confounding the association between presence of CMD and self-reported outcomes. Health selection is also likely to have played a part in the associations identified in this study.

8.3 Implications for policy and practice

There are many findings from this study with relevance for policy and practice, particularly in Jobcentre Plus.

Neurotic symptoms form a wide spectrum and are common among jobseekers. This partly stems from their wider adverse social and economic circumstances. It is important that the impact of this wider context is recognised by the staff who have contact with claimants. People with even relatively mild neurotic symptoms have lower confidence in their work-search abilities. Support aimed at improving perceptions of job search self-efficacy should be targeted widely, and not just at those with the most severe neurotic or other mental health symptoms. It may not be evident to staff which claimants have mild neurotic symptoms.

Some findings suggest that it may be beneficial to consider how best to bring up the issue of mental health and identify needs associated with mental health among claimants. People described reluctance to admitting to having mental health problems. However, where health was discussed with a PA this was generally found to be helpful, though its discussion was not widespread and there was evidence to suggest that health discussions tended to focus more on physical health problems.

The study points towards a number of individual characteristics which may indicate risk for claimants remaining on JSA for relatively longer periods of time or experiencing a decline in mental health. The characteristics that might indicate to a PA that someone needs additional support in order to enter employment include: being male, unmarried, living in a deprived area, lacking self-confidence in work-search abilities and having a child in the household. The warning signs indicating someone at risk of deterioration in mental health almost entirely relate to the non-work context (social support, and whether they are exposed to problems such as bullying or financial crisis). There may be a role for exploring health conditions (in particular, anxiety disorders like phobias and panic attacks) and wider social circumstances in more detail.

Being able to think clearly was an aspect of subjective wellbeing that predicted mental health trajectories during a JSA claim. People who reported difficulty with this had increased odds of a decline in mental health. This supports the importance of the support and discussion that takes place during interview with PAs. There may also be a role for referrals to cognitive behaviour counselling focused on ways to achieve goals.

8.4 The scale of the issue among jobseekers

Jobseekers were nearly twice as likely as people in the general population to have a severe neurotic symptoms for common mental disorders, that is, a level of symptoms almost certain to warrant treatment such as medication or talking therapy. Depressive symptoms can fluctuate, but anxiety disorders such as phobias and panic are more persistent, and in this study were associated with further deterioration in neurotic symptoms in the months that followed the start of a JSA claim.

There is evidence that CMDs, by their nature, erode beliefs about abilities and optimism about the future. And it is through this mechanism that CMDs are likely to contribute to poorer employment outcomes.

The difference between people who arrive on JSA with a long-term mental health condition and those who have recently developed one as a result of the life event that has put them on JSA is particularly striking and might also be something for policy-makers to consider.

Appendix A
Survey technical detail

The sample

Overview

The sample covered England, Wales and Scotland. It was drawn from the Department for Work and Pensions (DWP) administrative databases with a sample drawn from General Matching Service scans for three consecutive months. A list of named recipients who had recently commenced a Jobseeker's Allowance (JSA) claim was provided. There were no multiple recipient addresses in the sample file. The sample was designed to be representative of British JSA claimants aged 16-64. A sample of 5,000 JSA claimant addresses was drawn.

Drawing the sample

The sample was drawn from DWP General Matching Service scans for three consecutive months to ensure a list of recent claimants. Recipients with missing contact details (ten per cent) and those who have been previously sampled (six per cent) were excluded from the sample frame by DWP. Additional (but small) exclusions included those who were known to have deceased, be terminally ill, in prison or had provided a Jobcentre Plus address. Despite these exclusions this sample frame gives the most complete coverage of the JSA population available for research.

The sample was drawn in two stages: at the first stage a binary indicator of whether or not a recipient was in receipt of Employment and Support Allowance (ESA), Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) in the year prior to claiming JSA was created by DWP. This increased the representation of recipients with a history of mental illness.

The sample file for the ESA and non-ESA groups was sorted prior to sample selection. The stratifiers used were Government Office Region (GOR), sex and age. These variables were as at the date of extraction of claimant records, which were 7 January to 4 February 2011. There is a flag for ESA claimants that indicate whether or not their claim was primarily for a mental health problem, however, it was decided that this was not reliable enough to use in sampling (given the likelihood that mental health issues would either not be recorded or would be coded as secondary conditions).

The first stratifier was region; the ESA and non-ESA claimants were each sorted into 11 regions (nine GORs, with Scotland and Wales being treated as two separate regions). Within each of the regions, the claimants were then listed in increasing order of age and then by sex within this. Once the sampling frame had been stratified, 2,500 claimants were selected from each of the ESA and non-ESA groups, making a total sample size of 5,000.

At the second stage the sample profile was checked to ensure that it matched the population in terms of region, sex and age profile. Additional sample characteristics such as disability, partner and carer status, number of children in the household and highest qualification were also compared to the population to identify any potential sources of bias.

Claimants who had a start date that was three months or more before the extraction date were identified and removed from the sample (29 cases). This research is interested in identifying recent claimants of JSA; however, it can take a number of months to process a claim. This means that

any extract includes a proportion of 'older' cases that have recently been logged on the system but may have been receiving a claim for some months. It was important that the sample did not only reflect cases that are simple to process, therefore, a cut-off of three months prior to extraction was identified as a reasonable time-lag for processing claims which retained the majority of the sample but also ensured most cases were at a similar stage in their claims process. A further 52 cases were removed because they had obviously incomplete telephone numbers.

Finally, 4,400 recipients were selected from the remaining 4,919 using the same procedure as described at stage one to form the final issued sample.

Wave 1 survey pilot

Pilot aims

The aims of the pilot were to:

- Test the transference of the mental health assessment tool (the revised Clinical Interview Schedule, (CIS-R)) from face-to-face to telephone administration.
- Check feed forward of sample data, questionnaire filtering, question wording, response options, and interview length.
- Ensure the opt-out process, introduction, advance/thank you letter and voucher mailout, and other survey procedures work smoothly.
- Gather basic respondent perceptions of the study.

Pilot fieldwork

DWP drew a sample of 500 cases from administrative records. The purpose of drawing a larger sample than needed for the pilot fieldwork was to use this as an opportunity to test the sample specification by examining the distribution of selected cases by various characteristics and comparing with the profile of the wider JSA population. Eighty cases were issued for the pilot fieldwork. These were selected to represent addresses both within and outside of Wales (so that the process for producing the Welsh version of the advance letter could also be tested).

The advance letter was mailed out first class on DWP and NatCen headed letter paper in November 2010. Prior to this, DWP circulated a copy of the letter to Jobcentres so that staff were aware of the study and would be able to respond to any queries about it veracity.

Six interviewers (male and female) were briefed on the project at the NatCen Telephone Unit. The briefing was carried out by the Project Director. The DWP project manager attended and presented on the study background. Interviewers were provided with full written instructions. The interviewers covered a range of levels of experience. Three interviewers started work immediately after the briefing. The initial interviews were listened to by a supervisor. Interviewers were provided with pilot feedback forms to complete with comments and suggestions for improving the study procedures and questionnaire.

The pilot fieldwork took place between Tuesday 30 November and Monday 13 December 2010. Telephone numbers generally received up to 18 call attempts (one number with a series of broken appointments received 30). Call attempts were made on weekdays and weekends, and in mornings, afternoons and evenings.

The initial target had been to achieve 20 interviews, but in practice 31 full productive interviews (and one partial) were completed. Interviews were achieved in all countries (four in Wales), all GORs, and covered areas with a range of levels of local deprivation (from an Index of Multiple Deprivation (IMD) score of 2 through to 64).

A thank you letter, a helplines leaflet (with contact details for various national support groups) and a five pound high street voucher were sent to all productive participants.

Pilot recommendations

Overall, the survey procedures were found to work well and most participants were positive about taking part in the study and were glad of the token of appreciation. The questionnaire was found to be somewhat too long. A report submitted to DWP details all changes made to the sampling strategy, advance letter, and questionnaire as a result of the piloting.

Wave 1 survey fieldwork

Sample

DWP selected the sample from administrative records. The sample consists of named individuals of working age: women aged 16-59 and men aged 16-64 who started a claim for JSA within three months of the point of extraction from the database. England, Scotland and Wales were covered (the advance letter sent to addresses in Wales included a Welsh translation on the back).

The sample was selected to overrepresent people who were previously in receipt of ESA/IB (benefits that people get if they are assessed as in very poor health, including in poor mental health). So about half the sample had come from recent job loss or another non-benefit activity, and about half from a health related benefit for people out of work (ESA/IB). See Appendix A for more detail on the sampling strategy.

Advance letter and survey leaflet

An advance letter was sent on DWP headed paper to the selected cases. A survey leaflet was enclosed and the letter included a link to the survey website for further information. The opportunity to opt out of the survey in advance of an interviewer making contact, either by contacting DWP or NatCen, was offered.

Interviewer briefings and fieldwork

The researchers ran two half day interviewer briefings at NatCen Social Research's Telephone Unit in March 2011. Fieldwork started on the day of briefing. Fieldwork continued for eight weeks. Some addresses were contacted up to sixteen times in an attempt to make contact or due to missed appointments. The interview was a medium average of 35 minutes, and a wide range in length from 20 minutes up to 70 minutes. This was longer than the pilot in part because the small achieved sample on the pilot had better mental health than the main stage sample. The variation in length was expected as the questionnaire is heavily filtered. The longer interviewers tended to be with people with more mental health symptoms.

Permission for re-contact and data linkage

At the end of the interview all participants were asked for two permissions. The first was for permission to re-contact them in a few months time about the next stage of the research. The other permission sought was for data linkage. The wording used for these is given below. The proportion of participants agreeing to these is given in Table A3.

Permission for re-contact:

'Later on, we will be carrying out a final stage to this research. Would it be okay if one of our interviewers was to contact you about this nearer the time, to ask if you would like to take part? As a thank you, you would receive another high street voucher.'

Permission for data linkage:

'And finally, we can learn more about how helpful the services offered through Jobcentre Plus are if you give permission for the Department for Work and Pensions to combine your answers with administrative details they hold now (or in the future).'

'This would never affect any past, current or future claim you might have for benefits and, after linking, your name would not be held with the information so you would not be identified. It would be entirely confidential. Are you willing to allow us to join the information in this way?'

Interviewer – draw on if asked for more details:

We can get accurate dates of your benefit claims from DWP records. We could have asked you about this in the interview, but it would have taken time and remembering details of dates and types of benefit can be difficult. We hope to use two sources of information, although other information may be available in the future. One records who is receiving benefit, such as JSA or IB, and when they claimed it.

Thank you letter, helpline leaflet, and voucher

A thank you letter, a helplines leaflet (with contact details for various national support groups) and a five pound high street voucher were sent to all productive participants. The thank you letter specified whether or not the respondent had agreed to data linkage and/or re-contact for Wave 2. Instructions were given in case they wished to change their mind.

Ethical protocols and data security

Interviewer instructions and briefings included information on responding to any incidents that might occur (including the importance of reporting these to researchers) and ensuring that respondent data security and confidentiality protocols were strictly adhered to.

The advance letter, survey leaflet, helplines leaflet, thank you letters, and the wording of the data linkage permission request were all reviewed by the DWP.

Survey questionnaire coverage

The Wave 1 questionnaire collected data on:

- mental health, using a substantial structured assessment tool called the CIS-R and general wellbeing;
- work history, including perceived balance between effort and reward in the most recent job;
- risk and protective factors (recent traumatic events, financial strain, social support);
- use of treatment and services (such as health and social care services and treatment);
- partnership status, children and caring responsibilities; and
- permission to re-contact (for the Wave 2 survey or the qualitative interview) and for data linkage.

The questionnaire consisted of the following 14 modules. More details about specific scales and measures in the questionnaire are provided in Appendix C.

Table A.1 Wave 1 survey questionnaire coverage

Module	Topic
1	Respondent identification and survey introduction
2	Initial background details
3	Current activity and work history
4	Characteristics of current/last job (using the Effort Reward Imbalance Model)
5	Work-search activities, self-confidence and self-efficacy
6	Contact with Jobcentre Plus during current/most recent JSA claim
7	Health, disability and treatment and service use
8	Diagnosis of common mental disorders – revised Clinical Interview Schedule
9	Wellbeing Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and ONS WB questions
10	Stressful life events – The List of Threatening Experiences (LTE) questionnaire
11	Social support networks
12	Debt and financial strain
13	Socio-demographics
14	Permission for data linkage and re-contact

The Wave 2 survey questionnaire covered the same range of topics, but was shorter.

Wave 1 response rate

Two versions of the response rate calculation are presented below. The key difference is that in response version one, contact detail quality impacts on the response rate achieved. For response rate version two, numbers that were technically impossible for the Telephone Unit to achieve, for example because they did not exist or had been disconnected, were counted as 'out of scope'. The first response rate gives a better indication of issued sample coverage, while the second response rate gives a better indication of field work performance. The weights were able to address bias resulting from non-response.

Table A.2 Wave 1 survey response (with and without adjustment for contact detail quality)

	Response v1[a]		Response v2[b]	
	Bases	%	*Bases*	%
Total sample issued to TU	*4,399*		*4,399*	
Out of scope (died/institution)	*11*		*718*	
Unable (language/hospital/ill)	*200*		*200*	
In scope	*4,188*	100	*3,481*	100
Refusal	*896*	21	*896*	26
Non-contact	*1,213*	29	*506*	15
Productive	*2,079*	50	*2,079*	60

[a] This version of response calculation includes all cases that were not technically possible to achieve (number doesn't exist, disconnected, fax number etc.) to 'non-contact'.

[b] This version of response calculation assigned cases that were not technically possible to achieve (number doesn't exist, disconnected, fax number etc.) to 'out of scope'.

With full and partial participants combined, 2,079 productive participants were achieved.[66] The great majority gave permission for NatCen to re-contact them about Wave 2 of the survey (90 per cent) and for DWP to link their survey responses to administrative data (87 per cent).

Table A.3 Wave 1 survey response: partials and permissions

	n	%
Fully productive[a]	*2,004*	96
Partial productive	*75*	4
Agreement to re-contact for Wave 2	*1,875*	90
Agreement to data linkage	*1,806*	87

[a] For a case to count as productive, the CIS-R had to be completed. If it was not, the case was coded as a refusal and excluded from subsequent analysis.

The development of selection weights

The sample was stratified by JSA recipients who had transitioned from ESA, IB or SDA and those who had not. Recipients who had transitioned from such a benefit were, therefore, over-represented in the sample. This meant that they had a higher chance of selection than they would have done had a simple random sample been taken from the JSA population. An individual selection weight is required to correct this. This weight is equivalent to the number of eligible JSA recipients.

Modelling non-response to Wave 1

The response behaviour of the sample members was modelled using logistic regression and the results of the model were used to generate a non-response weight. A number of area level variables and individual characteristics were used to predict whether or not an individual took part in the

[66] Fifteen cases initially coded as productive, on investigation did not complete the CIS-R block and so have been reassigned as refusals.

survey. Area level variables include the 2010 IMD, urban/rural indicators[67], GOR[68], data from the 2001 Census and individual characteristic information provided by DWP.

The area-level census variables included in the modelling were percentage of:

- Population from a minority ethnic background.
- Population in non-manual occupations.
- Households council rented.
- Households private rented.
- Households owner occupied.
- Households not owning a car.

The variables provided by DWP and included in the modelling were whether or not the individual:

- Had a partner.
- Had any children.
- Was a carer.
- Was an ESA recipient.
- Was a Disability Living Allowance (DLA) recipient.
- Was an IB recipient.
- Has a mental health flag from a previous benefit.
- Has claimed ESA, IB or SDA in the previous 12 months.

The logistic regression model generates the probability of a case participating in the survey given their characteristics (based on the predictor variables). The non-response weights are then calculated as the inverse of the predicted probabilities. Hence participants who had characteristics associated with being reluctant to take part will have a smaller probability of being a respondent and a larger weight. Not all the variables used in the analysis made it into the final model. Variables not strongly related to an individual's propensity to respond to this survey were dropped from the analysis. The variables included in the final model are given in Table A.4.

67 Urban/rural indexes exist for England and Wales and Scotland consequently the variable included in the model is derived by combining both indexes.

68 Ten GORs were used in the weighting while nine were used for the sampling, as the characteristics of inner and outer London are likely to differ substantially (which would effect the weights attained).

Table A.4 The Wave 1 response model

	B	S.E.	Wald	df	Sig.	Exp(B)
% IMD quintiles			15.06	4	.00	
1 (least)	.21	.13	2.82	1	.09	1.23
2	.31	.11	8.62	1	.00	1.37
3	.09	.09	1.01	1	.31	1.10
4	.27	.09	10.01	1	.00	1.31
5 (most)					Baseline	
Age group			45.32	4	.00	
16-24	-.63	.13	22.26	1	.00	.53
25-34	-.64	.14	21.77	1	.00	.53
35-44	-.49	.14	12.24	1	.00	.61
45-54	-.16	.14	1.24	1	.27	.85
55-64					Baseline	
Gender (male)			24.15	1	.00	
Gender (female)	.33	.07	24.15	1	.00	1.40
Not receiving DLA			4.94	1	.03	
Receiving DLA	-.43	.19	4.94	1	.03	.65
Constant	.77	.23	11.22	1	.00	2.15

Notes to table:

1 The response is 1 = household responding to the survey, 0 = non response.

2 Only variables that are significant at the 0.05 level are included in the model.

3 The model R^2 is 0.024 (Cox and Snell).

4 B is the estimate coefficient with standard error S.E.

5 The Wald-test measures the impact of the categorical variable on the model with the appropriate number of degrees of freedom df. If the test is significant (sig < 0.05) then the categorical variable is considered to be 'significantly associated' with the response variable and, therefore, included in the model.

6 The Wald test for each level of the categorical variable is also shown. This tests the difference between that level and the baseline category.

Variables related to response were: IMD quintiles, age, sex, and receipt of DLA. Response was lowest for individuals living in deprived areas and among younger participants. Response was higher if among people who were older, female and not receiving DLA.

The non-response weights were combined with the selection weights to create the final non-response weight.

Calibration weights

The final stage of the weighting was to adjust the final non-response weights so the weighted sample matches the population in terms of age, sex and region. The data has been weighted to match to the British JSA claimant population. Population figures were provided by DWP with the sample. We weighted to the marginal age, sex and GOR distributions using raking-ratio (or rim) weighting.

Table A.5 Achieved sample sizes unweighted and weighted

	Unweighted achieved sample	Achieved sample weighted by NR and selection weight	Achieved sample weighted by final weight	JSA Population aged 16-64[1]
Age group				
16-24	28.8	38.0	37.9	37.9
25-34	21.2	23.5	24.6	24.6
35-44	20.0	17.7	17.7	17.7
45-54	20.4	14.5	14.0	14.0
55-64	9.6	6.3	5.8	5.8
Sex				
Male	60.3	64.4	65.7	65.7
Female	39.7	35.6	34.3	34.3
Government Office Region				
North East	5.9	5.6	5.7	5.4
North West	14.0	13.1	13.0	13.5
Yorkshire and Humber	8.9	9.3	9.4	10.3
East Midlands	7.2	7.4	7.4	6.8
West Midlands	8.7	8.3	8.3	9.7
South West	8.0	7.6	7.6	7.0
East of England	8.4	8.7	8.7	8.0
London	12.0	12.8	12.8	13.0
South East	9.9	10.8	10.8	10.2
Wales	5.4	5.4	5.4	5.1
Scotland	11.7	11.0	11.0	11.0
Total	2,094	2,094	2,094	287,334

[1] Population figures are from DWP extract as at January 2011.

There is only one level of weighting as only one person is selected per household; therefore, only an individual level weight is required. The weighted data exactly matches the population in terms of the calibration variables. The calibration weight is the final non-response weight to be used in any analysis of the Wave 1 survey data. This weight has been scaled to the final responding sample size.

Modelling non-response to Wave 2

All participants who agreed to be re-contacted at Wave 1 were invited to participate in the second stage of data collection. The response behaviour of the sample members to the follow-up was modelled using logistic regression and the results of the model were used to generate a second non-response weight.

A stepwise logistic regression model was used to determine which of the area, and area level census variables listed above were significant predictors of response to Wave 2. An advantage of using a

longitudinal design is that complete survey data is available from the Wave 1 data collection which provides additional information about the responders and non-responders. Therefore, the significant geographic variables were fixed in the model and a further stepwise logistic regression run to establish which individual characteristics or survey variables were indicative of response.
The following survey estimates were considered in the model:

- Age group.
- Gender.
- Ethnicity.
- Marital status.
- Number of adults and children in the household (derived and grouped).
- Highest educational qualification (derived – six levels).
- Age left education.
- Housing tenure.
- Occupational group.
- Whether done any paid work in the last seven days.
- If partner in the household, whether they are in paid work.
- Satisfaction with life.
- Social support (DLSS7).
- Stressful life events in last six months (derived and grouped).

The variables included in the final model are given in Table A.6.

Table A.6 The Wave 2 response model

	B	S.E.	Wald	df	Sig.	Exp(B)
% of households owner occupied (quintiles)			9.11	4	0.06	
1 (least)	-0.04	0.16	0.06	1	0.80	0.96
2	-0.13	0.15	0.71	1	0.40	0.88
3	-0.05	0.15	0.13	1	0.72	0.95
4	0.31	0.15	4.14	1	0.04	1.36
5 (most)					Base line	
Age group			41.42	4	0.00	
16-24	-1.05	0.20	27.07	1	0.00	0.35
25-34	-1.08	0.21	27.20	1	0.00	0.34
35-44	-0.67	0.21	10.44	1	0.00	0.51
45-54	-0.48	0.20	5.48	1	0.02	0.62
55-64						
Urban/rural indicator			5.86	3	0.12	
Urban >=10k	0.19	0.41	0.22	1	0.64	1.22

Continued

Table A.6 Continued

	B	S.E.	Wald	df	Sig.	Exp(B)
Town and fringe	0.03	0.44	0.01	1	0.94	1.03
Village	0.76	0.48	2.50	1	0.11	2.15
Hamlet and isolated dwelling					Base line	
Not London			6.98	1	0.01	
London	0.39	0.15	6.98	1	0.01	1.48
Household type			2.64	2	0.27	
Two adults and child/ren	0.16	0.12	1.82	1	0.18	1.17
One adult and child/ren	0.24	0.22	1.19	1	0.28	1.27
Adult/s only					Base line	
There are people who give me support and encouragement			6.14	2	0.05	
Not true	0.31	0.23	1.84	1	0.17	1.36
Partly true	0.29	0.13	4.93	1	0.03	1.34
Certainly true					Base line	
Highest qualification			85.14	6	0.00	
Degree	0.86	0.19	20.10	1	0.00	2.36
Teaching, HND, Nursing	0.10	0.23	0.18	1	0.67	1.10
A-Level	0.59	0.19	9.05	1	0.00	1.80
GCSE or equivalent	0.32	0.12	6.60	1	0.01	1.37
Foreign or other qualification	0.19	0.18	1.14	1	0.29	1.21
Item missing data	-1.89	0.29	42.77	1	0.00	0.15
No qualifications					Base line	
Spoken to a GP or family doctor in the last 12 months			9.61	1	0.00	
No	0.33	0.11	9.61	1	0.00	1.39
Health problem or disability that affects ability to work			5.95	1	0.01	
No	-0.31	0.13	5.95	1	0.01	0.74
Not receiving DLA			2.20	1	0.14	
Receiving DLA	-0.41	0.28	2.20	1	0.14	0.66
Not receiving ESA			1.98	1	0.16	
Receiving ESA	0.15	0.10	1.98	1	0.16	1.16
Constant	0.61	0.56	1.20	1	0.27	1.85

Notes to table:

1 The response is 1 = household responding to the survey, 0 = non response.

2 Only variables that are significant at the 0.05 level are included in the model.

3 The model R^2 is 0.095 (Cox and Snell).

4 B is the estimate coefficient with standard error S.E.

5 The Wald-test measures the impact of the categorical variable on the model with the appropriate number of degrees of freedom df. If the test is significant (sig < 0.05) then the categorical variable is considered to be 'significantly associated' with the response variable and, therefore, included in the model.

6 The Wald test for each level of the categorical variable is also shown. This tests the difference between that level and the baseline category.

Variables related to Wave 2 response were: proportion of owner occupied housing, age group, rural/urban character, whether or not the household is in London, family support, household type, highest qualifications, GP contact, health/disability affecting ability to work, receipt of ESA and receipt of DLA. Response was lowest for individuals who had missing qualification data at Wave 1 and among younger participants. Response was higher among individuals with higher qualifications, living in rural less deprived areas and receiving ESA.

The non-response weights were combined with the Wave 1 weight (accounting for selection and non-response) to create the final non-response weight.

Effective sample size

The effect of the sample design on the precision of survey estimates is indicated by the effective sample size (neff). The effective sample size measures the size of an (unweighted) simple random sample needed to provide the same precision (standard error) as the design being implemented. If the effective sample size is close to the actual sample size then we have an efficient design with a good level of precision. The lower the effective sample size is the lower the level of precision. The efficiency of a sample is given by the ratio of the effective sample size to the actual sample size. The effective sample size of this sample is 719, with an efficiency of 56 per cent.

Appendix B
Assessment of common mental disorders

B.1 Common mental disorders

This appendix details the process undertaken to:

- Calculate Clinical Interview Schedule – Revised (CIS-R) symptom scores.
- Calculate the total CIS-R scores.
- Apply algorithms for production of ICD-10 diagnoses; and
- Group ICD-10 diagnoses into broad categories.

B1.1 Description of the CIS-R derived neurotic symptoms

The CIS-R comprises 14 sections, each covering a particular area of neurotic symptoms as follows:

- Somatic symptoms – are characterised by a physical ache or pain/discomfort that cannot be attributed to a medical condition or to the use of drugs. Somatic symptoms often interfere significantly with a person's ability to perform important activities.
- Fatigue – the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax. A variety of other unpleasant physical feelings is common, such as dizziness, tension headaches, and feelings of general instability.
- Concentration and forgetfulness – this includes the inability to concentrate without the mind wandering and forgetting something important to the extent that it interferes with a person's ability to perform daily activities.
- Sleep problems – are characterised by a disturbance in the person's amount of sleep, quality or timing of sleep, or in behaviours or physiological conditions associated with sleep.
- Irritability – is associated with feeling short tempered and angry to the extent that it results in arguments or quarrels.
- Worry about physical health – this is defined by feelings of worry about a physical/serious physical illness to the extent that an individual is unable to take their mind off their health worries.
- Depression – is characterised by a lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common.
- Depressive ideas – are characterised by loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts are common.
- Worry – is associated with a persistent feeling of worry about things (other than physical health).

- **Anxiety** – is defined as generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances. The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness, and discomfort.
- **Phobias** – are a group of disorders in which anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous. As a result, these situations are characteristically avoided or endured with dread. Individual symptoms include palpitations or feeling faint and are often associated with secondary fears of dying, losing control, or going mad.
- **Panic** – the essential feature is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances and are, therefore, unpredictable. The dominant symptoms include sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality.
- **Compulsions** – are repetitive, purposeful and ritualistic behaviours or mental acts, performed in response to obsessive intrusion and to a set of rigidly prescribed rules.
- **Obsessions** – are defined as recurrent and persistent thoughts, impulses or images that are intrusive and inappropriate and cause anxiety or distress.

Neurotic symptoms are not reported on in this report.

B.2 Calculation of CIS-R symptom scores

Calculation of symptom score for somatic symptoms

Score one for each of:

- Noticed ache or pain/discomfort for four days or more in the past seven days.
- Ache or pain/discomfort lasted more than three hours on any day in the past week/on that day.
- Ache or pain/discomfort has been very unpleasant in the past week.
- Ache or pain/discomfort has bothered you when you were doing something interesting in the past week.

Calculation of symptom score for fatigue

Score one for each of:

- Felt tired/lacking in energy or four days or more in the past seven days.
- Felt tired for more than three hours in total on any day in past week.
- Felt so tired/lacking in energy that you've had to push yourself to get things done on at least one occasion during the past week.
- Felt tired/lacking in energy when doing things you enjoy or used to enjoy at least once during past week.

Calculation of symptom score for concentration and forgetfulness

Score one for each of:

- Noticed problems with concentration/memory for four days or more in the past week.
- Could not always concentrate on a TV programme, read a newspaper article or talk to someone without mind wandering in past week.

- Problems with concentration actually stopped you from getting on with things you used to do or would like to do.
- Forget something important in past seven days.

Calculation of symptom score for sleep problems

Score one for each of:

- Had problems with sleep for four nights or more out of past seven.
- Spent at least a quarter of an hour trying to get to sleep on the night with least sleep in the past week.
- Spent at least one hour trying to get to sleep on the night with the least sleep.
- Spent three or more hours trying to get to sleep on four nights or more in the past week.
- Slept at least for a quarter of an hour longer than usual sleeping on the night you slept longest.
- Slept for one hour or more longer than usual sleeping on the night you slept longest.
- Slept for more than three hours longer than usual on four nights or more in past week.

Calculation of symptom score for irritability

Score one for each of:

- Felt irritable or short tempered/angry on four days or more.
- Felt irritable or short tempered/angry for more than one hour on any day in past week.
- Felt so irritable or short tempered/angry that you wanted to shout at someone in past week (even if you hadn't actually shouted).
- Had arguments, rows or quarrels or lost your temper with someone in past seven days and felt it was unjustified on at least one occasion.

Calculation of symptom score for worry about physical health

Score one for each of:

- Worried about physical health/serious physical illness on four days or more in past seven days.
- Felt that you had been worrying too much, in view of actual health.
- Worrying had been very unpleasant in past week.
- Not able to take mind off health worries at least once by doing something else in past week.

Calculation of symptom score for depression

Score one for each of:

- Unable to enjoy or take an interest in things as much as usual in past week.
- Felt sad, miserable or depressed/unable to enjoy or take an interest in things on four days or more in the past week.
- Felt, sad, miserable or depressed/unable to enjoy or take an interest in things for more than three hours in total on any day in past week.
- When sad, miserable or depressed you did not become happier when something nice happened, or when in company.

Calculation of symptom score for depressive ideas

Score one for each of:

- Felt guilty or blamed yourself when things went wrong when it hasn't been your fault at least once in past seven days.
- Felt that you are not as good as other people during past week.
- Felt hopeless, for instance about your future, during the past seven days.
- Felt that life isn't worth living in past week.
- Thought of killing yourself in the past week.

Calculation of symptom score for worry

Score one for each of:

- Been worrying about things other than physical health on four or more days out of past seven days.
- Have been worrying too much in view of your circumstances.
- Worrying has been very unpleasant in past week.
- Have worried for more than three hours in total on any of past seven days.

Calculation of symptom score for anxiety

Score one for each of:

- Felt generally anxious/nervous/tense on four or more of past seven days.
- Anxiety/nervousness/tension has been very unpleasant in past week.
- When anxious/nervous/tense, have had one or more of following symptoms:
  - heart racing or pounding;
  - hands sweating or shaking;
  - feeling dizzy;
  - difficulty getting your breath;
  - butterflies in your stomach;
  - dry mouth; or
  - nausea or feeling as though you wanted to vomit.
- Felt anxious/nervous/tense for more than three hours in total in any one of past seven days.

Calculation of symptom score for phobias

Score one for each of:

- Felt nervous/anxious about (situation/thing) four or more times in past seven days.
- On occasions when felt anxious/nervous/tense, had one or more of the following symptoms:

  - heart racing or pounding;
  - hands sweating or shaking;
  - feeling dizzy;
  - difficulty getting your breath;
  - butterflies in your stomach;
  - dry mouth; or
  - nausea or feeling as though you wanted to vomit.
- Avoided situation or thing because it would have made you anxious/nervous/tense once in past seven days.
- Avoided situation or thing four times or more because it would have made you anxious, nervous or tense.

Calculation of symptom score for panic

Score one for each of:

- Anxiety or tension got so bad you got in panic (e.g. felt that you might collapse or lose control unless you did something about it) once in past week.
- Anxiety or tension got so bad you got in panic more than once.
- Feelings of panic have been very unpleasant or unbearable in past week.
- This panic/worst of these panics lasted longer than ten minutes.

Calculation of symptom score for compulsions

Score one for each of:

- Found yourself doing things over again (that you had already done) on four days or more in past week.
- Have tried to stop repeating behaviour/doing these things over again during past week.
- Repeating behaviour/doing these things over again made you upset or annoyed with yourself in past week.
- Repeated behaviour three or more times during past week.

Calculation of symptom score for obsessions

Score one for each of:

- Unpleasant thoughts or ideas kept coming into your mind on four days or more in past week.
- Tried to stop thinking any of these thoughts in past week.
- Became upset or annoyed with yourself when you have had these thoughts in past week.
- Longest episode of having such thoughts was a quarter of an hour or longer.

B.3 Calculation of total CIS-R scores

The total CIS-R score used in this report was obtained by summing the symptom scores described above. This total score reflects the overall severity neurotic symptoms and can range from zero to 57. For the presentation of data in this report the scores are grouped into four groups: 0-5; 6-11; 12-17; 18 and over. A score of 12 and over indicates significant levels of neurotic symptoms and can be considered the threshold score for assigning an assessment of neurotic disorder. A score of 18 and over suggests a level of symptoms likely to require treatment.

B.4 Algorithms for production of ICD-10 diagnoses

The common mental disorders reported in Chapter 2 were also derived from responses to the CIS-R schedule. The production of the six categories of disorder occurred in two stages: first, the participants' responses to the CIS-R were used to produce specific ICD-10 diagnoses of neurosis. This was done by applying the algorithms described below. Second, the range of ICD-10 diagnoses were grouped together to produce the six categories used in the calculation of prevalence.

F32.00 Mild depressive episode without somatic symptoms

1 Symptom duration ≥2 weeks

2 Two or more from:
- depressed mood
- loss of interest
- fatigue

3 Two or three from:
- reduced concentration
- reduced self-esteem
- ideas of guilt
- pessimism about future
- suicidal ideas or acts
- disturbed sleep
- diminished appetite

4 Social impairment

5 Fewer than four from:
- lack of normal pleasure/interest
- loss of normal emotional reactivity
- a.m. waking ≥2 hours early
- loss of libido
- diurnal variation in mood
- diminished appetite

- loss of body weight
- psychomotor agitation
- psychomotor retardation

F32.01 Mild depressive episode with somatic symptoms

1 Symptom duration ≥2 weeks

2 Two or more from:
   - depressed mood
   - loss of interest
   - fatigue

3 Two or three from:
   - reduced concentration
   - reduced self-esteem
   - ideas of guilt
   - pessimism about future
   - suicidal ideas or acts
   - disturbed sleep
   - diminished appetite

4 Social impairment

5 Four or more from:
   - lack of normal pleasure/interest
   - loss of normal emotional reactivity
   - a.m. waking ≥2 hours early
   - loss of libido
   - diurnal variation in mood
   - diminished appetite
   - loss of body weight
   - psychomotor agitation
   - psychomotor retardation

F32.10 Moderate depressive episode without somatic symptoms

1 Symptom duration ≥2 weeks

2 Two or more from:
   - depressed mood
   - loss of interest
   - fatigue

3 Four or more from:
   - reduced concentration
   - reduced self-esteem
   - ideas of guilt
   - pessimism about future
   - suicidal ideas or acts
   - disturbed sleep
   - diminished appetite
4 Social impairment
5 Fewer than four from:
   - lack of normal pleasure/interest
   - loss of normal emotional reactivity
   - a.m. waking ≥2 hours early
   - loss of libido
   - diurnal variation in mood
   - diminished appetite
   - loss of body weight
   - psychomotor agitation
   - psychomotor retardation

F32.11 Moderate depressive episode with somatic symptoms

1 Symptom duration ≥2 weeks
2 Two or more from:
   - depressed mood
   - loss of interest
   - fatigue
3 Four or more from:
   - reduced concentration
   - reduced self-esteem
   - ideas of guilt
   - pessimism about future
   - suicidal ideas or acts
   - disturbed sleep
   - diminished appetite

4 Social impairment

5 Four or more from:

- lack of normal pleasure/interest
- loss of normal emotional reactivity
- a.m. waking ≥2 hours early
- loss of libido
- diurnal variation in mood
- diminished appetite
- loss of body weight
- psychomotor agitation
- psychomotor retardation

F32.2 Severe depressive episode

1 All three from:

- depressed mood
- loss of interest
- fatigue

2 Four or more from:

- reduced concentration
- reduced self-esteem
- ideas of guilt
- pessimism about future
- suicidal ideas or acts
- disturbed sleep
- diminished appetite

3 Social impairment

4 Four or more from:

- lack of normal pleasure/interest
- loss of normal emotional reactivity
- a.m. waking ≥2 hours early
- loss of libido
- diurnal variation in mood
- diminished appetite
- loss of body weight
- psychomotor agitation
- psychomotor retardation

F40.00 Agoraphobia without panic disorder

1 Fear of open spaces and related aspects: crowds, distance from home, travelling alone
2 Social impairment
3 Avoidant behaviour must be prominent feature
4 Overall phobia score ≥2
5 No panic attacks

F40.01 Agoraphobia with panic disorder

1 Fear of open spaces and related aspects: crowds, distance from home, travelling alone
2 Social impairment
3 Avoidant behaviour must be prominent feature
4 Overall phobia score ≥2
5 Panic disorder (overall panic score ≥2)

F40.1 Social phobias

1 Fear of scrutiny by other people: eating or speaking in public etc.
2 Social impairment
3 Avoidant behaviour must be prominent feature
4 Overall phobia score ≥2

F40.2 Specific (isolated) phobias

1 Fear of specific situations or things, e.g. animals, insects, heights, blood, flying etc.
2 Social impairment
3 Avoidant behaviour must be prominent feature
4 Overall phobia score ≥2

F41.0 Panic disorder

1 Criteria for phobic disorders not met
2 Recent panic attacks
3 Anxiety-free between attacks
4 Overall panic score ≥2

F41.1 Generalised anxiety disorder

1 Duration ≥6 months
2 Free-floating anxiety
3 Autonomic over-activity
4 Overall anxiety score ≥2

F41.2 Mixed anxiety and depressive disorder

1 (Sum of scores for each CIS-R section) ≥12

2 Criteria for other categories not met

F42 Obsessive-compulsive disorder

1 Duration ≥2 weeks

2 At least one act/thought resisted

3 Social impairment

4 Overall scores: obsession score=4, or compulsion score=4, or obsession + compulsion scores ≥6.

B.5 Grouping ICD-10 diagnoses into broad categories

Depression

As with the preceding survey, F32.00 and F32.01 were grouped to produce mild depressive episode (i.e. with or without somatic symptoms). F32.10 and F32.11 were similarly grouped to produce moderate depressive episode. Mild depressive episode, moderate depressive episode and severe depressive episode (F32.2) were then combined to produce the final category of depressive episode.

Phobias

The ICD-10 phobic diagnoses F40.00, F40.01, F40.1 and F40.2, were combined into one category of phobia.

Categories for analysis

This process produced six categories of CMD for analysis:

- Mixed anxiety and depressive disorder.
- Generalised anxiety disorder.
- Depressive episode.
- Phobias.
- Obsessive-compulsive disorder.
- Panic disorder.

Appendix C
Scales and measures used

C.1 Wellbeing measures

C1.1 Short Warwick Edinburgh Mental Wellbeing Scale

The Warwick Edinburgh Mental Wellbeing Scale[69] (WEMWBS) was developed in recent years for assessing positive mental health (mental wellbeing). The short version[70] (SWEMWBS) used in Waves 1 and 2 of the survey consists of a seven positively worded item scale with five response categories. It covers most aspects of positive mental health (positive thoughts and feelings) currently in the literature, including both hedonic and eudaimonic perspectives.

Warwick Edinburgh Mental Wellbeing Scale – short version

I am going to read out some statements about feelings and thoughts. Can you tell me how much of the time over the last two weeks you have experienced each?

How much of the time over the last two weeks have you been...

Optimistic about the future?

Feeling useful?

Feeling relaxed?

Dealing with problems well?

Thinking clearly?

Feeling close to other people?

Able to make up your own mind about things?

Response options available were:

1 None of the time

2 Rarely

3 Some of the time

4 Often

5 All of the time?

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69 Tennant, R., Hiller, L., Fishwick, R., Platt, P., Joseph, S., Weich, S., Parkinson, J., Secker, J. and Stewart-Brown, S. (2007). *The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation*. Health and Quality of Life Outcome; 5:63.

70 Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) NHS Health Scotland, University of Warwick and University of Edinburgh, 2007, all rights reserved. http://www.healthscotland.com/documents/5238.aspx

C1.2 ONS wellbeing measures

Subjective wellbeing was also measured using the four items developed as part of the Office for National Statistics (ONS) programme Measuring National Wellbeing[71]. The programme aims to develop wellbeing indicators for inclusion in population monitoring. These four questions are currently still regarded as 'experimental', and so are subject to change. Methodological question testing and development continues.

ONS subjective wellbeing core items

For each of the following questions I would like you to give an answer on the scale 0 to 10, where 0 is 'not at all' and 10 is 'completely'.

- Overall, how satisfied are you with your life nowadays? (where 0 is 'not at all' satisfied and 10 is 'completely satisfied').
- Overall, how worthwhile do you feel are the things that you do in your life? (where 0 is 'not at all' worthwhile and 10 is 'completely worthwhile').
- Overall, how happy did you feel yesterday? (where 0 is 'not at all' happy and 10 is 'completely happy').
- On a scale where 0 is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

C.2 Self-efficacy measures

The Job Search Self-Efficacy Scale

The Job Search Self-Efficacy (JSSE) Scale is a six-item measure designed by the University of Michigan specifically for their JOBS intervention project.[72] Participants were asked to rate, on a 5 point Likert scale, how confident they are with specific job seeking behaviours such as making the best impression and getting points across in an interview, completing a good job application and résumé and three questions investigating confidence in speaking with various contacts regarding job openings. The scale categories range from 'not at all confident' through to 'a great deal confident'. Scores are summed and a mean score obtained to create a job search self-efficacy index with a higher mean indicating greater personal confidence in gaining employment.[73] It has been validated.[74]

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71 ONS (2011). *Initial investigation into Subjective Wellbeing from the Opinions Survey*. Office for National Statistics Report. http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/investigation-of-subjective-well-being-data-from-the-ons-opinions-survey/index.html

72 Vinokur, A.D., Schul, Y., Vuori, J. and Price, R.H. (2000). Two years after a job loss: Long-term impact of the JOBS program on reemployment and mental health. *Journal of Occupational Health Psychology*, 5 (1), 32-47.

73 Vinokur, A.D., Price, R.H. and Schul, Y. (1995). Impact of the JOBS intervention on unemployed workers varying in risk for depression. *American Journal of Community Psychology* 23, 39-74.

74 Christianson, J., Ingram, J., Foster, C. and Neighbors, D. (2007). Psychometric properties of the Job Search Self-Efficacy Scale. *Job-Search Self-Efficacy Scale (JSSES)*.

The Job Search Self-Efficacy (JSSE) scale

How confident do you feel about...?

Making the best impression in an interview

Talking to others to get job openings

Talking to others about potential employers

Making a list of your skills

Completing an application and résumé

Persuading potential employers

C.3 Threatening experiences and life events

We used a modified version of the List of Threatening Experiences Scale.[75] This included more information on experience of violence from a partner. It consists of a series of yes/no questions, relating to whether or not each event had been experienced in the past 12 months.

List of Threatening Experiences Scale

I am going to read out a list of incidents.

Could you tell me if you have experienced each of them in the past 12 months:

... looking for work without success for more than one month?

... major financial crisis, like losing the equivalent of three months income?

... a problem with police involving court appearance?

... something you valued being lost or stolen?

... unfair treatment in the workplace because of your age, sex, ethnicity, sexual orientation, or religion?

... bullying or violence in the workplace?

... bullying or violence from a spouse or partner?

... bullying or violence from anyone else?

... sexual abuse or violence from a spouse or partner?

... sexual abuse or violence from anyone else?

... being homeless or living in insecure or temporary housing?

... serious illness, injury or assault to yourself?

... the death or serious illness, injury or assault of a family member close relative or friend?

... separation due to marital difficulties, divorce or steady relationship broken down?

... a serious problem with a close friend, neighbour or relative?

A reduced version of this scale was used in the Wave 2 survey questionnaire.

[75] Brugha, T. and Cragg, D. (1990). The List of Threatening Experiences: the reliability and validity of a brief life events questionnaire. *Acta Psychiatrica Scandinavia*. 82:1:77-81.

C.4 Social network size and quality of social support

Social network size and quality was assessed used a validated measure also used on the National Psychiatric Morbidity Survey series.[76]

Social network size (DLSS)

The next few questions are about people you feel close to, including relatives, friends and acquaintances.

First of all I would like to ask you about the people that you live with.

How many adults who live with you do you feel close to?

Now I would like to ask about people you feel close to who do not live with you.

How many relatives aged 16 or over, who do not live with you, do you feel close to?

How many friends or acquaintances (who do not live with you) would you describe as close or good friends?

Thinking about all of the people who do not live with you and whom you feel close to or regard as good friends, how many did you communicate with in the past week?

Quality of social support

I would now like you to think about your family and friends. (By family I mean those who live with you as well as those elsewhere). Here are some comments people have made about their family and their friends.

For each statement, please say whether it is not true, partly true or certainly true for you.

There are people I know amongst my family and friends:

... who do things to make me happy.

... who make me feel loved.

... who can be relied on no matter what happens.

... who would see that I am taken care of if I needed to be.

... who accept me just as I am.

... who make me feel an important part of their lives.

... who give me support and encouragement.

Response categories: not true, partly true and certainly true.

[76] McManus, S. *et al*. Adult Psychiatric Morbidity in England, 2007: results of a household survey. The Health & Social Care Information Centre, Social Care Statistics. January 2009. http://www.ic.nhs.uk

C.5 Problem debt

The scale used to assess the level of problem debt was based on one originally produced for the Adult Psychiatric Morbidity Survey. Scale of the problem is indicated by the number of areas in which the participant experiences debt-related problems. Each is counted using a series of yes/no questions.

Number of types of problem debt

In the past year have there been times when you or your household were seriously behind in paying (within the time allowed) for any of the following items:

... rent?

... gas?

... electricity?

... water?

... mortgage repayments?

... Council Tax or Road Tax?

... credit card payments?

... mail order catalogue or hire purchase payments?

... telephone/mobile phone/or internet access?

... other loans?

... TV Licence?

... Child Support or Maintenance?

Appendix D
Logistic regression models

Further detail is given in this Appendix about the regression modelling reported in Chapters 4 and 7. Other information about the process is given in the relevant chapters. The stages of analysis were:

Stage 1 – Univariate analysis of each candidate variable that tested for basic association with the outcome variable (e.g. being on Jobseeker's Allowance (JSA) at Wave 2).

Stage 2 – The variables identified as significant at stage one were entered into a multivariable analysis with the other significant variables from the same block. A block is a set of variables on a related topic. This was repeated for each of the blocks.

Stage 3 – The variables identified as significant at stage two from each block were brought together into a single multivariable regression. This was repeated using a stepwise approach until all the variables in the final model were significant.

Tables D.1, D.3, D.6 and D.8 show all the variables that were tested, and whether or not they were significant at each stage of the modelling. Blue shading indicates that the variable was significant, or approaching significance (p=<~0.15), at that stage of testing. Tables D.2, D.4, D.5, D.7 and D.9 show the detailed results for the final models.

D.1 Predictors of being on JSA at Wave 2

Table D.1 Summary table of stages in the modelling of Wave 1 predictors of claiming JSA at Wave 2

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 1: Socio-demographics			
Age group			
Sex			
Ethnic group			
Block 2: Finance and debt			
Number of debts			
How household is managing financially			
Major financial crisis in past 12 months			
Insecure housing in past 12 months			
Has an employed partner			
Can keep home warm enough			

Continued

Table D.1 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 3: Employment, training and benefit history	■	■	
ESA or IB in past year	■	■	■
Drivers licence	■	■	
Any academic exams	■		
Any vocational qualifications	■	■	
Looked for work for 3+ months	■		
SES of last job	■		
Ever worked	■		
Bullied at work in past 12 months	■		
Discrimination at work in past 12 months	■		
Poor health a factor in leaving last job			
Childcare a factor in leaving last job			
Job insecurity in last job			
Block 4: Health and wellbeing			
CIS-R (2 groups) [a]			■
Depression			
Generalised anxiety disorder			
Phobias			
OCD			
Panic attacks			
Mixed anxiety and depression			
Suicidal thoughts in past week			
General health (excellent to poor)			
Any illness, disability, infirmity			
Illness, disability, infirmity affecting work			
Optimism (SWEMWBS1)	■	■	
Feeling useful (SWEMWBS2)	■	■	
Relaxed (SWEMWBS3)	■	■	
Deal well with problems (SWEMWBS4)	■		
Thinking clearly (SWEMWBS5)	■		
Feeling close to others (SWEMWBS6)	■	■	
SWEMWBS7			
Block 5: Social relationships			
Marital status	■	■	■
Household type	■	■	
Number of people close to	■	■	
Partner has been violent in past 12 months	■		
Being a carer			
Separated in past 12 months			

Continued

Table D.1 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Any children in the household			
There are people that I know who			
... do things to make me happy			
... make me feel loved			
... can be relied on no matter what			
... would see I am taken care of			
... accept me just as I am			
... make me feel part of their lives			
... give me support and encouragement			
Block 6: Threatening life events			
Number of types of threatening life events			
Contact with police in past 12 months			
Assaulted in past 12 months			
Relative assaulted or ill			
Serious problem with friend or neighbour			
Block 7: Area level factors			
Country			
Region			
IMD band			
Urban/rural			
Block 8: Attitudes and beliefs			
Whether wants a job			
Perceived impact of work on health			
Work-search self-efficacy 1			
Block 9: Jobcentre support			
Discussion of health with PA was 'useful'			
Satisfaction with Jobcentre Plus support			
Number of interviews with a PA [b]			
Number of job applications			

[a] CIS-R was not significant, but retained in the model for hypothesis reasons.
[b] Dropped because hard to interpret.

Table D.2 Adjusted odds for being on JSA at Wave 2 – detailed results

			95% CI	
	P	OR	Lower	Upper
Sex	0.013			
Men		1.557	1.097	2.211
Women		1		
Cold home	0.026			
No		0.569	.346	.936
Yes		1		
Financial crisis	0.001			
No		0.551	.386	.785
Yes		1		
Driver's license	0.031			
Yes		0.672	.468	.964
No		1		
CIS-R[a]	0.108			
0-11		0.714	.473	1.076
12+		1		
Marital status	<0.001			
Single		0.927	.564	1.522
Married or cohabitating		0.351	.202	.610
Separated, divorced or widowed		1		
IMD	<0.001			
IMD – least deprived		0.251	.110	.572
IMD – 2		0.372	.176	.783
IMD – 3		0.544	.255	1.160
IMD – 4		0.881	.409	1.899
IMD – 5		0.828	.369	1.858
IMD – 6		1.170	.458	2.991
IMD – most deprived		1		
'People accept me for who I am'	0.009			
Not true		0.496	.200	1.230
Partly true		1.948	1.161	3.269
Certainly true		1		

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

[a] Note non-significant p value.

D.2 Predictors of being in employment at Wave 2

Table D.3 Summary table of methodological stages in the modelling of Wave 1 predictors of being in employment at Wave 2

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 1: Socio-demographics			
Age group	■	■	■
Sex		■	■
Ethnic group	■	■	
Block 2: Finance and debt			
Number of debts			
How household is managing financially	■	■	
Major financial crisis in past 12 months	■		
Insecure housing in past 12 months			
Has an employed partner			
Can keep home warm enough	■	■	
Block 3: Employment, training and benefit history			
ESA or IB in past year	■	■	■
Employment status[a]	■	■	■
Driver's licence	■	■	■
Any academic exams	■		
Any vocational qualifications			
SES of last job			
Ever worked	■		
Bullied at work in past 12 months			
Discrimination at work in past 12 months	■	■	■
Poor health a factor in leaving last job	■		
Childcare a factor in leaving last job			
Job insecurity in last job	■		
Block 4: Health and wellbeing			
CIS-R (2 groups)	■	■	■
Suicidal thoughts in past week	■		
Depression	■		
Generalised anxiety disorder	■		
Phobias	■		
OCD			
Panic attacks	■	■	
Mixed anxiety and depression			
General health (excellent to poor)	■		
Any illness, disability, infirmity	■		
Illness, disability, infirmity affecting work	■	■	
Optimism (SWEMWBS1)	■		
Feeling useful (SWEMWBS2)	■	■	
Relaxed (SWEMWBS3)			

Continued

Table D.3 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Deal well with problems (SWEMWBS4)	■		
Thinking clearly (SWEMWBS5)	■		
Feeling close to others (SWEMWBS6)	■		
Able to make up mind (SWEMWBS7)			
Block 5: Social relationships			
Marital status	■	■	■
Household type			
Number of people close to	■		
Partner has been violent in past 12 months			
Being a carer			
Separated in past 12 months			
Any children in the household	■	■	■
There are people that I know who:			
... do things to make me happy			
... make me feel loved	■		
... can be relied on no matter what	■		
... would see I am taken care of	■		
... accept me just as I am	■		
... make me feel part of their lives	■		
... give me support and encouragement	■		
Block 6: Threatening life events			
Number of types of threatening life events			
Contact with police in past 12 months			
Assaulted in past 12 months			
Relative assaulted or ill			
Serious problem with friend or neighbour			
Block 7: Area level factors			
Country	■		
Region	■		
IMD band	■	■	■
Urban/rural	■		
Block 8: Attitudes and beliefs			
Whether wants a job			
Perceived impact of work on health			
Work-search self-efficacy 1	■	■	■
Block 9: Jobcentre support			
Discussion of health with PA was 'useful'	■		
Satisfaction with Jobcentre Plus support			
Number of interviews with a PA [b]	■		
Number of job applications			

[a] Final model excluded people in work at Wave 1 interview, to focus on change among those still claiming JSA at Wave 1.

[b] Dropped due to issues with interpretation.

Table D.4 Adjusted odds for being employed at Wave 2 – detailed results

			95% CI	
Wave 1 predictors	**P**	**OR**	**Lower**	**Upper**
Sex[a]	0.081			
Men	0.081	0.662	0.417	1.052
Women		1		.
Age group[a]	0.157			
16-24	0.059	2.905	0.959	8.801
25-34	0.372	1.612	0.565	4.601
35-44	0.056	2.658	0.975	7.246
45-54	0.064	2.538	0.946	6.808
55-64		1		
ESA/IB in past 12 months	0.003			
Yes	0.003	.556	0.376	0.822
No		1		
Drivers licence	0.026			
Yes	0.026	1.801	1.074	3.021
No		1		
Unfair treatment	0.008			
Yes	0.008	3.111	1.346	7.190
No				
Self-confidence in job interview[a]	0.052			
Not at all confident	0.018	.498	0.279	0.887
Quite confident	0.126	.666	0.396	1.121
Very confident		1		
CIS-R[a]	0.075			
0-11	0.075	1.657	0.950	2.890
12 or more	.	1		
Marital status[a]	0.297			
Single	0.758	.893	0.433	1.840
Married or cohabitating	0.293	1.472	0.716	3.025
Separated, divorced or widowed				
Any children in the household	0.010			
Yes	0.010	.477	0.272	0.837
No		1		
IMD	0.012			
IMD – least deprived	0.022	3.181	1.185	8.542
IMD – 2	0.198	1.848	0.725	4.712
IMD – 3	0.096	2.229	0.867	5.730
IMD – 4	0.628	1.269	0.484	3.322
IMD – 5	0.991	0.994	0.350	2.819
IMD – 6	0.269	0.494	0.141	1.728
IMD – most deprived		1		

Base: WSWB Wave 1 and Wave 2: people claiming JSA at Wave 1.

[a] Note non-significant p value.

Table D.5 Adjusted odds for being economically inactive at Wave 2 (not employed or on JSA) – detailed results

			95% CI	
Wave 1 predictors	**P**	**OR**	**Lower**	**Upper**
DLA	0.018			
No	0.018	0.300	0.110	0.816
Yes		1		
Carer	0.025			
Yes	.025	0.592	0.374	0.937
No		1		
Sex	0.266[a]			
Men	0.266	1.290	0.823	2.021
Women		1		
Age group	0.001			
16-24	0.000	4.560	2.094	9.927
25-34	0.002	3.310	1.578	6.942
35-44	0.000	3.654	1.854	7.202
45-54	0.001	3.237	1.638	6.394
55-64		1		
Employment status	<0.001			
In paid work	<0.001	4.992	2.352	10.597
Not in paid work		1		
Drivers licence	0.016			
Yes	0.016	1.735	1.107	2.720
No		1		
Marital status	<0.001			
Single	0.242	0.635	0.296	1.360
Married or cohabitating	0.001	0.274	0.129	0.579
Separated, divorced or widowed		1		

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

[a] Note non-significant p-value.

D.3 Predictors of a deterioration in mental health

Table D.6 Summary table of stages in the modelling of Wave 1 predictors of an deterioration in mental health (increased CIS-R score) at Wave 2

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 1: Socio-demographics	■		
Age group			
Sex			
Ethnic group			
Block 2: Finance and debt			
Number of debts			
How household is managing financially			
Major financial crisis in past 12 months			
Insecure housing in past 12 months			
Can keep home warm enough			
Block 3: Employment, training and benefit history			
ESA or IB in past year	■	■	
Employment status	■	■	
Drivers licence			
Any academic exams			
Any vocational qualifications			
Looked for work for 3+ months	■	■	
SES of last job	■		
Ever worked			
Bullied at work in past 12 months			
Discrimination at work in past 12 months	■		
Poor health a factor in leaving last job			
Childcare a factor in leaving last job			
Job insecurity in last job			
Block 4: Health and wellbeing			
CIS-R (2 groups)	■	■	■
Depression	■	■	■
Generalised anxiety disorder			
Phobias			
OCD	■	■	■
Panic attacks	■	■	■
Mixed anxiety and depression	■		
Suicidal thoughts in past week		■	
Longstanding illness, disability, infirmity	■	■	■
Illness, disability, infirmity affecting work	■		
Optimism (SWEMWBS1)			
Feeling useful (SWEMWBS2)		■	

Continued

Table D.6 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Relaxed (SWEMWBS3)		■	
Deal well with problems (SWEMWBS4)	■		
Thinking clearly (SWEMWBS5)	■	■	■
Feeling close to others (SWEMWBS6)			
Can make up own mind (SWEMWBS7)			
Block 5: Social relationships			
Marital status			
Household type			
Number of people close to	■	■	■
Partner has been violent in past 12 months			
Being a carer	■	■	
Separated in past 12 months			
Any children in the household		■	
There are people that I know who (DLSS)			
… do things to make me happy			
… make me feel loved			
… can be relied on no matter what			
… would see I am taken care of			
… accept me just as I am.			
… make me feel part of their lives			
… give me support and encouragement		■	■
Block 6: Threatening life events			
Number of types of threatening life events	■	■	■
Contact with police in past 12 months			
Assaulted in past 12 months	■	■	
Relative assaulted or ill			
Serious problem with friend or neighbour	■		
Block 7: Area level factors			
Country	■		
Region			
IMD band			
Urban/rural	■	■	■
Block 8: Attitudes and beliefs			
Perceived impact of work on health	■		
Work-search self efficacy 1			
Block 9: Jobcentre support			
Discussion of health with PA was ‘useful’			
Number of interviews with a PA			
Number of job applications	■		

Continued

Table D.6 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 10: change between Wave 1 and Wave 1			
Trauma between Wave 1 and Wave 2			
Employment status changed			

Table D.7 Adjusted odds for a decline in mental health[77] (increase in CIS-R score) between waves – detailed results

			95% CI	
Characteristics at Wave 1	**P**	**OR**	**Lower**	**Upper**
Primary group size	0.030			
0 or 1	0.243	0.458	0.123	1.702
2 or 3	0.016	2.349	1.172	4.709
4 to 9	0.811	1.047	0.720	1.520
10 or more		1		
People give me support and encouragement	0.009			
Not true	0.003	5.666	1.780	18.038
Partly true	0.971	1.011	0.572	1.787
Certainly true		1		
Number of types of trauma between Wave 1 and 2	<0.001			
Financial crisis only	0.014	2.057	1.161	3.647
Bullying only	0.007	3.794	1.452	9.912
Serious illness only	0.211	2.431	0.603	9.801
Illness/injury relative or friend	0.218	1.412	0.815	2.444
2 or more traumatic events	0.009	2.465	1.250	4.860
3 or more traumatic events	0.000	13.649	4.955	37.598
No traumatic events		1		

Continued

[77] Reference category: mental health stayed the same or got better.

Table D.7 Continued

			95% CI	
Characteristics at Wave 1	**P**	**OR**	**Lower**	**Upper**
Longstanding illness, disability or health condition	<0.001			
Yes	<0.001	1.986	1.365	2.890
No		1		
Been able to think clearly	0.013			
None or rarely	0.337	1.453	0.678	3.116
Some of the time	0.003	2.073	1.288	3.335
Often	0.011	1.733	1.134	2.648
All of the time		1		
CIS-R score	<0.001			
12 or more	<0.001	0.389	0.229	0.658
0 to 11		1		
Depressive episode[a]	0.051			
Present	0.051	0.379	0.143	1.003
Not present		1		
OCD[a]	0.073			
Present	0.073	0.313	0.088	1.114
Not present		1		
Panic disorder	0.046			
Present	0.046	4.531	1.026	20.011
Not present		1		
Urban/rural	0.015			
Rural	0.005	0.338	0.160	0.717
Fringe and town	0.663	1.154	0.605	2.201
Urban		1		

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

[a] Note that for these variables significance at the 95% level was not reached.

D.4 Predictors of a recovery/improvement in mental health

Table D.8 Summary table of stages in the modelling of Wave 1 predictors of an improvement in mental health (decline in CIS-R score) at Wave 2

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Block 1: Socio-demographics			
Age group			
Sex	■		
Ethnic group			
Block 2: Finance and debt			
Number of debts	■		
How household is managing financially	■	■	
Major financial crisis in past 12 months	■		
Insecure housing in past 12 months	■	■	
Can keep home warm enough	■		
Block 3: Employment, training and benefit history			
ESA or IB in past year	■	■	
Employment status	■	■	
Drivers licence			
Any academic exams			
Any vocational qualifications			
Looked for work for 3+ months	■	■	
SES of last job			
Ever worked			
Bullied at work in past 12 months			
Discrimination at work in past 12 months	■	■	
Poor health a factor in leaving last job	■		
Childcare a factor in leaving last job			
Job insecurity in last job			
Block 4: Health and wellbeing			
CIS-R (2 groups)	■	■	■
Depression	■	■	■
Generalised anxiety disorder	■		
Phobias	■	■	■
OCD	■	■	
Panic attacks		■	■
Mixed anxiety and depression	■		
Suicidal thoughts in past week	■		
Any illness, disability, infirmity	■	■	
Illness, disability, infirmity affecting work	■		
Optimism (SWEMWBS1)	■		
Feeling useful (SWEMWBS2)	■		
Relaxed (SWEMWBS3)			

Continued

Table D.8 Continued

All variables tested at Stage 1	Tested at Stage 2	Tested at Stage 3	Retained in final model
Deal well with problems (SWEMWBS4)	■		
Thinking clearly (SWEMWBS5)	■		
Feeling close to others (SWEMWBS6)	■		
Can make up own mind (SWEMWBS7)	■		
Block 5: Social relationships			
Marital status			
Household type			
Number of people close to			
Partner has been violent in past 12 months			
Being a carer			
Separated in past 12 months	■		
Any children in the household			
There are people that I know who			
... do things to make me happy	■		
... make me feel loved	■		
... can be relied on no matter what	■		
... would see I am taken care of	■		
... accept me just as I am.	■		
... make me feel part of their lives	■		
... give me support and encouragement	■		
Block 6: Threatening life events			
Number of types of threatening life events	■	■	■
Bullied or violence (not from partner)	■	■	
Contact with police in past 12 months	■		
Assaulted in past 12 months			
Relative assaulted or ill	■		
Serious problem with friend or neighbour	■		
Block 7: Area level factors			
Country	■		
Region	■	■	
IMD band	■	■	
Urban/rural			
Block 8: Attitudes and beliefs			
Perceived impact of work on health	■		
Work-search self efficacy 1			
Block 9: Jobcentre support			
Discussion of health with PA was 'useful'			
Satisfaction with Jobcentre Plus support			
Number of job applications			
Block 10: change between Wave 1 and Wave 2			
Trauma between Wave 1 and Wave 2	■	■	■
Employment status changed	■	■	■

Table D.9 Adjusted odds for an improvement in mental health[78] (decline in CIS-R score) between waves

			95% CI	
Characteristics at Wave 1	**P**	**OR**	**Lower**	**Upper**
Number of trauma types in the 12 months prior to Wave 1	0.003			
5 or more	0.012	3.848	1.349	10.979
3 or 4	0.001	4.808	1.855	12.464
1 or 2	0.030	2.766	1.106	6.916
0		1		
Number of types of trauma between Wave 1 and 2	0.023			
Financial crisis only	0.069	0.543	0.281	1.049
Bullying only	0.816	0.867	0.260	2.892
Serious illness only	0.897	1.121	0.200	6.298
Illness/injury relative or friend	0.301	1.321	0.779	2.238
2 or more traumatic events	0.201	0.634	0.315	1.275
3 or more traumatic events	0.002	0.176	0.060	0.517
No traumatic events		1		
Change in employment status between Wave 1 and 2	0.132			
Lost employment	0.421	.662	0.242	1.809
No change	0.045	.659	0.438	0.990
Entered employment		1		
CIS-R score	<0.001			
12 or more	<0.001	6.353	3.984	10.128
0 to 11		1		
Depressive episode	0.020			
Present	0.020	2.984	1.192	7.470
Not present		1		
Phobias	0.035			
Present	0.035	0.403	0.173	0.938
Not present		1		
Panic disorder	0.036			
Present	0.036	0.238	0.062	0.909
Not present		1		

Base: WSWB Wave 1 and Wave 2: participants to both waves only.

78 Reference category= mental health stayed the same or deteriorated.

Appendix E
Confidence intervals for key estimates

Table E.1 True standard errors and 95 per cent confidence intervals for CIS-R score (12+) and CMDs – Wave 1 sample

WSWB – Wave 1

Base	Characteristic	%	Sample size	Weighted sample size	True standard error	95% CI Lo	95% CI Up	Deft
Men	CIS-R score							
	12 or more	18.7	1,247	1,355.9	1.4	16.2	21.6	1.7
	CMDs							
	Mixed anxiety and depressive disorder	10.3	1,247	1,355.9	1.1	8.3	12.7	1.4
	Generalised anxiety disorder	3.4	1,247	1,355.9	0.5	2.5	4.6	1.1
	Depressive episode	4.6	1,247	1,355.9	0.7	3.3	6.3	1.3
	Phobias	4.2	1,247	1,355.9	0.7	3.0	5.7	1.2
	Obsessive compulsive disorder	2.7	1,247	1,355.9	0.5	1.8	4.0	1.2
	Panic disorder	1.1	1,247	1,355.9	0.3	0.6	2.0	1.2
	Any CMD	19.2	1,247	1,355.9	1.4	16.6	22.1	1.3
Women	CIS-R score							
	12 or more	28.6	832	723.1	2.0	24.8	32.6	1.2
	CMDs							
	Mixed anxiety and depressive disorder	6.8	832	723.1	1.1	5.0	9.2	1.2
	Generalised anxiety disorder	4.9	832	723.1	0.9	3.5	7.0	1.1
	Depressive episode	4.8	832	723.1	0.9	3.4	6.8	1.1
	Phobias	4.4	832	723.1	0.9	2.9	6.5	1.1
	Obsessive compulsive disorder	1.7	832	723.1	0.6	0.9	3.2	1.2
	Panic disorder	29.0	832	723.1	2.0	25.3	33.1	1.2
	Any CMD	14.9	832	723.1	1.6	12.0	18.3	1.2

Continued

Table E.1 Continued

WSWB – Wave 1

Base	Characteristic	%	Sample size	Weighted sample size	True standard error	95% CI Lo	95% CI Up	Deft
All recent JSA claimants	CIS-R score							
	12 or more	22.1	2,079	2,079.0	1.1	20.0	24.5	1.3
	CMDs							
	Mixed anxiety and depressive disorder	4.6	2,079	2,079.0	0.5	3.7	5.7	1.3
	Generalised anxiety disorder	4.7	2,079	2,079.0	0.6	3.7	6.0	1.1
	Depressive episode	4.4	2,079	2,079.0	0.5	3.4	5.6	1.2
	Phobias	3.3	2,079	2,079.0	0.5	2.5	4.3	1.2
	Obsessive compulsive disorder	1.3	2,079	2,079.0	0.3	0.8	2.0	1.2
	Panic disorder	22.6	2,079	2,079.0	1.2	20.4	24.9	1.2
	Any CMD	11.9	2,079	2,079.0	0.9	10.2	13.8	1.3

All Wave 1 participants: recent JSA claimants.

Table E.2 True standard errors and 95 confidence intervals for CIS-R score (12+) and CMDs – Wave 2 sample

WSWB – Wave 2

Base	Characteristic	%	Sample size	Weighted sample size	True standard error	95% CI Lo	95% CI Up	Deft
Men	CIS-R score							
	12 or more	19.3	747	1,243.4	1.9	15.9	23.2	1.3
	CMDs							
	Mixed anxiety and depressive disorder	9.2	747	1,243.4	1.4	6.8	12.4	1.4
	Generalised anxiety disorder	4.0	747	1,243.4	0.8	2.7	5.9	1.2
	Depressive episode	2.9	747	1,243.4	0.7	1.8	4.6	1.1
	Phobias	5.3	747	1,243.4	1.1	3.5	7.8	1.3
	Obsessive compulsive disorder	2.4	747	1,243.4	0.7	1.3	4.4	1.3
	Panic disorder	1.3	747	1,243.4	0.6	0.6	3.1	1.4
	Any CMD	20.4	747	1,243.4	1.9	16.9	24.5	1.3

Continued

Table E.2 Continued

WSWB – Wave 2

Base	Characteristic	%	Sample size	Weighted sample size	True standard error	95% CI Lo	95% CI Up	Deft
Women	CIS-R score							
	12 or more	19.9	532	750.1	2.2	16.0	24.5	1.2
	CMDs							
	Mixed anxiety and depressive disorder	10.1	532	750.1	1.7	7.2	13.9	1.2
	Generalised anxiety disorder	3.9	532	750.1	0.9	2.5	6.1	1.0
	Depressive episode	5.2	532	750.1	1.1	3.4	7.8	1.1
	Phobias	5.8	532	750.1	1.2	3.8	8.8	1.2
	Obsessive compulsive disorder	4.4	532	750.1	1.1	2.7	7.1	1.2
	Panic disorder	0.5	532	750.1	0.3	0.2	1.8	1.0
	Any CMD	20.6	532	750.1	2.2	16.6	25.3	1.2
All recent JSA claimants	CIS-R score							
	12 or more	19.5	1279	1993.5	1.4	16.9	22.5	1.3
	CMDs							
	Mixed anxiety and depressive disorder	9.5	1279	1993.5	1.1	7.6	11.9	1.3
	Generalised anxiety disorder	4.0	1279	1993.5	0.6	2.9	5.3	1.1
	Depressive episode	3.8	1279	1993.5	0.6	2.7	5.1	1.1
	Phobias	5.5	1279	1993.5	0.8	4.1	7.3	1.3
	Obsessive compulsive disorder	3.2	1279	1993.5	0.6	2.2	4.6	1.3
	Panic disorder	1.0	1279	1993.5	0.4	0.5	2.1	1.4
	Any CMD	20.5	1279	1993.5	1.4	17.8	23.5	1.3

All Wave 2 participants: recent JSA claimants.

Table E.3 True standard errors and 95 confidence intervals for limiting longstanding illness and suicidal thoughts in past week – Wave 1 sample

WSWB – Wave 1

Base	Characteristic	%	Sample size	Weighted sample size	True standard error	95% CI Lo	95% CI Up	Deft
Men	Limiting longstanding illness or disability	19.6	1,240	1,354.4	1.4	17.1	22.4	1.3
	Suicidal thoughts in the past week	4.5	1,247	1,355.9	0.7	3.3	6.2	1.3
Women	Limiting longstanding illness or disability	22.8	831	722.0	1.8	19.5	26.4	1.1
	Suicidal thoughts in the past week	5.2	832	723.1	0.9	3.6	7.3	1.1
All	Limiting longstanding illness or disability	20.7	2,071	2,076.4	1.1	18.7	22.9	1.2
	Suicidal thoughts in the past week	4.7	2,079	2,079.0	0.6	3.7	6.0	1.2

All Wave 1 participants: recent JSA claimants.

Appendix F
Qualitative study: topic guide

NatCen
National Centre for Social Research

National Study of Work-search and Wellbeing

Experiences and views of JSA claimants

Topic guide

Interview aims

To explore the experience of claiming JSA within the context of day-to-day life and specifically to understand how the claims process interacts with wellbeing.

- explore the views and experience of the participant making the JSA claim and their contact with the Jobcentre – especially in identifying triggers to stress or mental ill health;
- understand the circumstances leading to most recent JSA claim and mental wellbeing in run up to and since initiating claim;
- find out about participants' household circumstances, family and other support networks, day to day activities and how these interact with JSA experience and mental wellbeing;
- establish broad overview of participants' employment history and experience of benefit claims;
- identify and reflect on facilitators and barriers to job search activities;
- suggestions and ideas for improving the experience for JSA claimants: any gaps in service provision, information, support.

Guidance for interpretation and use of the topic guide: The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each participant. It does not include follow-up questions like 'why', 'when', 'how', etc. as respondents' contributions will be fully explored throughout in order to understand how and why views and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between interviews depending on individual circumstances and experiences.

Participants may or may not identify themselves as experiencing mental ill health. Researchers will explore participants' perceptions of their current and recent mental wellbeing and will reflect the terms used by participants to describe their mental wellbeing/ill health when exploring experiences of the claims process and identifying triggers for mental ill health.

Introduction

- Introduce self and NatCen (independent from DWP and Jobcentre).
- Explain reason for this follow up study (talking again to some participants from telephone interview to hear about how JSA claim sits in context of people's day to day lives, understand views and experiences, look at triggers for stress or periods of difficulty in JSA claims, identify areas for improved service delivery – different type of interview, not survey).
- In-depth interviews being carried out around the country with range of different people for whom (the telephone survey suggests) the experience may have been stressful – trying to find out more about elements of the claims process that trigger stress or difficulty and affect wellbeing.
- Discuss confidentiality (content of the interview remains within research team, DWP will not know who we speak to) and anonymity (no individuals will be named in report), as well as voluntary nature of interview/specific questions.
- Use of audio-recorder and data storage (encrypted recorders; secure data collection system, deletion after project).
- Length of interview (up to hour and a half).
- Any questions.

Participant background

- Background about participant, household, living arrangements
  - Whether live alone or with others
  - Length of time in current accommodation
- Day to day activities: overview
- Support networks
  - Contact with family/friends
  - Other regular contact with people
- Current and recent mental wellbeing and general health-overview
- Major life events experienced recently *(potential impact on claim process – look at within last year)*

Employment and benefit claim history

- Previous experiences of employment (if any)
  Depending on the extent of participant's experience, may need to focus on last couple of years – aim is to get an overview
  - Type of work undertaken
  - Length of employment
  - Views of working

- Previous experience of benefits claim
  Again, depending on participant's experience, may need to focus on last couple of years – aim is to get an overview
  - Type of benefits and length of claims
  - Views about claiming
- Expectations around finding work in the future *(if not already employed)*

Circumstances of most recent JSA claim

- Events leading up to recent JSA claim
  - Route to JSA: from employment or other type of benefit
  - Sequence of events
  - Other issues happening in participants' life at same time as making claim
  - Participants' views of these experiences

Experience of making the JSA claim

- Ask participant to walk through the claims process
  - finding out they needed to make the JSA claim and what they had to do in order to claim
  - experience of making the claim (contact with Jobcentre Plus and administration)
  - views of the claim process: how each element made them feel/what worked well/less well for participant and suggestions for improvement

Experience of being a JSA claimant

- Explore how/whether participant's day-to-day life is affected as a result of being on JSA
  - day to day activities undertaken: how time is filled (including any job search activities)
  - what it feels like for participant to be unemployed:
  - impact on family/friends/relationships
  - interaction with other life events
  - self-esteem
  - managing finances
  - overall mental wellbeing
- Explore whether participant views this as having been a stressful time or not *(or time of mental ill health – depending on how participant sees their mental wellbeing)*
  Possibilities for probing: will depend on participant's experience and how the interview has flowed to this point:
  - Prompt: some people have described this as having been a stressful time/time that causes depression/feeling anxious -explore participants' response
  - Prompt: participant to reflect on a time in their lives they have found stressful/difficult and compare that with the experience of claiming JSA
  - Prompt: extent to which claims process triggers or causes stress/ill health and how it does so.

For those who have entered employment

- Ask participant to describe the events leading to employment and the experience of moving from JSA back into work (establish what, if any, role Jobcentre Plus played).
- Explore aspects of return to work which participant found easy/less easy and reasons.
- Find out what, if anything, could have supported participant during this transition.
- Views of being back in work (on relationships; self-esteem; finance; wellbeing etc).

- Views of the future

Ideas and suggestions

- Ask participants to reflect on the interview and suggest any ways their experience of going through the JSA claim process and/or the move back into work could have been made easier
  - support, information, training, employment opportunities

- Thank participants for their time and thoughts.
- Give £20 and get receipt signed.
- Reassure re confidentiality and provide information card about sources of support/further formation.
- Ask if would like to be told when the research findings become available OR a participant summary of findings. If so take address/stable contact. Ensure you update findings database when returning to office.
- Check if they have further questions.
- Discuss whether would be happy to take part in another telephone survey.

The national study of work-search and wellbeing is a mixed methods study of the psychological health and wellbeing of Jobseeker's Allowance (JSA) claimants, involving over 2,000 participants across Great Britain. The main component of the research was a two-wave telephone survey of a cohort of unemployed people who began a claim for JSA in the first quarter of 2011. In addition, qualitative interviews were conducted with participants identified with symptoms of stress, anxiety or depression during wave one survey interviews.

The study examined the nature and extent of common mental disorder (CMD) among recent JSA claimants. It includes information on the personal, social, economic, employment, service related and other factors that predict presence and change in mental health. The study was conducted by NatCen Social Research.

If you would like to know more about DWP research, please contact:
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Upper Ground Floor, Steel City House, West Street, Sheffield, S1 2GQ.
http://research.dwp.gov.uk/asd/asd5/rrs-index.asp

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