



Department
for Work &
Pensions



Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot

September 2015

Research Report No 906

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Summary

This study was commissioned to evaluate a pilot offering telephone-based psychological wellbeing and employment-related support from specialist providers, aimed at Jobseeker's Allowance (JSA) claimants struggling with their job search. This was one of the pilots proposed by RAND Europe as a potentially effective early intervention for benefit claimants with common mental health conditions.¹

The evaluation was designed to identify learning from the Telephone Support pilot to inform a large-scale trialling of the intervention. In-depth interviews were carried out with eight Jobcentre Plus (JCP) Work Coaches, seven Provider staff and thirty-two claimants who had participated in the intervention. Management Information (MI) analysis was undertaken to provide further insights into pilot take-up, retention and outcomes.

The key findings of this study were:

- of 569 claimants that were referred to Telephone Support, 146 (26 per cent) completed at least one intervention phone call after the initial assessment call. Of these, 91 (62 per cent of those who started the intervention) completed. Claimants found the delivery format to be acceptable, although screening may be required to identify those for whom this would be most suitable;
- a number of measures to help facilitate engagement and retention were identified; these included further information to claimants about the intervention; clear messaging around its voluntary nature; and continuity of the caseworker;
- the Telephone Support intervention was intended to be tailored to the specific needs of claimants. Although this flexibility was a key strength, further service development should ensure core 'key ingredients' are identified and remain unchangeable;
- Vocational Rehabilitation Consultants' (VRCs) were pivotal to the intervention success. Further implementation would benefit from additional VRC training on the range of support that could be offered to participants, thus reducing the risk that support received by claimants reflects the strengths and preferences of VRCs;
- MI analysis indicated that there were positive changes in claimants' wellbeing, self-efficacy and mental health when comparing pre-test and post-test scores. This is consistent with findings from qualitative interviews with claimants;
- with no comparison group, the quantitative results do not allow us to conclude that the observed positive change in outcomes is due to the Telephone Support intervention. This would need to be explored in a full impact evaluation.

¹ Van Stolk, C., Hofman, J., Hafner, M. and Janta, B. (2014). *Psychological wellbeing and work: Improving service provision and outcomes*. A Report by RAND Europe.

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This report represents the views of the authors. Any inaccuracies are our own.

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List of abbreviations

CBT	Cognitive Behavioural Therapy
CV	Curriculum Vitae
DH	Department of Health
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GAD-7	Generalized Anxiety Disorder 7 Item Scale
GP	General Practitioner
GSE	General Self Efficacy Scale
IAPT	Improving Access to Psychological Therapies
IPS	Individual Placement and Support
JSA	Jobseeker's Allowance
JSSE	Job Search Self Efficacy Index
MI	Management Information
NatCen	NatCen Social Research
OECD	Organisation for Economic Co-operation and Development
PHQ-9	Patient Health Questionnaire
UK	United Kingdom
US	United States
WHO-5	WHO-5 Wellbeing Index
VRC	Vocational Rehabilitation Consultant

Summary

Policy context

In 2013 the Department for Work and Pensions (DWP) and the Department of Health (DH), jointly-commissioned RAND (Europe) to look at how to improve employment and health prospects for people with common mental health conditions.² Four models of support were proposed for further investigation, including the Telephone Support intervention.

The Telephone Support intervention was a telephone-based combination of psychological wellbeing and employment-related support from specialist providers and aimed at Jobseeker's Allowance (JSA) claimants who were struggling with their job search. It was piloted between August and December 2014 in the North East Yorkshire and Humber, and South Yorkshire Jobcentre Plus districts.

Research aims and method

The evaluation was designed to provide insights into the performance of Telephone Support intervention and identify learning from its implementation and delivery, with a view to informing a large-scale trialling of the intervention. To meet these aims, in-depth interviews were carried out with Jobcentre Plus staff, Provider staff and claimants who participated in the intervention. Analysis of Management Information (MI) was also undertaken to provide insights into pilot take-up, retention and outcomes.

To meet these aims, in-depth interviews were carried out with Jobcentre Plus staff, provider staff and claimants who participated in the intervention. Analysis of Management Information (MI) was also undertaken to provide insights into pilot take-up, retention and outcomes.

Referral and take-up of Telephone Support

In total, 569 claimants were referred to the Telephone Support intervention. Of these, 146 started the intervention (i.e. completed at least one intervention phone call after the initial assessment call). The rate of completion (retention rate) for those who started the intervention was 62 per cent, with 91 claimants (16 per cent of total referrals) ultimately completing the intervention.

To increase awareness of the intervention and details of what it offered, face-to-face meetings between the Provider and the Work Coaches referring claimants to the intervention were recommended by both the Telephone Support Provider and Jobcentre Plus staff.

To ensure appropriate referrals were made to the intervention, both staff and claimants recommended improving Work Coaches knowledge of who the intervention was aimed at and effective screening of claimants to minimise the number of inappropriate referrals.

To encourage take-up of the intervention, staff and claimants made five recommendations. These included: (a) providing further information to claimants about the provider and the format and content of the support offered; (b) offering clear messaging around the voluntary

² Ibid.

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nature of the intervention, mentioned particularly by claimants;(c) providing continuity of the caseworker between the initial assessment and main intervention to build trust and rapport, and aid retention; (d) using reminders, such as text alerts, so claimants know when to expect contact from the provider; and (e) providers alerting Work Coaches where there has been no contact between the provider and the claimant.

Telephone Support delivery

The Telephone Support intervention aimed to build resilience to the set-backs experienced while job-seeking. A key strength of the intervention was that it was designed to be tailored to meet the specific needs of claimants. However, this also led to variation in the content and the format of the support delivered – particularly around the number and duration of calls.

In terms of the format, it was clear that the telephone delivery of the support was acceptable to claimants, although screening may be required to identify those for whom this would be most suitable. Similarly, weekly calls lasting no longer than an hour worked for claimants, although those with specific issues (for example, memory recall issues) may require more frequent calls.

Variation in the content of the support resulted in claimants receiving three types of support: (a) employment-related support only; (b) emotional wellbeing support only; or (c) a mixture of emotional and job search support. Provider staff delivering the support recommended setting clear and measurable objectives with claimants in determining the content of the support.

The role of the Vocational Rehabilitation Consultant (VRC) was viewed by claimants as pivotal to their experiences of the intervention. Four recommendations emerged from claimants on how VRCs should deliver their support: (a) VRCs should aim to deliver the support in a person-centred way (i.e. listen to and tailor their support according to claimant needs and deliver it flexibly); (b) VRCs should have the knowledge and experience in delivering both employment and wellbeing support and advice; (c) there should be continuity in the VRC across both the initial assessment call and the delivery of the intervention and (d) VRCs should offer the option for claimants to contact them outside of the formal sessions. A key implication of these recommendations is that VRCs should be encouraged and supported (for example, through training) to tailor their support according to claimant needs.

Engagement and retention

Out of 569 claimants referred to the Telephone Support intervention, 250 were successfully contacted for an initial assessment phone call. Out of those contacted, 146 claimants took up the intervention. The rate of completion (retention rate) for those who started the intervention was 62 per cent, with 91 claimants (16 per cent of total referrals) ultimately completing the intervention.

The evaluation found that levels of engagement could not simply be described in terms of completion or non-completion. Claimants fell into four groups: engaged completers; disengaged completers, involuntary (engaged) non-completers and voluntary (disengaged) non-completers. A range of factors adversely impacted on engagement and completion. These included factors external to the intervention, such as low claimant motivation at the start of the intervention (for example, if they felt they did not need the support) and changes in personal circumstances (for example, bereavements). Factors internal to the intervention

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included challenges engaging with the intervention format, such as not having a rapport with VRCs, as well as claimants feeling that the intervention content did not meet their employment and/or wellbeing needs.

Provider staff and Work Coaches made five recommendations to improve delivery of telephone support: (a) ensure claimants have a clear understanding of the intervention, including its format, content and the level of engagement required; (b) balance flexible and tailored support with the need for some sort of structure, such as goal setting, which provides claimants with targets and a sense of progress; (c) improve communication between Work Coaches and the provider, to support claimant engagement; (d) explore the feasibility of initial face-to-face contact with VRCs to foster trust and build rapport prior to the start of the Telephone Support; and (e) provide text reminders for calls to claimants.

Perceived impacts

A questionnaire completed at the start and end of the intervention was used to track outcomes. The questionnaire incorporated five validated instruments to monitor changes in wellbeing, self-efficacy and mental health. All five measures showed improvements between pre- and post-test scores.

Findings from qualitative interviews with claimants supported these results by indicating that there were five key positive outcomes where the intervention worked well: (a) improved self-esteem in general and in relation to the job-market; (b) enhanced levels of self confidence in both job searching and in addressing wider personal issues (for example, stress and anxieties); (c) a more positive outlook towards employment and life in general; (d) a reduced sense of isolation during the course of the intervention; and (e) the support acting as a gateway that encouraged claimants to take up external support for mental health issues (for example, through their GPs).

The qualitative interviews indicated that there were a number of intervention and claimant specific factors that influenced outcomes. Intervention specific factors included: (a) action plans, which helped claimants step out of their comfort zones; (b) the quality of the VRC support, particularly their person-centred approach; (c) receiving weekly calls, which served to reduce isolation; and d) how the intervention was terminated, with an abrupt termination adversely affecting mental health. A key claimant specific factor was the severity of the claimant's mental health condition, with those at the severe end finding it difficult to engage and therefore benefit from the intervention.

Conclusion

The results of this study indicate that further implementation of the Telephone Support intervention would benefit from a clear definition of who the intervention is aimed at and further enhancement of Work Coaches' understanding of who it is suitable for.

To aid engagement and retention, Providers should use text reminders and consistently specify dates and times for calls so claimants are expecting contact. Improving communication between Work Coaches and the provider may facilitate take-up by allowing Work Coaches to follow up claimants. In terms of delivery personnel, offering continuity of caseworker between initial assessment and the main intervention would also be helpful in building trust and rapport, so enhancing retention.

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Effective delivery of the intervention by the VRC is pivotal to the success of the intervention. Further implementation would benefit from additional VRC training on a range of support that could be offered to participants, reducing the risk of the support received by claimants reflecting the strengths and preferences of the VRCs.

In terms of intervention content, a key strength of the Telephone Support was its flexibility in allowing VRCs to tailor content according to claimant needs. However, in view of the variability of content, the intervention would benefit from a further service design development, particularly in terms of identifying the 'key ingredients' of this intervention that should remain unchangeable.

Analysis of five validated instruments that tracked changes in wellbeing, self-efficacy and mental health showed improvements between participant pre- and post-test scores. However, as a single-group study that lacked a comparison group, the quantitative results do not allow us to conclude that the observed positive change in outcomes is due to the Telephone Support intervention. A full impact evaluation is needed to allow a comparison between what actually happened and what would have happened.

1 Introduction

This chapter describes the policy background to the Psychological Wellbeing and Work Pilot and offers an overview of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot. It also sets out the aims and objectives of the evaluation, provides a brief explanation of the research methodology and describes the report structure.

1.1 Background to the pilot

This chapter describes the policy background to the Psychological Wellbeing and Work Pilot and offers an overview of the Group Work Psychological Wellbeing intervention.

In 2013 the Government's disability, health and employment strategy highlighted the prevalence of mental health problems in the population³, stating that at any given time around one in six people has a common mental health condition such as anxiety or depression⁴.

Although a prevalent issue, people with mental health conditions fare worse in the labour market with an employment rate of 43 per cent compared to 74 per cent for the general population.⁵ Nearly a quarter (23 per cent) of Jobseeker's Allowance (JSA) claimants report having a common mental health problem⁶ and nearly half (47 per cent) of Employment and Support Allowance (ESA) claimants report a mental health problem as their primary diagnosis.⁷ For individuals, these issues have far reaching consequences, as worklessness is associated with poorer health and wellbeing and a higher risk of poverty. Further, a recent report by the Organisation for Economic Co-operation and Development (OECD) estimated that the cost of mental ill-health to the economy of the United Kingdom is £70 billion (equivalent to 4.5 per cent of Gross Domestic Product (GDP)).⁸

Against this backdrop there is a growing body of evidence indicating that appropriate work is generally good for mental health and wellbeing, and can in fact reverse the adverse health

³ Department for Work and Pensions. (2013). *The disability and health employment strategy: The discussion so far*. Presented to Parliament by the Secretary of State for Work and Pensions by Command of Her Majesty December 2013. Cm 8763.

⁴ McManus, S., Meltzer, H., Brugha, T., Bebbington, P., and Jenkins, R. (2009). *Adult psychiatric morbidity in England (2007): Results of a household survey*. Leeds: The NHS Information Centre for Health and Social Care.

⁵ Department for Work and Pensions. (2015). *Labour Force Survey analysis of disabled people by region and main health problem*. February 2015. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/406369/labour-force-survey-disabled-people.pdf; These estimates are based on the quarterly Labour Force Survey Q4 (October – December) 2013 and Q4 2014.

⁶ McManus, S., Mowlam, A., Dorsett, R., Stansfeld, S., Clark, C., Brown, V., Wollny, I., Rahim, N., Morrell, G., Graham, J., Whalley, R., Lee, L., Meltzer, H. (2012). *Mental health in context: the national study of work-search and wellbeing*. DWP Research Report No. 810.

⁷ Department for Work and Pensions (2014). *DWP Tabulation Tool*. <http://tabulation-tool.dwp.gov.uk/100pc/tabtool.html>. (Data accessed November 2014).

⁸ OECD. (2014). *Mental Health and Work: United Kingdom*, Mental Health and Work, OECD Publishing.

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effects of unemployment.⁹ In 2013, the Department for Work and Pensions (DWP) and the Department of Health (DH) jointly commissioned RAND Europe to look at how to improve employment and health prospects for people with common mental health conditions. The findings and recommendations were set out in the report, *Psychological Wellbeing and Work: Improving Service Provision and Outcomes*, which was published in January 2014.¹⁰

The report concluded that the interaction between mental health and employment is complex and a 'one size fits all' solution is not appropriate. It argued for more integration between existing treatment and employment services, timely access to co-ordinated treatment and employment support and application of evidence-based models of support. The following four models of support were proposed for further investigation:

- 1 Piloting of embedded vocational support, based on the Individual Placement and Support model (IPS), in the Improving Access to Psychological Therapies programme (IAPT).
- 2 Piloting of a group-based intervention (Group Work) based on the University of Michigan's JOBS II model, which aimed to foster job-search self-efficacy and resilience to job-search setbacks.
- 3 Piloting of Jobcentre-commissioned, third-party provision of combined telephone-based psychological and employment-related support.
- 4 User research to inform online mental health and work assessments and support.

Based on these recommendations, a series of small-scale feasibility pilots were established to examine the most effective design of the pilot interventions and the most effective delivery mode. These pilots were jointly commissioned by DWP and DH and took place in 2014¹¹.

This report is the evaluation of the feasibility phase of the Telephone Support pilot. The findings in this report will be used to design the intervention and delivery model of a larger-scale pilot in 2015, which will examine the impact that the intervention has on benefit off-flows, employment, mental health and wellbeing measures, and sustained outcomes.

1.2 Overview of the Telephone Support pilot

1.2.1 Telephone Support

In their report RAND Europe proposed that a telephone-based combination of psychological wellbeing and employment-related support from specialist providers could be an effective early intervention for benefit claimants.¹²

⁹ Waddell, G. and Burton, A.K. (2006). *Is work good for your wellbeing?* London: The Stationery Office.

¹⁰ Van Stolk, C., Hofman, J., Hafner, M., and Janta, B. (2014). *Psychological Wellbeing and Work: Improving Service Provision and Outcomes*. A report by RAND Europe.

¹¹ For findings from the other pilots see Steadman, K. and Thomas, R. (2015). *An Evaluation of the 'IPS in IAPT' Psychological Wellbeing and Work Feasibility pilot*. The Work Foundation/Department of Health. London. Callanan, M., Mok, T. M. and Edovald, T. (2015). *Evaluation of the Group Work Psychological Wellbeing and Work Feasibility Pilot*, DWP Report No. 905. Department for Work and Pensions. London.

¹² Van Stolk, C., Hofman, J., Hafner, M., and Janta, B. (2014). *Psychological Wellbeing and Work: Improving Service Provision and Outcomes*. A report by RAND Europe.

The report suggested that by implementing this intervention, for each £1 spent to achieve an employment outcome, the Government would save £1.12. Furthermore, compared to other options proposed in the report, this option has a low cost per participant (about £250) and has a potential to reach a good number of people with common mental health conditions.¹³

1.2.2 The delivery of the Telephone Support programme

The pilot ran from August 2014 to December 2014 in North East Yorkshire and Humber and South Yorkshire Jobcentre Plus districts. The intervention involved several steps.

Jobcentre Plus Work Coaches were responsible for identifying and referring claimants to the provider. Using referral guidance, Work Coaches identified and referred those claimants who they perceived to have unmet mental health or wellbeing needs that might impede effective job search.

Upon receipt of the referral, within ten working days the provider conducted an initial telephone assessment interview to establish claimant need. This call (discussed in detail in Section 2.1.4) was usually conducted by a separate team, prior to cases being allocated to a Vocational Rehabilitation Consultant (VRC) who would subsequently deliver the intervention.

The Provider then delivered telephone-based combined employment and wellbeing support interventions, based around the requirement of the individual but addressing specifics such as:

- assessing employment related wellbeing needs;
- offering psychological wellbeing and employment-related support to better undertake effective job search;
- setting action plans and milestones using the Claimant Commitment agreed between claimant and Work Coach as a starting point where available; and
- identifying the claimant's challenges to employment and helping the claimant to understand the impact that these issues can have on their personal circumstances and wellbeing.

In general, the engagement with the claimant remained telephone-based. However, the provider could refer the claimant to additional services, such as computerised Cognitive Behavioural Therapy (CBT), counselling and complementary services such as the Improving Access to Psychological Therapies (IAPT) service.

1.3 Evaluation of the Telephone Support pilot

This section provides an overview of the evaluation aims and methodology.

1.3.1 Evaluation aims and objectives

The evaluation of the feasibility pilot aimed to:

- provide evidence for whether Telephone Support should be piloted on a larger scale;
- provide insights into the performance of Telephone Support;
- identify learning from the implementation and delivery model of the pilot to inform potential for wider piloting.

¹³ Ibid.

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The evaluation was conducted by the National Centre Social Research (NatCen), an independent not-for-profit research organisation.

1.3.2 Design and methods

This section gives an overview of the evaluation design and methodology, providing a summary of the qualitative and quantitative strands of the study.

Qualitative strand

The qualitative strand of the study was designed to enable a comprehensive exploration of the Telephone Support pilot, examining how potential participants were identified and referred, how the intervention was delivered and views on its impacts. It included interviews with Jobcentre Plus staff, provider staff and claimants.

The qualitative fieldwork was carried out across the two participating Jobcentre Districts. Further details on the sampling and recruitment of these interviews can be found in the Technical Annex (Appendix A).

Jobcentre Plus staff interviews. Two Jobcentre Plus Single Point of Contacts (SPOCs) and six Jobcentre Plus Work Coaches were interviewed across the two participating districts to explore their experiences of referring to the intervention, their views on outcomes and the factors that affect these. Participants were purposively selected based on three key criteria: their role; the Jobcentre Plus district; and, for Work Coaches, the Jobcentre Plus office in which they were based. Interviews with Jobcentre Plus staff were conducted by telephone and lasted approximately 30 to 45 minutes.

Provider staff interviews. Five VRCs who delivered Telephone Support were interviewed, as well as a provider manager with operational oversight of the pilot and another member of staff who was involved in the initial assessment process. Interviews with provider staff were conducted by telephone and lasted around 45 minutes.

Claimant interviews. Thirty-two claimant interviews were carried out (16 in each district). Interviews were conducted by telephone and explored claimant views and experiences of the Telephone Support intervention, including the referral process, experiences of the referral process, and experiences of the intervention and perceptions of outcomes. Claimants were purposively selected based on three primary criteria: age; gender; and Jobcentre Plus district. Interviews lasted no longer than an hour and claimants received £20 as a 'thank you' for their time.

The interviews were conducted with the use of a topic guide, designed in collaboration with the Department for Work and Pensions (DWP) (see Appendix B for staff topic guides and Appendix C for claimant topic guides). Fieldwork took place between December 2014 and March 2015 and interviews were digitally recorded with participants' consent.

Quantitative strand

In order to explore participant engagement and retention as well as initial effects of the Telephone Support Intervention, analysis of Management Information (MI) collected by the provider was carried out. Further details on the analysis of MI can be found in the Technical Appendix (see Appendix A – Technical annex).

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The descriptive analysis was conducted to explore the flows of numbers of participants entering and exiting the intervention, and the characteristics of participants such as age and gender.

Pre- and post-measures on the three key outcomes listed below were compared in order to track participants' progress in relation to the stated objectives of the pilot.

- Wellbeing (WHO-5 Wellbeing Index);
- Self-efficacy (general and job-search) [Job Search Self-Efficacy Index (JSSE); General Self-Efficacy Scale (GSE)]; and
- Mental health (Generalized Anxiety Disorder 7 Item Scale (GAD-7); Patient Health Questionnaire (PHQ-9)).

A brief description of the measurement instruments can be found in Table A.2 in Management Information section of Appendix A – Technical annex.

To estimate changes in outcome indicators during the life of the intervention, mean scores were compared between pre-test items taken at intake and post-test items taken at the end of the intervention. The difference between participants' pre- and post-measures were then used to show change in expected outcomes.

1.4 Report structure

The report presents integrated findings from the qualitative and quantitative elements of the evaluation. To preserve the anonymity of participants, names have been changed in illustrative case examples. The findings are presented in the following chapters:

Chapter 2: a description of the referral process and approaches to referral and targeting. The chapter also explores perceived enablers and barriers to both referral and take-up of the Telephone Support intervention.

Chapter 3: this chapter reports on the delivery of Telephone Support, describing the support received and views and experiences of the intervention. It also explores the role of VRCs delivering the intervention.

Chapter 4: a description of the levels of engagement and claimant retention on the Telephone Support intervention, exploration of engaged and disengaged programme participants and the profile of intervention participants.

Chapter 5: a presentation of perceived impacts in terms of participant wellbeing, work related self-efficacy and mental health. This chapter draws on both MI and qualitative data collected as part of the pilot.

Chapter 6: a discussion of key learnings from the Telephone Support pilot and the implications of the evidence emerging from the study for a larger-scale piloting of the intervention.

2 Referral and take-up

This chapter reports findings on referrals and take-up of the Telephone Support intervention. It explores views on who the intervention is appropriate for, approaches to referral and selection of claimants, as well as enablers and barriers to referral and take-up.

2.1 Referral to the Telephone Support intervention

This section reports on levels of referral to the intervention and how participants were identified. It also explores enablers and barriers to referrals, and the referral process from the perspective of claimants.

2.1.1 Overview of the referral process

Jobcentre Plus Work Coaches were responsible for identifying potential Telephone Support participants from their caseload and introducing the intervention to them. Referrals were initially made by phone to a central contact at the Telephone Support provider and followed up with completion of a referral form. The provider aimed to contact all referrals to carry out an initial assessment call within ten days of the referral being made.

2.1.2 Approaches to referral and selection of claimants

Work Coaches who referred participants to Telephone Support identified the following groups as suitable for referral:

- those with mental health needs, anxiety and depression;
- those with low confidence and/or low motivation, who were perceived to be struggling with their job search and had been unemployed for longer periods; and
- those who were experiencing difficult life events, for example, bereavement.

Staff providing Telephone Support felt the intervention was most appropriate for two groups in particular:

- 1 Individuals struggling with their job search, but actively seeking work and 'job ready'. This group included (a) the short-term unemployed (under a year) and (b) those recently made redundant or seeking a return to work after absence. Provider staff's view was that for this group, the job search focus of Telephone Support was particularly beneficial, including interview technique practice, support with CVs and applications and help with identifying new opportunities and potential job opportunities.
- 2 Individuals with low self-esteem or whose confidence had been affected by their job search. Provider staff's perspective was that for this group, the cognitive behavioural therapy (CBT) elements of Telephone Support, signposting to other provision [for example, Improving Access to Psychological Therapies (IAPT) services, local advice services] and provision of regular support and goal-setting was of benefit.

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Staff delivering the intervention felt it was less suitable in cases where individuals needed more than 'light-touch' short-duration support. This included those with severe mental health conditions (for example, severe depression, post-traumatic stress disorder or bipolar disorder), and cases where staff felt the range of barriers were multiple and complex and beyond the scope of the intervention.

'I had people with... very serious mental health problems that were more than something you can really talk to someone on the phone with... I have dealt with one girl who was actually suicidal as I was speaking to her and luckily we got help for her that day...I think once you're talking about...really serious mental health conditions then telephone support isn't - I don't say it's not helpful. But there needs to be other stuff involved there as well; it shouldn't be the main support platform for someone like that.'

(Vocational Rehabilitation Consultant)

In some of these instances, staff delivering the intervention felt it could still be of benefit, but realistic expectations of what could be achieved should be set, commensurate with the light-touch and short duration of the provision.

Staff also felt that Telephone Support was less suitable for individuals whose circumstances meant they struggled to engage with the intervention, because of the degree of commitment and motivation required. This included individuals with substance misuse problems, and those with chaotic lives or low motivation that meant the format of the intervention (in the form of regular phone contact) was challenging to maintain.

2.1.3 Levels of referral and enablers and barriers to referral

In total there were 569 referrals by Jobcentre Plus offices to Telephone Support. Jobcentre Plus staff identified a number of enablers and barriers to referral. Enablers included the use of open questioning to allow claimants to identify their needs, providing time for claimants to consider the support offered before agreeing to take it up and stressing the voluntary nature of participation.

The barriers to referral could be divided into: those that were linked to pilot implementation; and those that were linked to the intervention format and content.

Barriers linked to pilot implementation included:

- **Variable awareness of the pilot amongst Jobcentre Plus Work Coaches.** Awareness of the pilot was variable and not consistent across all Work Coaches in the pilot areas, with some not making any referrals as a result. Work Coaches observed that this may have been due to a breakdown in communication resulting in information not being cascaded to their team, or possibly because a high caseload and a wide range of provision available made it difficult for them to keep up to date with the full range of interventions available.
- **Limited information on the content/format of the intervention.** Work Coaches reported varying understanding of the purpose and content of the intervention. Consequently, they required further details from the provider on who the intervention was suitable for and more detail on the content of the intervention to enable them to answer claimants' questions and 'sell' the intervention to them. The short timescale of the pilot meant it was not possible for the provider to hold face-to-face meetings with all the referring Work Coaches, but for future roll-out Work Coaches felt this would be valuable.

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[If] we get emails and there's not really any provision for us to ask the person that's running it any questions... The things that we refer to, the claimant will ask us questions, and we've had to say, "I don't know the information. But when you speak to them, you'll be able to ask them your questions." I think it makes us look a bit incompetent. I think they may lose faith in us a little bit more. The more prepared we are, then the more we can, we can push things and the more we can promote them.'

(Work Coach)

Provider staff also acknowledged that Work Coaches needed further detail on the intervention and reported that during initial assessment phone calls claimants were sometimes unclear about the purpose of the intervention, what it involved and who was delivering it. In particular, there were claimants who thought that the intervention was mandatory, or misunderstood its focus and were expecting to receive counselling. Provider staff felt that misunderstandings of this kind undermined claimants' confidence in the intervention and reduced participant engagement and ultimately take-up.

'I don't think the Jobcentre advisors had that much information on the actual service to be honest. They were really vague and that's not just one Jobcentre... They knew the basic information, but if the candidate wanted further information then they wouldn't be able to provide that because they just didn't have it... When we do that initial triage call the candidate would say "Well we don't even know why you're ringing us" or "We're not sure what this programme is about" or "We don't have much information". So we did have candidates challenge us on that side of things.'

(Telephone Support provider staff)

- **Short duration of the pilot.** The short duration of the pilot made it difficult to raise awareness of the intervention amongst Work Coaches. Furthermore, among those who were aware of the pilot, difficulties were experienced in identifying, preparing and referring claimants in the timescales available. In addition, Work Coaches reflected that they were more likely to refer claimants to interventions on which they had received positive feedback from past referrals, and the short timescales for this pilot meant there was limited scope for feedback from past participants.
- **Use of the term 'psychological wellbeing'.** Work Coaches felt that using the term 'psychological wellbeing' was off putting for some claimants and Work Coaches recommended not using this phrase to promote the intervention.
- **Confidentiality and the referral process.** Referrals to the intervention were typically made by phone with the claimant present. Some Work Coaches reported finding it difficult to discuss the needs of the claimant over the phone during the referral process, highlighting the open-plan nature of Jobcentre Plus offices and the potentially sensitive nature of the conversation.

Jobcentre Plus staff felt that there were a number of issues linked to the intervention content and its format that impacted on levels of referral, including:

- **Discussion of mental health needs.** Broaching issues related to mental health with claimants was challenging for Work Coaches who might not have had experience of discussing such needs previously. They identified a need for training for Work Coaches in how to identify mental health needs and discuss them effectively with claimants, to enable them to make appropriate referrals.

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- **Support format.** There was a view from Jobcentre Plus staff that claimants preferred face-to-face support because it was easier to build rapport and establish trust and confidence. In some instances therefore, the telephone-based format was felt to have put off potential participants. Examples were provided of previous face-to-face support that had been well received, including provision under the Condition Management Programme.
- **Support duration.** Work Coaches reported that the short duration of the support (typically six sessions, one delivered each week) meant that some claimants did not feel it would adequately meet their needs and consequently decided not to take-up the intervention. This was exacerbated by the short duration of the pilot, with claimants referred at later stages of the pilot receiving a shorter period of support.

2.1.4 Claimant experiences of selection, referral and initial assessment

This section explores claimant experiences of both the referral by the Jobcentre Plus Work Coach and the initial assessment phone call made by the provider prior to the start of the intervention.

Jobcentre Plus referral

Claimants generally found the Jobcentre Plus referral to be convenient and quick. This is because their Work Coaches took the lead in the referral process so that claimants did not have to find out about the intervention themselves or complete any onerous applications forms.

Claimants experienced variable approaches to selection by Jobcentre Plus staff; the three main experiences reported were:

- **Appropriate selection.** Claimants perceived referrals as appropriate because their needs had been accurately identified and matched the support that the intervention provided. The way in which claimant needs were identified varied; in some instances Work Coaches perceptively drew on their interaction with claimants to correctly identify needs, while in other cases claimants themselves brought their needs to the attention of Jobcentre Plus staff.
- **Lack of clarity on why they were selected.** In contrast to the above, claimants felt that referrals were made without reference to their emotional and/or employment related needs. They were simply asked to go on the intervention without being told why they were selected.
- **Inappropriate selection.** When it was clear why they were selected, claimants felt it was inappropriate in instances where Work Coaches had incorrectly assumed that the claimant's specific employment or emotional needs made them suitable for the intervention.

The appropriateness of selection was of limited concern to the long-term unemployed, who had grown accustomed to attending courses and so were not concerned with why they were selected for this particular intervention. However, for other claimants, their perceptions of the appropriateness of their referral influenced their experiences of the referral process and, in some instances, their motivation for participation and experiences of the intervention delivery. Claimants welcomed the intervention as an additional source of support where they felt it met their needs, as accurately identified by their Work Coach. Conversely, where claimants disagreed with their Work Coach's assessment of their needs, they were confused

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about why they had been referred or questioned the value of the intervention. This was particularly the case where Work Coaches had incorrectly assumed that claimants had mental health conditions, such as anxiety or depression.

Case illustration: Claimant feeling selection was appropriate

Belinda also heard about the intervention through her Work Coach. During one of the routine appointments, Belinda broke down in tears in front of the Work Coach because she was struggling to find work and was experiencing a relationship breakdown at home. She felt she could no longer cope.

The Work Coach explained that she was referring her to a telephone support intervention that used CBT and would give her the emotional tools to deal with the stressors in her life. Belinda was grateful to the Work Coach for picking up on these issues and for referring her to an intervention that may be of help.

(Completer, Female, Aged 25-49)

Case illustration: Reasons for selection not clear

Jenny heard about the intervention during a routine meeting with her Work Coach. She was given limited information about the intervention. The Work Coach said that they had been asked to select certain people for a telephone support service delivered by a counsellor.

Although Jenny welcomed any support that the Jobcentre Plus could give, she left the meeting with her Work Coach feeling unclear about why she was selected or what the intervention actually involved.

(Non-completer, Female, Aged 25-49)

Supporting the views of provider staff and Jobcentre Plus Work Coaches that the information they had on the intervention at the point of referral was minimal, claimants generally also reported that they were given limited information. In some instances Work Coaches attributed this to the intervention being new and claimants were told that the provider would give further information.

'Well she [Work Coach] said it's like one-to-one support, you know, and – she did sort of stress that it was a pilot and I don't know that she knew too much about it really, but she said it's just come out or something and, ... "Somebody will be ringing you in the next ten days", but she did stress that it wasn't, you know, mandatory, sort of thing.'
(Completer, Male, Aged 50+)

Where information was provided by the Work Coach, it was generally limited to the purpose of the intervention and how it would be broadly delivered, rather than the content of the intervention. The purpose of the intervention was framed in one of three ways:

- **Emphasis on the wellbeing component.** The intervention would help with new or ongoing emotional issues faced by claimants. For example, it would help with confidence and anxiety issues.
- **Emphasis on the job search and work-related components.** For example, the intervention would help to update the claimant's interview or IT skills. As discussed earlier, this may be because staff found it difficult to broach the issue of mental health with claimants and/or they thought the phrase 'psychological wellbeing' might deter claimants.

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- **Emphasis on both components.** The intervention would help with claimants' wellbeing issues but also focusing on the job search and work-related components.

In cases where claimants received more detailed information on the delivery of the intervention, this included that the sessions would be one-to-one, delivered over the phone, and by an external third party organisation. In some instances the Work Coaches mentioned the estimated number of calls claimants could expect to receive or the time period over which calls would be made (estimates ranged from six to nine calls or from six weeks to six months). These estimates did not always match up with what claimants eventually received, as providers delivered the intervention flexibly to meet claimant needs.

'Well, she [Work Coach] just mentioned there was a service that rings you up every week, you know one day a week and talked about your wellbeing and stuff like that and it was a wellbeing welfare type of call. It's "Are you all right?" and "How are things going?" and this type of thing and she asked me if I'd like to take part in it. I says "Yeah"'

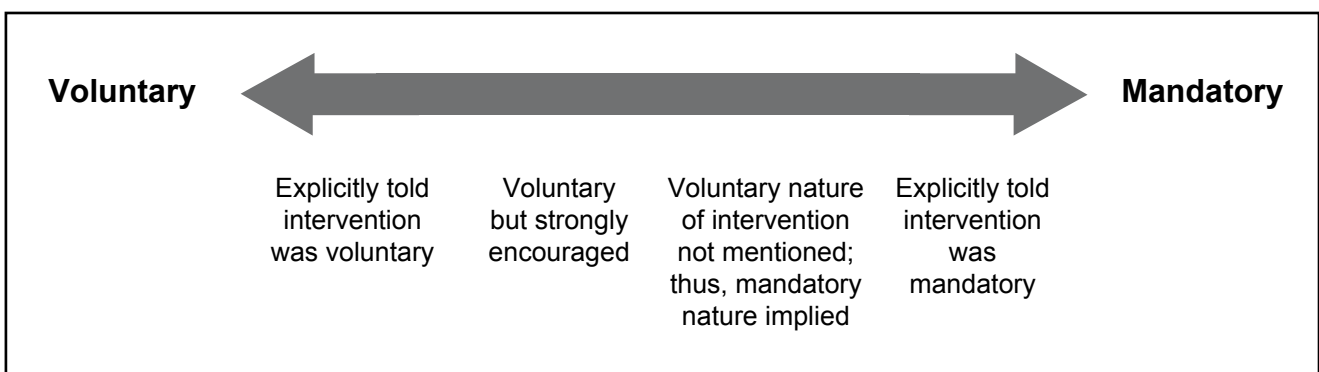
(Completer, Female, Aged 25-49)

Not all claimants wanted additional information about the intervention. However, those who did wanted information for three reasons:

- to get a better understanding of who the provider organisation was, given that they would be asked to trust and open up to them;
- to feel less anxious about what the actual delivery of the intervention would entail, particularly if they had underlying anxiety issues; and
- to give claimants a better understanding of what the next stages of the process would involve.

Another key aspect of the messaging was around whether the intervention was voluntary or mandatory. The Telephone Support intervention was designed as voluntary, but claimants reported receiving one of four messages, which either emphasised or undermined this message to varying degrees.

Figure 2.1 Messaging around the voluntary/compulsory nature of the intervention



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The two quotes below illustrate how the compulsory nature of the intervention was either explicitly mentioned or suggested.

'Yeah, well I felt, it [being on the intervention] won't do any harm to try it... I've got nothing to lose, it can only be helpful and she [Work Coach] seemed to think it was a good thing and she was sort of pushing it a bit.'

(Completer, Female, Aged 25-49)

'Yeah, I think so [intervention was mandatory]. I think she [Work Coach] more or less said I had to sort of have it because I had health, mental health problems. I think she said mental health problems from what I can remember.'

(Completer, Female, Aged 50+)

Claimants tended to be more receptive to the intervention when its voluntary nature was explicitly mentioned. Understanding that the intervention was voluntary helped claimants to frame it as an intervention that was there to support them, rather than something they had to do under the threat of sanctions. This increased their engagement and investment in the intervention, compared to the hostility or indifference expressed by claimants who felt the intervention was mandatory. However, there were also claimants who, despite being told it was voluntary, were not convinced and felt they would be sanctioned for not participating in the intervention. One key reason for this mistrust was the experience of having been sanctioned before for non-compliance in relation to their benefits or other interventions.

Initial assessment call

Once a referral had been made to the intervention, the provider followed up with an initial assessment call to complete a pre-intervention assessment of wellbeing. This assessment was typically completed by a separate team, before cases were allocated to the Vocational Rehabilitation Consultant (VRC) who would follow up with the participant to deliver the intervention.

Claimants reported receiving their first call between one to three weeks after having spoken to their Jobcentre Plus Work Coach about their referral. Occasionally, claimants reported receiving the call sooner, such as three to four days after the Jobcentre Plus referral, or did not recall having received an initial call. The recurrent view was that waiting a couple of weeks for the start of the intervention was not too long and provided enough time for claimants to prepare themselves. The exception to this was claimants who were experiencing immediate wellbeing issues in their personal life that affected their job search activities, such as relationship breakdowns, and these claimants needed emotional support much sooner.

Claimants reported variation in who contacted them, the duration of initial call and what was discussed. The person who contacted them was either the VRC from the provider organisation who would eventually deliver the Telephone Support, or someone who was tasked with doing the initial screening work with the claimant.

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Analysis of referral data indicates that there was a low level of engagement with initial assessment, as assessments were successfully completed with 250 claimants (just under half, or 44 per cent, of the referrals made). Possible reasons for this are discussed in relation to take-up more generally in section 2.1.6. Management Information (MI) data collected by provider organisations showed that the most common length of the initial assessment phone call for all three groups – non-starters, dropouts and completers¹⁴ – was 20-29 minutes (Table 2.1).

Table 2.1 Length of initial phone call, by whether completed intervention

Length of initial phone call ¹	Non-starters	Dropouts	Completers	<i>Column percentages</i>
				All who received initial phone call
10-19 minutes	38	29	39	37
20-29 minutes	46	40	41	43
30-39 minutes	13	29	14	17
40 minutes or more	3	2	6	4
<i>Base (excludes missing data on length of phone call)</i>	<i>104</i>	<i>55</i>	<i>90</i>	<i>249</i>

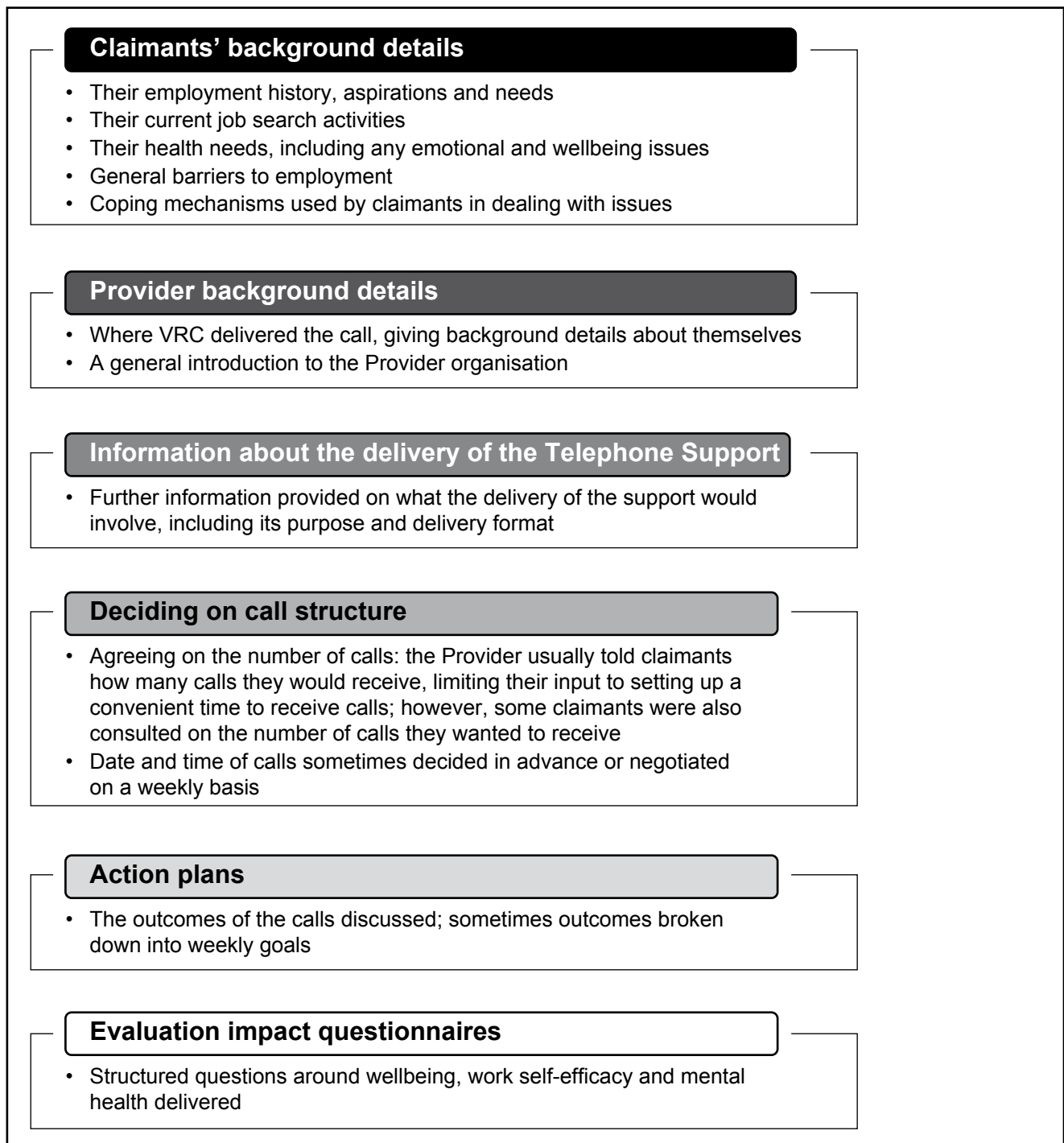
¹ This is the assessment phone call prior to the intervention starting.

Claimants viewed the calls as an important introduction to the intervention; giving an opportunity for the provider and claimant to get to know one another, for the claimant to gain further information and reassurances about the intervention, and for the provider to have an opportunity to collect baseline outcome data. Accordingly, the discussion usually covered one or more of the issues outlined in Figure 2.2 in varying depth.

¹⁴ Non-starters are defined as those who completed an initial assessment call, but did not participate beyond this point. Dropouts are defined as those who completed at least one phone call after the initial assessment call but did not complete the intervention. Completers are defined as those who completed the intervention as planned (typically six sessions).

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Figure 2.2 Discussion points during the initial assessment provider call



Claimants particularly appreciated receiving further information about the intervention and at least an overview of what their involvement would entail, including how often they would be called and how the calls would be arranged. This helped claimants make an informed decision around continuing with the intervention and to prepare for it mentally. However, the variation in the provision of information left some claimants needing more information. This 'information deficit' ranged from not knowing how the intervention would benefit them and whether there was an action plan informing each session to not knowing whether the support would be offered over the telephone or when to expect their next call.

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Claimants also had mixed views on the questions that were asked as a part of the outcome evaluation (see Chapter 5 for further details). Although it was acknowledged that the questions were an important part of the pilot, claimants had the following reservations:

- **The questions were unexpected and intrusive.** Claimants who expected the intervention to be only work-related were confused as to why they were asked emotional wellbeing questions. This sometimes led to claimants questioning why they were on the intervention and feeling ‘ambushed’ by being asked questions of a personal nature.

‘It [first call] did [make me feel nervous], the first one... I didn’t expect her [VRC] to ask me about it [mental health issues] or whatever. I think if – when the Jobcentre are sending you on these things or getting people to ring you, I think the Jobcentre should tell you more about it. Because I had no idea, I was just told that it was a pilot scheme and that was it, I hadn’t got a clue what... I think, personally, I think they should tell you what it’s all about or what they’re going to say to you or whatever, ‘cause I hadn’t a clue.’

(Completer, Female, Aged 50+)

- **The questions were difficult to answer.** This was for two reasons: claimants sometimes found it hard to use response scales to rate their emotional wellbeing. and they had yet to establish a rapport with the provider and so felt awkward answering personal questions from a stranger over the telephone.

Although VRCs did not typically complete these initial assessment calls, when they were involved they were critical in shaping claimants’ experiences of the initial call and in setting positive expectations about the forthcoming intervention. In particular, claimants appreciated VRCs that came across as person-centred, knowledgeable and approachable. These qualities reassured claimants that their advisor would be supportive and understanding; key aspects of these qualities are outlined below and are discussed in depth in Chapter 3:

- Actively listening to the needs and concerns of claimants without judgement.
- Having a polite and engaging telephone manner.
- Providing reassurances on what the intervention would involve and that their discussions would be confidential.
- Being knowledgeable about the intervention and the employment or mental health conditions faced by claimants.
- Convincing claimants that they and the VRC would work as partners in the intervention.

2.1.5 Level of take-up

In total there were 569 referrals by Jobcentre Plus Work Coaches to the Telephone Support pilot. Of these, 250 claimants were successfully contacted for an initial assessment phone call (44 per cent of total referrals). The take-up rate for those contacted was 58 per cent, with 146 claimants taking up the intervention.¹⁵ This report defines take-up as having completed at least one intervention phone call after the initial assessment call.

The rate of completion (retention rate) for those who started the intervention was 62 per cent, with 91 claimants (16 per cent of total referrals) ultimately completing the intervention. An overview of take-up, completion and dropout rates is summarised in Table 2.2, and further summarised later in Figure 4.1.

¹⁵ Those who took up the intervention (‘starters’) were the ones who had an initial assessment phone call and at least one subsequent intervention call.

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Table 2.2 Take-up, drop-out and completion rates

	Count	Column percentages (all referred)	Column percentages (all assessed)	Column percentages (all started)
Completed intervention	91	16	36	62
Started then dropped out	55	10	22	38
Assessed but did not start	104	18	42	–
Referred but not assessed	319	56	–	–
Total count	569	569	250	146

Base for 'all referred': all claimants referred to the intervention by Jobcentre Plus. Base for 'all assessed': all those recorded as completing an initial assessment call. Base for 'all started': all who completed at least one intervention phone call.

2.1.6 Barriers to take-up

As indicated in Table 2.2, 42 per cent of claimants had the initial assessment call but disengaged from Telephone Support after the initial call, with the VRCs either unable to make contact with them, or claimants declining further contact.

Jobcentre Plus and provider staff identified the following possible reasons for less than half of referrals reaching the initial assessment stage (44 per cent), and further attrition between the initial assessment call and starting the intervention:

- Given the nature of the issues participants might be dealing with (such as anxiety or low confidence), staff felt a reasonably low take-up of the intervention was to be expected.
- Anxiety and other mental health conditions meant some participants were reluctant to answer phone calls they were not expecting, or from an unfamiliar telephone number.
- The cost of listening to voicemail messages or returning calls meant participants were not always able to return calls or respond to messages left by the provider.
- Some claimants raised concerns over the confidentiality of the intervention, and were consequently reluctant to engage.
- There was limited scope for Work Coaches to specify a time and date for the initial assessment call at the point of referral, and to provide additional context to facilitate engagement with the provider when making contact with the participant.
- During the initial assessment call, participants gained a clearer sense of what the intervention involved and decided not to take it further because they:
 - had misunderstood the nature of the intervention (for example, they thought it was counselling) and once this was clarified they decided not to take it up;
 - were under the impression that it was mandatory and withdrew when they realised it was a voluntary intervention.

2.1.7 Levels of motivation and engagement on referral

A number of factors influenced claimants' motivations to participate in the intervention.

These included:

- perceptions of whether the intervention was voluntary or mandatory;
- whether claimants had unmet employment or wellbeing needs and how pressing these were;
- confidence in the ability of the intervention to meet these wellbeing needs;
- desire to contribute to the pilot and to raising awareness of the mental health conditions that are often associated with unemployment;
- the length of time they were unemployed and their exposure to previous interventions and courses.

Accordingly, claimants can be categorised into three groups in terms of their motivation levels: motivated; neutral or passive; and unmotivated or hostile. These will be described in more detail below. A high level of motivation at the start of the intervention generally translated into a high level of engagement throughout the telephone sessions, as highly motivated claimants were most receptive to and willing to invest in the intervention. There were three exceptions to this:

- When the delivery and format of the provider service did not meet claimants' expectations (discussed in Chapter 3).
- When claimants' expectations of the intervention content were not met. For example, they expected to receive more employment-related support than they did or they received less emotional wellbeing support than they needed.
- When claimants had acute emotional wellbeing issues, such as severe depression, which restricted their participation in the intervention.

Motivated claimants

Claimants were motivated to do the course where they felt they could benefit from it or help other claimants by participating in the pilot. These were claimants with either long-standing emotional and/or employment related issues that had not been addressed or were at a point in life where they needed additional support, for example, when transitioning from ESA to JSA or experiencing a particular emotional issue in their life, such as a relationship breakdown.

The types of support needed included:

- **Support for mental health conditions.** This included support around anxieties, confidence issues experienced by both those with mental health conditions and claimants in general (e.g. the long-term unemployed), depression and self-esteem issues. These issues sometimes were focused on finding work, for example, anxieties around job searching or interviews, but could also be much more widely entrenched in the claimants' life, such as depression. A key appeal of the intervention was that it acted as a gateway to emotional support from trained staff that claimants felt they could not access elsewhere.
- **Job search support.** This ranged from needing support around specific job search skills, such as sending CVs via email, to simply wanting to talk to an advisor outside of the Jobcentre Plus to gain a new perspective on job searching.

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- **The need for both emotional and job search support.** There were claimants who felt they needed both types of support mentioned above.

Neutral or passive claimants

These were claimants who were not overly invested in the intervention at the start and/or had mixed views but were still open to participating in the pilot for the following reasons:

- **They were accustomed to going on programmes and courses.** This was particularly the case for the long-term unemployed who had a history of being placed on courses and so had become used to this.
- **They trusted their Jobcentre Plus Work Coach.** There were claimants who had developed a strong rapport with their Work Coach and trusted their judgment that the intervention would be suitable for them.
- **They were not convinced the intervention was for them but were nevertheless open to learning.** These were claimants who felt that the emotional and/or job search elements of the intervention would not be suitable for them. However, they agreed to go on it because they were open to any learning and training opportunities offered by the Jobcentre Plus, even where they had not been on courses previously.

Unmotivated or hostile claimants

These tended to be claimants who were resistant to intervention for two main reasons:

- **They did not need the support it provided,** as they were capable of looking for work on their own and/or did not have any emotional issues. They also felt they were not going to benefit from the intervention in any other way.
- **They felt removed from the labour market** because of acute mental health conditions, such as severe depression, and remained unconvinced of their ability to participate fully in the intervention as a result.

Claimants' resistance to the intervention was heightened by their perception that it was compulsory, as this added to the feeling that they were being made to do an intervention that would not benefit them.

These findings indicate that selecting claimants effectively and screening potential participants may help to improve the levels of engagement from referral to take-up.

2.2 Lessons learned

Findings from the pilot suggest the following steps would increase the number and quality of referrals:

- Hold face-to-face meetings with Work Coaches to increase awareness and provide more detail on the intervention, giving specific case examples, and further clarity on the range of support provided.
- Specify who the intervention is aimed at and communicate this effectively to Work Coaches. Effective screening may help to minimise the number of claimants who are unmotivated because their needs do not match the intervention or are too acute to be addressed by it.

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- Continue to ensure that the referral process requires minimal input from claimants.
- Use text reminders, and specify the date and time for the initial assessment call so that participants know when to expect contact.
- Alert Work Coaches to instances where there has been no contact between the provider and the claimant, to enable them to follow up with the claimant.
- Consider continuity of caseworker (for example, VRC) between initial assessment and main intervention to build trust and rapport and aid retention.

In terms of encouraging take-up, the following recommendations were made by staff and claimants:

- Provide detailed information about the provider and the format and content of the support so that claimants feel sufficiently informed and can make an adequate assessment of its usefulness.
- Ensure consistent messaging around the voluntary nature of the intervention.

3 Intervention delivery

This chapter reports on the delivery of Telephone Support, describing the support received and views and experiences of the intervention.

3.1 Overview of the Telephone Support intervention

Telephone Support was not governed by a prescribed format. Instead, it was designed to be a form of support that could be tailored to the specific needs of claimants. It was therefore important for this study to gain an insight into the varied format and content of the support that claimants received.

The intervention was designed as a short duration intervention and a case was considered 'complete' if the participant completed the number of calls set out in the initial assessment call (although there was flexibility to offer up to nine where this was felt to be necessary). Calls were typically made weekly, although there was flexibility to offer more regular or less frequent calls where this was felt to be appropriate.

The findings indicate that there was a great deal of variation in the content of the support, influenced by both claimant needs and the approach of the Vocational Rehabilitation Consultants (VRCs) delivering the support for the provider. These issues are discussed in detail below.

3.2 Experiences of intervention delivery

This section explores the key features of intervention delivery including views on the telephone-based format and intervention content, as well as the role of VRCs.

3.2.1 The format of the support

This sub-section details staff and claimant views on the structure of intervention delivery. This includes the following aspects of intervention delivery:

- Telephone format of the sessions.
- External providers delivering the support.
- Number of sessions.
- Frequency of sessions.
- Duration of sessions.

It is important to note that claimants' experience of the support rested as much on how it was delivered as it did on the content.

Telephone Support format

The Telephone Support pilot was designed to explore the feasibility and efficacy of telephone-based, combined wellbeing and employment-related support. Both provider staff and claimants had mixed views on providing support of this kind by telephone. Strengths of a telephone based format were felt to be:

- **Flexibility.** Being able to offer appointments at various times of day to fit in with other commitments and change appointments flexibly when necessary was seen as a key strength. This was particularly mentioned by provider staff.
- **Cost effectiveness.** Provider staff perceived the Telephone Support to be more cost-effective because it was less time intensive than face-to-face support, requiring no travel or physical meeting spaces.
- **Responsiveness.** Provider staff felt that the Telephone Support had the potential to be more responsive to need than face-to-face support because it could be provided more rapidly and cover a wide geographical area.
- **1-2-1 format.** Staff delivering Telephone Support felt its strength was the one-to-one format that allowed them to tailor the content to the individual concerned. The format gave participants the time to discuss the issues they wanted to address and for the support to be tailored accordingly. It was observed that a group based intervention would not provide this level of tailored support. Claimants also shared this view, particularly those that had anxiety about functioning in a group environment.

'I know it sounds a bit arrogant but it [1-2-1 support rather than group-based support] felt like you were the only one she [VRC] was looking after and that was fine for me. I don't mind doing group work, but so often [there is] a lot different to a lot of people... [some are] not really bothered about what's going on and I think that takes the whole group back, whereas I've found if things weren't going right over the phone with [VRC] it would only be me to blame. ... like I say, the fact that you feel like you're the one that's being looked after gave me that little bit more confidence.'

(Completer, Male, Aged 25-49)

- **Anonymity.** One key reason claimants preferred telephone-based support was that it provided an anonymous space to discuss sensitive health and emotional wellbeing issues. Claimants sometimes felt they would be too anxious to discuss these issues in person or in a group environment.

However, VRCs and claimants who voiced reservations over providing support of this kind over the phone had the following concerns:

- **Building trust and rapport.** Some VRCs raised concerns that it was difficult to build trust and rapport over the phone, particularly when they had never met the participant in person. This view was supported by some Jobcentre Plus staff who said some claimants were reluctant to discuss personal and sensitive issues over the phone with someone they had not met. Claimants elaborated on this by explaining that two factors impeded their ability to build rapport over the telephone:
 - they felt uncomfortable not being able to 'put a name to a face' of the VRC; and
 - they felt uncomfortable not being able to pick up on non-verbal cues during the interaction that would be helpful in establishing the 'sincerity' of the VRC.

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- **Practical limitations.** VRCs raised a number of practical issues including problems with incorrect telephone numbers, and participants not answering calls and not being able to return calls or pick up voicemails because of the associated costs. Work Coaches also acknowledged this as an issue, and examples were given of participants who said they had never been contacted despite the provider having made several attempts. One key insight provided by claimants as to why they would not answer calls was a reluctance to answer a call when the telephone number was withheld. An additional practical consideration for claimants was that the calls tied up their telephone lines. Although claimants were not clear why this was important, the inference was that the phone lines were not free for Jobcentre Plus or potential employer contact.
- **Preference for group support.** Claimants who preferred a group intervention felt that it would have enabled them to benefit from peer support.

External provider delivering the support

Claimants did not comment on this extensively. However, where claimants preferred an external provider, this was for two reasons: (a) the perception that Jobcentre Plus support was not geared towards addressing wellbeing issues and (b) they associated the Jobcentre Plus with enforcing work search activities and sanctioning and so did not feel able to talk openly about issues with their Work Coach.

Number of sessions

As discussed earlier, there was variation in the number of sessions that claimants received. Claimants had four views on the number they received:

- **Claimants did not want to have any more sessions than they did.** There were three reasons for this: (a) claimants felt that the support had addressed their needs and did not need to extend it; (b) some were indifferent to the support received and were not particularly inclined to want more sessions; and (c) some were unhappy with the support they were receiving and were content with terminating it.
- **Claimants wanted more sessions.** This tended to be for two reasons: (a) they were given the expectation at referral by the Work Coach that they would receive more sessions than they did and/or (b) the support had only just begun uncovering key wellbeing issues, which needed further sessions to address.
- **Claimants wanted an opportunity to review and extend sessions.** One view among claimants was that there should be an opportunity to review the duration of the intervention at the end and to extend it where claimants were still experiencing significant issues. However, it must be noted that this would have resource implications for providers.
- **Follow-up sessions.** Another view among claimants was that the support should not end abruptly after the six to nine session. Rather, that the provider should conduct a limited number of follow-up calls a few weeks after the end of the intervention (for example, two weeks and then four weeks after) in order to check-in on claimants and to assess whether further support was needed.

Frequency of sessions

The recurrent view was that weekly sessions worked well. Claimants indicated that there were three reasons for this:

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- **Eased isolation.** There were claimants with emotional wellbeing issues, such as depression and anxieties, who had very little contact with other individuals outside of their regular Jobcentre Plus appointments. These claimants welcomed and looked forward to the opportunity to speak to someone that understood them on a weekly basis.
- **Enabled enough time for developments.** The weekly appointment gave enough time for claimants to work on the 'homework' set by VRCs and also for developments to take place in their employment and wellbeing. This ensured that there was something meaningful to discuss the following week with the claimant's VRC.
- **Out of session contact.** Claimants were more accepting of the weekly call structure when they had the option to contact VRCs outside of the agreed sessions. This gave them the option to access support if they experienced work-related or wellbeing issues in between calls. This support was particularly important for those with more acute wellbeing issues and/or those going through a particularly difficult emotional period in their life.

Claimants who wanted calls much more frequently tended to be those with memory issues and so needed the additional calls to remind them of what was discussed and the action points they had to work on.

Duration of sessions

The recurrent view amongst claimants was that an hour was sufficient to cover both the employment and wellbeing aspects of the intervention. One view was that anything less than an hour would not be sufficient to cover both the employment and wellbeing needs of the claimant. However, there were claimants with severe depression who found it difficult to concentrate for an hour.

3.2.2 The content of the support

This sub-section provides an overview on the content of the support received by claimants and their views on this support.

Overview of the content of the support

As a pilot with no prescribed or pre-existing course content there was variation across VRCs in terms of their approach. The content of telephone calls and the support provided varied depending on the needs of the individual and to some extent was influenced by the VRCs background and preferences. As a result, claimants had varied experiences which fell into three broad categories:

- **Employment-related support primarily offered.** This included support around CVs, IT skills, completing applications, improving interview skills and online job searching.
- **Emotional wellbeing support primarily offered.** VRCs supporting claimants around both work-related and non-work-related emotional issues. These included support around stress, anxiety and depression.
- **A mixture of emotional and job search support.** This was done either consistently throughout the intervention or VRCs tapered one form of support for another in response to claimant needs. For example, a VRC re-focused their attention from general wellbeing advice to specifically building the confidence of a claimant to contact employers when it became clear this was the key issue.

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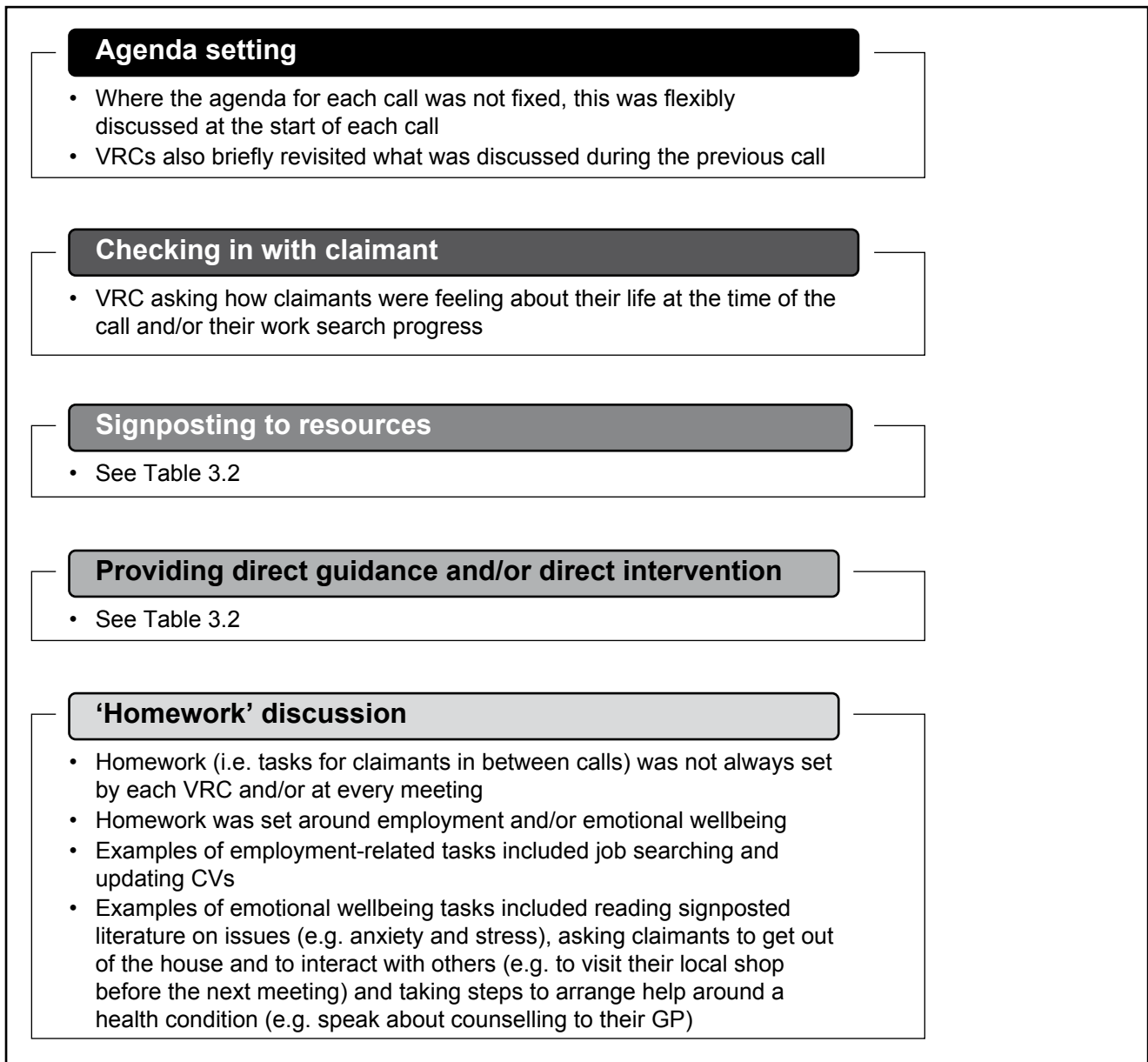
VRCs' approaches to delivering support also varied and ranged from listening to claimants to much more active forms of support. One form of active support was VRCs acting as gateways to key information by signposting claimants to useful resources around mental health conditions (for example, literature and websites on anxiety, stress) and/or work related support (for example, sending job descriptions to refocus claimants' work aspirations and signposting claimants to local computer literacy courses). Another form of active support was VRCs providing direct guidance and sometimes actually directly intervening to help claimants. As Table 3.1 illustrates, direct intervention was particularly used for employment-related support.

Table 3.1 Types of support delivered to claimants

Type of support	Emotional wellbeing	Employment related
Direct guidance	<ul style="list-style-type: none"> Encouraging claimants to access external health support, such as seek counselling or pain management help Building resilience by helping claimants frame job setbacks positively 	<ul style="list-style-type: none"> Building claimant's confidence to talk to their Work Coach about being sanctioned on Jobseeker's Allowance (JSA) Advice on how to deal with interviews
Direct intervention	N/A	<ul style="list-style-type: none"> Chasing up job applications with employers on the claimant's behalf Providing input to CVs Providing a practice interview with the claimant over the phone Doing job searches for claimants Uploading CVs on job sites for claimants

A typical telephone session had one or more of the components identified in Figure 3.1.

Figure 3.1 Components of telephone discussions



Claimant views on the support

This sub-section details claimant views on the following aspects of the intervention:

- action plans;
- agenda for each call;
- the type of support offered;
- signposting and advice; and
- homework.

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Action plans

Claimants with an action plan found this useful as a motivational device which enabled them to work to defined employment and/or wellbeing related goals. This motivational effect was amplified where VRCs gave claimants tools, such as diary templates, to log their progress against these goals.

Person-centred support

VRC qualities are discussed at length in the next section. It is worth noting here that claimants valued VRCs showing flexibility in their approach. A key part of this was ensuring that the agenda for discussion was flexible enough to meet the needs of claimants on a weekly basis. However, the recurrent view was that some form of broad agenda for discussion was needed in order to help claimants prepare for each discussion and to give shape to the weekly discussions, even if VRCs deviated from this structure to meet claimant needs.

The type of support offered

Given the variability in claimant needs and VRC delivery, the balance of wellbeing and/or emotional support offered by VRCs did not always meet claimants' need. There were claimants who felt they did not get enough employment and/or wellbeing support, whilst others felt the support was just right for them. Those that valued employment support exclusively tended to be the short-term unemployed who wanted to improve the skills needed to get into employment quickly and/or those that did not feel they had wellbeing issues. However, the recurrent view was that the wellbeing support was highly valued by claimants, for the following reasons:

- **It ensured support was 'holistic'**. Claimants valued that the support was not just about trying to get them into employment but addressing some of the underlying emotional issues that increased claimant's distance from the labour market.
- **It was person-centred**. Claimant issues were not reduced to their inability to find work but treated as part of the wider considerations in their life.
- **It was different to the employment-related support accessed by the long-term unemployed**. The long-term unemployed tended to have gone through a number of work-related courses in the past and so valued the emotional support that the intervention offered.

Signposting and advice

Claimant experiences of this aspect of the support were positive where they felt that the signposted resources were (a) relevant to their needs; (b) they had not come across the resources before or could not access these themselves; and (c) the resources were related to what had been discussed during the telephone sessions. Relevance was also key to positive experiences of the advice given. Claimants appreciated advice that was targeted and specific to their needs rather than generic. For example, a claimant looked unfavourably on the generic advice to take up yoga to manage his stress, when really the claimant required targeted information on how to manage stress on a day-to-day basis and in specific situations, such as job interviews.

VRCs observed that their specialist expertise in both wellbeing and employment, and the time they had each week with participants meant they were well placed to signpost participants to relevant support for both wellbeing and employment.

Homework

Where homework was effective, it enabled claimants to appreciate their own progress throughout the intervention and helped to inform each discussion, enabling continuity between calls. Claimants had positive experiences of the homework where it was relevant to their needs; reflected what was discussed at the session; was manageable in the timeframe; reflected the claimant's ability; and was flexible. That is, claimants could do it at their own pace if they were struggling and the nature of the homework could change to take account of claimant needs.

These activities differed to the work-related activities claimants are expected to undertake while on JSA because they could focus on wellbeing or work. There were also no sanctions attached to the activities agreed, giving claimants the freedom to adapt the activities or change focus if they wished.

3.2.3 Role of the Vocational Rehabilitation Consultants

The primary role of VRCs prior to the pilot was to provide 'in work' support to help individuals sustain employment. VRCs volunteered to work on the Telephone Support pilot for its duration. Staff employed in the VRC role came from a range of backgrounds, including occupational therapy, employment advice, and mental health support.

Training received by VRCs for the Telephone Support pilot focused on the logistics of pilot implementation, for example, the case management system and the referral process. In terms of intervention content, the VRCs drew on their experience of providing in-work support and drew on a range of resources held by the provider including action planning tools and factsheets. VRCs also had regular meetings to discuss pilot delivery, share good practice and address any implementation issues.

If piloted on a larger scale in the future, VRCs recommended additional training on the range of support that could be offered to participants (while still allowing enough flexibility for content to be tailored to individuals). This would ensure all VRCs are familiar with the full range of options available and would reduce the risk that the content of Telephone Support is determined by the strengths and preferences of the delivery staff rather than the needs and preferences of the participant.

For claimants, the support received from VRCs was central to their experience of the intervention. Although claimants had varying employment and wellbeing needs, they tended to reflect favourably where VRCs were seen to have both the 'softer skills' needed to develop rapport and trust, and tangible knowledge of the issues they faced and the resources that could help. This enabled claimants to feel they could speak openly and had their individual needs heard, understood and accommodated. This was particularly important as claimants were asked to disclose personal issues over the telephone to someone they had not met. Accordingly, claimants valued three core qualities in VRCs that are summarised in Table 3.2.

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Table 3.2 Core VRC qualities valued by claimants

Qualities of VRC	Key aspects of quality
<p>Approachable. The ability to provide a relaxed and collaborative environment for open discussion.</p>	<ul style="list-style-type: none"> • Polite and informal. Having a polite telephone manner and the ability to provide a relaxed environment. This included the use of humour to put claimants at their ease. • Collaborative. VRCs treating claimants as an equal partner was seen to be important in helping to establish a trusting relationship. A key part of this was VRCs encouraging claimants to talk about their concerns, to ask questions and taking their views seriously. • Reassuring. VRCs providing reassurances around confidentiality of the discussion where appropriate.
<p>Person-centred. The willingness to treat the claimant as an individual</p>	<ul style="list-style-type: none"> • Active listening. VRCs listening to claimant issues and needs without judgment. <p>Tailored support. Tailoring support according to the needs articulated by claimants. This included a flexible approach to support, for example moving from open discussions to more goal-based support if claimants felt that was more appropriate.</p> <p>Flexibility in delivery approach. As discussed earlier, claimants valued a ‘non-scripted’ approach which had two elements: (a) discussion not being tied to fixed agendas, allowing claimants to raise issues that were important to them; (b) claimants able to reschedule sessions for personal and/or health-related reasons.</p>
<p>Professional and supportive. This related to the reliability of the service offered by VRCs, their interest and engagement in claimant issues and the quality of advice they provide</p>	<ul style="list-style-type: none"> • Reliability of service. Claimants valued VRCs who called at agreed times and did not miss any calls. This minimised the inconvenience of taking part and served to reinforce the view that VRCs were invested in the intervention. • Interest and engagement with claimant issues. This was particularly influential when VRCs listened to and showed understanding of wellbeing issues, which some clients had not voiced or had taken seriously by others before. VRCs demonstrated this by: genuinely taking the time to listen and pick up on issues faced by claimants; showing interest in the day-to-day issues faced by claimants; providing contact details for out of session contact; and, following up on action points and promises in between calls. • Quality of work and wellbeing-related advice. Good quality advice was important in shaping favourable views about the intervention. Claimants had mixed views on which qualities of the VRC enabled them to provide good advice; but suggestions included:

Continued

Table 3.3 Continued

Qualities of VRC	Key aspects of quality
	<ul style="list-style-type: none"> – Age and experience. Claimants perceived the quality of advice to be adversely affected by VRCs lacking in personal experience of wellbeing issues and/or experience delivering support around this area. For example, claimants sometimes felt that their VRC had not worked with claimants that had depression or anxiety issues or, conversely, they had only worked with those that had acute emotional wellbeing issues. Claimants sometimes attributed a lack of experience if they perceived the VRCs to be young (for example, how young they sounded on the phone). – Qualifications. Claimants appreciated it if the VRC appeared to be qualified in delivering support. For example, some claimants appreciated receiving support from VRCs who seemed to be trained counsellors or psychologists from the way they delivered the support. – Confidence. Claimants appreciated VRCs that came across as confident and comfortable in being able to deliver the support over the telephone. – Ability of VRCs to help claimants frame their situation positively, that is, to use a Cognitive Behavioural Therapy (CBT) approach (where applicable) to allow claimants to positively view their own abilities, situation and setbacks around work and wellbeing.

The two case illustrations below provide contrasting experiences of VRCs based on some of the qualities discussed above.

Case illustration: Person-centred support received

Judy had not been in work for a while as she experienced mental health issues as a result of a close family member passing away a few years ago. Judy found it difficult to get motivated but also felt guilty about not being in work.

One of the key aspects of the support she valued was her interaction with the VRCs. She found them to be *'very encouraging'* and supportive. They did not judge her on her condition or on her not being in work and provided her with a space to talk about her issues, which she was not used to. It was this supportive element which boosted her confidence in herself and her ability to find work.

(Completer, Female, Aged 25-49)

Case illustration: Generic, inflexible support received

Ben had a history of wellbeing issues, including suffering from depression for a number of years. He came into the intervention hopeful that the VRC would be able to help him and offer something different to the Jobcentre Plus support he received.

However, he found the way the VRC delivered the support *'lacked flexibility'* and was *'a little bit rigid'*. Rather than talk about his mental health issues, the VRC seemed to go through a list of fixed questions each week and did not deviate from this agenda. As a result, he felt that the support *'wasn't really tailored to...a single person'*. *It felt 'just like talking to me advisor [Work Coach]...it was nothing new'*.

(Completer, Male, Aged 25-49)

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Claimants felt that VRCs' willingness to share their own relevant experiences of (particularly) mental health conditions helped to develop rapport and to encourage claimants to open up about issues. For example, a shared understanding developed between one claimant and their VRC when the VRC shared their experience of depression. However, disclosure did not seem to be crucial in shaping claimants' experiences of the support where VRCs demonstrated they had one or more of the core qualities, such as approachability, outlined in Table 3.2.

According to staff delivering the intervention it was not typical for VRCs to complete initial assessment calls as these were completed by a separate centralised team. However, where claimants reported that this initial call was conducted by their VRC, this was preferred because it helped to build rapport and meant claimants did not have to repeat information.

As the above case illustration on generic and inflexible support demonstrates, not all claimants were happy with the service they received from their VRC, particularly if this went against some of the core VRC qualities outlined in Table 3.2. Often, this meant that claimants reported not getting as much as they needed from the intervention. Occasionally, claimants reported that their relationship with the VRC had an adverse impact on their wellbeing. For instance, a claimant reported that their existing anxiety issues were exacerbated by the prospect of talking to their VRC each week (see the case illustration for George in Chapter 5). In such cases, claimants would have liked a mechanism for making a complaint about their VRC and the support they were receiving. Although such mechanisms did exist, awareness was not widespread, and resulted in claimants bringing issues to the attention of their Jobcentre Plus Work Coach informally instead.

3.3 Lessons learned

The claimant and provider staff findings point to the following recommendations for the format of the intervention:

- **It is clear that delivery of the support was acceptable to claimants.** However, given that some claimants were reluctant to take up telephone support, screening may be necessary to identify which claimants this support would be most suitable for. In addition, it may be helpful for claimants to meet their VRC in person prior to the start of the call in order to build rapport and trust.
- **Claimants should have an input into when the calls are arranged.** This enables claimants to identify a slot where they are free, can talk in private and prevents the inadvertent missing of calls.
- **Weekly calls seem to work for claimants.** However, screening may need to be done in order to identify claimants with specific issues (such as memory-related issues) who may require much more frequent calls to benefit. However, this may have resource implications for the provider.
- **Calls should last no longer than an hour** in order not to adversely affect claimant's concentration.
- **Number of sessions.** The intervention may need to build in a review at the end of the allocated sessions in order to determine whether claimants could benefit from additional sessions and/or if they need to be signposted to other support. However, this may need to be balanced against the short-term nature of this intervention.

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The following recommendations relate to the content of the support delivered:

- **Clear, measurable objectives.** Provider staff delivering the Telephone Support stressed the importance of setting clear measurable objectives for the intervention that are appropriate for an intervention with a relatively short duration.
- **Tailoring of support.** Claimants came with a wide variety of needs and issues. A key implication of this is that the VRCs should be encouraged and supported (e.g. through training) to further tailor the support to the needs of claimants.

The following recommendations relate to the VRCs, who were central to the delivery of the intervention:

- **VRCs should continue to be responsible for the weekly calls.** Claimants may not be reliable and/or able to afford the cost of making weekly calls.
- **VRCs should aim to deliver the intervention in a person-centred way,** tailoring support based on the needs of claimants and delivering this in a flexible manner.
- **VRCs should continue to provide the option for claimants to contact them outside of the formal sessions.** This is likely to engender trust and build rapport between claimant and VRC. Although this has resource implications, it must be noted that not all claimants took up the offer, but appreciated it nonetheless.
- **VRCs should be knowledgeable and experienced in delivering both employment and wellbeing support and advice.** This may require training and upskilling VRCs to work outside of their delivery 'comfort zones'.
- **There should be continuity in the VRC.** Having the same VRC across both the initial assessment call and the delivery of the intervention can be helpful in establishing rapport and trust with claimants' right from that start of the intervention. However, this needs to be balanced against the resourcing considerations faced by providers.

4 Engagement

This chapter explores the levels of engagement and retention among claimants once they started the intervention, based on the Management Information (MI) data and claimant interviews.

4.1 Retention on the Telephone Support intervention

As previously summarised at Table 2.2 (in Section 2.1.5), the data indicates that attrition occurred at different points after the referral was made. Three hundred and nineteen out of the 569 referrals (56 per cent) did not have an initial assessment call. A further 18 per cent of total referrals (104 people) received the initial assessment call but did not then move on to the actual intervention calls (and in nearly all of these cases, calls were not scheduled either). This 'non-starter' group comprised 42 per cent of the 250 people who successfully completed the initial assessment call.

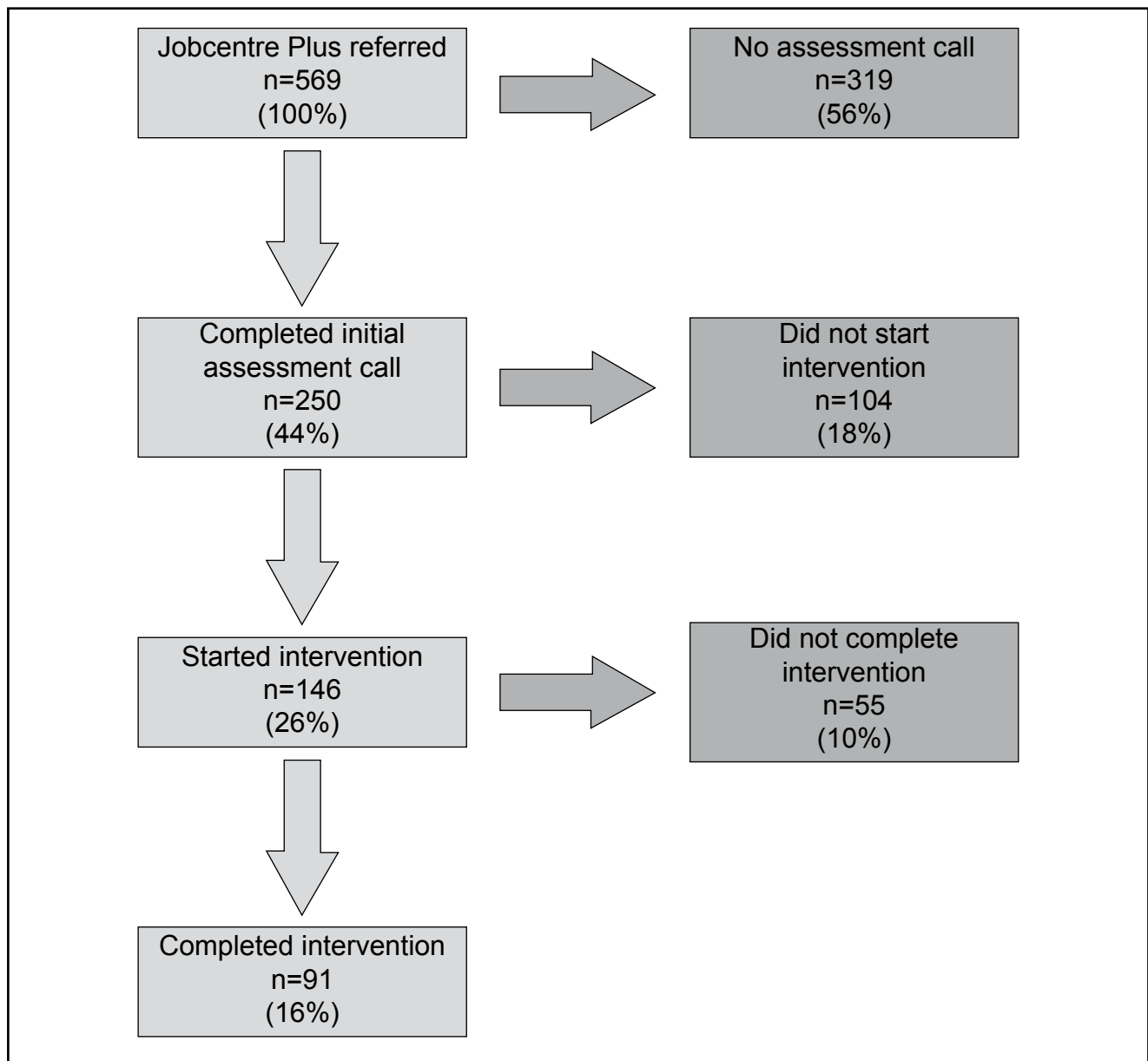
In total, 91 people (62 per cent of all claimants who started the intervention) were recorded as having completed. These 91 people comprised 16 per cent of all referrals and 36 per cent of all those who received the initial assessment call.

A further 55 people were dropouts or 'non-completers', in that they took the initial assessment call and at least one intervention call¹⁶, but are recorded in provider data as not having completed the intervention. This group comprised 22 per cent of those who received the initial assessment call, and 10 per cent of all referrals.

Figure 4.1 summarises this information in a flowchart of intervention recruitment and retention.

¹⁶ In this analysis, 'starting the intervention' is defined as having completed at least one intervention phone call after the initial assessment call.

Figure 4.1 Flowchart of intervention recruitment and retention



The MI data provides further information on the characteristics of the three groups that took the initial assessment call: non-starters, completers and dropouts.

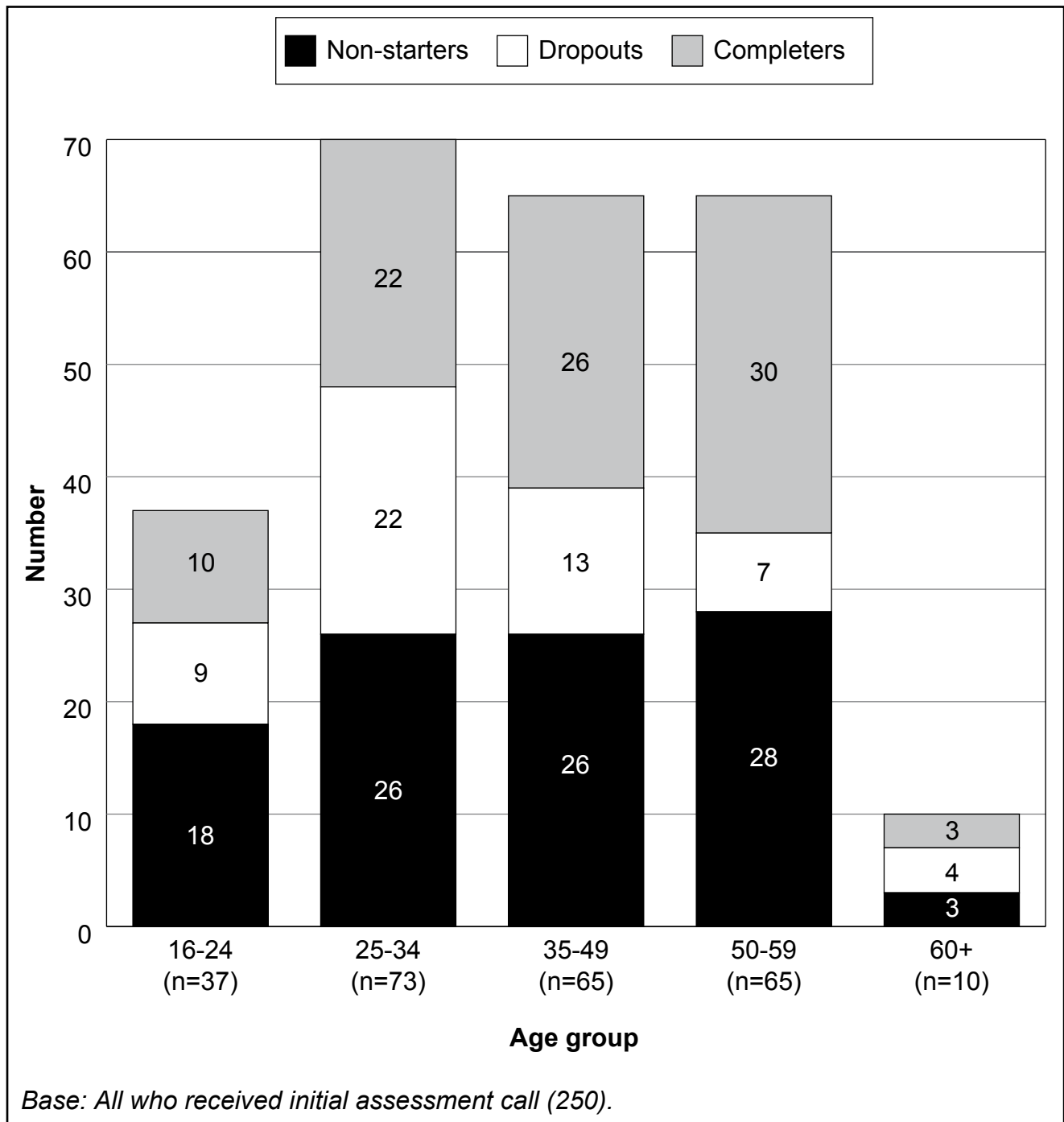
However, there is no data available on the characteristics of claimants who did not have an initial assessment phone call and so this group is excluded from the tables below.

In terms of the profile of Telephone Support participants, the MI data indicates that dropouts (who started but did not complete the intervention) had better self-rated general efficacy scores in the pre-test assessment compared with completers, and that this difference was statistically significant ($p < 0.01$).¹⁷ Dropouts also tended to be younger than non-starters and completers (Figure 4.2) and were also less likely to have previously been on Employment Support Allowance (ESA). These differences were not statistically significant. There was otherwise little difference between the groups at baseline.

¹⁷ $P < 0.01$ means that there is less than a one per cent chance that a difference in mean scores of this size would have occurred at random.

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Figure 4.2 Numbers of referrals by age group and take-up



The following tables provide a breakdown of the profile of Telephone Support participants by gender (Table 4.1), length of time on Jobseeker's Allowance (JSA) (Table 4.2), whether claimants had previously been on ESA (Table 4.3), and whether claimants had previously been on the Work Programme (Table 4.4).

MI data indicated that gender was fairly similarly and evenly distributed across the three groups. Those not taking up the intervention were very slightly more likely to be men compared with the other groups, although this difference was not statistically significant.

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Table 4.1 Gender of participants, by whether completed intervention

	<i>Column percentages</i>			
	Non-starters	Dropouts	Completers	All¹
Men	56	53	49	53
Women	44	47	51	47
<i>Base (excludes those with missing data on gender)</i>	<i>101</i>	<i>55</i>	<i>89</i>	<i>245</i>

¹ 'Non-starters' completed no intervention call, 'dropouts' took at least one intervention call but were not recorded as having completed the intervention, and 'completers' are recorded as completing the intervention, including those with missing post-test data.

Most participants had been claiming JSA for a short period, with 53 per cent claiming for six months or less. However, 21 per cent had been on the JSA for three or more years. Those who started the intervention but dropped out were more likely to have been on JSA for the shortest period, compared to those who did not take up the intervention or those who completed the intervention, although this difference was not statistically significant.

Table 4.2 Length of time on JSA, by whether completed intervention

	<i>Column percentages</i>			
Length of time on JSA	Non-starters	Dropouts	Completers	All
< 3 months	33	46	39	38
3 - 6 months	22	6	11	15
6 - 9 months	8	6	3	6
9 - 12 months	9	10	9	9
12 - 18 months	1	6	2	3
18 - 24 months	3	4	2	3
2 - 3 years	5	2	9	6
3 years +	20	20	24	21
	(100)	(100)	(100)	
<i>Base (excludes missing data)</i>	<i>101</i>	<i>50</i>	<i>88</i>	<i>239</i>

The same proportion of non-starters and completers had been on ESA before (51 per cent). Dropouts, however, were less likely to have been previously on ESA (42 per cent), although this difference was not statistically significant.

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Table 4.3 Whether has previously been on ESA, by whether completed intervention

<i>Column percentages</i>				
Whether has previously been on ESA	Non-starters	Dropouts	Completers	All
Yes	51	42	51	49
No	49	58	49	51
<i>Base (excludes missing data)</i>	<i>101</i>	<i>50</i>	<i>88</i>	<i>239</i>

Just over a third of participants had been on the Work Programme (36 per cent), with little difference between the three groups. Completers were slightly more likely to have been on the Work Programme (39 per cent) when compared to non-starters (34 per cent) and dropouts (35 per cent), although this difference was not statistically significant.

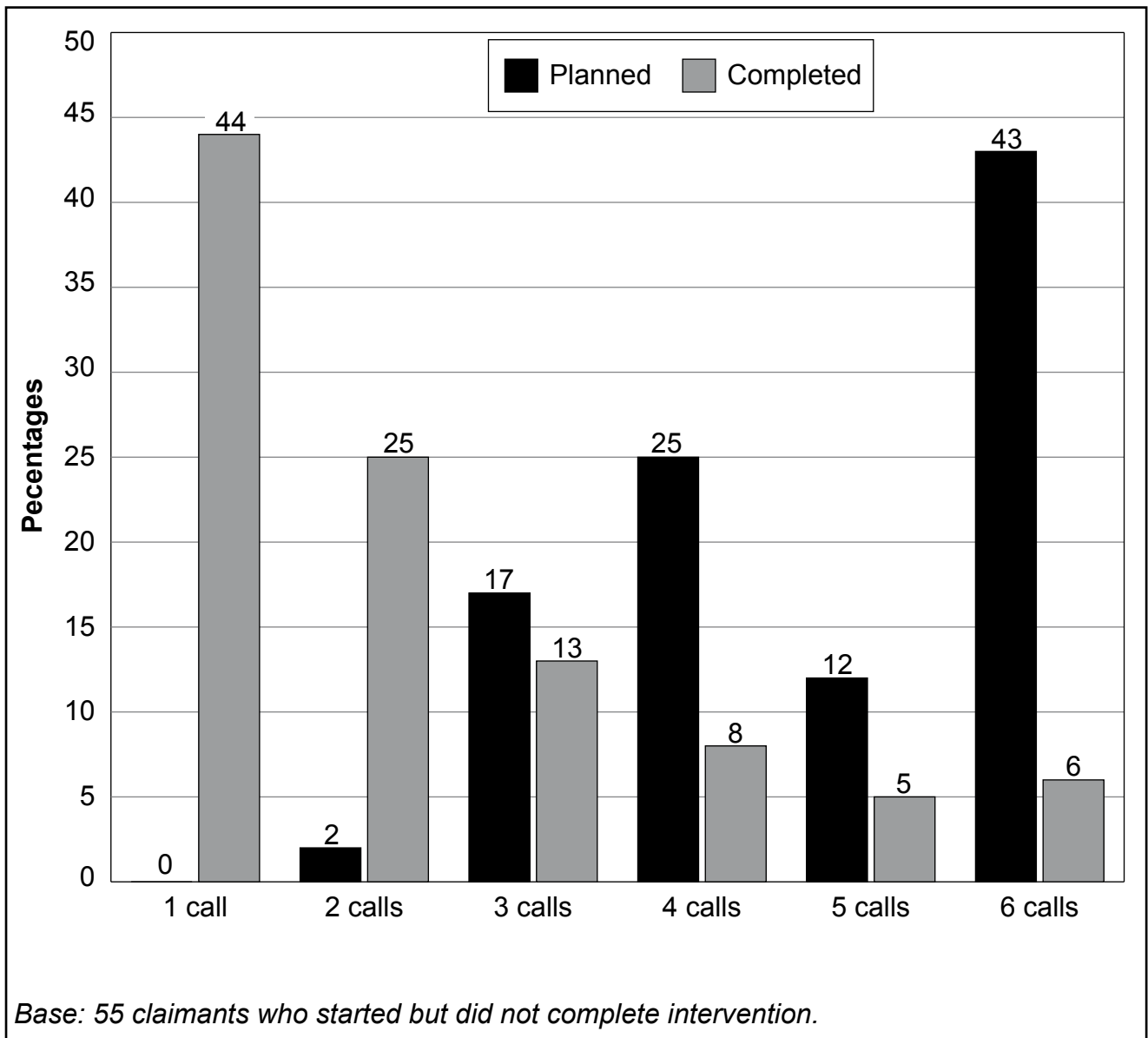
Table 4.4 Whether has been on the Work Programme, by whether completed intervention

<i>Column percentages</i>				
Whether has been on Work Programme	Non-starters	Dropouts	Completers	All
Yes	34	35	39	36
No	66	65	61	64
<i>Base (excludes missing data)</i>	<i>100</i>	<i>49</i>	<i>87</i>	<i>236</i>

For the group of participants who dropped out of the intervention, 80 per cent had dropped out after two calls, with a majority completing only one intervention phone call (Figure 4.3). This suggests that these participants made the decision to discontinue early on in the intervention.

Providers also recorded the reasons for claimants completing or exiting the intervention early. These are broken down in (Table 4.5) by those who did not take up the intervention in the first place (non-starters), dropouts and completers. However, there are limitations to how this information can be interpreted, as the provider did not give a category that would cover claimants who exited the intervention by not answering the phone at the appointment time (and who therefore did not give a reason for exit). It is unclear whether such claimants would have been coded to 'Changed mind/do not wish to continue' category as the most prevalent category or another category.

Figure 4.3 Calls planned versus calls completed, for participants who dropped out



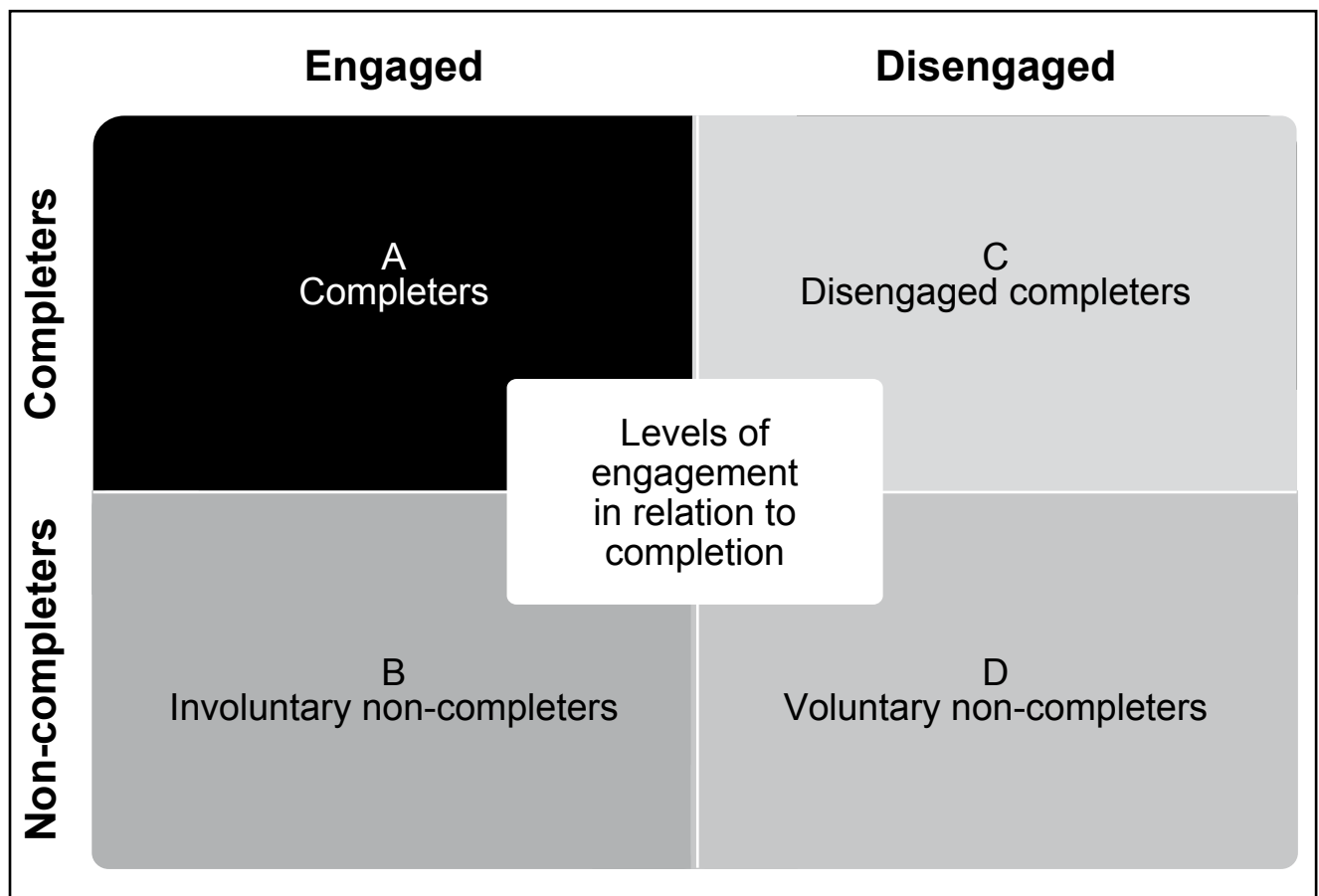
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Table 4.5 Reason recorded for exit, by whether completed intervention

Reason recorded for exit	Column percentages			
	Non-starters	Dropouts	Completers	All
Completed forecast number of appointments	–	–	100	36
Changed mind/do not wish to continue the intervention	67	80	–	46
Not happy with intervention/ not perceived as useful	24	9	–	12
Claimed ESA	3	4	–	2
Found a job	4	2	–	2
Other	2	2	–	1
Dropped claim (JSA)	0	4	–	1
<i>Base (all cases complete)</i>	<i>104</i>	<i>55</i>	<i>91</i>	<i>250</i>

The qualitative interviews with provider and Jobcentre Plus staff, as well as claimants provide further insights into not only the factors that affected retention and non-completion, but also the nuanced relationship between claimant engagement with the intervention and completion/non-completion. This relationship is summarised in Figure 4.4.

Figure 4.4 Engagement and retention



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Figure 4.4 indicates that completion was not always an indication that claimants were engaged with the intervention. Conversely, non-completion was not always due to a lack of engagement with the intervention. These findings are explored in depth below.

- **Group A: Engaged completers.** These were claimants who were invested in the intervention because they either appreciated how the intervention was delivered (for example, talking to a Vocational Rehabilitation Consultant [VRC] on a weekly basis) and/or felt they were benefiting from the intervention in terms of their job search and/or emotional wellbeing. Aside from this engagement, there were also other characteristics that helped them complete:
 - They were highly motivated at the start of the intervention and so more receptive and willing to invest in the intervention. As discussed in Chapter 2, there were exceptions to this, particularly when claimants' initial high motivations were undermined by poor delivery or the intervention did not match their expectations of what it would be.
 - Determined personality. They described themselves as someone who was motivated to complete anything they started.

[Reason why claimant completed course] I was feeling an improvement by each week and I wanted – it was helping me because I wanted to help myself and I don't think, I think you've got to want to help yourself in order to make any use out of the sessions 'cause they're hard work.'

(Completer, Female, Aged 25-49)

- **Group B: Engaged (involuntary) non-completers.** These claimants were engaged with the intervention but left it involuntarily. This was due to two reasons: (a) VRCs inexplicably not contacting them, sometimes after the claimant missed a call and (b) claimants having to leave the intervention due to circumstances beyond their control (e.g. having to travel to another country, moving to ESA, finding employment or their mental health deteriorating).
- **Group C: Disengaged completers.** These claimants felt they were not enjoying the process of being on the intervention and/or did not think they were achieving positive outcomes (classified as 'Not happy with intervention/not perceived as useful' in the exit interviews). However, they persisted on the intervention because they thought it was compulsory and were anxious about being sanctioned and/or they were hopeful it would improve right until the end.
- **Group D: Disengaged (voluntary) non-completers.** These claimants left because they were disengaged. That is, they did not like the way the intervention was delivered, felt they were not benefiting from it and/or were not in the right frame of mind due to other things going in their life (for example, bereavements, court cases or their mental health deteriorating). A non-completer below explains why they found it so hard to engage with the intervention due to severe mental ill health.

'I thought that really I was in such a bad space at the time [of the intervention], I was actually so stressed out, sometimes she [VRC] was due to ring and I'd be really just saying, "I just can't. I haven't done anything since the last time you rang" because I was in such a bad place, literally. I'm glad I'm not like that now. I think with hindsight I was actually too ill to even, you know, function, really. I think with hindsight maybe I should've been signing on as a sick person, not a looking for work person 'cause I was in such a bad place...'

(Non-completer, Female, Aged 25-49)

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The above typology touches on the factors that provider staff and claimants felt had an adverse effect on retention. These factors can be broadly divided into those related to the intervention and those external to it and are summarised below:

- External factors. These included the following:
 - Claimants' motivations at the start of the intervention. Those who were hostile at the start of the intervention were less likely to persist with it.
 - Changes in personal circumstances. This included life events (for example, bereavements, imprisonments and having to travel abroad) and health-related issues, such as a deterioration of mental health.
- **Intervention format.** This included the following:
 - Challenges engaging with the intervention format. This included sustaining regular contact with VRCs over a number of weeks due to low motivation, chaotic home lives and substance abuse issues.
 - Not having a rapport with the VRC. Feeling VRCs lacked the positive qualities outlined in Chapter 3 that affected claimants' engagement with the intervention. This included instances where VRCs did not call claimants back if they had missed a session.
- **Intervention content.** Claimants feeling that the intervention content did not help them in their employment and/or mental health conditions. In some instances, provider staff reported ending the support early because the intervention was not suitable for their employment needs (for example, they were too far from the labour market) or wellbeing needs (for example, they had learning difficulties and entrenched mental health issues not suitable for a short intervention).

4.2 Lessons learned

Some of the suggestions made, particularly by claimants, refer to a better screening of claimant needs and messaging about the intervention, particularly around its voluntary nature. These have been covered in the discussion about referrals (Chapter 1). Additional suggestions relevant for this chapter suggested particularly by provider staff and Jobcentre Plus Work Coaches include:

- Ensure potential participants have a clear understanding of the content of the intervention, what they can expect to get from it and what level of engagement is expected.
- Provide structure to the calls, setting goals so calls feel productive and participants have a sense of moving forward.
- Provide text reminders for calls.
- Improve communication between the Work Coach and the provider to facilitate engagement, including the possibility of a 'warm handover' involving the Work Coach, telephone support provider and participant to facilitate engagement.
- Consider initial face-to-face contact to foster trust and build rapport, subsequently followed-up on the phone.

5 Perceived impact

This chapter reports on the perceived impacts of the Telephone Support intervention. It reports on the indicators of the intervention's effectiveness by comparing pre- and post-measures on a number of outcomes.

The chapter also draws on the claimant and staff reflections on the perceived impacts of the intervention. The final section also provides an overview of the factors that claimants and provider staff felt contributed to these outcomes.

5.1 Outcome measures

Participants were asked to complete a questionnaire during the initial assessment phone call, i.e. before any intervention phone calls had been received. The questionnaire was repeated again during their final scheduled phone call. The questionnaire used five validated indices to track changes in wellbeing, self-efficacy and mental health.

- Wellbeing (WHO-5 Wellbeing Index).
- Self-efficacy (general and job-search) [Job Search Self Efficacy Index (JSSE); General Self Efficacy Scale (GSE)].
- Mental health (Generalized Anxiety Disorder 7 Item Scale (GAD-7); Patient Health Questionnaire (PHQ-9)).

A brief description of the measurement instruments can be found in Table A.2.

Mean differences in pre- and post-test scores is presented below. It was not possible to undertake multivariate regression analysis due to the small sample size of complete post-test results.

The chapter also draws on the participant's own reflections on the impacts of the intervention as well as the views of Jobcentre Plus and provider staff.

For all five measures, the average score improved between the pre-test and the post-test, and these improvements were all statistically significant. Figure 5.1 and Figure 5.2 summarise the changes in average scores, grouped and scaled for ease of interpretability, as two measures show improvement when scores go up; while three show improvement when scores go down.

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Figure 5.1 Changes in mean scores for JSSE and wellbeing (WHO-5)

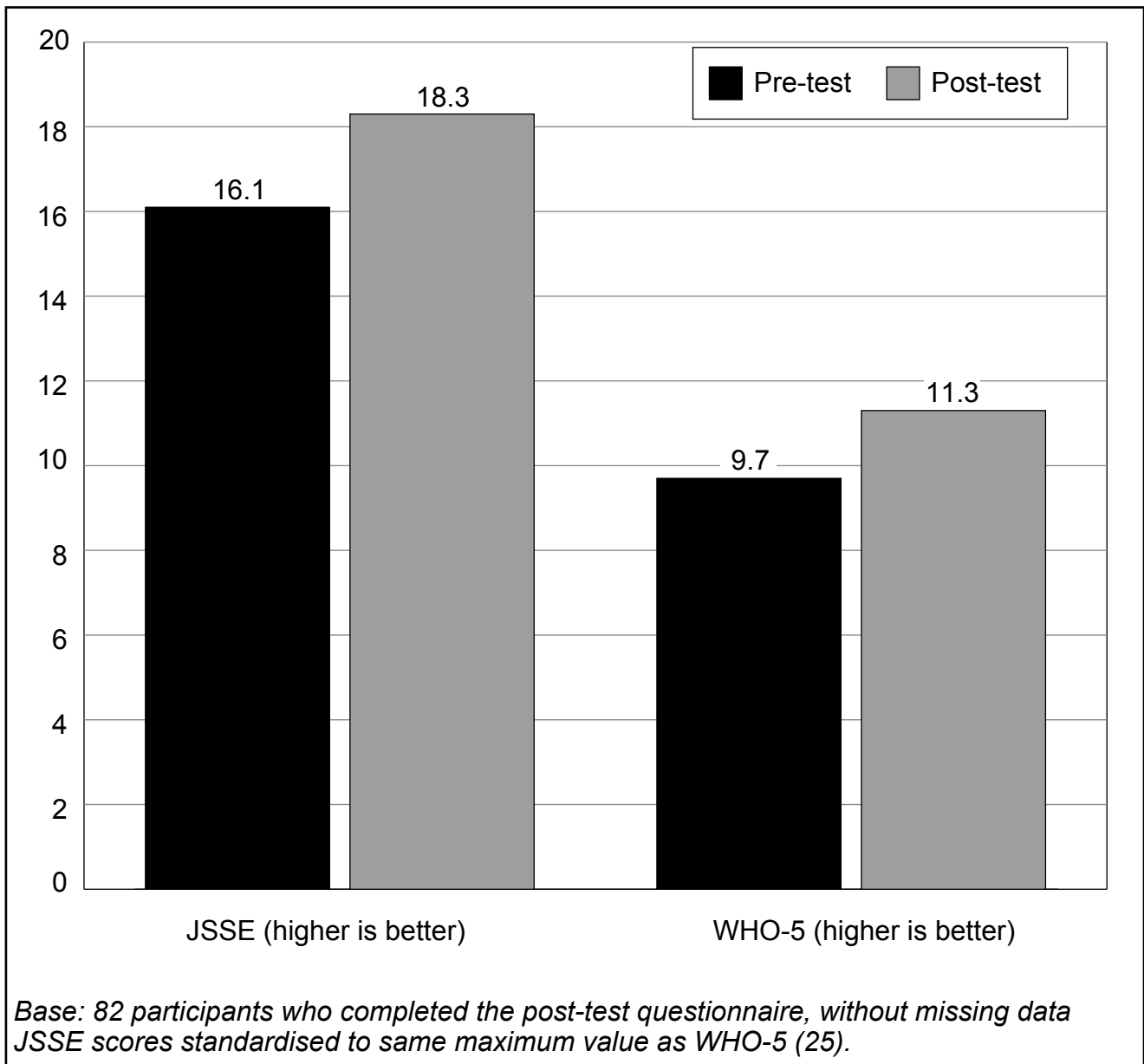
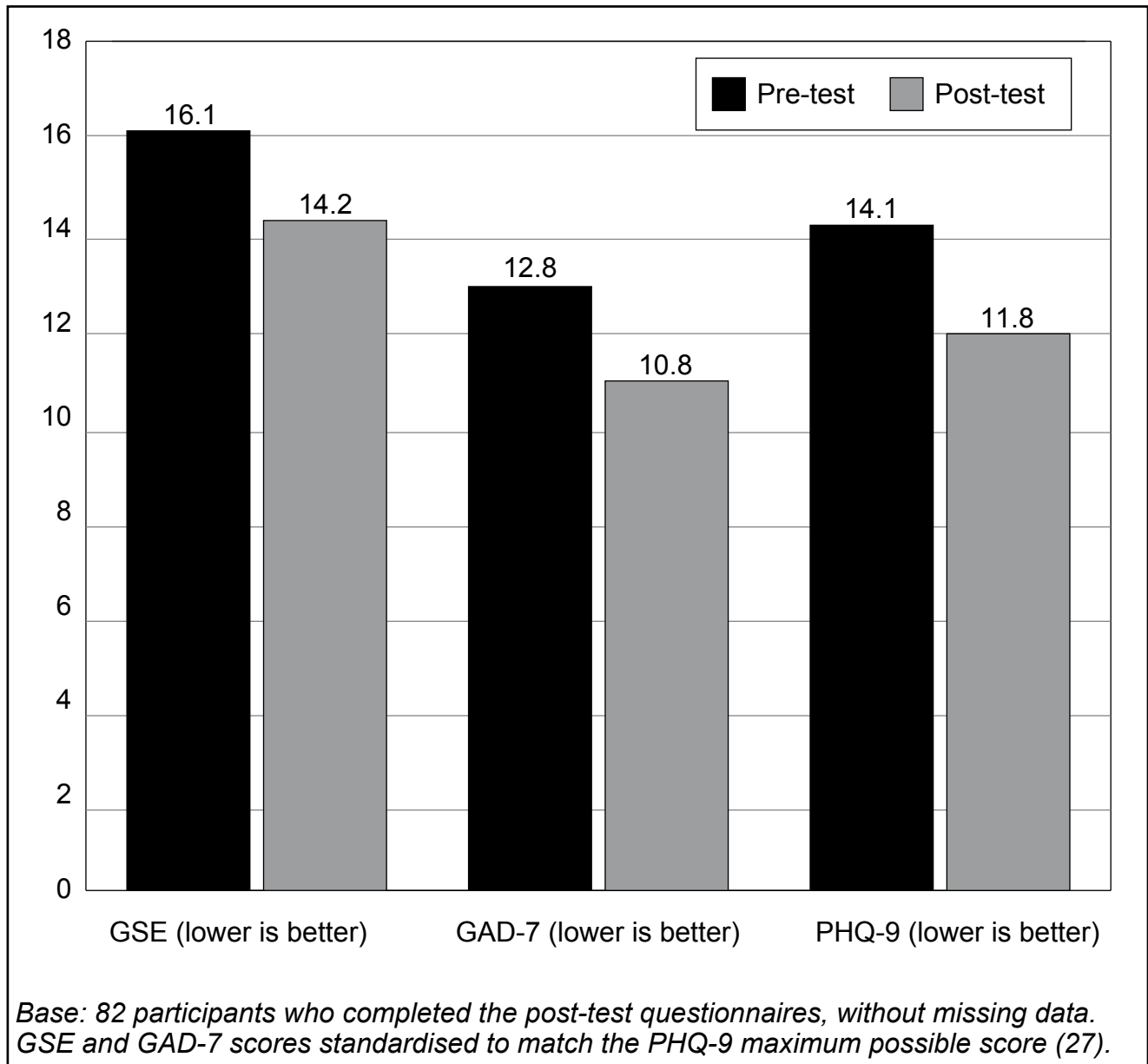


Figure 5.2 Changes in mean scores for GSE), anxiety (GAD-7) and depression (PHQ-9)



5.2 Wellbeing and mental health impacts

5.2.1 Wellbeing impacts

The WHO-5 Wellbeing Index measures current mental wellbeing. As indicated above, higher score indicates better wellbeing.

There was an increase in average WHO-5 wellbeing scores for Telephone Support participants who completed the pre-test (at intake) and the post-test (at the end of intervention) questionnaire. The proportion classed as having 'poor wellbeing' reduced from 72 per cent to 58 per cent. The improvement was statistically significant ($p < 0.05$).¹⁸

¹⁸ $P < 0.05$ means that there is less than a 5 per cent chance that a change in mean scores of this size was due to random chance.

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When testing improvement for men and women individually, there was not a statistically significant improvement in men's scores; and when testing two broad age bands individually, there was not a statistically significant improvement in scores for the under-50 age group. As there was a skew towards under-50 men in the sample, and regression analysis was not possible due to small sample size, we cannot control for different factors to show whether it is age or gender that is associated with the lesser impact.

Table 5.1 Wellbeing (WHO-5) pre-test and post-test scores

	Mean¹
WHO-5 pre-test score	9.74
WHO-5 post-test score	11.29
	Column percentage²
Poor wellbeing pre-test	72
Poor wellbeing post-test	58
<i>Base²</i>	82

¹ Raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life. A score below 13 indicates poor wellbeing.

² Participants without missing information. Only those who completed the intervention have a post-test score.

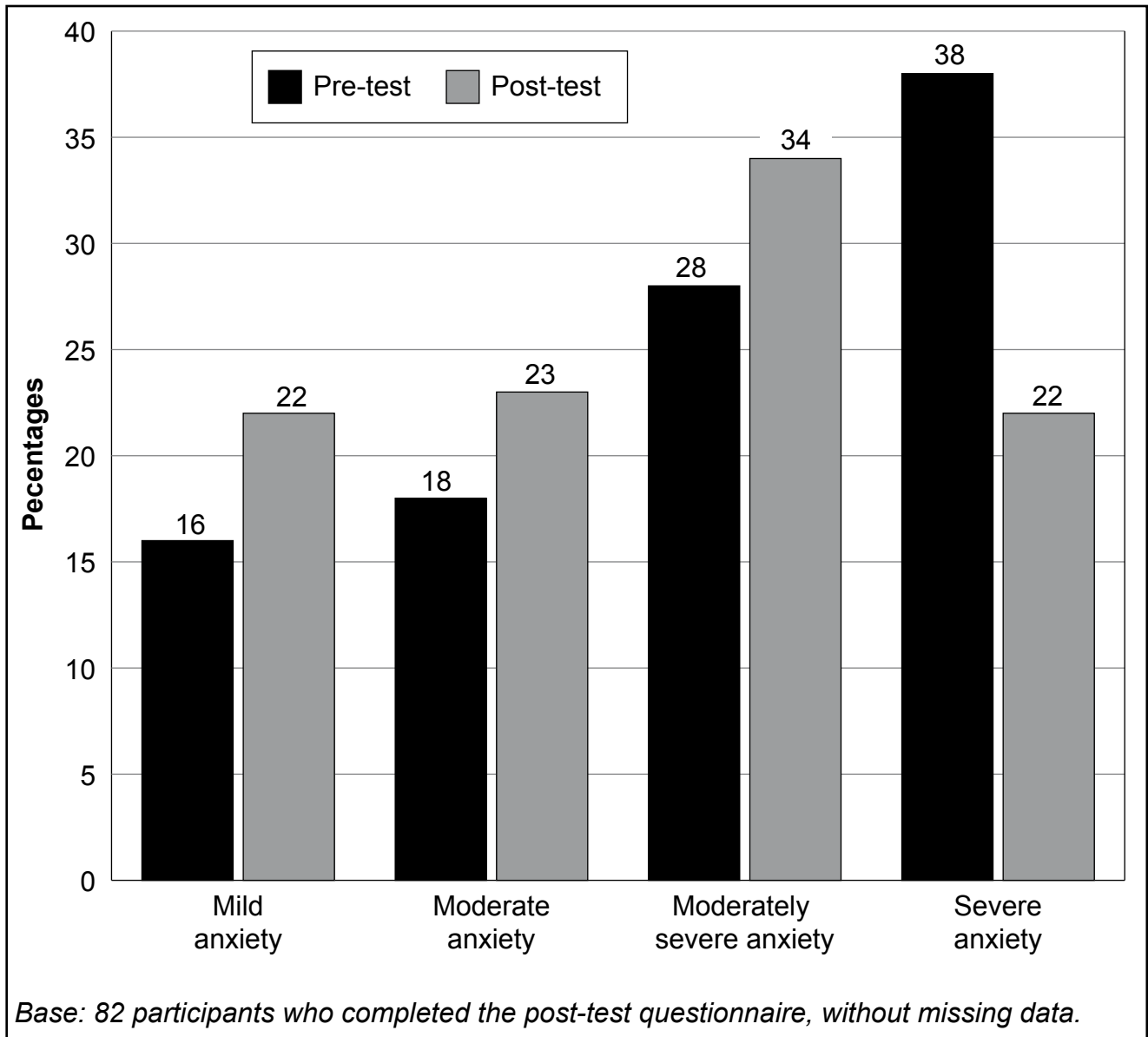
5.2.2 Mental health impacts

Two measures were used to provide an indication of specific mental health impacts – the GAD-7 test to explore the severity of anxiety and the PHQ-9 test to screen for depression. Both measurement instruments allow for the grouping of all the results into four levels, from mild to severe. Improvement in average scores between the pre-test and post-test was statistically significant for both measures ($p < 0.001$).¹⁹ The distribution of results across clinical cut-offs for both measures suggest that people moved from higher to lower levels of anxiety or depression over the course of intervention.

Of all claimants recorded as completing the intervention, the proportion of claimants in the two most severe categories of anxiety decreased by 10 percentage points, from 66 per cent to 56 per cent (Figure 5.3). The proportion of those in the most severe category decreased by 16 percentage points. Changes in distribution between the categories suggests that claimants overall were shifting towards the milder end of the anxiety scale.

¹⁹ $P < 0.001$ means that there is less than a 0.1 per cent chance that a change in mean scores of this size was due to random chance.

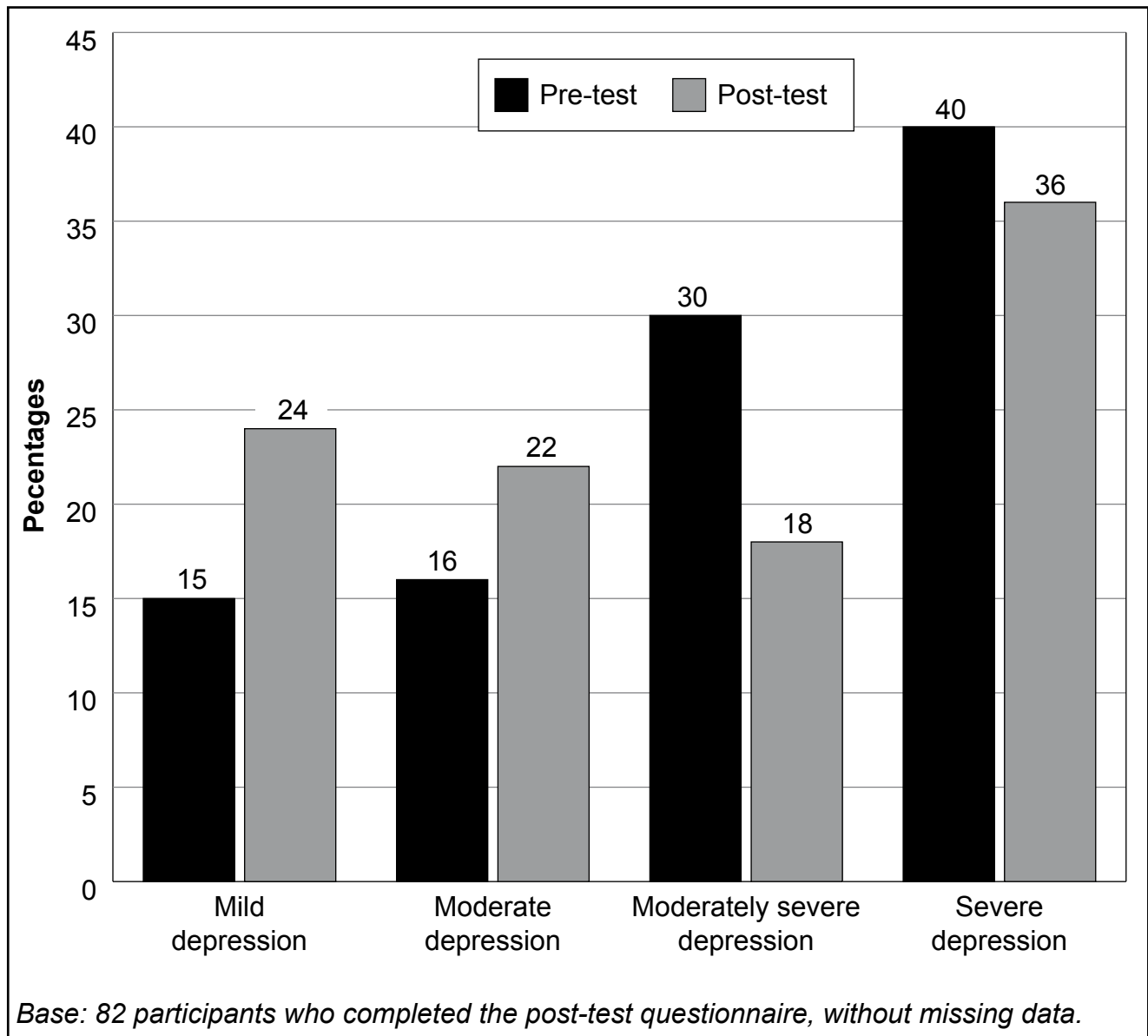
Figure 5.3 Distribution of GAD-7 scores between four levels of anxiety



Similarly to anxiety, the proportion of claimants with severe-to-moderately severe depression decreased by 16 percentage points, from 70 per cent to 54 per cent of all who completed the post-test (Figure 5.4). The proportion of those in the severe depression category decreased by four percentage points, and those in the moderately severe category decreased by 12 percentage points. Again, this indicated an overall movement towards milder depression amongst claimants by the end of the intervention.

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Figure 5.4 Distribution of PHQ-9 scores between four levels of depression



5.2.3 Qualitative findings on wellbeing and mental health

Claimants reported five key positive outcomes of the intervention:

- **Improved self-esteem.** This entailed claimants realising their self-worth generally and, more specifically, in relation to being able to offer something valuable to the job market. Claimants felt this had a positive impact on their resilience to setbacks in their job search. Vocational Rehabilitation Consultants (VRCs) also observed this positive impact.
- **Confidence.** Reported confidence did not only refer to job-search related outcomes (for example, the number of jobs applied for and improved confidence in interview performances), but also a wider level of confidence in being able to address personal issues, such as stress and anxieties, and in interacting with people that claimants did not know. VRCs also noted the improved confidence in claimants to apply for jobs and attend interviews.

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- **A more positive outlook to employment and life in general.** Relating to the above, claimants felt much more positive about their chances of finding employment.
- **Feeling less isolated during the course of the intervention.** The weekly calls helped claimants feel less isolated and provided much needed social interaction.
- The support as a gateway for encouraging claimants to take up external support for mental health issues. For example, a claimant felt that their VCR had helped them to acknowledge depression as an issue and encouraged them to talk to a General Practitioner (GP) as part of their action plan. VCRs also agreed that this was an important impact of the intervention in helping to link claimants to their GP and the Improving Access to Psychological Therapies (IAPT) service.

'I wasn't seeing my GP [to talk about depression and back pain]. I hadn't seen him for quite a few months and she [VRC] advised me to go and see my GP, you know, like 'cause of my depression and so I did.'

(Completer, Female, Aged 25-49)

However, there were also claimants who reported deterioration in their wellbeing as a result of the intervention. This included the intervention adversely affecting confidence, self-esteem and anxiety levels. The reasons for this are outlined in the next sub-section.

Factors contributing to wellbeing and mental health outcomes

The qualitative interviews identified a number of factors relating to the intervention and the claimants. These are summarised in Table 5.2, followed by two case studies to illustrate the impact of these factors.

Table 5.2 Factors contributing to the wellbeing and mental health outcomes

Type of factor	Factor	How it contributed to outcomes
Intervention specific	Action plans	The action plans sometimes helped claimants to step outside of their comfort zones in a supportive way.
	Quality of the VRC	A person-centred and supportive approach was key. This included: <ul style="list-style-type: none"> • Using a Cognitive Behavioural Therapy (CBT) approach in helping claimants to frame job setbacks in positive terms. • Actively listening to claimants. In particular, the non-judgmental approaches taken by VRCs enabled claimants to voice and validate their concerns, bolstering their sense of self-worth and self-esteem. Conversely, claimants reported deterioration in existing mental health conditions (for example, depression) where the VRC consistently did not listen to their need and was antagonistic in their approach.
	Weekly calls	Weekly calls reduced the sense of isolation felt by claimants.
	Abrupt termination of the intervention	Where the intervention was terminated earlier than the claimant anticipated, this exacerbated feelings of abandonment and negatively impacted on self-esteem.

Continued

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Table 5.2 Continued

Type of factor	Factor	How it contributed to outcomes
Claimant related	What claimants brought into the intervention	<p>Claimants with a high level of motivation and engagement tended to report positive outcomes in relation to their wellbeing. This may be due to a number of reasons, including:</p> <ul style="list-style-type: none"> • this group of claimants tended to come in to the intervention with definite wellbeing issues; • high motivation was associated with a high level of engagement with the intervention. This meant that claimants were invested in the intervention and so benefited from it. <p>However, there is evidence to indicate that claimants with particularly severe mental health conditions (for example, entrenched depression) found it difficult to engage with the intervention and so did not benefit from it as much.</p>

Case illustration: Claudette felt that the VRC contributed to the positive wellbeing outcomes she experienced

Claudette has been on Employment and Support Allowance (ESA) for a little while before coming back onto JSA. A lack of confidence in being able to find work was a key barrier for Claudette. She did not feel she was 'worthy' of finding work. Her Work Coach referred her to the intervention.

Claudette felt supported and encouraged by her VRC. They listened to her without judgement, reassured her that being unemployed was not her fault and that there was a job out there for her. Claudette came to regard her VRC *'just like a friend'*.

One of the key changes Claudette noticed was that her self-worth and confidence grew. She felt 'worthy' enough to think about entering the job market and less nervous as a result about doing job interviews. This helped her to take up voluntary work, which she hopes will help her chances of finding work.

(Completer, Female, Aged 50+)

Case illustration: George felt his emotional wellbeing had deteriorated because of the VRC

George had a number of mental health conditions ranging from depression to anxieties that he was struggling with prior to the intervention. He agreed to join the intervention because he felt it may help his issues.

However, he continually clashed with his VRC during the course of the intervention. There was a number of reasons for this, including: he felt that the VRC would not listen to him and so he had to keep repeating himself, the VRC was unprofessional in occasionally missing calls, as well as *'arrogant'* and antagonistic in his approach. For example, the VRC insisted that George did not have to declare his health condition in job applications whereas George thought that this was necessary.

As result of this interaction, George felt his anxiety levels worsened. As George puts it: *'my anxiety, the hot sweats and everything else, [I had] when it came to the phone call and sometimes not been able to eat because he was coming to the phone. Then afterwards there, it really caused harm. It caused me a lot more harm than, than anything and set me back a bit actually.'*

(Completer, Male, Aged 25-49)

5.3 Self-efficacy and job search impacts

The JSSE is a self-rated measure of how confident people are in nine job search skills. A higher score means higher self-efficacy. For those who completed the Telephone Support intervention and the post-test, average test scores increased from 3.21 to 3.65 (Table 5.3). This improvement was statistically significant ($p < .001$).²⁰

Table 5.3 JSSE pre-test and post-test score

	Mean ¹
JSSE pre-test score	3.22
JSSE post-test score	3.65
<i>Base</i> ²	82

¹ This is an index with a minimum of 1 and maximum of 5, with a higher number indicating a more positive score.

² Participants without missing information. Only those who completed the intervention have a post-test score.

Participants also completed the GSE Index, in which a lower score indicates higher general self-efficacy. This measure also showed an improvement with the average GSE pre-test score 2.98 and the average post-test score 2.63 (Table 5.4). This improvement was statistically significant ($p < 0.01$).²¹

Table 5.4 GSE pre-test and post-test score

	Mean ¹
GSE pre-test score	2.98
GSE post-test score	2.63
<i>Base</i> ²	82

¹ Index range is 1 to 5, with a lower number indicating a more positive score.

² Participants without missing information. Only those who completed the intervention have a post-test score.

²⁰ $P < .001$ means that there is less than a .1 per cent chance that a change in mean scores of this size was due to random chance.

²¹ $P < .01$ means that there is less than a 1 per cent chance that a change in mean scores of this size was due to random chance.

5.3.1 Qualitative findings on self-efficacy and job-search impacts

Claimant interviews indicate that the intervention had the following positive impact on both self-efficacy and job search:

- **Reaffirmed and reassured claimants that employment was attainable.** The intervention helped to convince the long-term unemployed, those transitioning from ESA to JSA or on the verge of going back on the ESA that there they were employable and that there was a job out there for them.
- **Reaffirmed job goals.** The intervention helped to reassure claimants that they had targeted the right career when they had experienced job setbacks. For example, this reassurance helped one claimant complete a work-related course they were on.
- **Refocused job goals.** The intervention enabled claimants to reflect on the types of employment they were searching for. Where appropriate, it also enabled claimants' to reconsider their employment goals by drawing attention to the transferable skills they had and giving them the necessary confidence to apply for these jobs.
- **Built resilience to setbacks.** This is because of the above points and is illustrated by the quote below.

'Yeah, she [Work Coach] was very encouraging. She put me on the – the right path, where – a different – completely different way of thinking of job search as it was or it is now, it's a lot better now. Yeah, it's not a case of oh God, another disappointment, it's not that. It's, okay, they [job rejection] don't want me, it's their tough luck. I'll go and find somebody else.'

(Telephone Support, Completer, Male, Aged 50+)

- **Enhanced their job search and application skills.** This included updating CVs, signposting claimants to useful job search websites and helping claimants think through the application completion process. This sometimes led to claimants and VCRs both reporting an increase in the number of applications undertaken.
- **Improved skills that directly contributed to making claimants more employable.** For example, by helping claimants up-skill their IT knowledge through signposting suitable courses.

Factors contributing to self-efficacy and job search outcomes

The qualitative interviews identified a number of factors relating to the intervention and the claimants. These are summarised in Table 5.5.

Table 5.5 Factors contributing to self-efficacy and job search outcomes

Type of factor	Factor	How it contributed to outcomes
Intervention specific	Quality of the VRC	<p>A person-centred and supportive approach was key. This included:</p> <ul style="list-style-type: none"> • VRCs positively reinforcing the message that employment was within the grasp of claimants. • VRCs validating claimants' job goals, despite the setbacks they faced. • VRCs being able to refocus job goals through actively listening to claimants needs and perceptively picking up on transferable skills that could be used elsewhere. • Tailoring support according to the specific employment-related needs of claimants. • VRCs signposting claimants to appropriate job sites and resources.
Claimant related	What claimants brought into the intervention	<ul style="list-style-type: none"> • Levels of motivation and engagement affected how claimants interacted with the intervention and hence employment-related outcomes. • Claimants' perceptions of the job market also had an impact on the work-related outcomes. Claimants reported finding the job-search helpful but did not sometimes feel any close to finding work because of a perception that there were not enough jobs in their area or more widely.

5.4 Lessons learned

- Overall, measures of self-efficacy, wellbeing and mental health indicated positive change over the course of intervention when comparing the pre- and post-test scores for each measure.
- As with delivery, key intervention-related factors that contributed to these included the quality of the VRC in delivering a person-centred, targeted and supportive service, the action plans which positively challenged perceptions of what they were capable of and the weekly calls, which reduced isolation.
- However, there were also non-intervention-related factors that influenced outcomes that may need to be considered. These include effectively screening claimants to ensure that the severity of their wellbeing issues does not affect their participation and monitoring claimant motivation and engagement throughout the intervention.

6 Conclusions

This chapter brings together the key lessons learnt from the evaluation of the Telephone Support pilot and discusses the implications for a larger-scale piloting. The chapter begins with an outline of the broad lessons learned and then draws on the individual chapter summaries to provide a detailed summary of recommendations.

6.1 Participant identification, recruitment and retention

A key feature of successful interventions is clarity around what the intervention is, what the intervention is trying to achieve and for whom, and how the intervention is supposed to work. The results of this study indicated that, for example, there was variation in Jobcentre Plus Work Coaches' understanding of what the Telephone Support intervention was trying to achieve which led to inconsistent messaging when engaging with claimants at the referral stage. The findings of this study suggest that further implementation could benefit from face-to-face meetings with Work Coaches and providers to increase Work Coaches' awareness of the intervention and provide them with more detail on the intervention (including its voluntary nature), giving specific case examples, and further clarity on the range of support provided.

Another key aspect of successful intervention delivery is to ensure that the intervention reaches the people for whom it is intended. The results of this study indicated that claimants' engagement with Telephone Support was relatively low and led to a low level of intervention take-up. On the one hand, the views of staff interviewed indicated that this was to be expected given the nature of the issues faced by claimants (for example, anxiety, low confidence, and severe depression). On the other hand, participants suggested that further clarity was required at the referral stage about what the intervention involved, what it provided, by whom, over what period, for how long, and with what frequency. To improve Work Coaches' ability to identify suitable participants, one suggestion from this study is that further specification of who the intervention is aimed at is needed. This should be communicated effectively to Work Coaches. Effective screening may help to minimise the number of claimants who disengage because they feel their needs do not match the intervention or are too acute to be addressed by it.

As for participant engagement and retention, the findings suggest that further steps could be taken to improve participant engagement throughout the intervention. In logistical terms, providers could use text reminders, and specify the date and time for the initial assessment call so participants are expecting contact. Further processes could also be developed to allow providers to alert Work Coaches to instances where they have failed to establish contact with claimants, to enable Work Coaches to follow up with the claimant. This is particularly important as the findings suggest that anxiety and other mental health conditions meant some participants were reluctant to answer phone calls they were not expecting, and where the telephone number was unfamiliar. In terms of personnel, offering continuity of caseworker (for example, Vocational Rehabilitation Consultant (VRC)) between initial assessment and main intervention would also help to build trust and rapport and aid retention.

6.2 The role of Vocational Rehabilitation Consultant

The findings suggest that VRCs played a pivotal role in the successful delivery of the Telephone Support intervention after the referral from the Work Coach. As mentioned in Section 6.1, having VRCs involved as early as possible in the intervention helped to start the process of trust and rapport building between claimants and VRCs. As such, claimants would have appreciated the VRC delivering the intervention to be the one making the initial assessment call (which sometimes was the case), in place of caseworkers.

VRC were also key to the delivery of the actual intervention. The findings suggest that it is crucial to ensure that VRCs are equipped with relevant skills and knowledge, and have the right personal characteristics to deliver the Telephone Support intervention to increase the likelihood of achieving the desired outcomes for claimants. Although claimants had varying employment and wellbeing needs, they appreciated VRCs that had appropriate knowledge of delivering both psychological wellbeing and employment-related support. This was seen to give VRCs the versatility to address wellbeing needs and support whilst also taking into account the work or job goals of claimants. Claimants also reflected favourably where VRCs had 'soft skills' and experiences of working with this claimant group. There were a number of core qualities that claimants emphasised that enabled them to comfortably engage with the intervention and disclose personal issues over the phone to someone they had not met.

It is therefore important that a suitable VRC is in post to deliver the intervention. This requires not only careful recruitment of VRCs but adequate training, continuing professional development, high-quality supervision and practical support. It is also important to ensure that VRCs have access to materials setting out in detail how the intervention works, what needs to be done when and by whom, and how to respond to unusual but predictable circumstances. An adequate training period with supervised practice and continuous support from providers could significantly improve the overall intervention delivery (including engagement and retention) and thus participant experiences as well as desired outcomes. This view is supported by VRCs participating in this study suggesting that they could benefit from additional training on the range of support that could be offered to participants (while still being able to tailor the content to individual claimants).

6.3 Intervention improvements

The underlying model for Telephone Support is to offer a telephone-based intervention, which may include telephone-based Cognitive-Behavioural Therapy (CBT), guided self-help and other light touch health psychological interventions alongside employment support.

One of the strengths of the Telephone Support pilot was the flexible nature of the intervention that allowed VRCs to tailor the content to the claimant's needs and priorities. However, the intervention would benefit from a further service design development, particularly setting out what is essential to impact and therefore unchangeable. Finding the fertile ground between fidelity to the core components and adaptability is crucial as even the most effective interventions can fail when they are not delivered as intended. Fidelity to the design has repeatedly been shown to be an essential element of an intervention's success. However, adaptability is also important to support not only tailoring to claimants' individual needs but an intervention's scalability and wider take-up.

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As indicated in Section 6.2 above, VRCs interviewed as part of this study suggested that a larger-scale implementation would benefit from additional VRC training on the range of support that could be offered to participants. This would ensure all VRCs are familiar with the full range of options available and also reduces the risk that the content of the support reflects the strengths and preferences of the VRCs, as opposed to the needs and preferences of the participant. This view supports the idea of specifying the programme theory for the intervention, identifying the core components of Telephone Support while leaving enough room to tailor the content for claimants' needs.

6.4 Outcomes and impact

A key element of any programme piloting and larger-scale implementation is the collection of Management Information (MI) on various aspects of programme delivery such as participant characteristics, data on intervention receipt (for example, the number of sessions attended), and data on participant outcomes of interest such as wellbeing, work self-efficacy and mental health. As part of the Telephone Support intervention, providers collected data on some participant characteristics alongside pre-and post-intervention data on the abovementioned outcomes using standardised instruments.

The results of the study indicated that there was an overall positive change in participant outcomes when comparing the pre-test and post-test results. Furthermore, there were a number of factors that contributed to this positive change, including the quality of the VRC in delivering a person-centred, targeted and supportive service, the action plans which positively challenged perceptions of what claimants were capable of and the weekly calls, which reduced isolation. The study results also suggested that there were additional factors that could affect the outcomes and may need to be considered in further implementation. These included the effective screening of claimants to ensure that the severity of their wellbeing issues does not affect their participation and the monitoring of claimants' motivation and engagement throughout the intervention as a way of helping to achieve successful outcomes.

However, as a single-group evaluation that lacked a comparison group, the quantitative results emerging from the study do not allow us to conclude that the observed positive change in outcomes is due to the Telephone Support intervention. In order to establish causal relationships between the intervention and expected outcomes, larger-scale piloting should focus on impact evaluation as outlined below.

It has to be noted that causal relationships are difficult to identify. For example, we cannot observe what would have happened to participants if they had not received the Telephone Support intervention. This underlines the importance of the concept of the 'counterfactual'. The counterfactual is an estimate of what would have occurred in the absence of the intervention under evaluation (a theoretical what-if outcome).²² By subtracting the counterfactual from the observed change (factual)²³, the impact evaluation would allow us to assess the effect of an intervention, in this case of Telephone Support.

²² Morgan, S. L., and Winship, C. (2007). *Counterfactuals and causal inference: Methods and principles for social research*. New York: Cambridge University Press.

²³ Heckman, J.J., and Smith, J.A. (1995). Assessing the case for social experiments. *Journal of Economic Perspectives*, 9(2), 85-111.

In reality, we can observe average outcomes for those who participate in the intervention, i.e. who were ‘treated’, but we cannot observe the counterfactual results, i.e. what would have been the average outcomes of those same people if they had remained ‘untreated’. These would need to be estimated, typically using either a control group in the case of a randomised controlled trial, or a comparison group in the case of a quasi-experimental design.

The quality of the counterfactual and impact evaluation’s capacity to rule out alternative explanations to observed results depends heavily on how comparable the treatment group is to the control group. This is why larger-scale piloting should focus on understanding how (and which) claimants are recruited to participate in Telephone Support, and whether a valid comparison sample can be selected.

6.5 A detailed summary of the lessons learned

Complementing the broad overview of key learning discussed above, the table below draws on the individual chapter summaries to provide a detailed set of recommendations relating to referral and take-up, intervention delivery, engagement and perceived outcomes.

Table 6.1 Detailed recommendations

Key issue	Detailed recommendations
Referral and take-up	<p>Improving the number and quality of referrals:</p> <ul style="list-style-type: none"> • Hold face-to-face meetings with Work Coaches to increase awareness and provide more detail on the intervention, giving specific case examples, and further clarity on the range of support provided. • Specify who the intervention is aimed at and communicate this effectively to Work Coaches. Effective screening may help to minimise the number of claimants who are unmotivated because their needs do not match the intervention or are too acute to be addressed by it. • Continue to ensure that the referral process requires minimal input from claimants. • Use text reminders, and specify the date and time for the initial assessment call so that participants know when to expect contact. • Alert Work Coaches to instances where there has been no contact between the Provider and the claimant, to enable them to follow up with the claimant. • Consider continuity of caseworker (e.g. VRC) between initial assessment and main intervention to build trust and rapport and aid retention. <p>Encouraging take-up:</p> <ul style="list-style-type: none"> • Provide detailed information about the Provider and the format and content of the support so that claimants feel sufficiently informed and can make an adequate assessment of its usefulness. • Ensure consistent messaging around the voluntary nature of the intervention.

Continued

Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot

Table 6.1 Continued

Key issue	Detailed recommendations
Intervention delivery – format of intervention	<ul style="list-style-type: none"> • It is clear that delivery of the support was acceptable to claimants. However, given that some claimants were reluctant to take up telephone support, screening may be necessary to identify which claimants this support would be most suitable for. In addition, it may be helpful for claimants to meet their VRC in person prior to the start of the call in order to build rapport and trust. • Claimants should have an input into when the calls are arranged. This enables claimants to identify a slot where they are free, can talk in private and prevents the inadvertent missing of calls. • Weekly calls seem to work for claimants. However, screening may need to be done in order to identify claimants with specific issues (such as memory related issues) who may require much more frequent calls to benefit. However, this may have resource implications for the provider. • Calls should last no longer than an hour in order not to adversely affect claimant’s concentration. • Number of sessions. The intervention may need to build in a review at the end of the allocated sessions in order to determine whether claimants could benefit from additional sessions and/or if they need to be signposted to other support. However, this may need to be balanced against the short-term nature of this intervention.
Intervention delivery – content of support	<ul style="list-style-type: none"> • Clear, measurable objectives. Provider staff delivering the Telephone Support stressed the importance of setting clear measurable objectives for the intervention that are appropriate for an intervention with a relatively short duration. • Tailoring of support. Claimants came with a wide variety of needs and issues. A key implication of this is that the VRCs should be encouraged and supported (e.g. through training) to further tailor the support to the needs of claimants.
Intervention delivery – VRCs	<ul style="list-style-type: none"> • VRCs should continue to be responsible for the weekly calls. Claimants may not be reliable and/or able to afford the cost of making weekly calls. • VRCs should aim to deliver the intervention in a person-centred way, tailoring support based on the needs of claimants and delivering this in a flexible manner. • VRCs should continue to provide the option for claimants to contact them outside of the formal sessions. This is likely to engender trust and build rapport between claimant and VRC. Although this has resource implications, it must be noted that not all claimants took up the offer, but appreciated it nonetheless. • VRCs should be knowledgeable and experienced in delivering both employment and wellbeing support and advice. This may require training and upskilling VRCs to work outside of their delivery ‘comfort zones’. • There should be continuity in the VRC. Having the same VRC across both the initial assessment call and the delivery of the intervention can be helpful in establishing rapport and trust with claimants’ right from that start of the intervention. However, this needs to be balanced against the resourcing considerations faced by Providers.

Continued

Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot

Table 6.1 Continued

Key issue	Detailed recommendations
Engagement	<ul style="list-style-type: none"> • Ensure potential participants have a clear understanding of the content of the intervention, what they can expect to get from it and what level of engagement is expected. • Provide structure to the calls, setting goals so calls feel productive and participants have a sense of moving forward. • Provide text reminders for calls. • Improve communication between the Work Coach and the Provider to facilitate engagement, including the possibility of a 'warm handover' involving the Work Coach, telephone support Provider and participant to facilitate engagement. • Consider initial face-to-face contact to foster trust and build rapport, subsequently followed-up on the phone.
Perceived impact	<p>Key intervention related factors that contributed to positive change in the outcome measures included:</p> <ul style="list-style-type: none"> • Quality of the VRC in delivering a person-centred • Targeted and supportive service • The action plans which positively challenged perceptions of what they were capable of • The weekly calls, which reduced isolation. <p>There were also non-intervention related factors that influenced outcomes; these included the need to:</p> <ul style="list-style-type: none"> • Effectively screening claimants to ensure that the severity of their wellbeing issues does not affect their participation • Monitor claimant motivation and engagement throughout the intervention.

Appendix A

Technical annex

A.1 Introduction

This technical report provides further detail on the methodology of the evaluation of the Telephone Support intervention, which was piloted as part of the Psychological Wellbeing and Work Pilots in two Jobcentre Plus districts. The evaluation was comprised of three strands of activity: a quantitative analysis of outcome related Management Information (MI); and two qualitative strands of activity exploring the views and experiences of staff and claimants, as outlined in Table A.1.

Table A.1 Types of participant groups

Participant group	Further details
Staff – Jobcentre Plus	<ul style="list-style-type: none">• Single Point of Contact (SPOC)• Work Coaches involved in the referral of claimants to the intervention
Staff – Provider	<ul style="list-style-type: none">• Strategic staff/Managers• Delivery staff of the Telephone Support intervention
Claimants	<ul style="list-style-type: none">• Claimants that had attended one or more sessions

Each strand of activity will be discussed in turn and the report also provides copies of the interview topic guides used with the different participants.

A.2 Management Information

Analysis of secondary data explored various aspects of participant engagement and participation as well as initial effects and factors likely to influence outcomes of the Telephone Support intervention. MI data collected by the provider was analysed. To obtain an estimate of the take-up rate, provider data was compared with overall referral figures provided by the Department for Work and Pensions (DWP).

A.3 Data quality of sample

The robustness of the analysis depends on having complete data for a high proportion of the participants. Complete data would include that on each participant's characteristics, the five measures of their wellbeing, self-efficacy for work and mental health status, recorded both at outset and at completion of the intervention.

Of the claimants who completed the intervention, the ratio of complete to item missing data was 90:10 (82 complete cases out of 91). A ratio of 90:10 is often used in survey analysis as a maximum 'acceptable' level of item missing data, and can be a conservative expectation of administrative data.

A.4 Intervention implementation

For Telephone Support, summary statistics are reported on:

- The flow numbers of participants entering and exiting the intervention;
- Characteristics of participants, which include:
 - age;
 - gender;
 - length of time on Jobseeker’s Allowance (JSA);
 - whether claimants had previously been on Employment Support Allowance (ESA); and
 - whether claimants had previously been on the Work Programme.

In addition to summary statistics, MI data analysis on participant outcomes such as wellbeing, work self-efficacy and mental health was carried out on the following measures (see Table A.2 for further details):

- wellbeing;
- work self-efficacy; and
- mental health.

Table A.2 Description of measurements instruments

Outcome	Measure	Description
Wellbeing	WHO-5 Wellbeing Index (WHO-5)	The measure consists of five positive statements about wellbeing, for example, ‘I have felt cheerful and in good spirits’. Respondents indicate whether they have been feeling this way ‘All of the time (5)’ through to ‘None of the time (0)’. Raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life. A score below 13 indicates poor wellbeing.
Work self-efficacy	Job Search Self Efficacy Index (JSSE)	The measure consists of nine job search skills that respondents indicate how confident they are in doing. Responses are recorded on a 5-point scale, ranging from ‘not at all confident’ (1) to ‘a great deal confident’ (5). Therefore a higher score indicates higher job search self-efficacy.
	General Self Efficacy Scale (GSE)	The measure consists of three general self-efficacy statements that respondents indicate how often apply to them. Responses are recorded on the 5-point scale, ‘Always’ (1), to ‘Never/hardly ever’ (5).
Mental health	Generalised Anxiety Disorder 7 Item Scale (GAD-7)	The measure includes seven questions used to assess how often respondents have been feeling anxious, with each rated from ‘Not at all’ (0) to ‘Nearly every day’ (3). These are then combined into an index ranging from 0 to 21, and can be grouped into scores: 0-5 mild, 6-10 moderate, 11-15 moderately severe anxiety, 16-21 severe anxiety.
	Patient Health Questionnaire (PHQ-9)	The brief depression screening questionnaire asks how often respondents have been bothered by nine problems, with each rated from ‘Not at all’ (0) to ‘Nearly every day’ (3). These are then combined into an index ranging from 0 to 27, and can be grouped into scores: 0-5 mild, 6-10 moderate, 11-15 moderately severe depression, 16-27 severe depression.

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Data analysis took the form of significance testing of changes in scores between pre-test and post-test. As the take-up and completion rate for the intervention was low, the achieved sample of 82 complete cases was small. This prevented more advanced analysis such as regression analysis to explore predictive characteristics of outcomes, which had been initially part of the analysis plan.

A.5 Staff interviews

This strand explored Jobcentre Plus and provider staff experiences of pilot implementation, intervention delivery and perceived impacts. In-depth interviews were conducted over the telephone with senior staff and those involved in the delivery of the Telephone Support intervention. Staff interviewed for this strand included:

- Jobcentre Plus SPOC;
- Jobcentre Plus Work Coach;
- Delivery staff of the provider organisation;
- Strategic staff of the provider organisation.

A.5.1 Sampling

Jobcentre Plus staff sample

A sample frame of 341 Jobcentre Plus staff members in the pilot areas was drawn by DWP and sent to NatCen. The sample frame provided the contact details of all SPOCs and Work Coaches responsible for referring customers to the Telephone Support intervention. Where the required number of Work Coaches could not be recruited from the original DWP sample file, SPOCs contributed to the sample frame by identifying additional Work Coaches who had made referrals to the intervention (see also section on Recruitment).

All participants were purposively selected based on three key criteria: their role; the Jobcentre Plus district; and, for Work Coaches, the Jobcentre Plus office in which they were based. Work Coaches' level of experience of working with the unemployed was also monitored as a secondary criterion without quotas attached. Table A.3 presents the sample achieved across the two Jobcentre Plus districts involved in the Telephone Support intervention.

Table A.3 Achieved sample of Jobcentre Plus staff involved in Telephone Support

Criteria	Sub-criteria	District 1	District 2
Role	SPOC	1	1
	Work Coaches	3	3
Jobcentre Plus offices – Work Coaches	Office A	1	
	Office B	1	
	Office C	1	
	Office D		1
	Office E		1
	Office F		1
Total		8	

Provider staff sample

In total, seven provider staff involved in the delivery of the Telephone Support intervention were interviewed. Table A.4 presents the achieved sample.

Table A.4 Achieved sample of provider organisation staff

Provider organisation staff	Participated in interviews
Strategic staff/Managers	1
Delivery staff/Facilitators	6
Total	7

A.5.2 Recruitment

The interview recruitment process was designed to ensure consent was informed, voluntary and ongoing. For Jobcentre Plus staff recruitment involved the following steps:

- DWP provided a list of Jobcentre Plus staff in the pilot areas to NatCen.
- Advance emails were sent to selected staff, which outlined the nature of the study, and provided details about participation and assurances around the voluntary nature of the study. Emails were accompanied by an information sheet, which provided further details about the study.
- Follow-up calls to selected staff were made a week after the email had been sent by the research team. These calls enabled researchers to provide further information about the study and address any questions and concerns, and provided participants with an opportunity to opt-out.

In some instances, SPOCs helped identify Work Coaches who had made referrals to the pilot. Where this was the case, Work Coaches were approached and asked to participate and the voluntary nature of their participation was stressed.

To recruit provider staff, the research team liaised with a lead contact at the provider organisation who helped to organise interviews with delivery staff. Individual staff were then contacted by email to confirm the time and date for the interviews. A leaflet was also provided outlining the purpose of the evaluation and the confidential and voluntary nature of their participation.

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A.5.3 Data collection

Interviews with Jobcentre Plus staff were conducted by telephone and lasted approximately 30-45 minutes. Interviews explored the aims of the intervention, experiences of referral and take-up, as well as the perceived impacts of the intervention.

Interviews with provider staff were also conducted by telephone and lasted around 45 minutes. These interviews explored the aims of the intervention, implementation and delivery of the pilot, perceived impacts, recommendations and reflections on the intervention.

Topic guides were designed by NatCen for each participant group in collaboration with DWP (Appendix B). Fieldwork took place between December 2014 and February 2015.

A.6 Claimant interviews

Claimant interviews explored views and experiences of Telephone Support, including the referral process, experiences of the support, reasons why they completed or failed to complete all of their support sessions and perceptions of outcomes.

A.6.1 Sampling

DWP drew on its records to identify 215 participants who were receiving the Telephone Support intervention across two Jobcentre Plus districts. Claimants were selected purposively based on three primary criteria: age; gender; and Jobcentre Plus district. The outcome of involvement (i.e. whether claimants had completed all of the required sessions or left prior to this) was monitored as secondary criteria with no quota attached. Table A.5 provides a breakdown of the achieved sample.

Table A.5 Achieved sample of claimants involved in the Telephone Support

Criteria	District 1 (N=16)	District 2 (N=16)	Total achieved	Total aimed for
Gender				
Male	10	7	17	16
Female	6	9	15	16
Age				
16-24	2	0	2	Min 4
25-49	8	10	18	Min 16
50+	6	6	12	Min 10
Involvement outcome				
Completers	11	12	23	N/A
Non-completers	5	4	9	N/A

A.6.2 Recruitment

An opt-out process was conducted, which involved the following two stages:

- Claimants were sent advance letters informing them of the study, explaining what participation would entail and providing them with the opportunity to opt-out by freepost, telephone or email.

- Claimants who did not opt-out after a seven day period were contacted by NatCen's Telephone Unit, who answered queries and conducted a short screening exercise with those who indicated they would like to take part. The exercise confirmed that the claimant had received the intervention and other basic information on the sample file, including whether they had completed the intervention or not.

A.6.3 Data collection

Fieldwork with customers took place between February and March 2015. Interviews were conducted by telephone using a topic guide that was developed in collaboration with DWP (Appendix C). The guide covered claimants' reasons for taking part in the intervention, experiences and views of the selection, referral and take-up process, their engagement with the Telephone Support intervention, their experiences and the outcomes of their participation.

Interviews lasted no longer than an hour and claimants received £20 in cash as a 'thank you' for their time.

A.6.4 Analysis

All interviews were digitally recorded with participants' permission and later transcribed verbatim. Interview transcripts were analysed using the 'Framework' approach and facilitated by NVivo 10. This method was developed by the Qualitative Research Unit at NatCen.

The first stage of analysis involved familiarisation with the transcribed data and identification of emerging issues to inform the development of a thematic framework. This is a series of thematic matrices or charts, each chart representing one key theme (for example, views of the referral process or perceptions about outcomes). The column headings on each theme chart relate to key sub-topics, and the rows to individual respondents. Data from each case was then summarised in the relevant cell and links made within the NVivo software to the sections of the transcript that relate to each summary so that it was possible to return to a transcript to explore a point in more detail or extract text for verbatim quotation.

This approach ensured that the analysis was comprehensive and consistent and that links with the verbatim data were retained. Organising the data in this way enabled the views, circumstances and experiences of all respondents to be explored within an analytical framework that was both grounded in, and driven by, their own accounts. The thematic charts allowed for the full range of views and experiences to be compared and contrasted both across and within cases, and for patterns and themes to be identified and explored.

Appendix B

Staff interview topic guides

B.1 Jobcentre Plus Single Point of Contact (SPOC)

*The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like **Why? When? How?** as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. Researchers are not tied to phrasing the questions as they are presented in this topic guide – these are for guidance only.*

Aims of the interview

The overall aim of the Psychological Wellbeing and Work Feasibility Pilot evaluation is to inform future considerations on what types of support work best and assist claimants with their mental health and to move closer to the labour market. The aim of the interviews with Jobcentre Plus SPOC is to explore their experiences of the implementation of the Telephone Support pilot from a strategic perspective and to gather their perspective on the pilot.

Accordingly, the topic guide explores the following issues:

- Role and aims
 - Overview of participant role and length of experience
 - Their role in relation to Telephone Support pilot
 - Understanding of aims of the Telephone Support pilot
- Implementation of Telephone Support pilot
 - Communication with provider, administration, timescales, funding.
 - Key learning in relation to implementation
- Selection, referrals and take-up
 - How the referral process has worked and any recommendations for changes
 - Levels of take-up and barriers/enablers to take-up and retention
- Telephone Support delivery
 - Views on pilot content and recommendations for changes
- Perceived impacts
 - Work coach/advisor feedback on pilot – strengths and weaknesses
 - What helped/hindered
- Recommendations and reflections
 - Key learning from pilot
 - Desirability and feasibility of pilot expansion

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Phase	Theme	Sub-theme	Probes and prompts
<p>1. Introduction (<i>Aim: to introduce the evaluation and NatCen. To ensure participant gives informed consent and has an opportunity to ask questions</i>)</p>	<p>Introducing NatCen and the study</p>	<p>Purpose of interview. To explore their experiences of the implementation of the programme, its delivery and and their views of the impacts on claimants. To gather their insights and recommendations for improvements to the pilot.</p> <p>NatCen has been commissioned by DWP to carry out an evaluation of the Psychological Wellbeing and Work Pilots. The aim is to inform future development of the most promising interventions.</p> <p>Participation. The interview will take about 1 hour</p>	<ul style="list-style-type: none"> • No wrong or right answers • Participation is voluntary • Confidential. The report will not name any individuals who participated • Permission to record. Recording means we have an accurate record of what was said. The recording is kept securely in accordance with the data protection act and only the research team have access to it • Any questions. Including any concerns they have
<p>2. Role and aims (<i>Aim: to explore participants' current role and level of experience. To explore their understanding of the aim of the Telephone Support pilot.</i>)</p>	<p>Overview of their role</p>	<p>Explore the nature of their current role and length of experience</p>	<ul style="list-style-type: none"> • Overview of SPOC role • Role of SPOC in Telephone Support Pilot • Length of time in current role
	<p>Aims of pilot</p>	<p>Explore participants understanding of the aims of the Telephone Support pilot</p>	<ul style="list-style-type: none"> • Understanding of Telephone Support pilot <ul style="list-style-type: none"> – Aims/goals – Views on information they have about the pilot & its purpose • Any recommendations/ improvements to information provided to Jobcentre Plus staff • What buy in/support did they have from district management (e.g. time made available, encouraged, asked about this work)

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3. Implementation <i>(Aim: to explore participants' experience of pilot implementation from the perspective of participating Jobcentre Plus')</i>	Pilot implementation from perspective of Jobcentre Plus	Explore details of pilot implementation – communication with provider, administration, timescales, funding.	<ul style="list-style-type: none"> • Communication between Jobcentre Plus and Telephone Support provider <ul style="list-style-type: none"> – What helped/hindered • Administration of pilot <ul style="list-style-type: none"> – What helped/hindered • Timescales for pilot implementation <ul style="list-style-type: none"> – Nature of any delays • Funding <ul style="list-style-type: none"> – How provider is paid
	Key learning from implementation	Identify key learning in relation to implementation of pilot (to inform potential future roll-out)	<ul style="list-style-type: none"> • Any recommendations/improvements to pilot implementation • What worked well • What worked less well • Suggestions for improvement
4. Selection, referrals and take-up <i>(Aim: to explore who the pilot is targeted at, level of referrals and views on take-up. To gather insights and feedback on referrals and take-up to inform future development)</i>	Selection	Explore experiences of selection pilot – who the Telephone Support pilot is aimed at, views on whether right groups targeted	<ul style="list-style-type: none"> • Understanding of who the pilot is aimed at • Were they able to implement the referral guidance to ensure appropriate referrals. • Any issues with referral guidance • Any particular claimant characteristics which were perceived to be associated with referral/take up
	Referral	Gather feedback on referral rates – higher or lower than anticipated and reasons	<ul style="list-style-type: none"> • Overview of referral rates <ul style="list-style-type: none"> – Higher or lower than anticipated – Reasons – Variation between Jobcentre Plus offices • Any recommendations/improvements to referral process

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	Take-up	Explore their view on level of take-up – feedback from provider & Jobcentre Plus staff on barriers and enablers to take-up and any recommendations to encourage take-up.	<ul style="list-style-type: none"> • Conversion of referrals to take-up • Enablers/barriers to take-up <ul style="list-style-type: none"> – Reasons for non take-up • Levels of completion <ul style="list-style-type: none"> – What helped/ hindered completion • Any differences between different types of people/ districts/Jobcentre Plus offices • Any recommendations to encourage take-up/ completion
5. Telephone Support delivery <i>(Aim: to explore their understanding of the support provided by the pilot and anything they would like to change).</i>	Telephone Support overview	Overview of Telephone Support delivery	<ul style="list-style-type: none"> • Overview of their understanding of what support is provided • Recommendations for changes
	Staff feedback	Explore nature of feedback SPOC has received from Jobcentre Plus work coaches/advisors	<ul style="list-style-type: none"> • Nature of feedback from Work Coaches/ Advisors <ul style="list-style-type: none"> – Strengths of pilot – what worked well – What worked less well
6. Perceived impacts <i>(Aim: to identify perceived impacts from the perspective of Jobcentre Plus SPOC).</i>	Views on impact	Explore what they think the impact/ benefits are to the customer of receiving the telephone support on coping with job search setbacks	Changes/Impacts on: <ul style="list-style-type: none"> • self-esteem, self-belief • Strategies to deal with setbacks e.g. in job search
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on taking positive steps towards a job goal/job	Changes/ Impacts on: <ul style="list-style-type: none"> • Job search motivation • Job search skills/ efficacy • Belief that work is possible
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on their feelings of wellbeing	Changes/ Impacts on: <ul style="list-style-type: none"> • individual's wellbeing <ul style="list-style-type: none"> – feeling more positive/less positive/ no change

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7. Key learning/ recommendations <i>(Aim: to explore overall key learning from pilot and summary of recommendations. To gather views on feasibility /desirability of wider pilot).</i>	Key learning from pilot	Anything they would do differently/improve	<ul style="list-style-type: none"> • Key learning from pilot • Recommendations for changes
	Wider roll-out	Views on value/ feasibility of larger pilot	<ul style="list-style-type: none"> • Views on overall value of approach • Views on feasibility of rolling out to larger pilot
8. Closing interview	<ul style="list-style-type: none"> • Thank them for their time • Ask them if there is anything else they would like to add • Reassure them about confidentiality 		

B.2 Jobcentre Plus Work Coaches/Advisors

*The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like **Why? When? How?** as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. Researchers are not tied to phrasing the questions as they are presented in this topic guide – these are for guidance only.*

Aims of the interview

The overall aim of the Psychological Wellbeing and Work Feasibility Pilot evaluation is to inform future considerations on what types of support work best and assist claimants with their mental health and to move closer to the labour market. The aim of the interviews with Jobcentre Plus work coaches and advisors is to explore their experiences of referring claimants to Telephone Support and their views on delivery and impacts.

Accordingly, the topic guide explores the following issues:

- Role and aims
 - Overview of participant role and length of experience
 - Understanding of aims of Telephone Support pilot
- Selection, referral and take-up
 - How work coaches/advisors select claimants for pilot
 - How the referral process has worked and any recommendations for changes
 - Levels of take-up and barriers/enablers to take-up and retention
- Telephone Support delivery
 - Overview of work coach /advisor understanding of pilot content and recommendations for changes
 - What worked well/less well
- Perceived impacts
 - Claimant feedback on pilot – strengths and weaknesses
 - On resilience, mental and emotional wellbeing and distance from labour market
 - What helps/hinders
- Recommendations and reflections
 - Key learning from pilot
 - Desirability and feasibility of pilot expansion

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Phase	Theme	Sub-theme	Probes and prompts
<p>1. Introduction (<i>Aim: to introduce the evaluation and NatCen. To ensure participant gives informed consent and has an opportunity to ask questions</i>)</p>	Introducing NatCen and the study	<p>Purpose of interview. To explore their views and experiences of referring claimants to Telephone Support pilot. To explore their experiences of the implementation of the pilot and their views of the impacts on claimants they have referred. To gather their insights and recommendations for improvements to the pilot.</p> <p>NatCen has been commissioned by DWP to carry out an evaluation of the Psychological Wellbeing and Work Pilots. The aim is to inform future development of the most promising interventions.</p> <p>Participation. The interview will take about one hour</p>	<ul style="list-style-type: none"> • No wrong or right answers. • Participation is voluntary • Confidential. The report will not name any individuals who participated. • Permission to record. Recording means we have an accurate record of what was said. The recording is kept securely in accordance with the data protection act and only the research team have access to it. • Any questions. Including any concerns they have.
<p>2. Role and aims (<i>Aim: to explore participants' current role and level of experience. To explore their understanding of the aim of the Telephone Support pilot.</i>)</p>	Overview of their role	Explore the nature of their current role and length of experience	<ul style="list-style-type: none"> • Overview of role • Length of time in current role
	Aims of pilot	Explore participants understanding of the aims of the Telephone Support pilot	<ul style="list-style-type: none"> • Understanding of Telephone Support pilot <ul style="list-style-type: none"> – Aims/goals – Views on information they have about the pilot and its purpose • Any recommendations/ improvements to information provided to work coaches advisors (e.g. hand-outs, Frequently Asked Questions, etc)

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<p>3. Selection, referrals and take-up (<i>Aim: to explore who the pilot is targeted at, level of referrals and views on take-up. To gather insights and feedback on referrals and take-up to inform future development</i>)</p>	<p>Selection</p>	<p>Explore how work coaches/advisors select claimants for the pilot</p>	<ul style="list-style-type: none"> • Which claimants they would target for the pilot <ul style="list-style-type: none"> – Rationale • Were they able to implement the referral guidance to ensure appropriate referrals. • Any issues with referral guidance • Any particular claimant characteristics which were perceived to be associated with referral/ take up • Ease of engaging potential participants i.e. level of comfort and ease, and why (comfort around engaging on wellbeing needs) • Support to target individuals <ul style="list-style-type: none"> – Extra time to target individuals as part of their caseload – Senior management support/ engagement etc)
	<p>Referral</p>	<p>Gather feedback on the referrals process and how well it is working e.g. ease of referral/speed of provider response</p>	<ul style="list-style-type: none"> • Level of referrals they've made <ul style="list-style-type: none"> – Higher or lower than anticipated – Reasons – Whether refer more or less than colleagues • Administration of referral process <ul style="list-style-type: none"> – Referral process – Timescales for referrals • Any recommendations/ improvements to referral process

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	Take-up	Explore their view on level of take-up – what helped/hindered take-up and any recommendations to	<ul style="list-style-type: none"> • Conversion of referrals to take-up • What helped/hindered take-up <ul style="list-style-type: none"> – Reasons for non take-up • Levels of completion/ attrition <ul style="list-style-type: none"> – What helped/ hindered • Any recommendations to encourage take-up/ completion
4. Telephone Support delivery (<i>Aim: to explore their understanding of the support provided by the pilot and anything they would like to change.</i>)	Telephone Support overview	Overview of Telephone Support delivery	<ul style="list-style-type: none"> • Overview of their understanding of what support is provided • Recommendations for changes
	Claimant feedback	Explore nature of feedback work coaches/ advisors have received from claimants about the pilot	<ul style="list-style-type: none"> • Nature of feedback from claimants • Strengths of pilot – what worked well • Weaknesses of pilot – what worked less well
5. Perceived impacts (<i>Aim: to identify perceived impacts from the perspective of Jobcentre Plus work coaches / advisors working with claimants. Particularly in relation to emotional and mental wellbeing and distance from labour market).</i>	Views on impacts	Explore what they think the impact/ benefits are to the customer of receiving the Telephone Support on coping with job search setbacks	Changes/Impacts on: <ul style="list-style-type: none"> • self-esteem, self-belief • Strategies to deal with setbacks e.g. in job search
		Explore what they think the impact/ benefits are to the customer of receiving the Telephone Support on taking positive steps towards a job goal/ job	Changes/Impacts on: <ul style="list-style-type: none"> • Job search motivation • Job search skills/ efficacy • Belief that work is possible
		Explore what they think the impact/ benefits are to the customer of receiving the Telephone Support on their feelings of wellbeing	Changes/ Impacts on: <ul style="list-style-type: none"> • individual's wellbeing – feeling more positive/less positive/ no change

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6. Key learning / recommendations <i>(Aim: to explore overall key learning from pilot and summary of recommendations. To gather views on feasibility /desirability of wider pilot)</i>	Key Learning from pilot	Anything they would do differently/improve	<ul style="list-style-type: none"> • Key learning from pilot • Recommendations for changes
	Wider roll-out	Views on value/ feasibility of larger pilot	<ul style="list-style-type: none"> • Views on overall value of approach • Views on feasibility of rolling out to larger pilot
7. Closing interview	<ul style="list-style-type: none"> • Thank them for their time • Ask them if there is anything else they would like to add • Reassure them about confidentiality 		

B.3 Telephone Support delivery staff

The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like **Why? When? How?** as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. Researchers are not tied to phrasing the questions as they are presented in this topic guide – these are for guidance only.

Aims of the interview

The overall aim of the Psychological Wellbeing and Work Feasibility Pilot evaluation is to inform future considerations on what types of support work best and assist claimants with their mental health and to move closer to the labour market. The aim of the interviews with Telephone Support delivery staff is to explore their experiences of implementation and delivery of the pilot to inform decisions about whether to move to larger scale trials.

Accordingly, the topic guide explores the following issues:

- Role and aims
 - Overview of participant role, route into role and previous experience
 - Overview of the purpose of the Telephone Support
- Selection, referral and take-up
 - Who the intervention is aimed at and why
 - How the referral process has worked and whether the intervention is reaching its target audience
 - Levels of take-up and barriers/enablers to take-up and retention
- Telephone Support implementation
 - Views and experiences of implementation including training, set-up and logistics and any improvements/developments
- Telephone Support delivery
 - Overview of content of Telephone Support
 - Features of effective delivery

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- Perceived impacts
 - On resilience, mental and emotional wellbeing and distance from labour market
 - What has helped and what has hindered
- Recommendations and reflections
 - Key learning from pilot
 - Desirability and feasibility of pilot expansion

Phase	Theme	Sub-theme	Probes and prompts
1. Introduction (<i>Aim: to introduce the evaluation and NatCen. To ensure participant gives informed consent and has an opportunity to ask questions</i>)	Introducing NatCen and the study	<p>Purpose of interview. To explore their views and experiences of delivering Telephone Support. To explore the implementation and delivery of the pilot and their views of the impacts on participants. To gather their insights and recommendations for improvements to the pilot.</p> <p>NatCen has been commissioned by the Department for Work and Pensions (DWP) to carry out an evaluation of the Psychological Wellbeing and Work Pilots. The aim is to inform future development of the most promising interventions.</p> <p>Participation. The interview will take about one hour</p>	<ul style="list-style-type: none"> • No wrong or right answers. • Participation is voluntary • Confidential. The report will not name any individuals who participated. • Permission to record. Recording means we have an accurate record of what was said. The recording is kept securely in accordance with the data protection act and only the research team have access to it. • Any questions. Including any concerns they have.
2. Role and aims (<i>Aim: to explore participants' background, previous experience and route into current roles. To explore their understanding of the aim of the Telephone Support pilot.</i>)	Overview of their role	Explore the nature of their current role, route into current position and previous experience.	<ul style="list-style-type: none"> • Overview of role • Length of time in current role • Route into current role • Professional background • Previous experience of employment/ wellbeing support
	Aims of pilot	Explore participants understanding of the aims of the Telephone Support pilot	<ul style="list-style-type: none"> • Purpose of Telephone Support sessions <ul style="list-style-type: none"> o Aims/goals o Rationale for telephone support

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3. Selection, referrals and take-up (<i>Aim: to explore who the pilot is targeted at, level of referrals and views on take-up. To gather insights and feedback on referrals and take-up to inform future development</i>)	Selection	Explore who the intervention is aimed at & who it is most appropriate for	<ul style="list-style-type: none"> • Who intervention is aimed at <ul style="list-style-type: none"> o Rationale • Any types of people this might be less appropriate for <ul style="list-style-type: none"> – Rationale
	Referral	Gather feedback on the referrals process and how well it is working e.g. levels of referrals and their appropriacy, any recommendations for changes	<ul style="list-style-type: none"> • Levels of referrals <ul style="list-style-type: none"> – Higher or lower than anticipated – Appropriacy of referrals • Administration of referral process <ul style="list-style-type: none"> – Information received – Timescales for referrals • Any recommendations/improvements to referral process
	Take-up	Explore levels of participation – what hindered and what helped take-up and any recommendations to encourage take-up.	<ul style="list-style-type: none"> • Levels of retention • What helped/what hindered take-up and completion • Any differences between different types of people • Any recommendations to encourage take-up/retention
4. Telephone Support implementation <i>(Aim: to explore how the pilot has been implemented and lessons for future development)</i>	Staff training	Explore views on training received – confidence in delivering telephone support	<ul style="list-style-type: none"> • Staff training/supervision <ul style="list-style-type: none"> – Training received – Level of supervision/support • Recommendations for changes /amendments

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	Logistics and set-up	Explore views on the set-up and logistics of delivering Telephone support	<ul style="list-style-type: none"> • Case load <ul style="list-style-type: none"> – Size and manageability • Continuity of care <ul style="list-style-type: none"> – Ability to provide continuity of support • Working hours <ul style="list-style-type: none"> – Hours telephone support is offered • Recommendations for changes
5. Telephone Support delivery (<i>Aim: to explore content of Telephone Support pilot, including the initial assessment process and ongoing support. To include views on what features of pilot are most effective and why.</i>)	Telephone support overview	Ask respondent to provide their view of the service delivered (e.g. what they thought were the key features of Telephone support delivery e.g. number of sessions, typical length, frequency. Include recommendations for changes.	<ul style="list-style-type: none"> • Length of sessions <ul style="list-style-type: none"> – Typical length – Views on adequacy • Frequency of sessions <ul style="list-style-type: none"> – Typical frequency and level of variation • Length of support <ul style="list-style-type: none"> – How long support is provided for – 6 to 9 sessions max? – Views on sufficiency • Recommendations for changes
	Initial assessment	Ask respondent to describe their role and explore views and experiences of the initial telephone assessment	<ul style="list-style-type: none"> • Initial assessment phone call <ul style="list-style-type: none"> – How pilot aims explained – What covered in assessment – Views on usefulness – How information recorded • Recommendations for changes

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	Ongoing support	Explore views and experiences of providing ongoing telephone support	<ul style="list-style-type: none"> • Overview of range of support offered <ul style="list-style-type: none"> – Wellbeing support – Employment support • Ratio of wellbeing/ employment support <ul style="list-style-type: none"> – Which in more demand – How they work together • Level of tailoring to individual • Use of action plans/ goal setting <ul style="list-style-type: none"> – Availability of Employment Plan – Usefulness • Recommendations for changes
	Features of effective delivery	Explore the key features of the approach which they perceived to be effective	<ul style="list-style-type: none"> • Features of effective delivery <ul style="list-style-type: none"> – What works well and why – What is less effective and why • Views on telephone format <ul style="list-style-type: none"> – Strengths – Weaknesses • Features that are missing • Features that could be dropped
6. Perceived changes/ impacts <i>(Aim: to identify perceived changes/impacts particularly in relation to the individual's feelings of wellbeing, their jobsearch skills, belief about work and how they cope with setbacks)</i>	Impacts	Explore what they think the impact/benefits are to the customer of receiving the telephone support on coping with job search setbacks	Changes/Impacts on: <ul style="list-style-type: none"> • self-esteem, self-belief • Strategies to deal with setbacks e.g. in job search
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on taking positive steps towards a job goal/job	Changes/Impacts on: <ul style="list-style-type: none"> • Job search motivation • Job search skills/ efficacy • Belief that work is possible
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on their feelings of wellbeing	Changes/ Impacts on: <ul style="list-style-type: none"> • individual's wellbeing <ul style="list-style-type: none"> – feeling more positive/less positive/ no change

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7. Key learning/ recommendations <i>(Aim: to explore overall key learning from pilot and summary of recommendations. To gather views on feasibility /desirability of wider pilot)</i>	Key learning from pilot	Anything they would do differently/improve	<ul style="list-style-type: none"> • Key learning from pilot • Recommendations for changes <ul style="list-style-type: none"> – Implementation – Delivery
	Wider roll-out	Views on value/ feasibility of larger pilot	<ul style="list-style-type: none"> • Views on overall value of approach • Views on feasibility of rolling out to larger pilot
8. Closing interview	<ul style="list-style-type: none"> • Thank them for their time • Ask them if there is anything else they would like to add • Reassure them about confidentiality 		

B.4 Telephone Support strategic staff

The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like **Why? When? How?** as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. Researchers are not tied to phrasing the questions as they are presented in this topic guide – these are for guidance only.

Aims of the interview

The overall aim of the Psychological Wellbeing and Work Feasibility Pilot evaluation is to inform future considerations on what types of support work best and assist claimants with their mental health and to move closer to the labour market. The aim of the interview with the strategic lead for the Telephone Support service provider is to explore their experiences of implementation and delivery of the pilot from a strategic perspective to help inform a possible wider pilot.

Accordingly, the topic guide explores the following issues:

- Role and aims
 - Overview of participant role, route into role and previous experience
 - Overview of the purpose of the Telephone Support
- Selection, referral and take-up
 - Who the intervention is aimed at and why
 - How the referral process has worked and whether the intervention is reaching its target audience
 - Levels of take-up and barriers/enablers to take-up and retention
- Telephone Support implementation
 - Views and experiences of implementation including training, set-up and logistics and any improvements/developments

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- Telephone Support delivery
 - Overview of content of Telephone Support
 - Features of effective delivery
- Perceived impacts
 - On resilience, mental and emotional wellbeing and distance from labour market
 - What helps/hinders impacts
- Recommendations and reflections
 - Key learning from pilot
 - Desirability and feasibility of pilot expansion

Phase	Theme	Sub-theme	Probes and prompts
1. Introduction (<i>Aim: to introduce the evaluation and NatCen. To ensure participant gives informed consent and has an opportunity to ask questions</i>)	Introducing NatCen and the study	Purpose of interview. To explore their views and experiences of delivering Telephone Support. To explore the implementation and delivery of the pilot and their views of the impacts on participants. To gather their insights and recommendations for improvements to the pilot. NatCen has been commissioned by DWP to carry out an evaluation of the Psychological Wellbeing and Work Pilots. The aim is to inform future development of the most promising interventions. Participation. The interview will take about one hour	<ul style="list-style-type: none"> • No wrong or right answers. • Participation is voluntary • Confidential. The report will not name any individuals who participated. • Permission to record. Recording means we have an accurate record of what was said. The recording is kept securely in accordance with the data protection act and only the research team have access to it. • Any questions. Including any concerns they have.
2. Role and aims (<i>Aim: to explore participants' background, previous experience and route into current roles. To explore their understanding of the aim of the Telephone Support pilot.</i>)	Overview of their role	Explore the nature of their current role, and their role in relation to the Telephone Support pilot.	<ul style="list-style-type: none"> • Overview of role • Nature of their role in relation to the Telephone Support pilot.

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	Aims of pilot	Explore participants understanding of the aims of the Telephone Support pilot	<ul style="list-style-type: none"> • Purpose of Telephone Support sessions <ul style="list-style-type: none"> – Aims/goals – Rationale for telephone support
3. Selection, referrals and take-up (<i>Aim: to explore who the pilot is targeted at, level of referrals and views on take-up. To gather insights and feedback on referrals and take-up to inform future development</i>)	Selection	Explore who the intervention is aimed at and who it is most appropriate for	<ul style="list-style-type: none"> • Who intervention is aimed at <ul style="list-style-type: none"> – Rationale • Any groups less appropriate for <ul style="list-style-type: none"> – Rationale
	Referral	Gather feedback on the overall referral process and how well it is working (across both districts) e.g. levels of referrals and their appropriacy, any recommendations for changes	<ul style="list-style-type: none"> • Levels of referrals (overall) <ul style="list-style-type: none"> – Higher or lower than anticipated – Appropriacy of referrals – Nature of any variation <ul style="list-style-type: none"> • Across Jobcentre Plus offices • Across districts • Administration of referral process <ul style="list-style-type: none"> – Information received – Timescales for referrals • Any recommendations/improvements to referral process
	Take-up	Explore levels of take-up including retention (across both districts) – barriers and enablers to take-up and any recommendations to encourage take-up / retention.	<ul style="list-style-type: none"> • Levels of take-up (compared to referral level) • Levels of retention • Enablers/barriers to take-up and retention • Any differences between different types of people/districts/Jobcentre Plus offices • Any recommendations to encourage take-up/participant engagement

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<p>4. Telephone Support implementation (<i>Aim: to explore how the pilot has been implemented and lessons for future development</i>)</p>	<p>Staff training</p>	<p>Views on staff recruitment/ training – how staff were selected, nature of any recruitment. Overview of training/ supervision provided</p>	<ul style="list-style-type: none"> • Staff selection/ recruitment <ul style="list-style-type: none"> – How staff selected as telephone support advisors/ previous experience – Any recruitment specifically for pilot – Characteristics looked for in advisors • Staff training/ supervision <ul style="list-style-type: none"> – Level of training provided – Level of supervision/support • Recommendations for changes /amendments
	<p>Logistics and set-up</p>	<p>Explore views on the set-up and logistics of delivering Telephone support from a strategic perspective</p>	<ul style="list-style-type: none"> • Caseloads for telephone advisors <ul style="list-style-type: none"> – How determined – Views on manageability • Continuity of care <ul style="list-style-type: none"> – How continuity is maintained • Working hours <ul style="list-style-type: none"> – Hours telephone support is offered • Recommendations for changes
<p>5. Telephone Support delivery (<i>Aim: to explore content of Telephone Support pilot, including the initial assessment process and on-going support. To include views on what features of pilot are most effective and why.</i>)</p>	<p>Telephone support overview</p>	<p>Overview of Telephone support delivery e.g. number of sessions, typical length, frequency. Include recommendations for changes.</p>	<ul style="list-style-type: none"> • Length of sessions <ul style="list-style-type: none"> – Typical length – Views on adequacy • Frequency of sessions <ul style="list-style-type: none"> – Typical frequency and level of variation • Length of support <ul style="list-style-type: none"> – How long support is provided for – 6 to 9 sessions max? – Views on sufficiency • Recommendations for changes

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	Features of effective delivery	Explore what are the key features of the approach that are effective	<ul style="list-style-type: none"> • Features of effective delivery <ul style="list-style-type: none"> – What works well and why – What is less effective and why – Content most effective/least effective • Views on telephone format <ul style="list-style-type: none"> – Strengths – Weaknesses • Features that are missing • Features that could be dropped
6. Perceived impacts <i>(Aim: to identify perceived impacts particularly in relation to emotional and mental wellbeing and distance from labour market. To explore with participants key features of pilot that lead to impacts and nature of any barriers to impacts).</i>	Views on impacts	Explore what they think the impact/ benefits are to the customer of receiving the telephone support on coping with job search setbacks	Changes/Impacts on: <ul style="list-style-type: none"> • self-esteem, self-belief • Strategies to deal with setbacks e.g. in job search
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on taking positive steps towards a job goal/ job	Changes/Impacts on: <ul style="list-style-type: none"> • Job search motivation • Job search skills/ efficacy • Belief that work is possible
		Explore what they think the impact/ benefits are to the customer of receiving the telephone support on their feelings of wellbeing	Changes/Impacts on: <ul style="list-style-type: none"> • individual's wellbeing <ul style="list-style-type: none"> – feeling more positive/less positive/ no change
7. Key learning / recommendations <i>(Aim: to explore overall key learning from pilot and summary of recommendations. To gather views on feasibility /desirability of wider pilot)</i>	Key Learning from pilot	Anything they would do differently/ improve	<ul style="list-style-type: none"> • Key learning from pilot • Recommendations for changes
	Wider roll-out	Views on value/ feasibility of larger pilot	<ul style="list-style-type: none"> • Views on overall value of approach • Views on feasibility of rolling out to larger pilot
8. Closing interview	<ul style="list-style-type: none"> • Thank them for their time • Ask them if there is anything else they would like to add • Reassure them about confidentiality 		

Appendix C

Claimant topic guide

*The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like **Why? When? How?** as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. Researchers are not tied to phrasing the questions as they are presented in this topic guide – these are for guidance only.*

Aims of the interview

The overall aim of the Psychological Wellbeing and Work Feasibility Pilot evaluation is to inform future considerations on what types of support work best to assist claimants with common mental health problems achieve better employment and wellbeing outcomes.

Interviews with claimants on the Telephone Support aim to provide insights into the most effective design for delivering this support option. *Please note: The Telephone Support option is not as prescribed as the JOBS II Group Work option.*

The interview will meet this objective by exploring the claimant journey in to and through the support option, their experience views of the support received and will touch on the impact of the support in helping them think about returning to work, including which aspects of the support were most helpful.

Accordingly, the topic guide explores the following issues:

- Background of claimant
 - Recent employment history and previous barriers to work
- Selection, referral and take-up
 - The process of hearing about the intervention and what they heard
 - Why they wanted to be on the intervention
 - Their experience of the full referral process
- Engagement with the intervention
 - Whether intervention completed or not, and why
 - What helped/hindered their engagement with the project
- Experience of the Telephone Support option
 - Views on the content and form of the support
 - Views on the support workers

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- Outcomes – i.e. the perceived benefits of taking part, including:
 - Anything changed as a result of receiving the Telephone Support (if not, why not? If so, why?)
 - How are they now getting on with finding work
 - Have they changed in any other way as a result of receiving the Telephone Support (e.g. feeling more positive/less positive/no difference)
 - In what way receiving the Telephone Support contributed to perceived outcomes

Equal weight should be given to all of the sections. However, if running out of time please focus on the highlighted (in yellow) areas.

Phase	Theme	Sub-theme	Probes and prompts
1. Introduction <i>(Aim: to introduce the evaluation and NatCen. To ensure participant gives informed consent and has an opportunity to ask questions)</i>	Introducing NatCen and the study	<p>Thank them for taking part.</p> <p>Purpose of interview. The Department for Work and Pensions (DWP), the Government department in charge of benefits and Jobcentres, is looking at how they support customers find work. As a part of this, DWP would like to understand customers' views and experiences of the Telephone Support they received and how well it worked.</p> <p>Interviewer – if necessary, remind them what this support was (job search support they received over the telephone, involved one call a week for a period of time by someone from Remploy).</p>	<p>Who NatCen is. NatCen is a research organisation that is completely independent of DWP.</p> <p>Why they have been selected. As part of the study, we are talking to people who have received the Telephone support.</p> <p>Reassurances</p> <ul style="list-style-type: none"> • Participation voluntary. We can stop interview at any time and we can move on if they don't want to answer a question. • No wrong or right answers. Just want to hear their experiences and views. We may ask obvious questions, but important to hear what they have to say in their own words. • Participation is anonymous and confidential. We will not name anyone that has taken part to the DWP or to anyone else. The report will not name any individuals who participated.

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			<p>Taking part</p> <ul style="list-style-type: none"> • Duration. The interview will last up to an hour. • Incentives. We will send £20 cash by recorded delivery. • Permission to record. Recording means we have an accurate record of what was said. The recording is kept securely in accordance with the data protection act and only the research team have access to it. • Any questions. Including any concerns they have.
<p>2. Background (Aim: to gain context about their work history and constraints they have faced.)</p> <p>Interviewer instructions: Keep discussion brief</p>	<p>About them</p>	<p>Overview of recent employment (last four years) (keep brief)</p>	<ul style="list-style-type: none"> • Had any regular work in last four years • How much of the last four years spent on benefits
		<p>Overview main constraints to work – reasons for unemployment (keep brief)</p>	<ul style="list-style-type: none"> • Qualifications • Experience • Confidence and self-esteem • Any additional health concerns • Whether jobs available • Anything else
<p>3. Selection, referrals and take-up</p> <p><i>(Aim: to explore claimant experience of being targeted, their reasons for take-up, effectiveness of the referral process, and what could be improved.</i></p> <p>Interviewer instructions: Emphasis on the messages they received about the support, reasons for take-up and improving the referral process.</p>	<p>Process of hearing about the intervention</p>	<p>Explore how they heard about the Telephone Support (keep brief)</p>	<ul style="list-style-type: none"> • Work coaches (most cases) • Other claimants • When told (usually during advice sessions)

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		<p>Key messages they received about the Telephone Support</p>	<p>What were they told about:</p> <ul style="list-style-type: none"> • What the support was about • The type of support they would receive • Expectations of participating • Who it was for/Why were they selected <p>How did they feel about being selected/identified</p>
	<p>Reasons for take-up</p>	<p>Their reasons for agreeing to take part in the Telephone Support (or not)</p>	<p>Factors influencing decision to take part. e.g.</p> <ul style="list-style-type: none"> • Voluntary nature of support – Non-compulsion/no sanctions • Something else (e.g. my have been told it was mandatory!)
	<p>Experience of the referral process</p>	<p>What was their experience of the referral process</p>	<p>A very brief overview of what happened after the initial conversation with work coach</p> <ul style="list-style-type: none"> • What did work coach tell you would happen next? • What happened next/ when • Length of time before provider contacted them (should be within 10 days) <p>Their experience of the referral process</p> <ul style="list-style-type: none"> • What worked well • What could have been better? • What could be improved

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<p>4. Experiences of the Telephone Support <i>(Aim: To explore claimant experiences of the intervention and what could be done to improve it)</i></p> <p>Interviewer instructions: <i>A fuller description of the Telephone Support is required as this is tailor-made to needs of claimant</i></p> <p><i>Emphasis should be on their views on the form and content of the workshops</i></p>	<p>Experience of the support</p>	<p>Description of the form of support – how long it lasted, what it entailed. (Important to cover this to get a sense of what the telephone support looked like for claimants. Keep this factual though)</p>	<ul style="list-style-type: none"> • What was discussed at the first call from Remploy advisor <ul style="list-style-type: none"> – Employment needs – Number of calls agreed and why – What else was discussed • Support following on from the first call. <ul style="list-style-type: none"> – Number of calls actually received – Duration of calls <ul style="list-style-type: none"> – any flexibility in these – What was discussed at – was this set or did it vary? – Where calls received – Process of agreeing actions plans and homework – Did they have the same advisor – Any support received outside of the agreed number of calls • Missing sessions <ul style="list-style-type: none"> – Whether they missed sessions – If so, what happened?
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	<p>Views on the support</p>	<p>Views on the form and content of the Telephone Support option</p>	<ul style="list-style-type: none"> • Was it what they expected? If not, why not? • What worked well • What could have been better? • Suggested improvements/ anything they would add <p>Prompt for views on:</p> <ul style="list-style-type: none"> • Support tailored enough to meet needs • Length and frequency of calls • Set/structured of discussion • Sense of progress – e.g. too many actions plans or not enough progress • Homework. Relevance, whether they felt able to complete this and how this was monitored by advisor. • Action plans. Relevance of these to claimant. • Whether Telephone Support touched on wellbeing. Did it meet their wellbeing needs? If not, explore why. • How it differed from work support normally received e.g. from Jobcentre • Any issues talking on the phone (e.g. comfortable over the phone, able to talk in privacy etc...)
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		<p>Views on the advisors delivering the support</p>	<ul style="list-style-type: none"> • What they did well • What could have been better? • Suggested improvements <p>Prompt on how they saw the advisor and their delivery of sessions, including how this impacted on the experience of sessions. Prompt around:</p> <ul style="list-style-type: none"> • Style and skills delivering advice • Understanding of claimant's situation • Knowledge and skill in offering support/ strategies • Trust/confidence in the relationship • Approachability
<p>5. Engagement <i>(Aim: To explore different levels of engagement with the telephone support and the reasons behind this)</i> <i>Interviewer instructions: Level of engagement should be gauged very quickly.</i></p>	<p>Engagement</p>	<p>Explore how they would describe their level of engagement with the Telephone Support option (keep brief)</p> <p>Interviewer – This should be in the screening information. This is just about cross-checking this information.</p>	<p>Using prompts below, explore with participant where they are now, how they got on with the support and the reasons why?</p> <ul style="list-style-type: none"> • Still doing support (should be a few) • Completed full intervention (all days) • Couldn't make all the days but attended final session and/or most sessions • Decided to drop out and not come back

Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot

	<p>Completers or claimants still on support option or claimants</p>	<p>Specific reasons for staying in the Telephone Support option and any constraints overcome</p>	<p>These prompts can apply to both reasons for completing, and potential constraints they overcame.</p> <p>Reasons related to the Support option</p> <ul style="list-style-type: none"> • Relevance of option • Quality of advisor(s) and relationship with advisor • Feelings about homework/task • Logistical reasons (e.g. access to telephone, accessing a quiet space to talk) <p>Reasons outside of the Support Option</p> <ul style="list-style-type: none"> • Family • Childcare <p>Potential constraints to completion and if/how overcome</p>
	<p>Non-Completers</p>	<p>Specific reasons why they left the intervention (or didn't complete all the agreed number of telephone calls)</p>	<p>Reasons related to the Support option</p> <ul style="list-style-type: none"> • Relevance of option • Quality of advisor(s) and relationship with advisor • Feelings about homework/task • Logistical reasons (e.g. access to telephone, accessing a quiet space to talk) • Did not require all of the telephone sessions agreed (i.e. they had made sufficient progress) <p>Reasons outside of the Support Option</p> <ul style="list-style-type: none"> • Family • Childcare <p>Anything that could have kept them on the intervention.</p>

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<p>6. Outcomes (<i>Aim: to identify general outcomes and outcomes support option is specifically geared towards</i>).</p> <p>Instruction for interviewers: <i>Establish overview of specific impacts briefly, then use prompts to focus on specific change outcomes</i></p>	<p>Views on outcomes and reasons for outcomes</p>	<p>Explore whether they feel the Telephone Support has made a difference to them?</p> <p>If not raised spontaneously, prompt about specific support outcomes.</p> <p>Interviewer – For each outcome, explore enablers and constraints. Ask what it was about the support option that facilitated or was a constraint to outcome, i.e.:</p> <ul style="list-style-type: none"> • Support option components – action plans, homework • Generally delivery of support – once a week calls, length of calls 	<ul style="list-style-type: none"> • Did anything change for you because of the Telephone Support received? • If so, what • If not, why not. <p>(Interviewer – allow them to spontaneously to respond and then use the prompts in the row below)</p> <ul style="list-style-type: none"> • In terms of coping with job-search setbacks, whether anything changed for them as a result of receiving the Telephone Support? • In terms of enabling them to take a positive step towards a job goal, did anything change as a result of receiving the Telephone Support? <ul style="list-style-type: none"> – Using job search skills – Belief that work is possible for them – Putting an employment plan in place • In terms of their own wellbeing, has changed for them as a result of receiving the Telephone Support?
<p>7. Key learning/ recommendations (<i>Aim: to explore overall key learning from pilot and summary of recommendations</i>)</p>	<p>Key learning</p>	<p>What key messages would they give to DWP about what worked or not</p>	<ul style="list-style-type: none"> • 1-2 things they would keep about the intervention • 1-2 things they would change
<p>8. Closing interview</p>	<ul style="list-style-type: none"> • Thank them for their time • Ask them if there is anything else they would like to add • Reassure them about confidentiality 		