

Mental Health and Work



Commissioned by the cross government Health Work and Well-being Programme

contents

BACKGROUND	1
1.1 Introduction	1
1.2 Mental health problems and their prevalence	1
1.3 Factors that affect the prevalence of mental health problems	2
1.4 Association between mental health and physical health	2
1.5 Treatment and outcomes	2
1.6 The impact and cost of mental health problems	3
1.7 Mental healthcare in the 21st Century	6
WORK AND THE STIGMA OF MENTAL ILL HEALTH	7
2.1 Mental ill health as a cause of stigma	7
2.2 Stigma and the employment process	7
2.3 Stigma and discrimination in the workplace	9
MENTAL HEALTH AND EMPLOYMENT	11
3.1 The impact of mental ill health on performance at work	11
3.2 Common mental disorders and sickness absence	11
3.3 Return to work after sickness absence	14
MENTAL HEALTH PROBLEMS AND WORKLESSNESS	15
4.1 The impact of mental ill-health on employment rates	15
4.2 The effect of work and worklessness on mental health	16
4.2.1 Why work is important for mental health	17
4.3 Impact on the benefits system	18
SYSTEMS, SERVICES AND POLICY	19
5.1 The benefits trap	19
5.2 Support in the workplace	20
5.2.1 Occupational health	20
5.2.2 Primary care	22
5.2.3 Specialist mental healthcare providers	22
5.2.4 Improving access to psychological therapies	23
5.3 Pathways to Work	23
5.4 Specialist provision for workless people with severe mental illness	24
5.4.1 Policy	24
5.4.2 Support for work and employment for those with severe mental illness	25



6	THE RESEARCH EVIDENCE ABOUT WHAT WORKS	29
	6.1. Interventions to reduce sickness absence	29
	6.2. Specialist work schemes for people with severe mental illness	31
7	CONCLUSIONS	35
8	RECOMMENDATIONS	41
9	REFERENCES	45
	APPENDIX	55
	Evidence table of randomised controlled trials of work schemes for people with severe mental illness.	55

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1.1 Introduction

The Secretary of State for Health and the Secretary of State for Work and Pensions have asked Professor Dame Carol Black, National Director for Health and Work, to lead a review of the health-related factors that influence working life in Great Britain, and make recommendations. The review will inform policy and guide action in relation to health and employment.

The Review Team commissioned this supplementary report because mental health problems have a greater impact on people's ability to work than any other group of disorders. Mental ill health affects the productivity of those in work by impairing their ability to function at full capacity and it causes about 40% of all days lost through sickness absence (Sainsbury Centre for Mental Health, 2007). It also accounts for 40% of those claiming Incapacity Benefit and 23% of new claimants of Disability Living Allowance.

1.2 Mental health problems and their prevalence

People with mental health problems can be divided into three broad groups:

1. At any one time, one-sixth of the working age population of Great Britain experience symptoms associated with mental ill health such as sleep problems, fatigue, irritability and worry that do not meet criteria for a diagnosis of a mental disorder but which can affect a person's ability to function adequately (Office for National Statistics, 2001).
2. A further one-sixth of the working age population have symptoms that by virtue of their nature, severity and duration do meet diagnostic criteria (Office for National Statistics, 2001). These common mental disorders would be treated should they come to the attention of a healthcare professional. The commonest of these disorders are depression, anxiety or a mix of the two.
3. The most recent national survey found that about 0.5% of the population has a probable psychotic illness (Office for National Statistics, 2001) and the generally accepted estimate is that between 1% and 2% of the population will have a severe mental illness, such as schizophrenia, bipolar disorder or severe depression, which requires more intensive, and often continuing, treatment and care during their lifetime (Wing, 1994).

Although as a group those with a severe mental illness are more disabled than those with a common mental disorder, there is no clear cut relationship between diagnosis and disability at the individual level. A person with an anxiety disorder can be housebound and require intensive support from a carer whereas a person with schizophrenia can lead a normal life in all respects other than the subjective experience of their symptoms.

There was little change between 1993 and 2000 in the proportion of the population of working age that has mental health problems (Office for National Statistics, 2001). We will not know whether it has increased since then until the results of the survey undertaken in 2007 is published.



1.3 Factors that affect the prevalence of mental health problems

Compared with those who do not have a disorder, people aged 16 to 74 with a common mental disorder are more likely to be women (59%) and to be aged between 35 and 54 (45% compared with 38%). They are also more often disadvantaged socially in that they are more likely to be separated or divorced (14% compared with 7%), to live alone (20% compared with 16%) or as a one parent family (9% compared with 4%), to have no formal qualification (31% compared with 27%), to come from Social Class V (7% compared with 5%) and to be a tenant of a local authority or a housing association (26% compared with 15%) (Singleton et al, 2000). Because of these associations, there are more people with mental health problems in areas of the country that have high levels of social and economic deprivation. This is reflected in greatly increased rates of presentation and treatment of mental disorders in both primary and secondary care in socially deprived areas and, in particular, in deprived inner city areas (Moser, 2001; Harrison et al., 1995). In keeping with this, rates of claims for Incapacity Benefits on grounds of mental and behavioural disorders are highest in urban areas (Oxford Economics, 2007)

1.4 Association between mental health and physical health

People with mental health problems are more likely to develop physical health problems and vice versa. Furthermore, people with mental health problems can present to their GP or employer complaining of physical symptoms that have no physical cause. This can sometimes lead to missed or delayed detection of the underlying mental health problem. The interaction between physical and mental health is complex and it is often difficult to determine the direction of causal relationships.

1.5 Treatment and outcomes

Many people who develop a common mental disorder do not seek help from healthcare services or if they do their mental health problem is not detected (see section 5.2.3). Surprisingly little is known about the course of the mental health problem and the longer term outcome for this group of people. For those whose mental health problems are detected, there are drug and psychotherapeutic treatments that are effective for many people at both shortening the duration of the disorder and in reducing the likelihood of relapse. There are also effective treatments for the various types of severe mental illness such as schizophrenia, bipolar disorder and severe depression. The extent of recovery varies depending on a range of factors such as the nature of the illness, age of onset, severity of symptoms and the presence of other problems such as personality disorder or substance misuse. Some disorders are relapsing and ongoing drug treatment might be required that can itself cause adverse effects such as sedation. A minority of people have conditions that do not respond well to treatment and will experience continuing symptoms and sometimes a slow decline in social functioning. Mental health problems can be compounded by misuse of alcohol or illicit drugs.



1.6 The impact and cost of mental health problems

The World Health Organisation has calculated the number of years of life lost due to early death or disability caused by a range of health problems. It estimates that for the whole world mental health problems account for 13% of all lost years of healthy life (WHO, 2004) and as much as 23% in developed countries (Harnois and Gabriel, 2000).

The economic costs arise from two main sources:

1. The direct economic impacts of the behavioural or other consequences of mental health problems. This includes the effects of mental health symptoms on an individual's ability to work (impacting on their income and national productivity), the effects on the ability of family members or other carer to work and the other 'opportunity costs' of unpaid care.
2. The responses of the care system (broadly defined) to those consequences including the healthcare treatments and services provided to alleviate symptoms and meet needs, services provided by other systems (such as social care, housing, employment support, criminal justice, education, leisure services, transport, and social security), and out-of-pocket expenses by the individual or family for treatments, services, or travel to services.

The Sainsbury Centre for Mental Health estimates that the total cost of mental health problems was £77 billion in England in 2002/03 and £8.6 billion in Scotland in 2003/04 (Sainsbury Centre for Mental Health, 2003; SAMH, 2006). More than one-half of the total is accounted for by the imputed cost of impaired quality of life. If this is removed, the estimated cost of mental health problems in England and Scotland in these years was £39.5 billion. About 35% of this sum is accounted for by the costs of health and social care and 65% by lost economic activity. More recently, the Sainsbury Centre (2007) has estimated that impaired work efficiency ('presenteeism' – see section 3.1 below) due to mental ill health costs £15.1 billion, or £605 for every employee in the United Kingdom which is almost twice the estimated £8.4 billion annual cost of absenteeism. Some US studies put the cost of presenteeism at four or five times the cost of absenteeism (Goetzel et al., 2004; Stewart et al., 2003).

Table 1: Estimated annual costs to UK employers of mental ill health (Sainsbury Centre for Mental Health, 2007).

	Cost per average employee (£)	Total cost to UK employers (£billion)	Per cent of total
Absenteeism	335	8.4	32.4
Presenteeism	605	15.1	58.4
Turnover ¹	95	2.4	9.2
Total	1035	25.9	100

A number of other recent studies have made national cost estimates for particular disorders in both Great Britain and the USA. Although, due to methodological differences, these cannot be compared directly with one another, or with the estimates derived by the Sainsbury Centre, they all reach the same broad conclusions that overall costs are high and that a high proportion of costs are due to disrupted work patterns. None of these studies considered the costs of presenteeism.

Table 2: Estimated annual costs of specific disorders²

Type of disorder	Country	Cost in £billion and % of total cost			
		health and social care	lost productivity	Other	Total
Depression ³	England	0.4 (4%)	8 (89%)	0.6 (7%)	9
Bipolar disorder ⁴	UK	0.2 (10%)	1.8 (86%)	0.1 (4%)	2.1
Schizophrenia ⁵	England	2 (30%)	3.4 (51%)	1.3 (19%)	6.7

¹ The cost of replacing staff who leave their job due to a mental health problem

² Due to methodological differences and differences in the date conducted, these studies cannot be compared directly with one another or with the estimates derived by the Sainsbury Centre

³ Thomas and Morris, 2003

⁴ Das Gupta and Guest, 2002

⁵ Mangalore and Knapp, 2007



The overall cost of depression in England in 2000 was estimated to be £9 billion (Thomas and Morris, 2003). More than £8 billion of this cost was due to lost productivity as a result of work days lost resulting in claims for incapacity benefits. This figure is 23 times larger than the estimated costs falling to the NHS, which were £8 million for primary care consultation, £51 million for secondary health care and £310 million for medication. Lost future lifetime earnings were estimated to be £562 million due to 2615 deaths associated with depression (most of them suicides).

There are few estimates of the overall costs of anxiety disorders globally (Andlin-Sobocki and Wittchen, 2005), and none for the UK. However, studies in the USA point to the large employment-related impacts that generally outweigh health care expenditures (e.g. Rice and Miller, 1998; Greenberg et al., 1999). Absenteeism-related costs exceeded health service costs for people with social phobia in Britain (Patel et al., 2002), and are also high for obsessive compulsive disorder (Knapp et al., 2000).

The total cost of bipolar disorder in the UK in 1999/2000 was estimated to be £2.1 billion (Das Gupta and Guest, 2002). Ten percent of this cost fell to the NHS, 4% to other service systems, and 86% was attributed to excess unemployment (£1.51 billion), absenteeism from work (£152 million) and suicide (£109 million). The overall cost to society in England of schizophrenia was estimated to be £6.7 billion in 2004/05 (Mangalore and Knapp, 2007). Treatment and care costs falling directly to the public purse were £2 billion, with other costs falling to society amounting to nearly £4.7 billion. Within this latter sum, the cost of informal care and private expenditures borne by families was £615 million, and the costs of lost productivity due to unemployment, absence from work and premature mortality was £3.4 billion. An estimate was also included for the cost of lost productivity for family carers (£32 million). This study also estimated that about £570 million is paid out annually in social security benefits (plus around £14 million in the administration of these benefits).



1.7 Mental healthcare in the 21st Century

In England, the first National Service Framework developed by the Department of Health was for the mental health needs of working age adults (Department of Health, 1999). Scotland and Wales have also produced policy frameworks (Scottish Executive, 2001; Welsh Assembly, 2002). These and subsequent implementation guidance set out a common set of principles and values that underpin modern mental healthcare. These are relevant to this report:

1. Those providing care should have a sense of therapeutic optimism. The goal of care should be to promote “recovery”⁶ for people whose mental health problems cause significant disability.
2. Services should promote social inclusion and work actively to counter the stigma and discrimination that people with mental health problems face from society, including in the workplace.
3. The care package should encompass the range of health, social and behavioural issues that affect people with mental health problems. To achieve this, services must work across the interfaces between agencies including healthcare, social care, housing and employment.
4. Treatment and care should be evidence-based and draw on the growing number of national clinical practice guidelines.
5. People should be active agents in their care and be encouraged to express preferences and to exercise choice. This carries with it the assumption that people with mental health problems have responsibilities as well as rights.
6. The healthcare system has a wider responsibility to promote mental health as well as to treat mental illness. This includes influencing the formulation and delivery of social and economic policies including those relating to education, training and employment.

⁶ There are a number of definitions of recovery. One of the clearest is that adapted from the New Zealand Mental Health Commission by SAMH, the Scottish mental health charity: “recovery is happening when people can live well in the presence or absence of mental health problems and the many losses that come in their wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them” (SAMH, 2007).



work and the stigma of mental ill health



2.1 Mental ill health as a cause of stigma

Stigmatisation is the rejection by society of an individual with an attribute viewed by that society as negative and undesirable. Ostracisation and discrimination commonly follow. Although a number of health conditions lead to stigmatisation, mental health problems are second only to HIV/AIDS in this regard (Roeloffs et al., 2003). The World Health Organisation (2001a) and the World Psychiatric Association (Sartorius, 1997) believe that stigma is one of the greatest challenges facing people with mental health problems. The WHO stated its commitment to act against stigma in its Athens Declaration (WHO, 2001b) and, in the UK; the Royal College of Psychiatrists ran a five-year campaign to combat the problem (Crisp et al., 2000). Those with mental health problems who are workless are doubly stigmatised. This is because work is central to self-identity and to the way an individual is perceived by others. Also, it is only through work that the great majority can achieve a level of financial status that permits full participation in society.

2.2 Stigma and the employment process (Box 1)

Although the stigma of mental illness affects many aspects of the person's life it has the greatest impact on work (Roeloffs et al., 2003; Gaebel et al., 2005) and is experienced across all aspects of the employment process.

People with mental health problems find it more difficult to obtain work. Many human resources managers believe that those who have experienced psychiatric illness will be worse at their jobs and as a result they are more likely to request 'further information' if an appointee reveals such a history (Glozier, 1998). About half of employers would not wish to employ a person with a psychiatric diagnosis (Manning and White, 1995) and two-thirds of employers in the private sector and in small and medium-sized companies report that they have never knowingly done so (Chartered Institute of Personnel and Development, 2007). However, those companies that have employed people with a mental health problem do not generally regret the decision. In one recent survey, only 15% of such employers reported it as having been a negative experience.



Box 1: the impact of stigma on getting a job

One-half of employers would not knowingly employ a person with a psychiatric diagnosis:

Jo said: *“When I applied for a job as a cleaner at a care home, the manager called me and wanted to know more about my disability, which I’d declared. She pressed me so I said ‘I’ll be absolutely open with you. I’ve got a schizo-affective disorder and I hear three voices of people I knew’. There was complete silence on the phone. She didn’t say a word. So I said “Hello, are you still there?” All she said was “I’ll be in touch”. Anyway, a few days later, lo and behold, I received a rejection letter. To me her silence spoke volumes and I felt very discriminated against.”*

Shaun really wanted to apply for a job as a community warden. He said: *“I really wanted the job, but I decided not to apply. I knew I wouldn’t get it. Having a mental health problem is worse than having a criminal record when it comes to getting a job”.*

If an appointee reveals a history of mental illness as opposed to a physical disorder, HR managers are more likely to request ‘further information’:

Mandy applied to train as a psychiatric nurse, but because she is treated for depression the hospital’s occupational health nurse had to write to her consultant psychiatrist for a medical reference. Mandy said: *“This was taking a while and I was told by the nurse ‘I know it’s a nuisance, but we have to do this since that business with Beverley Allitt’. I felt as if because I have a mental illness I’m put into the same category as a murderer. Obviously I didn’t say anything as I wanted to be passed as fit and thought if I challenged her it would be seen as part of my illness.”*

Given the prevailing attitude among employers, it is perhaps not surprising that many people are reluctant to disclose their psychiatric history at the pre-employment assessment fearing the job offer might be withdrawn or that they will be treated differently as a result (Stuart, 2006). Although policies vary, this can put the person at risk of the job offer being withdrawn or of dismissal should information about past mental health difficulties emerge subsequently (Chartered Institute of Personnel and Development, 2007).

The experience of stigma and discrimination can adversely affect a person’s confidence leading them to doubt their ability to work. People with mental health problems who do find work are more likely to be underemployed, employed in low status or poorly remunerated jobs or employed in roles which are not commensurate with their skills or level of education (Stuart, 2006). They are over-represented in the secondary labour market, which consists almost entirely of part-time temporary jobs. Whilst many who have had mental health problems might value the flexibility, jobs in the secondary labour market are often unstable, poorly remunerated or open to exploitation. Employees have much less protection in law, and opportunities for training and career development are less easily available.



2.3 Stigma and discrimination in the workplace (Box 2)

Although some are treated sympathetically by their employers, people with mental health problems frequently report being denied opportunities for training, promotion or transfer (Michalak et al., 2007). Work colleagues tend to view mental illness as personal failure (Herman and Smith, 1989) and many report being uncomfortable working with a person who has mental health problems, particularly if they are currently unwell (Manning and White, 1995; Scheid, 2005). Colleagues react less charitably to psychotic illness, which can cause delusions (false beliefs) and hallucinations (hearing voices), than to other types of mental health problem such as anxiety and depression (Manning and White, 1995).

Given the expectation of discrimination and even dismissal, many people with mental health problems go to great lengths to prevent colleagues and managers knowing they are or have been ill (MacDonald-Wilson, 2005). Even if they do disclose, they will often wait until they have ‘made a good impression’ in the hope that this will off-set any negative prejudicial views already held. This attempt at concealment can make people reluctant to request time off for hospital or therapy sessions and reduce their chance of obtaining appropriate help from occupational health, counselling services or employees’ assistance programmes. Some people stop taking medication for fear that it will impair their work performance or that its effects might alert colleagues to their illness (Haslam et al., 2005).

Box 2: Discrimination in the workplace

Some report being treated sympathetically by their employer:

James, a City banker, said his employers allowed him to make a gradual return to work, starting back after a few months recovery with a reduced workload. James said: *“My colleagues deserve great credit for having supported my recovery. I was rather dreading their reaction after being off work following a serious episode of bipolar disorder. I even doubted whether it made sense to continue in a high-powered job. But once I explained things to them they could see I was still the same old James and that there was nothing to be afraid of. Economically their decision has paid dividends as I have been one of the highest earners in the years since returning to work.”*

Raza, a mental health charity worker, said: *“In one job I almost collapsed in the office at my desk. My line manager, who herself had experience of mental distress, came over to me we had a cup of tea together. She ordered a taxi to take me to the train station. Little things like that made me feel safe and able to open up to people about what I was going through. I probably worked harder for that organisation as a result too – so it made good business sense!”*



However, people with mental health problems frequently report being denied opportunities for training, promotion or transfer:

Diane, company secretary to a multi-national business in the city, was due to be the first woman to be appointed to the company's board of directors when she had her first admission to hospital with mental health problem. Diane said: *"When I walked back into the office after three months in hospital it went totally quiet. Nobody knew what to say. My job had been shared out amongst a few other people and they made me redundant soon afterwards. The managing director said: 'We can't have people like you in your position in the company'."*

Employees returning from a period of sick leave are more likely to be demoted or dismissed if they have a mental health problem:

David moved from a managerial job with a city council to what he thought would be an easier lifestyle with a 'quiet, backwater' district council. David said: *"I was working 80 hours a week. After seven months of over-work I had a breakdown and was signed off sick. They came back and said to me if you're not back at work within a week you're sacked. There was no support in place. It was horrendous. There was no compassion or sympathy. They sacked me a week later."*

Many people conceal their mental health problems from their colleagues:

Anna has mental ill health problems compounded by problem drinking. Although she found a new job, after having gained confidence from a period of rehabilitation, she said *"I still can't tell the people I work with about my problems, it's not the kind of thing you do where I am"*.

One-third of employers would not believe the information on a sick-note from an employee with a mental health problem (Manning and White, 1995) and, compared to those with 'physical' disorders, employees returning from a period of 'psychiatric' sick leave are likely to be more closely questioned, to be demoted or to be placed under greater supervision. A number have been dismissed (Michalak et al., 2007) and in one study 6.3% of workers with a serious mental illness reported that they had been fired, laid off or told to resign (Baldwin and Marcus, 2006). Understandably, people with mental health problems may be concerned about how taking of sick leave will be viewed and as a result remain in work and sometimes become more ill.



mental health and employment



3.1 The impact of mental ill health on performance at work

Mental health problems often cause fatigue and impaired attention, concentration and poor memory (Scheid, 2005; Lerner et al., 2004; Mancoso, 1990). These problems can be compounded by the effects of medication. However, 'functional impairment' at work is less common than 'affective impairment' such as emotional distress (Mintz et al., 1992) and there is only a weak association between the objective level of severity of a mental health problem and its impact on function at work (Dion et al., 1988; Tohen et al., 2000). Despite this, one large study found that depression has a greater negative impact on time management and productivity than any other health problem and is equivalent to rheumatoid arthritis in its impact on physical tasks (Burton et al., 2004). The problems caused by mental ill health can be a particular barrier to both high status jobs and those where there are high levels of contact with the public (Scheid, 2005).

Mental health problems are a major cause of presenteeism which is where an employee is unwell and remains in work but is less productive. As discussed in section 1.5, as much as 60% of the employment related costs of mental illness are due to presenteeism (Sainsbury Centre for Mental Health, 2007). This might be because people with mental health problems lack obvious outward signs and are reluctant to have to 'prove' they are ill because of the resulting stigma.

3.2 Common mental disorders and sickness absence

Figure 1 is a simplified representation of the complex path from being well to being long term sick. Many factors, including individual perceptions, beliefs and decisions, contribute to movement up and down the path and each step is not an unavoidable consequence of the preceding one. It is far from clear why certain employees develop symptoms at work or, having developed symptoms, attribute them to work. The nature of the work environment appears to be an independent risk factor for the development of symptoms in those in work, and, to some extent in predicting which employees with symptoms will take time off. At this point however, individual factors such as coping style become important. Beliefs and expectations of recovery are more prominent risk factors in those who are already off work, and common mental disorders are strong predictors of extended sick leave.

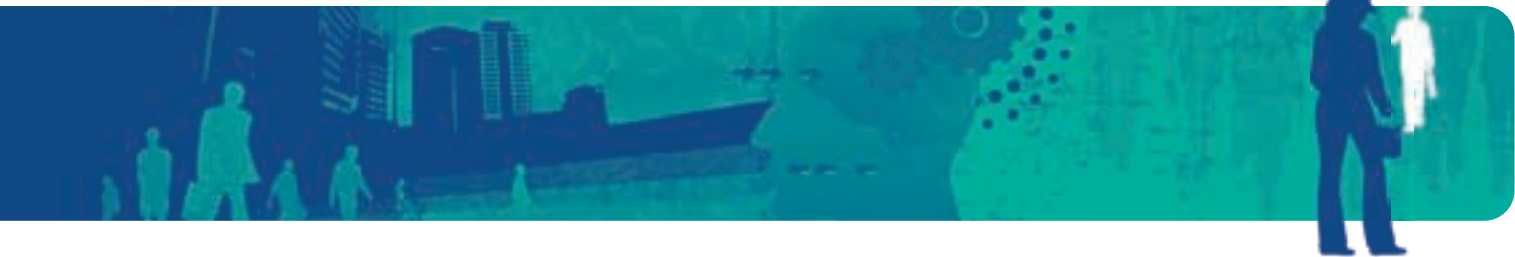
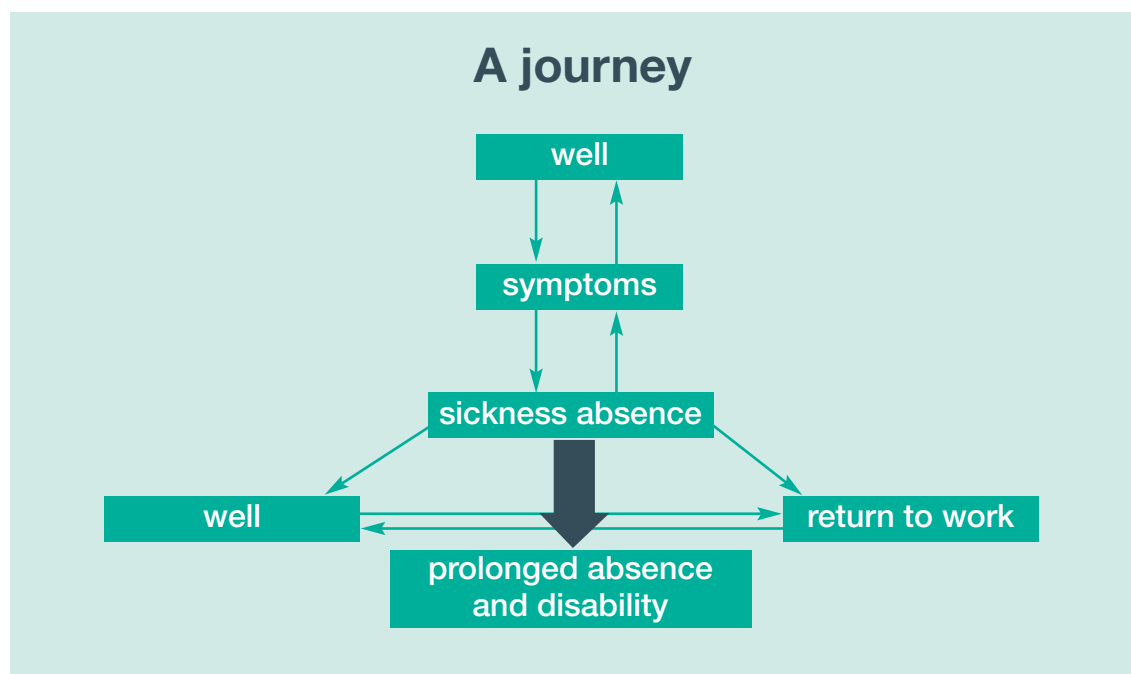


Figure 1: A simplified representation of the path from being well to being long term sick



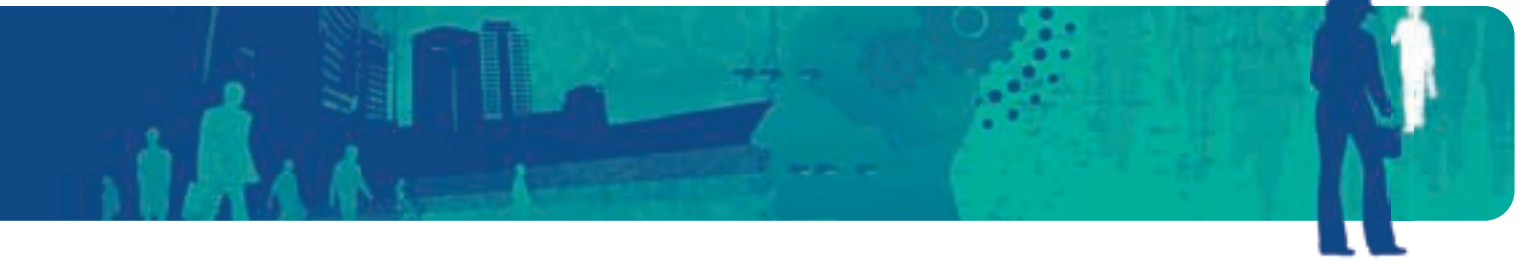
Women are both more likely to develop common mental disorders and to take sick leave for this reason (Stansfeld et al., 2003). However, this simple relationship does not hold for age. People aged under 35 are more likely to take sick leave due to mental ill health than those aged 50-59 if the prevalence of common mental disorders in the population is controlled for (Barham and Begum, 2005). These differences have not yet been explained.

Workers in particular jobs are more likely to develop common mental disorders or go off sick. This includes teachers, nurses, social workers, probation officers, police officers, the armed forces and medical practitioners (Seymour and Grove, 2005; Stansfeld et al., 2003). However, there appears to be no common 'toxic' thread running through the list of occupations. Within a workplace, people employed in lower status jobs have higher levels of psychological distress (Stansfeld and Marmot, 1992) and take more sick leave than those in higher status jobs (North et al., 1993). This is believed to be partly explained by differences in the psychosocial work environment relating to perceived level of control, reward and sense of achievement (Karasek and Theorell, 1990; Siegrist, 1996).



On average each mental health-related sickness absence spell lasts 21 days. For this reason, although mental health problems cause just 25% of absences of less than seven days, they account for 47% of long-term absences (Spurgeon et al., 2007; Confederation for British Industry, 2007; Unum Limited IfES, 2001). Compared with many common physical conditions, mental health problems are often gradual in onset and long lasting. Also, as well as trying to conceal the problem from their employer, people with mental health problems may delay seeking help until the problem is severe and so more difficult to treat (Dewa and Lin, 2000; Dewa et al., 2007). Finally, people with a common mental disorder also often have a physical illness. Whilst it might be the mental health problem that has tipped the balance and led to the taking of sick leave (Kessler et al., 2003), this may not be recognised, leading to a delay in receiving effective treatment and thus a delay in returning to work.

It is likely that official statistics understate the role of mental ill health in causing both short and long term absences. People with psychological distress may present to their GP with physical symptoms. A GP may not recognise, or be confident to diagnose a mental health problem in its early stage or may consider that to label it as physical will be in the patient's best interest (Glozier, 1998). Also, people with mental health problems are more likely to suffer musculoskeletal problems in the workplace (Glozier, 2002) and have greater levels of sickness absence from all causes (Hensing et al., 1997; Hensing and Spak, 1998; Jenkins, 1985).



3.3 Return to work after sickness absence

The longer a person is off sick, the more difficult it becomes for them to return to work and the less likely it is that they will return to work at all (Unum Limited IfES, 2001; Department for Work and Pensions, 2004). In part this is because many people with mental health problems fear that, no matter how good a recovery they have made, their symptoms will be made worse by going back to work. This is especially so for those who believe that work has either caused their health problem or made it worse (Jones et al., 2005).

For people with mental health problems, and depression in particular, improvement in ability to function well at work may lag behind those markers of improvement that doctors use to determine recovery such as improvement in subjective mood and the symptoms of depression such as restored sleep and return of appetite (Mintz et al., 1992; Goethe and Fischer, 1995; Adler et al., 2006). Thus a person might be passed as fit to return to work before they have attained previous levels of productivity. This creates the risk that employers interpret poor performance as lack of effort or motivation or competence and so create the conditions in which it is more likely that the person believes that they are starting to become ill again. Also, there is some evidence that work colleagues respond less favourably to people returning to work if their absence has been caused by a mental health problem (Glozier et al., 2006), particularly if they have had to cover for them.

4



mental health problems and worklessness



4.1 The impact of mental ill-health on employment rates (Box 3)

A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder⁷. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working full-time and a further 19% part-time (Meltzer et al., 2002)⁸. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).

Box 3: The impact of mental ill-health on people's ability to work

Liam, who has suffered from periods of depression for the last few years, said *"I was trying to deal with it myself, but it doesn't really work. Most days I would stay in bed. I didn't really get out, I was always in the house; I lost all my friends over it. It got really bad. I didn't think I could deal with it by myself, but I didn't like to seek advice from anyone."*

Liam tried to find employment but would experience overwhelming anxiety when calling about job vacancies or attending interviews – *"quite a few times I'd get the shakes and put the phone down before anyone had answered. It wasn't something I liked; it really did get in the way. When I had interviews, I didn't have any confidence and people could see that."*

Dov has had a number of jobs over the past seven years but, due to his mental ill health, few have lasted long. He said about one job *"I wasn't ill all the time, but the stress of work made me ill. I wasn't ready for the outside world. I couldn't get to work on time, all the time... then I got fired because I came late". Dov persisted despite his ill health and its impact on his ability to function properly – "I started a course in accountancy, and I was working two and a half days a week... but I couldn't handle it, so I quit the job, but carried on the course. Hoping that I could get a job later on maybe, but then I got ill again and went to hospital"*.

⁷ The results of a further survey conducted in 2007 will be published soon.

⁸ The various figures given in this section for the proportion of people with mental illness who are working vary because of differences in definitions and in the way in which the data were collected.



Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, pre-morbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. In 2004 just 21% of people considered disabled by a long-term mental illness were in work compared to 47% of disabled people overall (Social Exclusion Task Force, 2006). The employment rate for the UK working age population at that time was 74%.

4.2 The effect of work and worklessness on mental health (Box 4)

It has been estimated that about one-seventh of days lost due to mental health problems are attributed to work-related mental ill health (Sainsbury Centre for Mental Health, 2007). However, although work can be a stressor for some people in some circumstances, a recent comprehensive review of the research (Waddell and Burton, 2006) concluded that overall:

1. Work is beneficial to health and well-being.
2. Lack of work is detrimental to health and well being. The unemployed consult their GPs more often than the general population and those who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety. Unemployment is also associated with increased rates of suicide.
3. For people without work, re-employment leads to improvement in health and well-being and further unemployment leads to deterioration.
4. For people who are sick or disabled, placement in work improves health and psychosocial status.
5. The health status of people of all ages who move off welfare benefits improves.
6. These benefits apply equally to people who have mental health problems including those with severe mental health problems. There is no evidence that work is harmful to the mental health of people with severe mental illness.



The only caveats are that these conclusions do not apply to some individuals in some circumstances and that the social context and the nature and quality of the work are important factors.

4.2.1 Why work is important for mental health (Box 4)

It has been recognised since ancient times that work plays a central role in all people's lives (Thomas, 2001). It provides a monetary reward and is inseparable from economic productivity with its profits for the employer and its material benefits for society. As well as providing the monetary resources essential for material well-being, it links the individual to society (Schneider, 1998; Waddell and Burton, 2006).

The right to work is enshrined in Article 23 of the United Nations Declaration of Human Rights, which states that 'everyone has a right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment'.

Work gives the worker a social identity and status; social contacts and support; a means of structuring and occupying time; activity and involvement; and a sense of personal achievement (Warr, 1987). Unemployed people do not exploit the extra time they have available for leisure and social pursuits. Their social networks and social functioning decrease, as do motivation and interest, leading to apathy. People with mental health problems are especially sensitive to these negative effects of unemployment (Bennett, 1970). The social exclusion that they experience as a result of mental ill health is reduced by work and aggravated by unemployment (Social Exclusion Unit, 2004). Work is therefore central to two of the values that underpin mental healthcare for people with severe mental illness – social inclusion and recovery.

That as many as 90% of workless people who use mental health services wish to work (Grove, 1999; Secker et al., 2001) suggests that people with mental health problems are aware of the benefits of employment.

Box 4: why work is important to people with mental health problems

The benefits of work apply equally to people with severe mental illness:

Heinz, who had been out of work since being discharged from a mental health inpatient unit in 2001, said *"I got myself a job for 16 hours a week as a cleaner, but I couldn't hold it; I was dismissed. It was a tough experience and I was not so keen to try again... I was stuck in a 'being ill' type of condition". Despite this difficult experience, Heinz recognized that work was good for him – "for that period I was self reliant. I was off benefits because that had been my goal at the time, that I take advantage of the programme at the Job Centre Plus".*

After a further prolonged period of unemployment and isolation, Heinz found unpaid work at an employment scheme – *"there is a component of having something to do, the part-time work is therapeutic. It gives me an opportunity to stay in contact with a work-a-day type of atmosphere....I also volunteer with an organization which works with inmates... It means I have a purpose. It's a matter of having a feeling of self-worth."*



Brian's mental health problems started when he was a child. He was sent to prison when he was 19 and there he was diagnosed as having paranoid schizophrenia. He was transferred to hospital. Although 21 years later, he remains an inpatient, he attended a work scheme and then found work supporting other people who experience voices and teaching mental health professionals what it is like to live with the symptoms of severe mental illness – *“I actually got a paid post, but it only lasted six months because of funding. I was able to actually hold a job. For me, after 21 years without being able to do anything really, it was so fantastic.”*

4.3 Impact on the benefits system

Mental health problems considerably increase the risk of leaving employment compared to other health problems (Burchardt, 2003). Over the past 10 years, the proportion of all claimants of incapacity benefits who are claiming because of mental health problems has risen from 26% to 40% and it has overtaken musculoskeletal disorders as the commonest cause. This has happened because whilst the total number of new claimants has fallen, the number with mental health problems has stayed the same. The reasons for this are unclear.

In 2005, 15% of all those in receipt of Disability Living Allowance⁹ had mental health problems as the primary cause. Mental health problems accounted for 23% of all new claims over the preceding year and were the commonest single cause.

Mental health problems are a common cause of early retirement on medical grounds. For example, they account for 20% of all early retirements from the National Health Service (Pattani et al., 2001). The fact that for some occupations, up to one-third of people retired on medical grounds are back in work a year later (Brown et al., 2006) might suggest that better occupational health services could reduce the number of early ill health retirees. However, there has been very little research about early retirement and factors that influence this. Furthermore, what research there has been has focused on narrow professional groups and on the public sector.

⁹ Disability Living Allowance – sometimes referred to as DLA – is a tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled.

5



systems, services and policy



5.1 The benefits trap (Box 5)

People with mental health problems who receive incapacity benefits and/or Disability Living Allowance can earn up to £88.50 per week for up to one year as part of the 'permitted work' arrangement without it affecting their benefits. They can do so for a longer period under the 'supported permitted work' arrangement, if their health or social care worker co-signs the application.

However, many people with severe and enduring mental illness rely on Housing Benefit and Council Tax Benefit to make ends meet. The threshold of earnings for these is just £20 per week. In practice, many people whose earnings exceed this threshold will lose a high proportion of their Housing Benefit or Council Tax Benefit. Also, people whose work histories do not qualify them for incapacity benefits will receive Core Income Support with or without a Disability Premium. Again the limit for earnings for these benefits is £20.

Box 5: The benefits trap

The benefits of work apply equally to people with severe mental illness:

John, who has a longstanding severe mental illness, has not had a paid job for more than 20 years. He lives in a privately owned supported living facility with a weekly rent of £450. For the past nine years John has attended a work scheme as a volunteer and, as a result, his work skills and confidence have improved to the point that he feels ready to re-enter the labour market. In May 2007, the work scheme helped him to find a work placement at a local shopping centre. This led to him being offered a contract for 12 hours a week for three months at a wage of £5.65 per hour. The expectation was that, if successful, the contract would be renewed and then made permanent.

John was unable to take up the job offer because of the effect that it would have on his benefits. He would have lost a portion of his Housing Benefit and the effect on his rent payments would have been to force him to move out of his supported accommodation. Although John's ultimate goal is to live independently, and the paid work might have boosted his confidence sufficiently to allow him to take this step, he does not feel ready now. The result is that John feels that he is in a stalemate and that his ability to progress personally or financially has been blocked.

The system places people whose mental illness started at a young age, or who have been ill for a very long time at particular disadvantage.



5.2 Support in the workplace

5.2.1 Occupational health

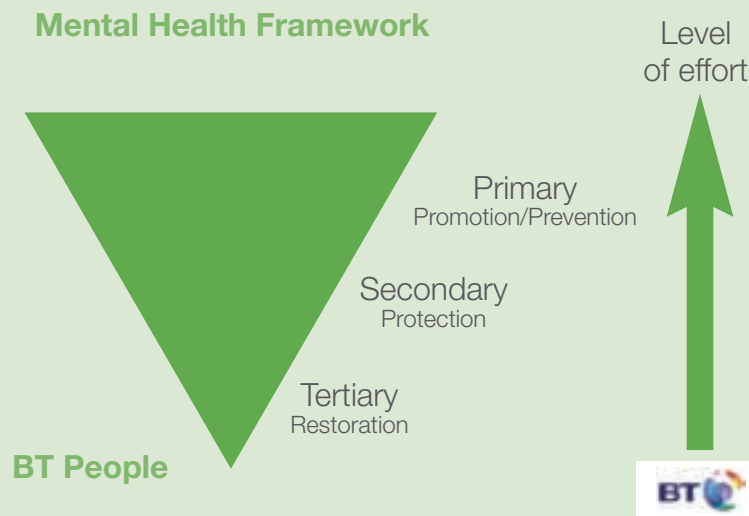
Only 3% of firms have a comprehensive occupational health service although 15% have more basic support. Larger companies are more likely to have higher levels of support (Health and Safety Executive, 2002). The World Health Organization has described occupational mental health as a “Cinderella subject”, particularly in countries like Britain where responsibility for public health and for occupational health and safety is split between two Government departments (Cox et al., 2004, p.180). Many occupational health workers have limited knowledge of the nature, impact and treatment of mental health problems although there are exceptions (see Box 6). As well as high quality training, occupational health workers require support from mental health professionals if they are to identify and manage mental health problems in their workers. However, few mental health workers have direct experience of occupational health practice. Also, the priority for specialist mental healthcare services is people with severe mental illness and not those with the common mental disorders that are most prevalent in the workplace.

Some organisations ask staff to complete regular health screens which include psychological assessments (see Box 6). This identifies people who might be suffering from a mental health problem and allows them to be directed to the appropriate service such as occupational health. Alternatively, if the screen is anonymous, employers can identify teams that appear to be in difficulty and examine the causes and potential solutions.

It is not in the scope of this report to comment in detail on the role of occupational health in creating a work environment that promotes mental health or one that reduces the likelihood of the workplace being a cause of mental health problems. However, the courts have consistently stated that there should be no distinction drawn between physical and psychological injury (e.g. *Hartman v South Essex Mental Health and Community Care NHS*, 2005). Employers therefore should create a culture where employees feel able to discuss difficulties that might cause mental health problems with their managers in the knowledge that they will receive a sympathetic hearing and a tolerant and flexible response within the limits of what the organisation can provide.



Box 6: Good practice in occupational mental health: BT's mental health framework



BT's health & safety strategy is to shift attitudes and behaviours from a dependent state to one of personal responsibility and collaboration. Implementation of their Mental Health Framework has led to improvements in well-being, engagement, productivity and reductions in sickness absence, as well as improvements in customer satisfaction.

Promotion of good mental health and well-being in ostensibly 'well' employees is done through Work Fit which was launched in 2004 as a joint initiative with the unions. Under the strapline 'Helping you to help yourself' it promotes small behavioural changes which will have a long term impact on health and wellbeing. These include keeping active, eating well and drinking sensibly, keeping in touch with friends and asking for help. In 2005, the Sainsbury Centre for Mental Health and MIND worked with BT on its fourth Work Fit programme, Positive Mentality.

Prevention of the development of mental health problems or the reduction of known risks is done by working to create good workplaces and good jobs, excellent leaders and supportive/competent managers, and by educating people for the job.

Protection involves early identification of those at risk to prevent escalation, to build resilience and allow early intervention. Employees complete STREAM, a validated, 30 item stress risk assessment questionnaire, on-line. Responses are categorised into Red, Amber or Green. Red and Amber ratings trigger a one-to-one meeting with the line manager to resolve issues. The tool is also used to compare and contrast different divisions and so identify hot spots in terms of the scale and nature of stress.

Restoration/intervention is aimed at resolving mental health and wellbeing problems quickly through a stepped care suite of proportionate interventions that help maintain people at work or return people to work as soon as appropriate. BT is currently developing Mental Health First Aid training as part of this suite.



Counselling and Employee Assistance Programmes

Over the past twenty years there has been a great increase in the number of employers who provide or contract for Employee Assistance Programmes many of which provide counselling (Carroll and Walton, 1999; Oher, 1999). In part, this has been driven by legislation and to reduce the likelihood of litigation. The Management of Health and Safety at Work Regulations 1999 requires employers to assess and to act to control the risk of stress-related ill health arising at work. An Appeal Court ruling in 2002 suggested that the provision of a counselling service was likely to satisfy an employer's duty of care in this respect, although the basis for this advice has been the topic of considerable debate (McLeod and Henderson, 2003).

5.2.2 Primary care

Three-quarters of people with a common mental disorder are receiving no treatment (ONS, 2001). Most people who do receive help are treated by primary care services. However, studies suggest that, on average, GPs detect only about one-half of the people with a mental disorder who present to them and under-treat depression and anxiety (Davidson and Melzer-Brody, 1999; Kessler et al., 1999). Detection rates are even lower for people whose mental health problems present as physical symptoms or for people with physical illness who have co-existing mental health problems (Kessler et al., 1999). Unfortunately attempts to increase the level of detection of common mental illness in primary care do not seem to improve clinical outcomes (Dowrick and Buchan, 1995). Despite these difficulties with early detection, longitudinal studies have demonstrated that general practitioners do tend to recognise mental illness during subsequent consultations (Kessler et al., 2002). General practitioners have a key role in the initial validation, labelling and treatment of any episode of sickness absence. Treatment guidelines for depression and anxiety focus on the important role general practitioners have in the management of common mental illness (NICE, 2004a and 2004b).

5.2.3 Specialist mental healthcare providers

Some of those suffering from a common mental disorder do not respond to treatment in primary care or have problems that are too complex to be managed by their general practitioner alone. However, because the priority for secondary care mental health services are those with severe and enduring mental illness and particularly those with psychosis, specialist mental healthcare providers make limited provision for people with common mental disorders. Many services operate inclusion or exclusion criteria that set a threshold of severity and discourage referrals from primary care. The criteria are often based on factors such as treatment resistance and risk of suicide rather than on functional impairment or impact of the mental disorder on ability to work. Furthermore, there are very long waiting lists for specialist psychological therapies, including cognitive behaviour therapy in most parts of the country. As a result of this gap between primary and secondary services, many people with more severe and prolonged mental disorders experience delays in receiving adequate treatment and care.



5.2.4 Improving access to psychological therapies

In 2006, the Department of Health established national demonstration sites at Doncaster and Newham to improve access to psychological therapies for people with depression and anxiety disorders. The new services have assessed more than 4,000 people many of whom might not otherwise have received a service and have reduced waiting to as little as 2 weeks. Early results suggest that recovery rates match those expected from trials in a clinical setting. Both sites have established working links with local Job Centre Plus services. In October 2007 the Government announced a £170 million programme to roll similar programmes out across England. The Department of Health has also commissioned an evaluation of the programme.

5.3 Pathways to Work

The Department for Work and Pensions' Pathways to Work pilots were set up to encourage people claiming Incapacity Benefits to return to work. They were introduced in three Job Centre Plus district pilot sites in October 2003 and four further districts in April 2004. New benefit claimants were required to attend a series of work-focussed interviews. They were also offered a condition management programme run in co-operation with local health providers to help them to better manage their health condition, including depression. Early findings were promising (Blyth, 2006). However, later results showed that, although people with physical health problems were more likely to be employed in the pilot areas, this was not the case for those with mental health problems (Adam et al., 2006; Bewley et al., 2007). Perhaps to be effective, such schemes have to offer people with mental health problems greater support into work (Sainsbury Centre for Mental Health, 2007). It is also important to note that the Pathways to Work pilots were only available to people who had started to receive benefits recently. We therefore do not know what effect such interventions might have on those who have been claiming benefits for longer periods. Also, the longer term outcome of the projects has yet to be assessed.



5.4 Specialist provision for workless people with severe mental illness

5.4.1 Policy

Guidance from the Department of Health/Department for Work and Pensions (2006) lists five key elements to a comprehensive range of vocational services for people with severe mental illness:

1. Clinical support leads within secondary services. These are mental health professionals within each team, who take a clinical perspective on vocational rehabilitation. They offer advice and guidance on vocational matters to other team members and provide brief interventions that help clients to achieve their vocational preferences and choice.
2. Employment specialists integrated within clinical teams. These people do not necessarily require a health or social services background. Their role is to identify and assess clients' vocational needs, help them to gain and retain employment, education and voluntary work and provide continuing support.
3. Public services as exemplar employers (see Box 7).
4. Supported work opportunities. Support may be offered to employees while they are in mainstream employment by a third party provider. For those people who would benefit from a specially constructed workplace, social enterprises and firms may be useful options (see Box 8).
5. Local partnership arrangements between specialist and mainstream providers with appropriate commissioner input.



Box 7: Public services as exemplar employers:

The User Employment Programme at South West London & St George's Mental Health NHS Trust

Established in 1995, the purpose of the 'User Employment Programme' was to increase access to ordinary existing jobs within mental health services for people who have themselves experienced mental health problems. Between 1995 and 2007, 142 people were supported in 163 posts within the Trust. On the 1st January 2007, 86% of these people continued to work within or outside the organisation or were engaged in professional training. At appointment, those with a diagnosis of schizophrenia had been unemployed for significantly longer periods than those with other diagnoses but there was no significant association between the length of time for which support was provided, type of job, grade of job or success in sustaining employment.

Access to benefit advice, to mainstream education and training and day care services should be part of the spectrum of services (Social Exclusion Unit, 2004; Sainsbury Centre for Mental Health, 2007). Recent guidance for commissioners of mental health services emphasises the need to refocus day care services into a community resource that promotes social inclusion, in which access to work and employment play a part. This is consistent with other recent policy initiatives including the Social Exclusion report (Social Exclusion Unit, 2004), Choosing Health White paper (Department of Health, 2004), the Adult Social Care Green Paper (Department of Health, 2005) and the Health, Work and Well-being strategy (HM Government, 2005).

5.4.2 Support for work and employment for those with severe mental illness

Work has always formed an important aspect of the care of the mentally ill and the large asylums provided sheltered employment for their patients. Work schemes became fragmented as community based mental health services developed with the running down of the large mental hospitals during the second half of the 20th century.

Approaches to work and employment for people with severe mental illness are shown in Box 8. The traditional schemes have offered sheltered work, and their more modern equivalents are the social firms. Other schemes have attempted to place people in open employment. The more traditional types of these schemes, often referred as "train and place", focus on reducing deficits related to the illness and on training in job skills to prepare patients for open employment. In contrast the supported employment schemes, developed in the USA, "place and train" by providing direct job placements, often in simple entry level occupations, and then offering support to the client and employer (Bond et al., 2001).



In addition, people with mental illness may choose to do voluntary work. Volunteering can sometimes provide the added satisfaction of helping others as “experts by experience” (see Box 4). There are many agencies that act as brokers between disabled people and the many opportunities for volunteering. The volunteer role, and the process needed to enable disabled people to become volunteers, requires the same kinds of support as paid employment. Some people may accept voluntary placements as part of work preparation.

Box 8: Types of work schemes for people with mental illness in the UK

Sheltered employment. Traditionally offer low grade, repetitive work often paying hourly rates that are well below the going rate for the job. Do not provide employment in the open market.

The Clubhouse model. Based on principles of meaningful activity and psychosocial rehabilitation, Clubhouses aim to support people in leading productive and meaningful lives within the community. They offer transitional employment schemes.

Social firms. Emphasis on creating a successful business that can support paid employment. Operates entirely as a business but its methods emphasise participation by employees in all aspects of the enterprise. Co-operatives and social enterprises may also be considered as social firms (see Box 9).

Supported employment schemes. Places clients in open competitive jobs without extended preparation and provides on the job support from employment specialists. There are several types including the assertive community treatment model, transitional employment, the job coach model and Individual Placement and Support (IPS).



Box 9: SMaRT, a small business that provides work for people with mental health problems and supports them into open employment

SMaRT (Socially Minded and Responsible Trading project) is a small business enterprise managed by First Step Trust, a registered charity that has work schemes across the country. It provides work for long term, unemployed people who are not yet ready for open paid employment because of mental health problems or other disadvantages. Based in Salford, SMaRT operates across two sites providing a range of Garage Services (MOT's repairs and servicing for cars and vans) and an End-of-Life-Vehicles de-pollution and recycling facility.

SMaRT provides real work in a demanding commercial environment that challenges the workforce to learn to handle the everyday stresses and pressures of work. It also provides formal work-based training and access to a range of qualifications, including City & Guilds and NVQs.

Although it has only been operating at full capacity for about 18 months, SMaRT has already provided more than 250 work experience places for people of all ages. Sixteen percent of the workforce are women and 30% are Black or from an ethnic minority. More than 80% of those recruited have been unemployed for more than one year (82%) with 45% being unemployed for more than 5 years or having never worked. Twenty-seven people have so far moved on to open employment.

Although the principal purpose of First Step Trust projects is to equip people for and move people on to open employment, the charity also seeks to promote people from the workforce to paid positions within its projects whenever possible.

Surveys carried out in the late 1990s in England identified 135 organisations, mainly small non-statutory agencies that offered sheltered employment, 77 that provided open employment and about 50 social firms (Grove and Durie, 1999). A survey in the northwest of England found a forty-fold variation in provision across health authority areas and a poor relationship between the schemes identified and the needs of the areas in which they operated (Crowther and Marshall, 2001). The highest level of provision was in the area with the lowest deprivation and unemployment levels.



Although there have been no recent national surveys, it is highly likely that there are too few work schemes to meet the need and that existing provision is irregularly distributed and does not take account of the recent evidence for effective approaches. The Sainsbury Centre for Mental Health estimated that the number of staff working in vocational and related day care services in England in 2003 was about one-third of that required to deliver the Government's mental health policy as summarised in section 5.4.1 (Boardman and Parsonage, 2007). Although some NHS mental healthcare providers employ vocational specialists who work in the IPS model (see Box 10), this is almost certainly an exception rather than the rule.

Box 10: An Individual Placement and Support (IPS) programme in South West London

South West London and St George's NHS Mental Health Trust has introduced Individual Placement and Support programmes to two boroughs. As part of this an employment specialist worker is integrated into each of the community mental health teams. The IPS programme assists people with a range of mental health problems, including many with psychoses. The IPS service shows advantages over a neighbouring borough that has pre-vocational services that are not integrated (Rinaldi and Perkins, 2007; Rinaldi and Perkins, 2007):

- an increase in people in open employment 12 months after the implementation of the IPS workers from 11% in the neighbouring borough to 32% in the borough with the IPS scheme;
- additional increases in people placed in mainstream education or training (6% to 16%) and voluntary work (7-15%);
- more people placed in employment, education or voluntary work in the integrated teams compared to the non-integrated pre-vocational services;
- lower costs of getting someone into open employment in the IPS services – this was 6.7 times higher in the pre-vocational service.



6.1 Interventions to reduce sickness absence

Despite their high prevalence in the workplace, there has been relatively little research about the effectiveness of interventions that assist people with common mental disorders to remain in work or return to work after a sickness absence. Most studies have been conducted outside the UK, where the labour market and other contexts are somewhat different, and some by evaluators with a commercial interest in the outcome. Not many have been published in peer-reviewed journals. Also, most evidence also comes from large, often multi-national corporations, with little relating to small and medium sized enterprises that usually do not have the resources to invest in substantial workplace-based initiatives. Two recent reviews of the research (Hill et al., 2007; Seymour and Grove, 2005) reached broadly similar conclusions which can be summarised as:

1. Stress management techniques may improve people's ability to cope with stress and to avoid stressful situations at work. Useful techniques are: teaching of problem solving skills, exercise and rehabilitation. However, workplace stress is a complex construct that can have beneficial as well as harmful consequences for an employee. There is no firm evidence that stress management techniques reduce the prevalence of common mental illness or of sickness absence. Also no studies have been conducted of the use of stress management in people who have already developed a common mental disorder.
2. For people who have common mental disorders that are affecting their work, brief individual therapy, mainly cognitive behavioural therapy¹⁰, in short courses of up to eight weeks may be beneficial. Booster sessions may be needed subsequently.
3. Interventions should be comprehensive and address both individual and organisation-level factors. There is little evidence on organisation-level interventions alone and what there is shows mixed results.
4. When people are off work due to mental disorders an early return to work is aided by line managers keeping in touch at least once every two weeks.

¹⁰ Cognitive behavioural therapy is a structured, problem oriented form of psychological intervention which aims to challenge specific thinking patterns and change behaviour. There is strong evidence of its effectiveness for a range of common mental disorders. Although it is usually delivered by a trained therapist, the National Institute for Health and Clinical Excellence has also recommended the use of CBT delivered by a computer for depression and some forms of anxiety.



What research there is into workplace mental health promotion provides some useful insights and hope that it might have a beneficial effect on the economic consequences of absenteeism, presenteeism, staff turnover and recruitment, and welfare payments. Future work in the UK to evaluate such interventions will probably require partnership between employers, trade unions and the government (Dewa et al., 2007).

Two US studies of workplace screening for depression followed by telephone-based care management by mental health professionals, published since the review by the British Occupational Health Research Foundation (Seymour and Grove, 2005) have shown economic benefits (Wang et al., 2006; 2007). An initial modelling study suggested modest gains in health-related quality of life at relatively low cost. The costs of the intervention to employers were lower than the savings in reduced absenteeism, presenteeism and employee turnover. In a subsequent randomised controlled trial, workers identified as having a depression-related disorder who then received counselling by telephone to encourage them to obtain psychotherapy and/or antidepressants, or telephone-based Cognitive Behavioural Therapy (CBT) had better mental health outcomes, higher rates of job retention and worked more hours, with positive financial benefits to employers.

Other US studies have demonstrated economic advantages. In one study enhanced depression care produced a small net benefit per worker. The impact was greater in companies that relied more on team working, where recruitment costs were high or where there were penalties for output shortfalls (Lo Sasso et al., 2006). A primary care depression management programme following the screening of workers for depression significantly improved productivity (by 6%) and reduced absenteeism (by 11 days over 24 months per individual with depression) (Rost et al., 2004). An earlier primary care study showed higher employment retention and fewer workplace conflicts for workers receiving an enhanced primary care intervention for depression (Smith et al., 2002).

Electricite de France and Gaz de France have implemented the APRAND programme (Action de Prévention des Rechutes des troubles Anxieux et Dépressifs) for their 140,000 employees. The aim is for company occupational health physicians, primary care doctors and social workers to identify anxiety and depressive disorders early. An evaluation showed that, of those workers on long-term sick leave identified as having anxiety or depressive disorders, those who subsequently participated in additional preventative activities had a 10-20% higher probability of recovery or remission at twelve months, compared with those who received usual care alone (Godard et al., 2006).



Few of the many studies that demonstrate the effectiveness of a range of pharmacological and psychological treatments in treating common mental disorders have measured their impact on employment status, work performance or absenteeism (McLeod and Henderson, 2003). The few exceptions, which were mostly conducted in the United States, suggest that the overall gain in labour output is much less marked than the reduction in symptoms (Timbie et al., 2006).

The conclusion of a systematic review, that counselling is effective in alleviating the symptoms of anxiety, stress and depression, and reduces sickness absence rates by 25-50% (McLeod, 2001), has been challenged (Henderson et al., 2003; McLeod and Henderson, 2003). Its critics contend that most of the studies reviewed have major methodological limitations and that the only true randomised controlled trial showed no benefit of counselling (Henderson et al., 2003). There is at best an absence of evidence that workplace counselling improves occupational outcomes.

6.2 Specialist work schemes for people with severe mental illness

Studies of work schemes for those with severe mental illness have mainly involved people who have schizophrenia. Appendix 1 summarises the main findings of randomised controlled trials conducted of such schemes.

The model that has been subject to the most research is known as Individual Placement and Support (IPS) (Becker et al., 1994), which stresses rapid job search on the basis of patient preference and continuing support to client and employer by an employment adviser working as an integral member of the mental health service (see section 5.4.2). Provided that the person is confident enough to believe that they are ready for paid work, the IPS approach to vocational rehabilitation does not require them to be symptom free. The principles of IPS are shown in Box 10. Systematic reviews of randomised controlled trials conclude that IPS schemes are more effective at helping people with severe mental illness to find jobs than are schemes that focus on pre-vocational training (Crowther et al., 2001; Twarnley et al., 2003; Waddell and Burton, 2006). Such schemes are recommended evidence-based practice in the USA (Bond et al., 2001).



These schemes are successful in getting about 50% of the people who enter them into employment, usually an entry level job. About one-half of these people remain in that job for more than six months. The long-term outcomes for these people are unknown because most studies of IPS have lasted for 24 months or less.

The first major randomised controlled study of the effectiveness of IPS outside North America, the EQOLISE trial, has just been published (Burns et al., 2007). This involved 312 people with severe mental illness (80% had schizophrenia) in six European countries, including England. After 18 months, 55% of people receiving IPS had worked for at least one day compared with 28% of those who attended the standard local vocation programmes. This large scale study is supported by the non-randomised evaluation of the use of IPS in day to day practice (Rinaldi and Perkins, 2007; Rinaldi and Perkins, 2007) (see Box 11).

Box 11: Critical components of the Individual Placement and Support model (after Bond, 2004)

- The goal is to achieve open paid employment.
- The agency providing supported employment is committed to competitive employment as an attainable goal for those with severe mental illness.
- Supported employment programmes use a rapid job search approach to helping clients obtain jobs directly (rather than providing lengthy pre-employment assessment, training and counselling).
- Staff and clients find individual job placements according to client preferences, strengths and work experiences.
- Assessment is continuous and based on real work experiences.
- Follow-on support is continued indefinitely.
- Supported employment programmes are closely integrated with mental health teams.
- Rehabilitation is an integral component of treatment of mental health rather than a separate service.



IPS is not necessarily an expensive model of provision. Unpublished figures from the EQOLISE trial indicate that it costs £2400 per person (at 2003 prices) over an 18-month period, and is lower than the cost of standard vocational rehabilitation. Figures from an earlier US study are similar (Latimer et al., 2004). In the European trial, this expenditure on IPS resulted in reductions in hospitalization (Burns et al., 2007). However, this impact has not been reported in any of the North American trials, perhaps because there is less reliance on in-patient services and lengths of stay are shorter than in most of the European countries included in the trial.

IPS services can be introduced without any net new expenditure if they replace equally costly traditional vocational rehabilitation services. The evidence suggests that the introduction of IPS may reduce hospitalisation and other mental health care costs to a modest extent on average, but to date this cannot be viewed as more than a tentative conclusion. The effect on clients' work earnings and tax revenue also tends to be small, although completed studies have only followed individuals for relatively short periods. The longer-term economic impacts could be greater given that one successful feature of IPS is that a number of clients ultimately are able to work with some consistency while relying on only minimal support.¹¹

Although IPS offers better outcomes than standard work schemes it would be imprudent to recommend the wider availability of this approach to rehabilitation on the assumption of expenditure savings. Nonetheless, long-term studies suggest that IPS yields important benefits beyond employment itself to a significant minority of clients (Becker et al., 2007), and the cost of the intervention is modest. Certain steps could be taken to improve cost-effectiveness:

1. Ensure that supported employment programmes are implemented with fidelity (Drake et al., 2006).
2. Increase incentives for people who have severe mental illness to return to work, and to work more hours (Becker et al., 2007; Burns et al., 2007).
3. Recognise that some clients are more likely to benefit from IPS than others (Zito et al., 2007) and consider better targeting. This must be done without disadvantaging people with severe mental illness who would benefit from other forms of vocational rehabilitation and who might, with this support, become suitable for IPS in the future.
4. Make cost savings by replacing other forms of vocational support, that do not move people who believe they are ready for paid work directly into employment, with IPS. Again this must not be at the expense of vocational services that support the rehabilitation of people who are not yet ready for IPS or which provide the health benefits of sheltered work to people who might never be ready for paid employment.

¹¹ Some of this material comes from an unpublished review by Eric Latimer (2008).





7.1 With regard to their impact on work, mental health problems can be grouped into three broad categories.

1. Symptoms associated with mental ill health such as sleep problems, fatigue, irritability and worry that do not meet criteria for a diagnosis of a mental disorder. These affect one-sixth of the working age population of Great Britain at any one time and can impair a person's ability to function at work.
2. Common mental disorders, particularly anxiety and depression, affect a further one-sixth of the working age population. These would be treated should they come to the attention of a healthcare professional. People with a common mental disorder are four to five times more likely both to be permanently unable to work than the rest of the population and three times more likely to be receiving benefits payments.
3. Severe mental illness, such as schizophrenia, bipolar disorder or severe depression affects about 1% of the working age population. People with these conditions usually require continuing and sometimes intensive treatment and care. Best estimates are that between 10% and 20% of this group are in paid employment.

7.2 Mental health problems cost the economy of Great Britain more than £40 billion each year (excluding the value of their effect on the quality of life of the individual). About two-thirds of the cost is due to their impact on people's ability to work.

7.2.1 About 11 million people of working age in Great Britain experience mental health problems and about 5.5 million have a common mental disorder. However, only about 1.3 million of these people are being treated.

7.2.2 Mental health problems affect those who have a job by:

1. adversely affecting work performance due to fatigue, poor concentration and memory problems. The cost of presenteeism in the UK alone is estimated to be £15.1 billion each year;
2. causing people to take time off and accounting for a high proportion of long-term sickness absence. The cost of absenteeism is estimated to be £8.4 billion.

	Cost per average employee (£)	Total cost to employers (£billion)	Per cent of total
Absenteeism	335	8.4	32.4
Presenteeism	605	15.1	58.4
Turnover ¹²	95	2.4	9.2
Total	1035	25.9	100

¹² The cost of replacing staff who leave their job due to a mental health problem



7.2.3 Many people whose occupational difficulties have been ascribed to other ('physical') causes, for example back pain, also have mental health problems which will significantly affect their occupational outcomes.

7.3 There is some evidence that the adverse impact of mental health problems on the economy is growing faster than that of physical health problems.

7.3.1 The proportion of all claimants of Incapacity Benefits who are claiming because of mental health problems has risen over the past decade from 26% to 40%. It is now the commonest cause.

7.3.2 Although they only accounts for 15% of all claims for Disability Living Allowance, mental health problems are now the commonest cause of new claims – accounting for 23% in 2005.

7.4 The challenges posed by mental health problems in relation to work are different to those posed by physical health problems in some important respects. These differences are apparent along the whole continuum from being healthy in work to long-term incapacity.

7.4.1 The causes of work-related mental ill health, and the inter-relationship between contributory factors, are less well understood than are the causes of work-related physical health problems.

7.4.2 People with mental health problems face more stigma and discrimination than do people with physical health problems, with the exception of those with HIV/AIDS. This adversely influences recruitment practice and treatment in the workplace.

7.4.3 Because of the stigma associated with it, people are more likely to attempt to conceal a mental health problem from their employer than they would a physical health problem. This, together with the fact that there may be no visible sign of a mental health problem, may prevent or delay its detection and therefore its treatment.

7.4.4 Occupational healthcare workers have less knowledge of mental health problems than of physical health problems and so are less well equipped to detect and advise about its management.

7.4.5 GPs fail to detect about one-half of people with a mental health problem who present to them and under-treat depression and anxiety. Detection rates are even lower for people whose mental health problems present themselves as physical symptoms or for those with co-existing physical illness.



7.4.6 Sickness absences due to mental health problems are likely to be longer than those caused by physical health problems. For this reason, they account for 25% of absences of less than seven days but 47% of longer absences.

7.4.7 Employees returning from a period of sick leave due to a mental health problem, as opposed to a physical health problem, are more likely to be demoted or placed under greater supervision.

7.4.8 Mental health problems considerably increase the risk of leaving employment compared to other health problems.

7.4.9 21% of disabled people with enduring mental health problems are in employment compared with 47% of all disabled people [does this reflect the evidence presented in the relevant chapter?].

7.5 Stigma and discrimination are major obstacles to the integration of people with mental health problems into the workplace. They affect all aspects of the employment process. The experience of stigma and discrimination can adversely affect a person's confidence leading them to doubt their ability to work.

7.5.1 People with mental health problems find it more difficult to find work because employers believe that they will not do the job well.

7.5.2 Although experiences vary, many people with mental health problems feel discriminated against in their workplace.

7.5.3 85% of employers who do employ people with mental health problems do not regret doing so.

7.6 Although it can cause stress to some people in some circumstances, work is usually beneficial and worklessness detrimental to health and well-being. This applies equally to people with mental health problems, including those with severe mental illness.

7.6.1 Whilst perceived “stress” at work is associated with increased sickness absence, it cannot simply be attributed to “toxic” occupational environments – other contextual factors are likely to be equally or more important



7.7 There are delays and inefficiencies in the detection and treatment of common mental disorders. Also, the longer that a person is off sick with mental health problems, the less likely they are to return to work. These two facts might be related.

7.7.1 Primary care has the lead role in both detecting and treating mental health problems and in determining who is fit to work. However, GPs detect only about one-half of the people with mental disorder who present to them and under-treat depression and anxiety. Detection and treatment rates are even lower for people whose mental health problems present as physical symptoms or for people with physical illness who have co-existing mental health problems.

7.7.2 Secondary mental healthcare providers have the skills to detect and treat common mental disorders but their priority is severe mental illness. Many specialist mental health services are reluctant to accept referrals of people with common mental disorders unless they pose a suicide risk or have proven resistant to treatment.

7.7.3 There is limited supply of, and often very long waits for, psychological therapies of a type shown to be effective in treating common mental disorders.

7.8 There is potential in the system that addresses work and mental health for perverse incentives and unintended consequences at all levels.

7.8.1 At the national policy level, the split of responsibilities between the Government departments responsible for health and for employment is a barrier to the integration and joint working that is required to manage the consequences of mental ill health for the labour force. In some respects, these problems are compounded by the challenge of devolved nature of Government in Great Britain.

7.8.2 At the level of a local service, why should NHS providers of primary care and of secondary mental healthcare invest in interventions that result in a saving in somebody else's budget through improved productivity and reduced benefits payments?

7.8.3 At the level of clinical practice, primary and secondary care healthcare workers have little incentive to encourage people with mental health problems back into work. This is particularly true for people with mental health problems who perceive that it is not in their interests to return to work for health and/or economic reasons. In these cases, the healthcare worker can risk damaging their relationship with the patient if they refuse to comply with a request for a sick note. Enabling a return to work is often not a priority for GPs and mental healthcare workers.



7.8.4 Specialist mental healthcare workers focus on symptom reduction and management of risk. Despite the concept of “recovery” being national policy, there has been less emphasis on functional outcomes, including work and occupation.

7.8.5 At the level of the individual with mental health problems:

1. There is a separation between healthcare workers and Job Centre Plus which includes the doctors who assess personal capability to work?. The former focus on symptom reduction and risk and the latter on occupational outcomes. This results in a lack of a coordinated approach to consideration of health and return to work or if coordination does occur, it happens late in the process.
2. Despite changes in recent years, there is still a “benefits trap” for some people with mental health problems and particularly for people with severe mental illness who became ill at a young age and/or have been ill for many years.

7.9 Brief individual therapy, and in particular cognitive behaviour therapy, helps people whose work is affected by a common mental disorder. However, few studies have measured the extent to which such interventions improve occupational outcomes including presenteeism (i.e. reduced productivity in work due to ill-health) and absenteeism.

7.10 The interactions between symptoms, work performance, sickness absence and return to work are complex and greatly influenced by contextual factors both in the individual and in the workplace. Also, recovery of function often lags behind reduction in symptoms. Therefore there is only a weak association between sickness absence and measures of disease severity. Thus, whilst better treatment of health problems in the working age population is necessary it is unlikely to be sufficient alone to reduce levels of sickness absence.



7.11 Individual Placement and Support' has the strongest evidence base of interventions aimed at helping workless people with severe mental illness to return to competitive paid employment. It will place about half of participants in a paid job. However:

1. IPS can only help people when they believe that they are ready for paid employment.
2. The evidence from the USA is that IPS often leads only to entry level jobs, many of which are part-time.
3. The long-term outcome of participants in IPS is unknown because most trials have been relatively short-term.
4. Although a randomised controlled trial that involved a service in Britain achieved similar results to the US studies, there has been little experience of operating IPS as part of the regular mental health services in this country.
5. The economic benefits of IPS are unproven.



8.1 The relevant Government departments in England, Scotland and Wales should coordinate or commission a programme to educate, train and raise awareness about issues that relate to work and mental health. This would include:

1. Action to address stigma and discrimination in the workplace. This might build on existing initiatives such as ‘Moving People’ (<http://www.movingpeople.org.uk/about/index.html>) and ‘SHiFT’ (<http://www.shift.org.uk/>).
2. Training of workplace line managers in how to recognize mental distress or ill-health and how to respond in ways that do not lead to unnecessary exclusion from the workplace. NHS Scotland (2007) and the English Department of Health’s Care Standards Improvement Partnership (2007) are trialling a programme developed in Australia called “Mental Health First Aid” which might be applied or adapted for this purpose.
3. Training of occupational health professionals in the detection and management of mental health problems. This would include the recognition that mental health problems can present themselves as physical symptoms and that mental health problems frequently co-exist with physical disorders.
4. Education of health and social care workers, including GPs, who care for people with mental health problems about the benefits of work to mental health and well-being.
5. Education of GPs about fitness for work and how to manage the fitness for work consultation with an emphasis on the benefits of work. This could be linked to the replacement of the sick certificate by a “fitness certificate”.

8.2 The relevant Government departments in England, Scotland and Wales should define what an employee could expect from their employer, and from the health service, if they develop a mental health problem. They should also define an employee’s responsibilities in relation to their mental health and its impact on their workplace. This might be couched as a set of standards, agreed between the Government departments, employers’ organisations and the Unions, against which employers and employees can gauge their own workplace. The standards might cover the following:

1. The presence of a system that improves the likelihood that an employer will identify employees who are experiencing mental health problems, and the role of the line manager in this.
2. Rapid access to assessment by a person competent to manage common mental disorders. The timing and location of this appointment should facilitate the person to continue working.



3. Rapid access to evidence-based treatment – medication and/or psychological therapy.
4. The responsibility of the employee to continue working while receiving treatment for their mental health problem and the reciprocal supports provided by the employer to enable the employee to do this.
5. Effective links with relevant agencies, including with primary care.

8.3 People with prolonged work absence, or who are at risk of this, should have rapid access to healthcare workers competent to prescribe and deliver evidence-based treatments, including psychological therapies.

8.3.1 It must be decided who will fund this because mental health services are unlikely to do so willingly.

8.4 People who are workless and who have mental health problems, including those with a severe and enduring mental illness, should be given support to find and retain a job when they believe they are ready for paid employment. If they are not ready for paid employment, they should be assessed and offered help for the problems that would prevent them from working.

8.4.1 The Department of Health's commissioning guidance for vocational services for people with severe mental health problems describes the range of services required.

8.4.2 Individual Placement and Support (IPS) is the intervention with the best evidence base and should be offered to people with severe mental illness when they believe they are ready for paid employment.

8.4.3 People with severe mental illness who do not believe they are ready for paid employment should be offered vocational advice. They should also have access to meaningful occupation such as voluntary work or other unpaid work. This work should be of a nature that builds work skills and confidence and whenever possible prepares the person for paid employment in the future.

8.4.4 Mental health services should pay greater attention to the vocational needs of people with severe mental illness. The Healthcare Commission might consider including in the annual health check for mental health trusts in England an indicator about how many people with severe mental illness are working, in a paid or unpaid capacity.



8.5 The Department for Work and Pensions intends to implement the Welfare Reform Act (2007), and in particular the replacement of Incapacity Benefit with the Employment and Support Allowance (ESA) in a way that takes full account of the needs of people with mental health problems. Monitoring of implementation should ensure that this has happened in practice.

8.5.1 When assessments for ESA are made mental health must be given equal consideration to physical health. To achieve this, staff that are responsible for assessing people for ESA and for supporting people into work should be sufficiently trained on mental health issues.

8.5.2 It is likely that a high proportion of people assigned to the “support group” will have mental health problems. It is important that the process does not consign this group automatically to permanent worklessness (see 8.4 above).

8.6 If the Department for Work and Pensions and the Departments of Health review the role that primary care plays in sickness certification, it should pay particular attention to its role in relation to people with mental health problems.

8.7 The Department for Work and Pensions should fund more work opportunities for people with severe mental illness. They should also introduce strong financial incentives for contractors for Pathways to Work to take on people with severe mental illness who require more than just job placement.

8.8 The NHS in the UK, the Department for Work and Pensions and other public sector organisations should be exemplary employers with regard to the employment of people with mental health problems.



8.9 Given the scale of the problem of work and mental health, it is surprising how little research has been undertaken in Great Britain on some key aspects of the issue. The Departments of Health and the Department for Work and Pensions might commission research to address some of the important unanswered questions. These include:

1. What are the factors that contribute to the development of symptoms of mental ill-health at work and to sickness absence and how do these interact with one another and with contextual factors?
2. What are the features of a mental health problem, of the individual, of the work environment and of the context that make work or returning to work difficult?
3. What is the impact of pharmacological, psychological and occupational interventions on the occupational and economic outcomes (presenteeism, absenteeism, job retention) for people who are working and have mental health problems?
4. What are the characteristics of the large number of people on long-term Incapacity Benefit by reason of mental and behavioural problems? What are their needs for care, to what extent have these been met and what is the potential for interventions to return these people to paid employment?
5. What are the factors that influence GP behaviour in issuing sick certificates to people with mental health problems and the duration of these certificates? These factors might relate to the characteristics of the patient, the attitudes and knowledge of the GP or the socio-economic make-up of the local population. What is the extent of variation in practice between GPs and how much of this variation is unexplained after patient factors have been accounted for?
6. What proportion of the group of people with severe mental illness would benefit from Individual Placement and Support by virtue of believing that they are ready for work? What are the needs of those who do not and how can these be met so that they can reach the point of being eligible for IPS?
7. What are the characteristics of those who retire early on grounds of mental ill health? What features of the individual and of the work environment influence such early retirement? What is the potential to reduce the prevalence of early retirement on grounds of mental ill health? Studies about this issue would need to take a population-based approach.

8.10 The Government departments responsible for health and for employment should analyse the potential of the current and planned system for perverse incentives and unintended consequences and work together to mitigate these (see 7.8 above).



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appendix 1

Evidence table of randomised controlled trials of work schemes for people with severe mental illness

Study	Systematic review ¹	Type of intervention ²	Inclusion/exclusion criteria ³	Characteristics of those randomised
Chandler et al. (1996) – RCT (people assigned to two ISAs [urban/rural] or two comparison groups [urban/rural]).	A, B, C, D, G	Integrated service agency (ISA) programme [Supported employment] v 'usual services' at either urban or rural locations.	SMI. Assessed for inclusion by a 'panel of clinicians' affiliated with the sites and the ISAs	n=439; Diagnosis: Schizophrenia=61%, Bipolar=13%, other=26%. Gender: 51% Male. Ethnicity: 74% White.
Drake et al., (1996) – RCT	A, B, C, D, E, G, I, J	IPS v Group Skills Training (GST). GST: prevocational training.	SMI (at least 2yrs of major role dysfunction), 20+yrs, Unemployed but interested in competitive employment.	n=143; IPS=74, GST=69. Diagnosis: Schizophrenia=47%, bipolar=43%, Other=10%. Age: 37 (mean). Gender: 48% Male. Ethnicity: 95% White. Substance use: 13%.
McFarlane et al., (1996) – RCT: Impact of family involvement on outcomes for people with SMI attending ACT	A, C, G	Assertive Community Team (ACT) and either: a) psychoeducational multifamily group or b) crisis family intervention.	SMI (psychotic illness) and one or more additional complicating factors, e.g. criminal convictions. Age: 18 – 45. Excluded: Acutely violent or suicidal patients and those with major medical illness or physical addiction requiring hospitalisation.	n=68 (a=37/b=31); Diagnosis: Schizophrenia, schizoaffective disorder and schizophreniform disorder. Age: 30 (mean). Ethnicity: 78% White. Gender: 65% Male.
Okpaku et al., (1997) – RCT	C, D, G, I	Multidisciplinary Case Management Intervention (IV) v Usual services (non-IV)	SMI (applicant for and beneficiaries of SSDI – disability benefits).	n=152; IPS=76 v EVR=76. Diagnosis: SMI Schizophrenia: 54% v 48%, bipolar: 13 v 8%, depression: 8% v 17%, other: 1 v 3%. BMI: 65% v 51% Age: 38.2 v 40.6yrs. Gender: 58% v 49% Male; Alcohol use: 13.2% v 4%; Drug use: 22.4% v 5% (sig).



Length of follow-up	Drop-outs from study	Number who obtained employment	Number who retained employment	Other (outcomes)
36 months	N/A	Participated in the work force during the three-year study: a) ISA (urban)=73%, b) non-ISA (urban)=15%, c) ISA (rural)=29%, d) non-ISA (rural)=11%.	N/A	Clients in the integrated programme had less hospital care, greater workforce participation, fewer group and institutional housing arrangements, less use of conservatorship, greater social support, more leisure activity, less family burden, and greater client and family satisfaction.
18 months	140 (90%) completed follow-up at 18 months	Competitive employment: IPS=78.1%, GST=40.3% (sig).	N/A	(%) worked more than 20hrs per week: IPS=46.6 v GST=22.4; Total hrs worked (m): 607 v 205; Total wages earned (m): \$3394 v \$1077; Tenure (weeks per job) (m): 20, 2.5, 4.8;
24 months	None	Group: a) 32% v b) 19% (p<.07) – overall employment, i.e. competitive and sheltered.	Employment rates decreased sharply in both cohorts at 24 months (% not provided).	Systematic family involvement enhances the rehabilitation and family-related outcomes of assertive community treatment. Patients in multifamily group treatment had better employment outcomes.
4 months	N/A	Work at all: IV= 51% v non-IV= 35% (nsig)		



Study	Systematic review ¹	Type of intervention ²	Inclusion/exclusion criteria ³	Characteristics of those randomised
Drake et al., (1999) – RCT	B, D, G, I	IPS v Enhanced vocational rehabilitation (EVR). EVR: Use of a stepwise prevocational approach [train and place].	SMI (at least 2yrs of major role dysfunction): IPS – Schizophrenia=unemployed	n=152; IV=76 v non-IV=76. Diagnosis: SMI Schizophrenia: 23%, Mood disorders: 21%, Anxiety disorder: 13%, other: 43%. Ethnicity: 60% White. Age: 36.8 (mean). Gender: 59% Male.
McFarlane et al., (2000) – Cohort study	B, C, D, E, G	Family-aided assertive community treatment (FACT) v Conventional vocational rehabilitation (CVR)	SMI; Schizophrenia, or mood disorder. 18 – 55yrs. Not employed competitively for the past six months, an available family member and an explicit wish to work.	n=69; FACT=37 v CVR=32. Diagnosis: Schizophrenia=73% v 56%, Mood disorder=27% v 44%. Age: 34 v 31. Gender: Male=65% v 75%. Ethnicity: White= 86% v 77%.
Lehman et al., (2002) – RCT	F, G, I, J	IPS v PRS (Psychosocial Rehabilitation Service)	SMI (Various criteria); receipt of disability benefits, or history of inpatient psychiatric care. Unemployed for a least 3 months prior to the study.	n=219: IPS=113 v PRS=106. Diagnosis: Psychotic: 76% v 74%, Mood disorder: 24% v 26%. Age: 41 v 41yrs (mean); Gender: 68% v 56% Male. Ethnicity: 22% v 27% White.
Mueser et al., (2004) – RCT	Not in any review papers	(x3) IPS, Psychosocial rehabilitation services (PRS) & ‘Standard service’ (SS).	SMI, lack of competitive employment, desire for competitive work.	n=204; IPS=68, PSR=67, SS=69. BMI=76% Diagnosis: SMI Schizophrenia=53%, schizoaffective=21%, bipolar=4.5%, depression=17%, other=4.5%. Age: 41yrs (mean). Gender: Male=62%.



Length of follow-up	Drop-outs from study	Number who obtained employment	Number who retained employment	Other (outcomes)
18 months	144 (95%) completed follow-up at 18 months	Competitive employment: IPS=60.8%, EVR=9.2% (sig).	N/A	Days to first job (m): IPS=125.6 v EVR=293.4; Total hrs worked (m): 322 v 27; Weeks worked (m): 15.1 v 1.2; Total wages earned (m): \$1875 v \$154;
18 months	N/A	Competitive employment – @ 12 months: FACT=37.1% v CVR=7.7%; @ 18 months 26.5% v 8.0%.	See previous column.	
24 months	84 (74%) v 64 (60%) completed follow-up at 24 months	Work at all: IPS=42% v PRS=11%; Competitive employment: 27% v 7%;		Employment outcomes were worse for people with psychotic diagnosis and those with active substance use disorders.
24 months	166 (81%) completed follow-up at 24 months.	Competitive employment: IPS=73.9%, PSR=18%, SS=27.5%.	N/A	Days to first competitive job: IPS=196, PSR=369, SS=218 (sig); (%) in competitive job: 75, 18, 28; (%) worked more than 20hrs per week: 34, 5, 13; Total hrs worked (m): 373, 40, 103; Total wages earned (m): \$2078, \$730, \$1943; Tenure (weeks per job) (m): 20, 2.5, 4.8;



Study	Systematic review ¹	Type of intervention ²	Inclusion/exclusion criteria ³	Characteristics of those randomised
Cook et al., (2005) – RCT	Not in any review papers	IPS+ v IPS. IPS+ involved supplementary training and support.	SMI, 18+, unemployed.	n=1273; IPS+=648 v IPS=625. Diagnosis: Schizophrenia IPS+=51% v IPS=50%. Job in past 5 yrs: IPS+=64% v IPS=60%. White: IPS+=51% v IPS=49%. Male: IPS+=53% v IPS=53%. Age: IPS+=38.5 v IPS=38.4.
Mueser et al., (2005) – RCT	Not in any review papers	IPS+ v IPS: Supplementary training skills for the workplace, in addition to ‘supported employment’. Training included: ‘how work changes your life’, ‘identifying workplace stressors’, ‘problem solving’, ‘managing mental health’, ‘making friends’, etc.	SMI (no specific diagnostic inclusion or exclusion criteria). Recently employed clients [last 2 months] (because to include unemployed clients may delay their job search), enrolled in a supported employment service. Approx. 20% declined inclusion due to ‘personal reasons’. All participants ‘express a desire to work’.	n=35; IPS+=17 v IPS=18. Diagnosis: 23=Schizophrenia, 4=depression/bipolar, 8=other. 28 men, 34 Hispanic (BME), 34 single, 30 had graduated high school. Age=37.7 (mean).



Length of follow-up	Drop-outs from study	Number who obtained employment	Number who retained employment	Other (outcomes)
24 months	824 (65%) completed follow-up at 24 months.	Competitive employment: IPS+=55% v IPS=34% (sig. Diff).	Data not available.	Working more than 40 hours per month: IPS+=51% v IPS=39%. Monthly earnings: IPS+= \$122/mo v IPS= \$99/mo (sig. Diff).
18 months	None	A total of 49 different jobs were held. 15 worked in one placement for total period.	Of the remaining 34 jobs, in 4 the client was laid off due to temp contract or seasonal work, in 26 cases the client quit, in 3 the client was fired, (1=no data).	In 34 of these jobs, the client disclosed their disorder to their employer, five did not. No sig diffs were found in the two groups in whether the ending of the job was coded as successful or unsuccessful. For 15 of the 18 months of follow-up there was a trend for a higher proportion of the experimental group to be working. Analysis indicated a sig effect for time $Z=-3.19$, $p<.001$, but not for group. The odds ration for the group effect was 1.42, indicating that the odds of working in the experiment group were 42% higher than the control group. This corresponds to an effect size of .21. Thus the work rates decreased over time, but did not differ by group. There was no significant difference between the two groups in terms of: total hours worked, wages earned or job duration.



Study	Systematic review ¹	Type of intervention ²	Inclusion/exclusion criteria ³	Characteristics of those randomised
Macias et al., (2006) – RCT	Not in any review papers	ACT v Clubhouse (CH)	SMI; Schizophrenia, or mood disorder. Age: 18+ and no major ‘mental retardation’.	n=174; ACT=85 v CH=89. Diagnosis: Schizophrenia= 60% v 44%, Age: 37 v 39. Ethnicity: 77% v 81%. Due to interaction effects, participants were subsequently disaggregated into: a) those who indicated an interest in employment at baseline, and b) those not interested in employment at baseline.
Burns et al., (2007) – RCT	Not in any review papers	IPS v Vocational Service (VS)	SMI (psychotic illness, including bipolar), 18+, had been ill and had a major role dysfunction for at least 2 years, had not been in competitive employment in the preceding year and wished to enter competitive employment.	n=315; IPS=156 v VS=156. Diagnosis: Schizophrenia=80%, Bipolar=17%, Other=3%. Work history: >1 month in past 5 years=56%, <1 month in past 5 yrs=44%.



Length of follow-up	Drop-outs from study	Number who obtained employment	Number who retained employment	Other (outcomes)
24 months	120 (69%) completed follow-up at 24 months	<p>a) 'Interested in employment' group (N=67): Work rates: ACT(n=40)=64% v CH(n=27)=47% (nsig); Length of employment (days): ACT=173 v 264 (sig); Total hours: 592 v 784 (sig); Earnings: \$3948 v \$6202. b) 'Not interested in employment' group (N=53): Work rates: ACT engaged in services faster ($p < .05$). Insufficient (n) to compare within group, however, those how gained employment in the 'not interested' group (n=12) stayed employed longer (172 v 124 days) and worked more (474 v 288 hours) than the 'interested' group.</p>	See previous column.	
18 months	225 (72%) completed follow-up at 18 months (IPS=24 v VS=63 dropped-out).	Working at least one day: IPS=55%, VS=28% (sig diff.).	Retained employment: IPS=135, VS=45 (sig. diff.)	Maintained jobs for longer periods days) IPS=214 v VS=108; Readmitted to hospital: IPS=20%, VS=31 (sig. Diff.) Amount of time in hospital (days): IPS=13.5 v VS=20. This study was pan-Europe (n=6), and was consistent across all countries.

¹ Code for the systematic reviews, e.g. A: Bond et al., (1997).

² Interventions are not always pure IPS, a range of alternative terms are used. Any additional details of process are rarely provided.

³ All studies indicate that work is a goal for the inclusion criteria unless stated, e.g. Marcias et al., (2006). No data were provided re: participants excluded due to not being ready for work.



Review papers

Review Paper	Code for the systematic review	Appears in other review papers
Bond et al., (1997)	A	(B) (C) (D) (E)
Bond et al., (2001)	B	(E) (F) (G) (H) (I)
Crowther et al., (2001)	C	(F)
Crowther et al., (2001)	D	(B) (E) (G)
Latimer (2001)	E	
Drake et al., (2003)	F	
Twamley et al., (2003)	G	
Morris & Lloyd (2004)	H	
Wallace & Tauber (2004)	I	
Wewiorski & Fabian (2004)	J	



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