

Improving Lives The Work, Health and Disability Green Paper

Mental Health Sector Response

This response is submitted on behalf of the mental health organisations:

- Mind
- Rethink Mental Illness
- Centre for Mental Health
- The Mental Health Foundation
- Royal College of Psychiatrists
- SAMH (Scottish Association for Mental Health)
- Hafal

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Executive Summary

Tackling a significant inequality – the case for action

1. Many people with mental health problems tell us that good and appropriate work can be positive for their mental health. However the workplace can also be one of the biggest drivers of poor mental health, with long hours, precarious or insecure work and poor line management all frequent contributors to high-levels of workplace stress.
2. People with mental health problems who are well enough to return to work need to be able to access suitable roles with the right support in place. If the Government is to meet its ambition to halve the disability employment gap, then it must focus its efforts on working with employers to make sure these roles exist, rather than focusing solely on the employability of people with mental health problems.

Supporting people into work

3. The best-evidenced intervention for people with mental health problems who are out-of-work is Individual Placement and Support (IPS). This approach has been shown through 17 international trials to produce better outcomes for people with mental health problems than any other employment programme.
4. People with mental health problems often tell us that the support they receive in Jobcentres is too rigid, impersonal, and target-driven. Many tell us that their Work Coaches simply do not listen to their concerns or ask them questions about their skills and ambitions. To shift this culture, Work Coaches need to be given the training, the time, and the flexibility to have meaningful conversations with the people they support.
5. The fear of benefit sanctions drives mistrust of the back-to-work support system. For the people with mental health problems we hear from, Jobcentres are not seen as safe or supportive environments where people feel genuinely able to explore the kinds of work that they might be capable of. If the benefits system is to truly work for people with mental health problems, it needs to be built on understanding and empathy, with personalised support delivered by skilled and experienced staff, and a culture of supporting people to fulfil their individual aspirations, not simply pressuring them to comply.

Assessments for benefits for people with health conditions

6. We are concerned that the Government's proposals on changing the purpose of the Work Capability Assessment will have a profoundly negative impact on

thousands of people with mental health problems. These proposals also run contrary to the recent acknowledgement from the Secretary of State for Work and Pensions that sanctions discourage people with mental health problems from engaging with the welfare system. Instead of extending the reach of conditionality and sanctions, the Government should make sure that everyone with a mental health problem is offered voluntary and personalised support.

7. The Work Capability Assessment is not fit for purpose for people with mental health problems. Despite several independent reviews, we still hear far too often from people with mental health problems who are deemed fit for work even where their mental health has a significant impact on their daily life. To reform the Work Capability Assessment, the Government should design and test alternative 'real-world' assessment systems, with meaningful input from disabled people and people with mental health problems

Supporting employers to recruit with confidence and create healthy workplaces

8. The stigma surrounding mental health still means that too many people do not feel able to seek support in the workplace. Too many employers do not feel confident about how to provide it. This can be particularly true of small-employers who lack access to HR teams, employee assistance programmes and occupational health services. Employers need to be supported to have an approach to managing the mental health of their staff which is both proactive and reactive. The Government should make sure that employers have access to practical guidance and information on issues ranging from managing sickness absence to building line-manager capabilities.
9. To explicitly address stigma and discrimination, the Government should be guided by approaches developed in national programmes such as Time to Change¹, England and Wales and See Me², Scotland. Both programmes champion a lived experience led approach to stigma and discrimination at work and encourage employers to create a work environment where staff feel safe and able to talk openly about mental health and support employees experiencing mental health issues to access their rights.
10. Despite the introduction of the Access to Work Mental Health Support Service, the number of people with mental health problems who benefit from the service each year remains low. Several reports including the 2011 Sayce review and a 2014 Work and Pensions Committee inquiry have found that the service is under-promoted, particularly to healthcare professionals. We recommend that the Government invests in a new awareness raising programme, highlighting the service to employers, employees and healthcare professionals.

¹ Time to Change. (2015). Bring Time to Change to your workplace. Retrieved from: <http://www.timetochange.org.uk/time-to-change-your-workplace>

² See Me. (2015). See me in Work Programme. Scotland; See Me. Retrieved from: <https://www.seemescotland.org/workplace/see-me-in-work/>

Supporting employment through health and high quality care for all

11. There is a significant treatment gap in mental healthcare in the UK, with about 75% of people with mental health problems receiving no treatment at all. If the Government is to meet its commitments to halve the disability employment gap, it needs to take action to improve the provision of broader mental healthcare services as well as employment-focused interventions. The consequences of poor access to treatment are wide-ranging, and can often include difficulty in retaining or moving into work.

12. It is crucial that both healthcare professionals and employment specialists have a shared understanding of what it means to think of work as a health outcome. This process needs to be healthcare-led and include clarity about what the current evidence shows, a thorough understanding of the impact poor quality work has on mental health, an understanding that for some people work will not be an appropriate option, and an appreciation of meaningful alternatives such as volunteering.

1: Tackling a significant inequality – the case for action

Mental health and work

13. Many people with mental health problems tell us that *good* and *appropriate* work can be good for their mental health. However the workplace can also be one of the biggest drivers of poor mental health, with long hours, precarious or insecure work and poor line management all frequent contributors to high-levels of workplace stress.³ⁱ
14. Despite an increasing number of employers taking positive steps to tackle stigma, people with mental health problems often feel uncomfortable talking about their health at work. In a 2014 Mind and YouGov survey, fewer than half of respondents with a diagnosed mental health problem had disclosed this to their employer. Also, fewer than a third of all respondents would feel comfortable talking to their managers about workplace stress.⁴ⁱⁱ This means that too many people with mental health problems are not able to seek adjustments to their roles that would help them stay well or have treatments to get them well. .
15. People with mental health problems who are well enough to return to work need to be able to access suitable roles with the right support in place. If the Government is to meet its ambition to halve the disability employment gap, then it must focus its efforts on working with employers to make sure these roles exist, rather than focusing solely on the 'employability' of people with mental health problems.
16. We are concerned that the Green Paper focuses heavily on the need to reduce the size of the ESA Support Group in order to reduce the disability employment gap. People with mental health problems in the Support Group have already gone through an assessment process that has found they face complex barriers to work. Many are simply too unwell to work, and a large number cannot access jobs that would give them the right support to manage their mental health. The Government must make sure that their renewed focus on health and work does not lead to a culture within healthcare and employment services where people with mental health problems are under severe pressure to find unsuitable work at the expense of their mental health.

Evidence-based support

17. The best-evidenced intervention for people with mental health problems who are out-of-work is Individual Placement and Support (IPS). This approach has been

³ Butterworth, P., Leach, L.S., Strazdins, L., Olesen, S.C., Rodgers, B. and Broom, D.H. (2011) 'The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey'

⁴ *Stressed out staff feel unsupported at work, says Mind* (2014) Available at: <http://www.mind.org.uk/news-campaigns/news/stressed-out-staff-feel-unsupported-at-work-says-mind/#.WKDd7mZQRKo>

shown through 17 international trials to produce better outcomes for people with mental health problems than any other employment programme.⁵ⁱⁱⁱ

18. IPS has been demonstrated to work well with people in contact with secondary mental health services. It is currently available to between 10,000 and 20,000 people and there are 14 'centres of excellence' delivering IPS to high fidelity. The Mental Health Five Year Forward View calls for this to be doubled by 2020. The Scottish Government will take responsibility for the successor programme to Work Programme and Work Choice from 2017, and has highlighted IPS as a successful model which could support people with mental health conditions in the 'Intensive Support' tier of their forthcoming devolved employability programmes from 2018.⁶

19. IPS is based on a set of eight principles which guide its approach:

- Focus on competitive employment as a primary goal
- Eligibility based on the individual's choice – no exclusions
- Use rapid job search (minimal pre-vocational training)
- Supported employment is integrated with the work of the clinical team
- Attention to client preferences. Job finding and support tailored to individuals needs
- Proactive job finding – emphasis on building relationships with employers
- Support available for unlimited period
- Benefits counselling should be provided to support transition

20. IPS has been found to be highly cost-effective, delivering savings within 18 months through reduced health service use among people who successfully enter appropriate employment. Smaller scale tests have also found IPS to be effective for people with addictions, people leaving prison and armed forces veterans with mental health problems.

21. As we know from the CMO's annual report on public mental health, the majority of mental healthcare takes place in primary care. We support the Government's current work to build the evidence-base for IPS for people with common mental health problems in primary care.

22. Work was funded by the Scottish Government to raise awareness and improve understanding of IPS amongst AHP staff in Scottish Health Boards, which resulted in additional commissioning of IPS services and external funding achieved to support NHS services⁷; this approach should be considered.

⁵ Modini, M., Tan, L., Brinchmann, B., Wang, M. Killackey, E., Glozier, N., Mykletun, A. and Harvey, S.B. (2016) 'Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence', *The British Journal of Psychiatry*

⁶ http://www.employabilityinscotland.com/media/590739/scottish_employability_support_services_-_final_presentation_glasgow_9_december.pdf

⁷ <http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4051726/Health%20works%20IPS%20final%20report.docx>

23. We would also urge the Government to use the established IPS principles to underpin all back-to-work support for people with mental health problems.

Evidence gaps

24. While there is a robust evidence-base behind IPS as a back-to-work support intervention, the evidence-base around retention and employer interventions is more limited.

25. In England, Time to Change, a national anti-stigma campaign run by Mind and Rethink Mental Illness, has had a positive impact in changing employer attitudes and behaviours.⁸ The most recent evaluation of the programme found that 85% of employers who signed the Time to Change pledge went on to change policies and practices within three months, with 47% seeing an increase in the number of employees disclosing mental health problems.⁹ However there is a need for more long-term research into the impact of anti-stigma initiatives and peer-support networks. There is also a need to understand particular barriers for different sizes of organisation and for historically under-represented sectors including retail and manufacturing. A 2015 YouGov survey for See Me, Scotland's Programme to tackle mental health stigma and discrimination, also found higher rates of experience of poor mental health amongst part-time workers compared with full-time employees.

26. There is good evidence surrounding the impact of line manager behaviour, the physical work environment, employer policies, and support tools for employees. However much of this comes from outside of the UK and focuses on larger employers.¹⁰

27. There is also a lack of evidence surrounding the impact of Government provided back-to-work support for people with mental health problems. Currently the data collected from Work Programme and Work Choice providers makes it possible to assess the impact of this support on people with mental health problems. The fact that no equivalent data exists for people receiving Jobcentre Plus support is a significant barrier to understanding how effectively Work Coaches are supporting people with mental health problems.

⁸ Henderson, C., Williams, P., Little, K. and Thornicroft, G. (2013) 'Mental health problems in the workplace: Changes in employers' knowledge, attitudes and practices in England 2006-2010', *The British Journal of Psychiatry*,

⁹ Time to Change (2016) *Time to Change Programme: October 2011 to March 2015, Summary of impact and learning (employers)*. Available at: http://www.time-to-change.org.uk/sites/default/files/TTC_Phase2_legacy_Employers.pdf

¹⁰ New Economics Foundation (2014) *Well-being at work A review of the literature*

28. The National Audit Office (NAO) recently found that sanctions have a negative impact on how likely people claiming ESA are to move towards work.^{11iv} This echoes what we have consistently heard from people with mental health problems. The Department for Work and Pensions currently do not break down sanctions data by health condition (e.g. using ICD code), meaning that organisations frequently have to rely on Freedom of Information Requests to understand how often people with mental health problems receive sanctions or referrals. This also means that it is impossible to know the proportion of people with mental health problems affected by sanctions varies across the Jobcentre network. We were pleased that the Secretary of State for Work and Pensions recently announced that he does not 'want sanctions to discourage those with mental health problems from engaging fully with the welfare system'. While we will continue to push for wider reform of the system of conditionality and sanctions, it is crucial that there is as much transparency as possible within the current system.

29. To improve the evidence-base for employment interventions for people with mental health problems the Government should:

- Continue to develop the evidence-base for IPS for people with common mental health problems.
- Commission further research into employer interventions with a focus on UK-based SMEs
- Regularly publish the DWP/HMRC mental health 'customer journey' data included within the technical annex to the Green Paper.
- Regularly publish sanctions data broken down by health condition (eg using ICD code).
- Continue to engage with research organisations, employers, and people with lived experience of mental health problems, to build the evidence-base around health and work.

¹¹ National Audit Office (2016) Benefit sanctions. .

2: Supporting people into work

2.1 Building work coach capability

30. The end of the Work Programme and Work Choice will mean that from April 2017 an increasing number of people with mental health problems will be supported directly through Jobcentres rather than through specialist provision. We are concerned that many Work Coaches do not currently have the training or skills to provide tailored and personalised support for people with mental health problems.
31. People with mental health problems often tell us that the support they receive in Jobcentres is too rigid, insensitive, and target-driven. Many tell us that their Work Coaches simply do not listen to their concerns or ask them questions about their skills and ambitions. To shift this culture, Work Coaches need to be given the training, the time, and the flexibility to have meaningful conversations with the people they support. This cannot just take place across one specific interaction, but has to be fundamental to the way Work Coaches work with people with mental health problems. It also requires a substantial increase to the 88 minutes a year allocated for Work Coaches to spend with people in the ESA WRAG.
32. People often find it difficult to talk about their mental health and how it affects them, even with those closest to them or healthcare professionals they trust. Jobcentres frequently lack accessible one-to-one meeting spaces, and almost all interactions take place in an open-plan office, with security staff visible. This remains an intimidating setting for many people with mental health problems who may struggle to feel comfortable to talk about their experiences.

“Discussing details of my mental health in an open plan office was embarrassing and upsetting.”

33. To equip Work Coaches to better support people with mental health problems to return to work, the Government should:
- Significantly increase the supply of Work Coaches and give them the flexibility to set longer appointments with people with mental health problems where these are requested.
 - Create a set of Jobcentre Plus performance measures which include customer satisfaction and improvements to well-being.
 - Use the recently announced reforms to the DWP estate as a chance to increase the provision of one-to-one meeting spaces in Jobcentres. The Department should also make sure that people with mental health problems are always informed where these spaces are available.

Health and Work Conversation

34. We are very concerned to see that the Health and Work Conversation will be mandatory. The threat of sanctions can make people with mental health problems more unwell, and fundamentally damages people's trust in the support provided by Jobcentres. This undermines the purpose of the intervention, as a person's first interaction with their Work Coach will be one based on the fear of sanctions rather than a positive sense of how they can benefit from support. This is a particular concern as the intervention takes place before a Work Capability Assessment (WCA) occurs and is likely to mean that people who are very unwell will be inappropriately mandated to attend. To make the Health and Work Conversation an intervention that is genuinely supportive for people with mental health problems, the DWP should make the intervention a voluntary offer.

Work Coach Mental Health Training

35. Steps to improve Work Coaches' knowledge and understanding of mental health are positive. It is crucial that this training goes further than general mental health awareness training, and gives Work Coaches a practical understanding of how to support people with mental health problems, and how to respond sensitively to people who are experiencing distress.

“Train staff to be able to explore each person's story individually, and to develop personalised plans for returning to work, or taking (sometimes small) steps toward that end. What works for one person won't work for everyone.”

36. People with mental health problems often tell us that Work Coaches lack understanding of how different kinds of jobs and working environments can affect a person's mental health. We know that successful approaches like Individual Placement and Support are built on trained advisers supporting people with mental health problems and employers to adjust roles and responsibilities.

37. To make further mental health training for Work Coaches effective, the DWP should:

- Support Work Coaches to develop practical skills around working sensitively and empathetically with people with mental health problems.
- Include content around mental health in the workplace, and the importance of tailoring a role to support someone's mental health.
- Commission an evaluation that will allow the Department to understand how this training affects Work Coaches' confidence and people with mental health problems' experiences.

Specialist Advice Trial

38. People with mental health problems frequently tell us that the support they receive in Jobcentres doesn't take into account their mental health. However it is vital that the Government does not blur the line between healthcare services and employment interventions that recognise and understand an individual's mental health condition.
39. While the Government has stated that the Specialist Advice Trial will be a voluntary offer, we are aware of many cases where people with mental health problems have believed they were being mandated to attend a healthcare intervention, often as a result of ambiguous and misleading instructions from their Work Coach. This damages trust between people with mental health problems and Jobcentre staff, and can lead to an environment where people feel suspicious of healthcare professionals. For this reason Work Coaches should be able to signpost people to local services, but healthcare interventions should not be delivered in Jobcentres themselves.
40. We would urge the Government to trial the concept of a 'three-way conversation' to provide more specialist advice, but with a broad understanding of who the third party could be. These do not need to be occupational health professionals, but instead should be people with lived experience of mental health problems, or experience working closely with people with mental health problems.

Changes to the Disability Employment Adviser role

41. We have been concerned at the reduction in the number of disability and mental health specialists working within Jobcentres in recent years. It is positive that the Government has begun to address that decline by committing to recruiting additional Disability Employment Advisers (DEAs).
42. For many people with mental health problems, their experience of back-to-work support hinges on whether they are able to talk to someone with a real understanding of how their health affects them. For this reason we would urge the Government to invest further in specialist roles so that each Jobcentre can draw on staff who have experience of working with people with mental health problems.
43. However, we are concerned that the Government has indicated that DEAs will now be expected to work primarily to support Work Coaches, as opposed to supporting disabled people directly. Where a similar approach has been adopted elsewhere in the welfare system, for example by the providers undertaking benefits assessments, we have seen specialists used as a 'backstop' after things have already gone wrong, rather than as a resource that generalists actively seek out in order to build their skills.

Community Partners

44. It is vital that Jobcentres build better relationships with local voluntary sector organisations that support people with mental health problems. While the introduction of mental health Community Partners is a positive move, this will also require addressing the significant concerns around mandation and sanctions that make many organisations wary of involvement with Jobcentres. It will also mean addressing the significant funding challenges that community groups and voluntary organisations face.
45. The remit of the Community Partner role is very broad, ranging from work with employers to individual case conferencing. There is a danger that this will mean that people in these roles will not have the time to develop a comprehensive knowledge or understanding of local services and community groups. Building trust and relationships takes time, and it is unclear whether these roles will continue to be funded beyond the initial one-year contract.
46. To improve the impact of mental health Community Partners, the Government should:
- Commit to funding these roles across the lifetime of this parliament.
 - Remove the expectation that Community Partners are involved in individual cases by increasing the number of DEAs and allowing Work Coaches room to specialise around mental health.
 - Give Community Partners a mechanism for leveraging the Flexible Support Fund to buy-in provision from the local voluntary sector.
 - Collate information about projects led by Community Partners and commit to replicating successful approaches across the Jobcentre network.

Flexible Support Fund

47. There is currently little clarity about what guidance, if any, Jobcentre managers are given about using the Flexible Support Fund to commission specialist support for people with mental health problems. With the reduction in funding for contracted-out support, and the lack of mental health specialism within Jobcentres, it is crucial that funds are available to allow people with mental health problems to choose the kind of support that will work for them.
48. The Government should make sure that Jobcentres have access to information and evidence that will help them make informed choices about commissioning and evaluating local employment support for people with mental health problems. They should also monitor what proportion of the Flexible Support Fund is used to fund this support, and intervene in areas where spend on disability and mental health is low.

2.2 Supporting people into work

49. In our response to Chapter 1 of the Green Paper we set out the case for the Individual Placement and Support approach for supporting people with mental health problems to return to work. There is a significant unmet need for these services and we would urge the Government to invest in expanding them, particularly in areas where we know the employment rate for people with mental health problems accessing services is low.
50. The Government's current approach to commissioned employment support remains 'black box', with generic contracts allowing a wide range of variation in the service that providers deliver. With the Work Programme we have seen this approach encourage generic support that is rarely tailored to the needs of people with mental health problems. This has led to poor outcomes, with only 11% of people with mental health problems finding work through the programme, compared with 34% of people with no recorded health condition. Instead we would encourage the Government to invest directly in approaches grounded in the IPS principles that have been shown to be effective.

Conditionality and sanctions

51. One of the key objectives of Government policy on sanctions and conditionality is to encourage people to return to work. However there is no evidence that sanctions are effective for people with mental health problems. We note that the National Audit Office's analysis of Work Programme sanctions data found that for people claiming ESA, a higher rate of sanctions was associated with poorer employment outcomes.
52. In February 2017 Mind surveyed over 2500 people with mental health problems who have experience of the benefits system. 90% of those who have been sanctioned and 89% of those who had been threatened with a sanction said that the experience had negatively affected their mental health. Only 1.3% of people with mental health problems who have experienced a sanction said that it made them more likely to move towards work. 60% said that sanctions had actually made them less likely to get a job, with a further 23% saying that sanctions had made no difference to how likely they were to get a job.

“Sanctions heaped on the pressure and made my mind more muddled and less able to cope with day to day activities as well as job hunting”

“My symptoms are worse for days before I have to go in for meetings and I struggle with self-harm, suicidal urges, insomnia and panic attacks [...] I am so terrified of getting something wrong or being misunderstood or not explaining myself (it is very

hard for me to describe accurately my own mental state) and so losing my benefits.”

53. It is widely accepted in health settings that it is vital to give people with mental health problems ‘choice and control’ over their treatment (as opposed to mandating treatment), both as a matter of ethical principle but also because it is the most effective way of encouraging genuine engagement with and commitment to plans for recovery.^{12v} By contrast The Behavioural Insights Team have noted that the anxiety caused by the possibility of sanctions may worsen people’s attention, self-control, long-term planning.^{13vi}
54. Sanctions also reduce incentives for Work Coaches to meaningfully tailor the support they offer to people with mental health problems. Many people with mental health problems will comply with what they are being asked to do in order to avoid being sanctioned. However this often involves undertaking work-related activity that is not tailored to their needs, in the knowledge that it will not be helpful for them. In recent research with people with mental health problems in the WRAG, only 23% of participants said that their support was appropriate for their needs and barriers to work.¹⁴ Removing the threat of sanctions would put a greater onus on Work Coaches to build positive relationships, understand the specific needs of people with mental health problems, and develop an appropriate offer of support.
55. The fear of benefit sanctions drives mistrust of the back-to-work support system. For the people with mental health problems we hear from, Jobcentres are not seen as safe or supportive environments where people feel genuinely able to explore the kinds of work that they might be capable of and discuss the way in which their mental health affects them. It is particularly notable that in multiple recent DWP pilots, people with mental health problems believed that they were being mandated to participate in programmes even where the Department intended them to be voluntary.^{15,16} This can exemplify the way in which people’s experiences of conditionality and sanctions effect how they engage with back-to-work support.

“You have to take away threats when dealing with ill or vulnerable people. It just backfires. If you offer people choice

¹² Shepherd, G., Boardman, J. and Slade, M. (2008) *Making recovery a reality*. Sainsbury Centre for Mental Health.

¹³ Gandy, K., King, K., Hurle, P.S., Bustin, C. and Glazebrook, K. (2016) *Poverty and Decision Making How behavioural science can improve opportunity in the UK*. The Behavioural Insights Team.

¹⁴ Mind (2014) *We’ve got work to do*. Available at: https://www.mind.org.uk/media/1690126/weve_got_work_to_do.pdf.

¹⁵ Department for Work and Pensions (2015) *Evaluation of the Group Work Psychological Wellbeing and Work Feasibility Pilot*.

¹⁶ Department for Work and Pensions (2015) *Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot*

and let them decide, you are empowering them and letting them build confidence. People know how their condition affects them and so they should be listened to. If there is a positive relationship built up between an advisor or mentor and a claimant that can only help.”

56. We believe that in order to support people with mental health problems to engage positively with the system the Government needs to remove the threat of sanctions altogether, and focus on developing a tailored voluntary offer of support.

57. There are also a number of clear steps the Government could take to lessen the impact of conditionality and sanctions within the current system:

- Building on the existing ‘yellow-card’ trials in Scotland, implement a true early-warning system. Unlike the current trials, this system should mean that people do not receive a sanction referral the first time they fail to comply with something they have been asked to do.
- Introduce legislation to require Work Coaches to undertake safeguarding activity before they impose a sanction referral. This should involve establishing whether an individual’s mental health was a factor in why they were unable to do what they were asked.
- Through training and guidance equip Work Coaches to understand the damaging impact of conditionality and sanctions for people with mental health problems, and the need to build the trust through positive engagement.
- Provide information to people about their rights to review and amend their Claimant Commitment especially if their health fluctuates.
- Provision of advocacy support when interacting with DWP has been shown to be beneficial for people with mental health problems in Scotland.

In-work support

58. Making sure people with mental health problems have the right support in place as they enter into work is vital. One of the successful features of the IPS approach is that it follows a ‘place-then-train’ model, providing intensive support to someone as they begin work. This might involve helping them put in place adjustments to their role, supporting them to think through their options around disclosure with colleagues, or helping them access tools to manage their mental health at work.

“If an employer allowed me certain privileges such as being flexible over hours or a parking space, that would elevate a lot of

pressure for me, they would get an excellent employee. I would be able to work without constantly being in fear I'm going to muck up and they will discover my mental health problems.”

59. The Government’s current trial of in-work support focuses on increasing hours and earnings. For many people with mental health problems returning to work, this focus is simply inappropriate. Instead support needs to centre on helping people stay well and put in place any adjustments they might need to their role. In some cases people may need support to reduce their hours rather than increase them. The trial also involves the use of mandation, which only adds further pressure and anxiety at a crucial and often challenging moment.

“I was trying so hard to keep going to my permitted work, but the pressure to do more or be sanctioned/ have the benefit ended was incredibly destabilising and made me more unwell.”

60. Currently the Access to Work Mental Health Support Service is intended to provide in-work support for people with mental health problems. Yet currently people with mental health problems are required to be in employment before they can access it. Our response to Chapter 4 of the Green Paper considers these issues in more detail.

61. To support people with mental health problems transition into work, the Government should:

- Commission back-to-work support based on the IPS approach, which provides intensive support to employers and people with mental health problems as they return to work.
- Refrain from extending in-work conditionality to people with mental health problems.
- Review the current structure of the Access to Work Mental Health Support Service and explore ways it can better connect with back-to-work support for people with mental health problems, and with health services in all parts of the UK.

Work and Health Programme

62. The Work Programme has not been effective at helping people with mental health problems return to work. 11% of people with mental health problems

have found work through the programme, when compared with 34% of people with no recorded health condition.^{17,18vii}

63. People with mental health problems have told us that the support they received through the Work Programme was generic and rarely took their mental health into account. The mandatory nature of the programme has often meant that people with mental health problems lacked trust in the support they were offered.

“I really could see that the company contracted to carry out work for the DWP, just didn't have staff trained in mental health rehabilitation, it was as if they expected you to behave like a well person and to be constantly in the same state. They didn't really have much to work with other than sanctions because the funding isn't sufficient to provide real solutions for the long term sick.”

64. We have also frequently heard cases where the quality of Work Programme support has been compromised by a culture of inflexible targets. One frequent example is people with mental health problems being pushed towards self-employment, even after informing advisers that they experience problems with managing money or need clear structures in place in order to manage their mental health.

65. We would urge the Government to learn from the mistakes of the Work Programme as it develops the new Work and Health Programme. It is positive that the new programme will be voluntary, but the Government must go further to make sure that new commissioning arrangements allow providers to be held to account on the quality of the service they deliver for people with mental health problems.

66. The Work and Health Programme represents a significant reduction in overall funding for contracted-out employment support when compared to its predecessors.¹⁹ The Government has previously said this reflects an approach of targeting support towards people with health conditions and disabilities. However we remain concerned that the focus on driving referrals from those ‘closer to work’ will mean that a large number of people with mental health problems who would benefit most from specialist support will simply not be able to access it.

¹⁷ Department for Work and Pensions (2016) ‘Work Programme Attachments’. Available at: <https://sw.stat-xplore.dwp.gov.uk/> (Accessed: 10 February 2017).

¹⁸ Department for Work and Pensions (2016d) ‘Work Programme Job Outcomes’. Available at: <https://sw.stat-xplore.dwp.gov.uk> (Accessed: 10 February 2017).

¹⁹ Oakley, M. (2016) *More than words: Rethinking employment support for disabled jobseekers*.

67. To give the Work and Health Programme the best chance of supporting people with mental health problems the Government should:

- Require prime providers to specify how they will make sure that people with mental health problems will receive a tailored and personalised service, and play an active role in monitoring how they deliver on those commitments at a local level. This should include publishing regular data and qualitative evaluations throughout the lifetime of the programme.
- Recognise in their commissioning arrangements that a 'job outcome' that involves working at least 16 hours a week may not be an appropriate measure of success for some people with mental health problems. The Government should develop performance indicators that include customer satisfaction and improvements to wellbeing.
- Compare and evaluate providers' services to further develop the evidence-base around supporting people with mental health problems to return to work.
- Provide Work Coaches with extensive training around referrals. They should be equipped to understand what the Work and Health Programme looks like in their area and have sensitive conversations with people with mental health problems about whether it is the right approach for them.

"Journey to Employment" Job Clubs

68. We support the expansion of voluntary peer-support as these approaches often give people with mental health problems more control over the kind of support they receive. As with other interventions announced in the Green Paper, it is vital that the Government funds these initiatives for enough time to properly understand their impact. Well-facilitated peer-support can bring a range of benefits, so it is important the Government considers measures like improved well-being, self-esteem and social-connectedness when evaluating the impact of these job clubs.

"I also think it would be really useful to hold sessions where people with a certain condition could meet with someone else with that condition who is working and they could share their experience and tips for what helps them to work with their problem."

2.3 Improving access to employment support

69. People with mental health problems in the Support Group have gone through an assessment process and been found too unwell to work or to engage with back-

to-work support. It is paramount that no one in this group face undue pressure to take steps towards work, and that all interventions and trials remain entirely voluntary.

“A lot of people in the Support Group suffer from anxiety and stress problems (like myself), they need a safe place and some level of security if they stand any chance of recovering [...]”

70. We hear from people with mental health problems in the Support Group who are unsure if they want to work but feel discouraged from exploring the possibility because of the potential consequence to their benefits if they begin work and then become more unwell. The current 12 week linking rule does not adequately address those fears; particularly for people with fluctuating conditions who might experience a deterioration in their mental health several months after beginning work.
71. We know that all too often WCA assessors fail to understand the impact of fluctuating conditions. This creates a real fear that people in the Support Group may find themselves penalised for exploring whether or not they feel capable of work. We have heard concerns from people with mental health problems that undertaking permitted work or engaging with support might mean that they will be moved to the WRAG, or declared fit for work, following a reassessment.
72. Some people with mental health problems might not be able to manage their mental health while working 16 hours a week in paid employment. However they might have other ambitions including volunteering in their community, or working a more limited number of hours. This means that the Department for Work and Pensions’ traditional understanding of a job outcome will not always be an appropriate measure when thinking about what support should be available for people in the Support Group.
73. As the Government explores providing additional support for people in the Support Group it should:
 - Make sure that all interventions and trials are entirely voluntary at every stage, and that Jobcentre staff are clear in how they communicate this.
 - Reinstate the 104-week linking rules so that people in the Support Group can easily reinstate their claim if they enter and subsequently fall out of work.
 - Listen to people with mental health problems in the Support Group about their own aspirations and needs when designing measures of success for new forms of support.
 - Explore ways to mitigate the impact of WCA reassessments, including by requiring assessors to make greater use of long-term awards.
 - Through the Universal Support programme, fund local authorities to provide benefits advocacy and advice services to help people who want to experiment with different working patterns understand their options.

3: Assessments for benefits for people with health conditions

Changes to the purpose and function of the Work Capability Assessment

74. We are very concerned that the Government's proposals on changing the purpose of the Work Capability Assessment will have a profoundly negative impact on thousands of people with mental health problems.

75. The suggestion set out in the Green Paper would give Work Coaches the discretion to impose requirements and sanctions on people within the ESA Support Group. There is no evidence that sanctions help people with mental health problems to move closer to work. Instead their presence in the system can make people's mental health worse and move them further away from the hope of work. This concern is especially relevant for those in the Support Group, many of whom are simply too unwell to engage with support. These proposals run contrary to the recent acknowledgement from the Secretary of State for Work and Pensions that sanctions discourage people with mental health problems from engaging with the welfare system.²⁰

76. In February 2017 Mind surveyed over 2500 people with mental health problems and experience of the benefits system. 91% were opposed to the idea of giving Jobcentre staff more discretion over setting requirements, with a further 6% saying they were unsure:

“People in the support group are there because their mental health is so severe, vulnerable and changeable. Coping with any stress is a challenge and exposing very vulnerable people to sanctions is highly likely to make their conditions much worse”

77. While we would urge the Government to fundamentally rethink the role of conditionality across the board, we are also clear that moving the test of conditionality from WCA assessors to individual Work Coaches will significantly exacerbate the problems of the current system.

78. At present there is a clear route that people with mental health problems can use to challenge an inappropriate WCA outcome through mandatory reconsideration and appeal. There is a public and identifiable set of criteria that people with mental health problems and those supporting them can use to challenge any decision which hasn't properly taken into account their mental health.

²⁰ Green, D. (2016) *A welfare system that works for all*

79. By contrast the process of challenging inappropriate requirements set by Work Coaches is little known. Beyond asking for a second opinion from another Work Coach, there is no way for someone with a mental health problem to formally challenge any inappropriate requirements in their Claimant Commitment until a sanction is imposed. Even at this stage, the decision about overturning a sanction rests on a Labour Market Decision Maker's interpretation of whether a requirement is reasonable. This process does not at any stage involve input from healthcare professionals or people with experience of mental health and disability.
80. We also know that Work Coaches' skills and experience around mental health vary significantly. There is also a significant number of recently recruited Work Coaches, who are unlikely to have had previous experience of supporting people with mental health problems. In its recent investigation into benefit sanctions, the National Audit Office rightly points out that the current system of sanctions results in a postcode lottery, where the likelihood of receiving a sanction depends on the attitude of the frontline staff and the culture of their local Jobcentre. Giving Work Coaches extra powers to set requirements on people who experience more complex barriers to work and issues with their health, will only increase the harmful impact of poor and variable decision-making.
81. Instead of extending the reach of conditionality and sanctions, the Government should make sure that everyone with a mental health problem who wants support to return to work can benefit from a voluntary and personalised offer of support. This does not need to take place within the WCA, and it does not require an additional formal assessment process. Instead the offer of support could be decided in conversations between people with mental health problems and their Work Coaches. These conversations should be led by the needs and wishes of people with mental health problems themselves, giving them choice and control over their own support.

Reform of the Work Capability Assessment itself

82. The Work Capability Assessment is not fit for purpose for people with mental health problems. Despite several independent reviews, we still hear far too often from people with mental health problems who are deemed fit for work even where their mental health has a profound impact on their daily life. This is born out through the very high success rate for ESA appeals which remain at 57%.²¹
83. While there are many practical issues surrounding the WCA, one fundamental problem with the current assessment system is that it aims to assess whether someone is theoretically able to work, without referencing the typical demands and requirements of jobs in the real world. People with mental health problems,

²¹ DWP, 'ESA: Outcomes of work capability assessments including mandatory reconsiderations and appeals: December 2016'.

for example, often do not satisfy the highest levels of the descriptor related to social engagement, on the basis that they have some occasional interactions with people unfamiliar to them. However these judgements do not take into account the nature and frequency of social interactions many people are expected to have in the workplace. Someone who might feel able to talk to a cashier they have grown familiar with, might experience severe anxiety if they were expected to work in retail where they would need to talk to many different customers in a short space of time.

84. Often those who are declared fit for work are deemed to need significant adjustments to any role they might undertake. These include working part-time, having a full-time support worker in place or having a role which does not involve frequent and sustained interactions with unfamiliar people. Despite the rarity of these roles, people with mental health problems are then moved on to Jobseeker's Allowance where they are mandated to spend 35 hours a week searching for and applying for jobs, instead of being helped to find employers who will take steps to support their mental health.
85. There are several countries around the world that adopt an approach to disability assessment which takes into account more of these 'real-world' factors. For example in Canada, age, education and work experience are all considered when determining whether a person is fit for work. In the United States, a large database of work requirements for different occupations is used to determine whether someone might be capable of doing an actual job.²² These systems bring their own challenges, but show definitively that it is possible to design an assessment system that does more to understand the impact mental health has on actual prospects of work.
86. To reform the Work Capability Assessment, the Government should design and test alternative 'real-world' assessment systems, with meaningful input from disabled people and people with mental health problems.

Addressing issues with the delivery of the current WCA

87. In 2014 the Upper Tribunal ruled that the WCA puts people with mental health problems at a substantial disadvantage.²³ It held that many people with mental health problems experience particular challenges when it comes to talking about how their condition affects them. We frequently hear from people who struggle in these assessments because they feel they need to minimise the impact their condition has on them as a result of societal stigma. Others tell us that the

²² Baumberg, B., Warren, J., Garthwaite, K. and Bamba, C. (2015) *Rethinking the Work Capability Assessment*.

²³ *SSWP & Ors v MM & DM* [2013]

anxiety of the assessment process itself can make it difficult for them to articulate their thoughts.

“It is hard to be honest with the person during the assessments as you do not know or trust them and often feel ashamed of not being able to normal things so it is hard to admit how things really are.”

88. Despite some improvements to assessor training and guidance, we still see a large number of negative experiences of assessments, and the rate of successful ESA appeals remains very high. Too often people tell us that their assessors simply did not understand their mental health. People with fluctuating conditions report that assessments focus heavily on their current situation, and they are not given space to talk about how their condition varies. Assessors also often fail to ask questions that take into account anxiety someone might feel before performing an activity or fatigue afterwards.

89. There are significant issues with the way medical evidence is collected and used as part of the WCA. Collecting high-quality evidence is of particular importance given the pressure and anxiety people with mental health problems experience in face-to-face assessments. Often a GP, therapist, community psychiatric nurse or psychiatrist will be in a position to provide evidence that will significantly improve the quality of an assessor’s decision-making. Too often this evidence is not collected, leading in poor decisions which are frequently overturned at appeal.

“I see my GP every 4 - 6 weeks for depression and anxiety and she is the one who is most knowledgeable about my illness, not someone I have never seen before in a 20 minute assessment.”

90. The Government has previously said that collecting evidence in every instance would place a heavy burden on healthcare professionals. However we see frequent cases where people with mental health problems themselves feel the need to collect their own evidence in order to support their claim, sometimes incurring a cost to do so. This requires time from the healthcare professional and from the person seeking evidence, but without the use of the ESA113, means that the evidence they collect is often generic and not taken into account as part of the assessment process.

91. To improve the experience of the current WCA for people with mental health problems, the Government should:

- Set an expectation that assessors should always seek evidence from the healthcare professionals of people with mental health problems.
- Signpost people with mental health problems to the ESA113 and explain its purpose, so that those who choose to collect their own evidence can make sure it will be relevant for their claim.
- Extend the ESA113 process to include community psychiatric nurses, psychiatrists and other healthcare professionals.
- Work with assessment providers to pilot specialist mental health assessors.

Data sharing across benefit assessments

92. We recognise that many people with mental health problems find the process of having to fill in lengthy forms, and gather medical evidence very onerous and anxiety inducing. We support the intention of making this process easier for people with mental health problems and avoiding any unnecessary duplication of time and energy. At the outset, we highlight that there are additional challenges to sharing data in Scotland due to devolution, and call on the UK Government to work with the Scottish Government and NHS in Scotland in this regard.

93. Any system that allows people to share data between assessments needs to give individuals complete control about what information is shared and how. It is vital that sensitive information about mental health is never shared without their full consent.

94. One of the issues in the current system is that people with mental health problems are often not given enough support to recognise the kind of evidence that would give them the best chance of receiving an accurate assessment decision. People too often receive a generic description of their condition from their GP which does not reflect the particular criteria on which ESA or Personal Independence Payment (PIP) are awarded. Any system of information sharing will need to communicate clearly to people how the assessments differ, and why someone might want to provide different kinds of information and evidence in order to address differences in their respective criteria.

95. To explore data sharing in a way which is sensitive to the needs and concerns of people with mental health problems, the Government should:

- Commission research with people who currently claim both ESA and PIP, and assessment providers, to understand how the differences in assessment criteria might affect the kind of evidence that people need to make their claim.
- Develop online systems that allow people with mental health problems to access evidence they have submitted for previous benefits assessments,

and decide whether or not they would like to share that evidence again for an upcoming assessment.

- Allow people with mental health problems to receive paper copies of previously submitted evidence by post, or in person at a Jobcentre, in advance of an upcoming assessment.
- Use any new online system to improve the way evidence from healthcare professionals is collected and stored.

Ending reassessments for people with long-term and severe conditions

96. We frequently hear from people with mental health problems who experience a great deal of anxiety at the prospect of repeated benefits assessments. We believe that where someone is in the Support Group and their healthcare professional has given them a long-term prognosis, they should be exempted from further reassessments. This could be achieved through amending the ESA50 form, and without the need for onerous additional processes. Assessors should also receive additional training so that they make greater use of long-term awards where it is unlikely an individual's situation will change significantly in the short-term.

97. The rationale for ending unnecessary reassessments applies across disability benefits, so we would urge the Government to put in place similar measures for PIP.

Changing the assessment process for people with long-term and severe conditions

98. One significant issue with the Work Capability Assessment is that too often assessors do not collect medical evidence from healthcare professionals, or where evidence does exist, do not take it sufficiently into account. If the Government is to create an improved assessment process for people with long-term or severe conditions, it needs to do more to make sure that assessors are proactively collecting and making use of additional evidence in every case.

99. The Green Paper suggests that this new process could be possible using existing forms of evidence available through the health and social care systems. This approach risks excluding the large number of people with mental health problems who, as a consequence of local funding pressures, are unable to access comprehensive packages of support through secondary healthcare services or social care services. Instead we would urge the Government to make sure that assessors collect bespoke evidence from a wide range of health and social care professionals including psychiatrists, therapists, community psychiatric nurses, GPs, and care-coordinators.

4: Supporting employers to recruit with confidence and create healthy workplaces

Employer information needs

100. Employers need to be supported to have an approach to managing the mental health of their staff which is both proactive (where they take steps to promote wellbeing and tackle the work-related causes of poor mental health) and reactive (where they are able to support staff who be experiencing a mental health problem). We know that many employers lack confidence when it comes to supporting employees' mental health in the workplace. This can be particularly true of small-employers who lack access to HR teams, employee assistance programmes and occupational health services. Some issues that employers frequently seek support with include:

- Building line-manager capabilities
- Developing organisational policies around mental health
- Managing sickness absence related to mental health
- Addressing performance issues related to mental health
- Supporting the mental health of remote workers
- Awareness-raising and anti-stigma work

101. It is important that resources for employers go beyond providing information and provide practical advice that can be easily adapted to their own context. One example is Mind's 'Wellness Action Plan', which supports managers and employees to have conversations about what keeps them well at work and what to do if they experience poor mental health. Another is Time to Change's employer pledge, which gives employers of all sizes a way to demonstrate their commitment to tackling mental health stigma, and develop an action plan to get their employees talking about mental health.

Role of anti-stigma work

102. In England, Time to Change, a national anti-stigma campaign run by Mind and Rethink Mental Illness, has had a positive impact in changing employer behaviour and confidence.²⁴ The most recent evaluation of the programme found that 85% of employers who signed the Time to Change pledge went on to change policies and practices within three months, with 47% seeing an increase in the number of employees disclosing mental health problems. Learning can also be taken from the national campaign in Scotland, See Me²⁵. The focus is to tackle mental health stigma and discrimination through a lived experience approach

²⁴ Henderson, C., Williams, P., Little, K. and Thornicroft, G. (2013) 'Mental health problems in the workplace: Changes in employers' knowledge, attitudes and practices in England 2006-2010', *The British Journal of Psychiatry*

²⁵ See Me: end mental health discrimination. (2017). Retrieved from: <https://www.seemescotland.org/>

where staff feel safe and able to talk openly about mental health and support employees experiencing mental health issues to access their rights.

Improving Access to Work

103. Despite the introduction of the Access to Work Mental Health Support Service, the number of people with mental health problems who benefit from the service each year remains low.^{26viii} Several reports including the 2011 Sayce review and a 2014 Work and Pensions Committee inquiry have found that the service is under-promoted, particularly to healthcare professionals.^{27,28}

104. A significant barrier is that people with mental health problems still have to self-refer through the telephone gateway. This can be a stressful and anxiety-inducing process, especially considering that people cannot ask a healthcare professional to complete the referral on their behalf. We have also heard of cases where gateway staff were unaware of the mental health support service or otherwise unable to answer questions about the kind of help it might be able to provide.

105. The support that the current service provides is often less tangible or easy to understand for both people with mental health problems and employers when compared with other support commonly purchased through the programme such as adaptive software or special equipment. This means that people with mental health problems often lack the confidence to apply for jobs, as they do not know what kind of support they might be able to receive once they are in the role. The current letter of eligibility does not provide sufficient information or assurance about the kind of support that someone will be able to access. The current system also means that the support risks starting too late, and missing the opportunity to help people with mental health problems talk to employers at interview stage about possible adjustments or support needs.

106. We have also seen cases where Jobcentres themselves are failing to promote the service. In a recent Mind focus group with people claiming ESA, no participants reported on being informed about the existence of the service by their Work Coach, despite several feeling that they might benefit from it.

107. To improve Access to Work for people with mental health problems, the Government should:

²⁶ Department for Work and Pensions (2016a) 'Access to Work: Individuals helped to end of March 2016'.

²⁷ Sayce, L. (2011) *Getting in, staying in and getting on*. Department for Work and Pensions.

²⁸ Work and Pensions Committee (2014) *Improving Access to Work for disabled people*. House of Commons.

- Incorporate knowledge and awareness of the Access to Work mental health support service into its planned 'work and health' training for healthcare professionals.
- Allow people to receive a specific guarantee of support before they have secured a job.
- Expand the service to include help with job brokering and conversations with employers at interview stage, and before beginning a role.
- Allow telephone referrals from healthcare professionals with the consent of the individual involved.
- Take steps to increase awareness of the mental health support service and how it works with both Access to Work gateway staff and Jobcentre staff.
- Improve the portability of Access to Work to allow people to move into another job without a lengthy re-application process for the equivalent support.
- Publish the breakdown, by condition, of the applications and awards for Access to Work on a regular basis.
- Expand Access to Work for work placements and temporary employment.
- Raise awareness of Access to Work amongst employers.

Statutory sick pay

108. Flexible working opportunities can be very important to help people with mental health issues manage their health needs alongside a job. This is particularly important during a phased return to work.
109. The existing statutory sick pay provisions do allow employees to claim statutory sick pay on a part-time basis. However these provisions are complex and often little known among employers, employees and GPs. The requirement to take four consecutive non-working days across a week adds an unnecessary barrier to people with mental health problems who as a result cannot spread their working days across the week.^{ix}
110. Currently employees have no entitlement to statutory sick pay on a day where they have worked for any amount of time. The Green Paper is right to point out that this creates a real barrier for people who want to make a phased return to work on reduced hours, or who plan to work their full hours but need flexibility to adjust their plans if they experience problems with their mental health. The Government's proposed solution addresses some of these issues. However as sick pay is not intended to be a means-tested entitlement we believe that employees should be entitled to claim sick pay on a pro rata basis regardless of whether their earnings exceed the statutory sick pay rate of £88.45 per week. For people with fluctuating conditions this would help lessen the anxiety that, on a given day, going home when they are unwell would mean forgoing any financial support.

111. It is crucial that people with mental health problems are not financially disadvantaged as a result of a decision to try a phased return-to-work. Currently taking statutory sick pay on a part-time basis still involves 'running down' an employees' total 28 week entitlement. This leaves people in a vulnerable position if they then need to take an extended period of sickness absence.
112. To improve the system of statutory sick pay for people with mental health problems the Government should:
- Allow employees to claim statutory sick pay on a pro-rata basis when making a phased return to work.
 - Allow employees a grace period where they can make a phased return to work without running down their entitlement to statutory sick pay. This additional entitlement period could be funded through both Government and employer contributions.
 - Remove the requirement for employees to have four consecutive non-working days across a seven-day period in order to retain their entitlement to statutory sick pay.
 - Further explore the viability of international approaches that require employers to develop a return to work plan. This needs to happen in tandem with improved support for employers to manage sickness absence.

5: Supporting employment through health and high quality care for all

5.1 Improving discussions about fitness to work and sickness certification

113. We recognise that many GPs do not currently issue a high number of 'may be fit for work' certificates and this number is particularly low for people with mental health problems. Where this option is used, the most frequently recommended adjustment for people with mental health problems is a phased return to work.²⁹
114. One key factor behind the low use of these certificates is that the current system requires GPs to trust that their patient's employer will always put in place genuinely supportive adjustments. It is hard to expect GPs to always trust that employers will be willing or able to act on their advice, particularly when so many people with mental health problems experience stigma, discrimination and poor support in the workplace.^x Tick-box options within the fit note, such as a 'phased return to work' or 'altered duties', also leave significant room for interpretation. As non-specialists GPs themselves are often not well placed to specify what these adjustments should look like in practice.

²⁹ Department for Work and Pensions (2014) *Evaluation of the Statement of Fitness for Work (fit note): quantitative survey of fit notes*

115. Current fit note guidance for GPs encourages them to think about the long-term health benefits of employment when making fit note decisions. However many GPs will rightly look to make sure that people with mental health problems do not suffer a deterioration in their health as a result of staying in an unsuitable work environment. Those who do issue a 'may be fit for work' certificate risk putting their patients in a situation where they are able to access neither statutory sick pay, nor a working environment that supports their mental health.

"The deputy head did not follow any support plan put in place and although you had a phased return, it was far too short and wasn't what my GP or Union recommended."

116. In some cases there will be other professionals involved in supporting someone's mental health who might be better placed than GPs to offer specific advice around their return to work. Psychiatrists, therapists, community psychiatric nurses and care co-ordinators, may be in a position to offer more specific advice around what adjustments someone might need to stay in their role.

117. One significant gap in the current fit note system is that it does not encourage GPs to have conversations with their patients about work options outside of their current employer. If a person's mental health is deteriorating as a result of a damaging workplace environment, the best option for that person might be support and encouragement to find a role that will better support their mental health.

118. To improve discussions about fitness to work, the Government should:

- Reform the process underpinning the 'may be fit for work' option in the current Fit Note. In the current system an employer accepting the advice of a 'may be fit for work' note automatically means the employee loses their entitlement to statutory sick pay. Instead employers should be required to draw up a return to work plan in response to a 'may be fit for work' certification. A GP can then provide a revised fit note if this plan is found to be inadequate.
- Extend the process of fit note certification to a wider range of healthcare professionals including therapists, psychiatrists and community psychiatric nurses.
- Provide a section of the Fit Note where a GP can provide any observations or comments about work someone might be able to do outside of their current employment situation. This should be easily separable from the part of the Fit Note an individual will be expected to share with their employer.

- Take account of the review of primary care in Scotland, and ensure coordination takes place with GPs in Scotland as well as the Scottish Government.

5.2 Access to mental health services

119. Within the last decade research has shown that the best job outcome results have not been obtained from stand-alone employment support and standalone mental health treatments. A robust combination of the two should be the goal. If the Government is to meet its commitments to halve the disability employment gap, it needs to take action to improve the provision of broader mental healthcare services as well as employment-focused interventions. The consequences of poor access to treatment are wide-ranging, and can often include difficulty in retaining or moving into work. While it is crucial that people with mental health problems can make use of specialist employment support, this is unlikely to be effective unless they are receiving appropriate support for their mental health.

“Personally I’m not getting the recommended treatment for my condition because it’s too expensive (intensive CBT). Better health services would also make it easier for people to get back into work.”

120. There is a significant treatment gap in mental healthcare in the UK, with 75% of people with mental health problems receiving no treatment at all.³⁰ Many children and young people find it difficult to get the help they need, and most get no support for their mental health problem.

121. Within the context of a growing demand for care, unmet need and constrained budgets, national leadership from the NHS and from Government is key to improving the lives of people with mental health problems over the course of this parliament. Yet mental health has been chronically underfunded for decades.

122. In England, The Five Year Forward View for Mental Health has set out ambitious plans to rectify this imbalance and improve mental health care. NHS England’s accompanying Implementation Plan commits additional funding and a timetable of action to ensure increased access to quality care. While repeated announcements of additional funding for mental health services have been positive, it is vital that we see this money reaching local services if we are to achieve the turnaround we need. All current indications suggest that, as yet, this is not happening.

³⁰ Nuffieldtrust (2015). *NHS spending on the top three disease categories in England*

123. Faced with unprecedented and growing demand for services, there is a clear need to look to prevention and early interventions to reduce the prevalence and the distress caused by mental health problems. There is considerable scope to increase interventions that reduce the incidence of people developing mental health problems and that increase the potential for sustained recovery after illness.

Quality of care

124. The IAPT programme has raised the profile of talking therapies. However, waiting times vary widely across England – in some places 60% of people wait over 90 days to receive treatment, but in others, over 95% of people wait less than 28 days. There is also a disproportionate focus on Cognitive Behavioural Therapy over other forms of talking therapy. In a 2013 survey of over 1,600 people accessing IAPT, almost 3 in 5 were not offered a choice at all. Different therapies work well for different people, so it is crucial that everyone is able to choose the type of therapy that's right for them.³¹

125. Similarly, people's experiences of emergency mental health care vary significantly, with many people unable to access adequate 24/7 crisis services and people increasingly sent out of area when beds are not available locally. These experiences have a negative effect on people's wellbeing and mental health.

126. Around one third of all GP appointments involve mental health. However many GPs feel unequipped to provide their patients with the support they need. Out of 21 mandatory clinical modules in the GP training curriculum, only one is dedicated to mental health. With high thresholds for getting specialised mental health support from secondary care services, and long waits for IAPT services, many people can feel stuck in primary care without the support they need.

Access to employment support

127. 5.6% of people in contact with secondary mental healthcare services in England are currently in employment.³² Yet there is limited provision of Individual Placement and Support across the UK. The implementation plan of the Five Year Forward View for Mental Health includes commitments to audit provision and target funding in order to double the number of people accessing IPS services in England by 2020.^{xi}

³¹ We need to talk coalition (2013) *We still need to talk*. Available at: http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

³² NHS England, 'Mental health Five year forward view dashboard: Q2 2016/2017'.

128. We note that when the IAPT programme was designed, it was envisaged that providers would recruit one employment adviser for every eight counsellors.^{xii} However in 2015, employment advisers made up only 2% of the total IAPT workforce. We would urge the Government to set out a timeframe for their commitment to double the current number, and to look to build on this target across the course of this parliament. The Government should explore the potential benefits of voluntary support provided by employment advisers in healthcare settings outside of IAPT.

129. We are concerned that the Green Paper discusses the possibility of creating additional IAPT places that would be allocated on the basis of employment status. As a therapeutic intervention, the overriding consideration for IAPT eligibility should always be someone's health needs. While being in good and appropriate work can be an important outcome for mental health, it does not and should not trump other considerations that might lead someone to need access to talking therapy. We want to see further investment in a range of talking therapies so that anyone who needs them can receive timely access, regardless of their employment situation.

5.3 Transforming the landscape of work and health support

Occupational health support

130. There is a significant need to increase access to occupational health support for the large number of people with mental health problems who work for small and medium sized employers. However it is crucial that any model of occupational health support meets the needs of people with mental health problems. The quality of existing private occupational health services is mixed, and often focuses heavily on physical conditions.

131. We would encourage the Government to work with existing occupational health providers, employers, mental healthcare professionals and other employment specialists to develop a code of best practice for the provision of occupational mental health support.

Improving Fit for Work

132. There remains a significant unmet need for better support in the workplace when someone first experiences a problem with their mental health. We are concerned that referrals to Fit for Work remain low. Given the large numbers of people with mental health problems and employers who would benefit from this support, we would urge the Government to retain and improve the programme, while investing in promoting it more widely.

133. The fact that Fit for Work relies on telephone-based support presents a significant barrier to access. Many people with mental health problems experience anxiety when talking on the phone, particularly when it comes to having sensitive conversations about how their mental health affects them. The lack of staff 'on the ground' also makes it harder to promote the service by developing relationships with local employers and healthcare professionals.

134. The language the DWP uses to communicate with GPs can also act as a barrier to building trust in the system. For example current Fit Note guidance states:

Patient beliefs about health and work vary widely and normally become apparent during a consultation. As with other health advice, you should emphasise the advantages to the patient's health of being at work. This information will not always be embraced enthusiastically.^{33xiii}

Encouraging GPs to focus on the health benefits of work, regardless of whether their patient feels this is right for them, and abstracted from their current work situation is misguided and inappropriate. It fails to recognise the need for work to be *good* and *appropriate* for that individual in order to bring any health benefits. This approach is unlikely to reassure GPs that DWP provided support will meet the needs of their patients.

135. We hear from some GPs who are reluctant to refer patients to Fit for Work because of negative perceptions of DWP services and the impact they might have on their patients' mental health. It is crucial that the Government recognise that negative experiences with sanctions and benefits assessments damage the way professionals and people with mental health problems perceive the back-to-work support system as a whole.

136. To improve referrals to Fit for Work from people with mental health problems, the Government should:

- Pilot expanding the service to include face-to-face support.
- Work with GPs to review how the DWP communicates with healthcare professionals.
- Embed trained staff in Jobcentre Districts who can work to promote the service with local employers and healthcare professionals.

5.3 Creating the right environment to join up work and health

³³ Department for Work and Pensions (2015c) *Fit for Work: Guidance for GPs*.

Encouraging joint working and co-location

137. One of the key barriers to greater joint working in the current system is the need for local authorities and healthcare services to align themselves around Jobcentre Plus' priorities and ways of working. The use of conditionality and sanctions, the narrow focus on job outcomes, and the physical environment of Jobcentres, all present challenges when attempting to integrate healthcare and employment support.
138. The devolution of the Work and Health Programme in Scotland, London and Manchester is an opportunity for the Government to learn from different approaches to designing and commissioning integrated employment support. We would urge the Government to use the learning from this work to inform the way Jobcentre districts work with their local partners.
139. To encourage greater joint working and co-location, the Government should:
- Remove the use of conditionality and sanctions for people with mental health problems. This would allow Jobcentres to build trusting relationships with local healthcare services and voluntary sector organisations.
 - Give Jobcentres greater flexibility in how they use staff resource.
 - Evaluate the devolved Work and Health Programmes with a view to replicating successful approaches with core Jobcentre Plus support.
 - Expand the Work and Health Innovation Fund to include a component dedicated to local innovation and partnership working.

Health and work indicators

140. We support the development of health and work indicators to support local commissioners to make better-informed decisions about mental health and employment services. This work should build on the current indicators under development through the Five Year Forward View for Mental Health. These include the employment rate of working-age adults in contact with mental health services, the number of people accessing IPS services, and the net movement of people into employment from IAPT.
141. There is a real need for local commissioners to invest in services that provide support to both people with mental health problems and their employers. The Government should consider additions to the annual Employer Perspectives survey in order to establish regional data on employer attitudes and confidence around supporting their employees' mental health.

The role of healthcare professionals

142. While healthcare professionals have a key role to play in supporting people with mental health problems' work aspirations, it is vital that any new training or

guidance emphasises that work only brings health benefits when it is appropriate to someone's needs and circumstances.

143. We have heard concerning examples of Jobcentre staff using the language of 'work as a health outcome' to encourage people with mental health problems to accept any job, regardless of the quality of the work or the employer's understanding of mental health. It is crucial that both healthcare professionals and employment specialists have a shared understanding of what it means to think of work as a health outcome. This should include clarity about what the current evidence shows, a thorough understanding of the impact poor quality work has on mental health, an understanding that for some people work will not be an appropriate option, and an appreciation of meaningful alternatives such as volunteering. We recommend that the Government work with healthcare professionals' organisations to develop the existing consensus statement into a more detailed approach to health and work.

Summary of recommendations

1: Tackling a significant inequality – the case for action

Recommendation 1: Use the established Individual Placement and Support principles to underpin all back-to-work support for people with mental health problems.

Recommendation 2: Continue to develop the evidence-base for IPS for people with common mental health problems.

Recommendation 3: Commission further research into employer interventions with a focus on UK-based SMEs

Recommendation 4: Regularly publish the DWP/HMRC mental health 'customer journey' data included within the technical annex to the Green Paper.

Recommendation 5: Regularly publish sanctions data broken down by health condition (e.g. using ICD code).

2: Supporting people into work

Recommendation 6: Significantly increase the supply of Work Coaches and give them the flexibility to set longer appointments with people with mental health problems where these are requested.

Recommendation 7: Create a set of Jobcentre Plus performance measures which include customer satisfaction and improvements to well-being.

Recommendation 8: Use the recently announced reforms to the DWP estate as a chance to increase the provision of one-to-one meeting spaces in Jobcentres. The Department should also make sure that people with mental health problems are always informed where these spaces are available.

Recommendation 9: Make the Health and Work Conversation a voluntary intervention.

Recommendation 10: Provide additional training to equip Work Coaches to develop practical skills around working sensitively and empathetically with people with mental health problems.

Recommendation 11: Work Coach training should include content around mental health in the workplace, and the importance of tailoring a role to support someone's mental health.

Recommendation 12: Conduct an evaluation that will allow the Department to understand how additional Work Coach training affects Work Coaches' confidence and people with mental health problems' experiences of support.

Recommendation 13: Widen the scope of the Specialist Advice Trial to include a broader range of professionals with experience supporting people with mental health problems.

Recommendation 14: Continue to invest in Disability Employment Adviser roles so that each Jobcentre can draw on staff who have experience of working with people with mental health problems.

Recommendation 15: Commit to funding the Community Partner roles across the lifetime of this parliament.

Recommendation 16: Clarify and focus the role of the Community Partner so that people performing these roles have sufficient time and support to build an in-depth understanding of local voluntary sector provision.

Recommendation 17: Give Community Partners a mechanism for leveraging the Flexible Support Fund to buy-in provision from the local voluntary sector.

Recommendation 18: Collate information about projects led by Community Partners and commit to replicating successful approaches across the Jobcentre network.

Recommendation 19: Create guidance for Jobcentre staff on using the Flexible

Support Fund to commission evidence-based support for people with mental health problems.

Recommendation 20: Monitor what proportion of the Flexible Support Fund is used to fund mental health support, and intervene in areas where spend on disability and mental health is low.

Recommendation 21: Remove the threat of sanctions for people with mental health problems and focus on developing a tailored voluntary offer of support.

Recommendation 22: Building on the existing 'yellow-card' trials in Scotland, implement a true early-warning system. Unlike the current trials, this system should mean that people do not receive a sanction referral the first time they fail to comply with something they have been asked to do.

Recommendation 23: Introduce legislation to require Work Coaches to undertake safeguarding activity before they impose a sanction referral. This should involve establishing whether someone's mental health was a factor in why they were unable to do what they were asked.

Recommendation 24: Through training and guidance equip Work Coaches to understand the damaging impact of conditionality and sanctions for people with mental health problems, and the need to build the trust through positive engagement.

Recommendation 25: Commission back-to-work support based on the IPS approach, which provides intensive support to employers and people with mental health problems as they return to work.

Recommendation 26: Refrain from extending in-work conditionality to people with mental health problems.

Recommendation 27: Review the current structure of the Access to Work Mental Health Support Service and explore ways it can better connect with back-to-work support for people with mental health problems.

Recommendation 28: Require prime providers for the Work and Health Programme to specify how they will make sure that people with mental health problems will receive a tailored and personalised service, and play an active role in monitoring how they deliver on those commitments at a local level. This should include publishing regular data and qualitative evaluations throughout the lifetime of the programme.

Recommendation 29: Recognise in the Work and Health Programme commissioning arrangements that a 'job outcome' that involves working at least 16 hours a week may not be an appropriate measure of success for some people with

mental health problems. The Government should develop performance indicators that include customer satisfaction and improvements to wellbeing.

Recommendation 30: Compare and evaluate Work and Health Programme providers' services to further develop the evidence-base around supporting people with mental health problems to return to work.

Recommendation 31: Provide Work Coaches with extensive training around Work and Health Programme referrals. They should be equipped to understand what the programme looks like in their area and have sensitive conversations with people with mental health problems about whether it is the right approach for them.

Recommendation 32: Continue to expand and evaluate the impact of voluntary peer-support job clubs.

Recommendation 33: Make sure that all interventions and trials involving the Support Group are entirely voluntary at every stage, and that Jobcentre staff are clear in how they communicate this.

Recommendation 34: Reinstate the 104-week linking rules so that people in the Support Group can easily reinstate their claim if they enter and subsequently fall out of work.

Recommendation 35: Listen to people with mental health problems in the Support Group about their own aspirations and needs when designing measures of success for new forms of support.

Recommendation 36: Explore ways to mitigate the impact of WCA reassessments, including by requiring assessors to make greater use of long-term awards.

3: Assessments for benefits for people with health conditions

Recommendation 37: Make sure that everyone with a mental health problem who wants support to return to work can benefit from a voluntary and personalised offer of support. This does not need to take place within the WCA, and it does not require an additional formal assessment process. Instead the offer of support could be decided in conversations between people with mental health problems and their Work Coaches. These conversations should be led by the needs and wishes of people with mental health problems themselves, giving them choice and control over their own support.

Recommendation 38: To reform the Work Capability Assessment, the Government should design and test alternative 'real-world' assessment systems, with meaningful input from disabled people and people with mental health problems.

Recommendation 39: Set an expectation that Work Capability Assessment assessors should always seek evidence from the healthcare professionals of people with mental health problems.

Recommendation 40: Signpost people with mental health problems to the ESA113 and explain its purpose, so that those who choose to collect their own evidence can make sure it will be relevant for their claim.

Recommendation 41: Extend the ESA113 process to include community psychiatric nurses, psychiatrists and other healthcare professionals.

Recommendation 42: Work with assessment providers to pilot specialist mental health assessors.

Recommendation 43: Any system of information sharing will need to communicate clearly to people how the assessments differ, and why someone might want to provide different kinds of information and evidence in order to address differences in their respective criteria

Recommendation 44: Commission research with people who currently claim both ESA and PIP, and assessment providers, to understand how the differences in assessment criteria might affect the kind of evidence that people need to make their claim.

Recommendation 45: Develop online systems that allow people with mental health problems to access evidence they have submitted for previous benefits assessments, and decide whether or not they would like to share that evidence again for an upcoming assessment.

Recommendation 46: Allow people with mental health problems to receive paper copies of previously submitted evidence by post, or in person at a Jobcentre, in advance of an upcoming assessment.

Recommendation 47: Use any new online system to improve the way evidence from healthcare professionals is collected and stored.

Recommendation 48: The rationale for ending unnecessary reassessments applies across disability benefits, so we would urge the Government to put in place similar measures for PIP.

Recommendation 49: If the Government is to create an improved assessment process for people with long-term or severe conditions, it needs to do more to make sure that assessors are proactively collecting and making use of additional evidence in every case.

4: Supporting employers to recruit with confidence and create healthy workplaces

Recommendation 50: Incorporate knowledge and awareness of the Access to Work mental health support service into the planned work and health training for healthcare professionals.

Recommendation 51: Allow people using the Access to Work mental health support service to receive a specific guarantee of support before they have secured a job.

Recommendation 52: Expand the Access to Work mental health support service to include help with job brokering and conversations with employers at interview stage, and before beginning a role.

Recommendation 53: Allow telephone referrals to the Access to Work mental health support service from healthcare professionals with the consent of the individual involved.

Recommendation 54: Take steps to increase awareness of the Access to Work mental health support service and how it works with both gateway staff and Jobcentre staff.

Recommendation 55: Improve the portability of Access to Work to allow people to move into another job without a lengthy re-application process for the equivalent support.

Recommendation 56: Publish the breakdown, by condition, of the applications and awards for Access to Work on a regular basis.

Recommendation 57: Expand Access to Work for work placements and temporary employment.

Recommendation 58: Raise awareness of Access to Work amongst employers.

5: Supporting employment through health and high quality care for all

Recommendation 59: Allow employees to claim statutory sick pay on a pro-rata basis when making a phased return to work.

Recommendation 60: Allow employees a grace period where they can make a phased return to work without running down their entitlement to statutory sick pay. This additional entitlement period could be funded through both Government and employer contributions.

Recommendation 61: Remove the requirement for employees to have four consecutive non-working days across a seven-day period in order to retain their entitlement to statutory sick pay.

Recommendation 62: Further explore the viability of international approaches that require employers to develop a return to work plan. This needs to happen in tandem with improved support for employers to manage sickness absence.

Recommendation 63: Reform the process underpinning the 'may be fit for work' option in the current Fit Note. In the current system an employer accepting the advice of a 'may be fit for work' note automatically means the employee loses their entitlement to statutory sick pay. Instead employers should be required to draw up a return to work plan in response to a 'may be fit for work' certification. A GP can then provide a revised fit note if this plan is found to be inadequate.

Recommendation 64: Extend the process of fit note certification to a wider range of healthcare professionals including therapists, psychiatrists and community psychiatric nurses.

Recommendation 65: Provide a section of the Fit Note where a GP can provide any observations or comments about work someone might be able to do outside of their current employment situation. This should be easily separable from the part of the Fit Note an individual will be expected to share with their employer.

Recommendation 66: Pilot expanding the Fit for Work service to include face-to-face support.

Recommendation 67: Work with healthcare professionals to review DWP guidance for GPs.

Recommendation 68: Embed trained staff in Jobcentre Districts who can work to promote the Fit for Work service with local employers and healthcare professionals.

Recommendation 69: Remove the use of conditionality and sanctions for people with mental health problems. This would allow Jobcentres to build trusting relationships with local healthcare services and voluntary sector organisations.

Recommendation 70: Give Jobcentres greater flexibility in how they use staff resource to allow more innovative ways of working.

Recommendation 71: Evaluate the devolved Work and Health Programmes with a view to replicating successful approaches with core Jobcentre Plus support.

Recommendation 72: Expand the Work and Health Innovation Fund to include a component dedicated to local innovation and partnership working.

Recommendation 73: Consider additions to the annual Employer Perspectives survey in order to establish regional data on employer attitudes and confidence around supporting their employees' mental health.

Recommendation 74: Work with healthcare professionals' organisations to develop the existing consensus statement into a more detailed approach to health and work.
