Work and Pensions Committee - Welfare to work inquiry

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

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

Executive Summary

- Fundamental reform is needed to improve the support for people with mental health problems in the ESA Work-Related Activity Group (both those with mental health problems as a primary and secondary condition).
- Not only is current back-to-work support unsuccessful in supporting significant numbers of people with mental health problems back-to-work, it is making people more unwell and pushing them further from work.
- Back-to-work support is often generic and untailored. It does not look to support the main reason why people are out of work – their mental health – or address the barriers to work associated with this.
- There are insufficient specialist and local providers providing back-to-work support.
- Inappropriate levels of conditionality continue to be used despite negative impacts on people with mental health problems, the support they receive and a lack of evidence to show it has any positive impact on success rates of back-to-work support for this group.
- Without an understanding of the scale of the challenge or the need for fundamental reform of back-to-work support for people with mental health problems, the Government is unlikely to achieve better results.

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1. Mainstream back-to-work support isn't working for people with mental health problems on ESA

1.1. The Work Programme has supported only 8 per cent of 162,000 participants with 'Mental and Behavioral Disorders'[1] on ESA into sustained employment.[2] This is simply not good enough. Whilst statistics are not collected for Jobcentre Plus (which itself supports around 100,000 people who are on ESA because of their mental health), the very low overall off-flow rates from ESA suggest that its support is similarly ineffective at supporting this cohort.

1.2. Not only are these schemes failing, but they are also having a negative impact on people's mental health and pushing them further from work. Research undertaken by Mind found that of 400 people using the Work Programme or Jobcentre Plus support:

- 83 per cent said it had made their mental health worse
- 82 per cent said it had made their confidence much worse
- 76 per cent said it led them to feeling less or much less able to work

[1] Primary Health Condition as defined by the International Classification of Diseases, 10th Revision, published by the World Health Organisation

[2] DWP (2015) DWP Tabulation Tool: 162130 people with mental health problems have been attached to the Work Programme. Of this number, only 13380 (or 8 per cent) have gained employment

- 83 per cent said it had made their self-esteem worse.[3]

1.3. For these reasons, there needs to be extensive reform of back-to work support for people with mental health problems. We believe this means addressing fundamental assumptions which underlie back-to-work support, and addressing the key issues outlined in this response.

1.4. There are better ways of delivering back-to-work support for people with mental health problems and we include some effective examples in Appendix I. Much research has also been undertaken into successful schemes such as the Individual Placement and Support model, but substantial reforms would be needed to genuinely incorporate the principles of these approaches into current Government support.

1.5. The Government has invested in pilots offering different types of support for people with mental health problems. However, the scale of these pilots is not commensurate with the challenge we are facing. In total there are over 250,000 people with 'Mental and Behavioral Disorders' receiving ESA WRAG, yet the proposed changes only affect a small proportion of this group. For example, of the four RAND Europe pilots aimed at supporting people with mental health problems, only one focuses specifically on the 250,000 ESA WRAG cohort.

1.6. Despite some progress, there remains a lack of understanding about mental health across the whole back-to-work system: how people are assessed for benefits and support, the way people are communicated with, the activities people are asked to undertake, and the threats of punishment for failing to engage with these activities.

Current problems with welfare-to-work

2. Mainstream back-to-work support fails to provide appropriate or tailored support for people with mental health problems

2.1. The Work Programme was intended to provide "each individual with what they need"[4] to move into work. For people with mental health problems, it has failed to do so. Several research reports into the support provided for the ESA cohort have indicated that the personalised support which was intended has not been provided.[5] The lack of a personalised approach has also been evidenced by the poor success rates of the programme.

2.2. The DWP's most recent evaluation of participants' experiences of the Work Programme, found that only a few participants were referred to training provision or support designed to address their specific barriers to employment.[6] Further, a report into the Jobcentre Plus offer found ESA claimants and "particularly those with a mental health condition" were less likely to receive tailored support than other claimants. [7] A pan-disability research report supports these conclusions, finding that of 550 recipients of Jobcentre Plus and Work Programme support:

- Only 23 per cent of people felt their 'action plan' of support was appropriate for them
- Only 21 per cent felt involved in making the plan and agreeing to the activities

[3] Mind (2014) We've got work to do
[4] DWP (2012) The Work Programme: The First Year
[5] For more information see: Catherine Hale (2014) Fulfilling Potential? ESA and the fate of the Work-Related Activity Group, DWP (2012) Work Programme Evaluation: Findings from the first place of a qualitative research on, Mind (2014) We've got work to do and Work and Pensions Committee (2013) Can the Work Programme work for all user groups
[6] DWP (2014a) Work Programme Evaluation – An independent assessment of participant experience
[7] Department of Work and Pensions (2013) The Jobcentre Plus Offer: Final evaluation report

- Only around 30 per cent felt their adviser had adapted activities to take account of their condition and the impact it had on their ability to engage.[8]

This research supports the qualitative evidence that our organisations receive on a regular basis from our beneficiaries.

3. Current payment structures lead to a lack of specialist support and innovation

3.1. Evidence from Work Programme providers indicates that there is limited use of specialist subcontractors in supply chains, with most turning to in-house staff.[9] Payment structures make it difficult for small charities and organisations to enter the provider market, with too much risk attached to contracts. This is a loss as these organisations are much better placed to provide appropriate support and often have better success rates at supporting people into employment.

3.2. There is also an implicit assumption that good support will be ensured by payment by results. This has not been the case, especially for the mental health cohort. However, other forms of payment, such as block funding have proven more successful for this cohort, as evidenced in Appendix I. The DWP should reconsider its payment structures in order to ensure the best providers of support are being used. The Key Performance Indicators should be reviewed within both Work Programme and Work Choice, especially in terms of employment outcomes for individuals with mental health problems, and progression towards work should be measured and valued, rather than the 'harder' outcomes of simply getting a job.

4. Conditionality is counterproductive and having a negative impact on support and its success

While we accept that there may be a role for conditionality where someone in the WRAG is simply refusing to engage with any support through choice rather than as a result of their mental health problem. However, in the vast majority of cases we do not believe that conditionality should be the default option for the reasons outlined below.

4.1. ***There is a lack of specialist support offered to claimants because of conditionality*****.** Many specialist providers do not want to be involved in back-to-work support because they may be required to refer clients for a sanction. This would undermine and compromise the relationship between staff and clients. If there was less of a focus on mandation, and more people could be referred to sub-contractors on a voluntary basis, local Minds and other specialist organisations would be more willing to be involved.

4.2. ***Being placed under pressure and being threatened with punishment has a negative impact on people with mental health problems*****.** By mandating someone to attend certain activities, an adviser is placing pressure on a claimant. This pressure is increased when the activity is inappropriate for someone with a mental health problem, as often is the case. Dealing with pressure and stress can be extremely difficult for some people when experiencing a mental health problem, and is most likely the cause for the statistics outlined in paragraph 1.2.

4.3. ***Conditionality negatively impacts on the important relationship between claimant and adviser.*** In an independent report for the DWP on employment support for people with a mental health conditions, Litchfield, Perkins and Farmer wrote "the actions of the adviser and the relationship they build with their client are key to helping any individual back to work."[10] This is generally

[8] Catherine Hale (2014)
[9] DWP (2014a)

accepted to be true across the sector and was included in a DWP Research Report which stated "trusting relationships between claimants and case managers is key to success in overcoming claimants' concerns and building confidence about going back to work". [11] Yet this important relationship is negatively impacted by the "us and them" approach created by conditionality. We do not believe this has been truly acknowledged by the DWP, despite evidence in a recent evaluation which found that a "number of providers felt that sanctioning could have adverse impacts on the relationships between participants and their advisers".[12]

4.4. Conditionality removes choice and control from the claimant, which are vital in recovery. Removing choice and control through mandation goes against some of the most basic principles of supporting people with mental health problems as outlined by NICE Guidance:
"Offer help, treatment and care in an atmosphere of hope and optimism"
"Foster client's autonomy and promote active participation in treatment decision"
"That shared decision making should be a key part of any service"[13]

"Treatment and care should take into account people's needs and preferences" with the patient having the *"opportunity to make informed decision about their care and treatment"*[14]

4.5. Further, conditionality goes against widely agreed principles of control in recovery:
"Recovery is about building a meaningful and satisfying life, as defined by the person themselves"
"Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency')"[15]

4.6. Whilst back-to-work support does differ from treatment in its aims, just like healthcare, it is supporting people who are there primarily because of their mental health condition. To step so far away from evidenced guidance and widely accepted practice seems illogical and counter-productive.

4.7. *By restricting choice, conditionality promotes poor support*. By taking away choice (both in what support a claimant can attend and whether they attend or not) providers are able to offer poor or inappropriate support because they can simply mandate someone to go. If mandation was not an option, providers would have to improve the support they offer to incentivise claimants attend. Conditionality removes the notion of choice, leaving only flawed payment structures to ensure providers improve support.

4.8. *There is a disproportionate impact on people with mental health problems*. Whilst there are notional safeguards in place to protect 'vulnerable customers', they are not working. Not only are a disproportionate number of people with mental health problems being sanctioned, but a large number are being incorrectly threatened with a sanction, which end up being cancelled or

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[10] Litchfield P, R Perkins, P Farmer (2009) Realising Ambitions: Better employment support for people with a mental health condition
[11] Department for Work and Pensions (2013) What works for whom in helping disabled people into work?
[12] Department for Work and Pensions (2014b) Work programme Evaluation: Operation of the commissioning model, finance and programme delivery
[13] NICE Guidance (2011) Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (http://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#care-and-support-across-all-points-on-the-care-pathway, accessed 2nd July 2015)
[14] NICE Guidance (2011) Generalised anxiety disorder and panic disorder (with or without agoraphobia (http://www.nice.org.uk/guidance/cg113/chapter/Person-centred-care, accessed 2nd July 2015)
[15] Shephard G., Jed Boardman, Mike Slade (2008) Making recovery a reality

declared “non-adverse”. The impact of these inaccurate sanctions on the relationship between the claimant and the support they receive should not be underestimated:

- For the year Jan 2014 – Dec 2014 on average 58 per cent of sanctions for people in the ESA WRAG are received by people with mental health problems, despite people with mental health problems making up 50 per cent of this group[16]
- Since 2011, only 29 per cent of sanction referrals for people with mental health problems have resulted in a sanction[17]

4.9. These statistics go against DWP comments that only a small number of people are affected by the sanctioning regime. It has a large presence, affects how support is offered by providers, affects choice, affects the relationship between adviser and customer and creates a negative environment in which support is offered. All of which are counter-productive in helping someone with a mental health problem.

4.10. We believe people with mental health problems face high numbers of sanctions referrals because of a lack of understanding about the symptoms of mental health coupled with the provision of poor and inappropriate mandated support. It is also worrying that there are large amounts of inconsistency amongst providers in sanction referrals. A DWP report found “there were considerable differences in the levels of discretion used in the process of referring participants for sanctioning” and “beliefs about what counted as a good reason varied across providers”.[18]

4.11. ***There is no evidence that conditionality works for people with mental health problems.*** Conditionality has become an unchallenged aspect of back-to-work support. Yet, there is no evidence to show that this policy has a positive impact on the success of back-to-work support for people with mental health problems. The only pilot that has included analysis on the impact of conditionality for people with mental health problems “did not find a statistically significant impact from Pathways [the pilot] on any of the work, earning and self-reported outcomes”.[19] Further, the Equality Analysis of the changes to the Welfare Reform Act 2012 (which increased the activities someone with mental health problems could be mandated to) stated that “it is not possible to predict the behavioral response to the revised system.”[20]

4.12. ***Conditionality is based on an assumption of a lack of motivation or willingness to work.*** This is not the case for people in the mental health cohort who, it is widely acknowledged, show a high rate of desire to get into work.[21] We would argue that rather than designing support that doesn’t work for 250,000 people in order to stop a small minority from cheating the system, support should be focused on the needs of the majority who do want to work if the support is right.

5. The health of claimants is neglected, despite it being the main barrier to work

5.1. Welfare to work schemes only focus on employment outcomes, rather than the progress an individual has made towards work or improvements in their health. Support therefore becomes

[16] Figure calculated using Freedom of Information Request 2015-1994
[17] Figure calculated using Freedom of Information Request 2015-1994
[18] Department for Work and Pensions (2014) Work Programme Evaluations: Operation of the commissioning model, finance and programme delivery
[19] Department for Work and Pensions (2009) Research Report No 601 The impact of Pathways to Work on work, earnings and the self-reported health in the April 2006 expansion areas
[20] Department for Work and Pensions (2012) ESA (Sanctions)(Amendment) Regulations 2012 – Equality Analysis
[21] Litchfield P, R Perkins, P Farmer (2009)

focused on achieving this goal as soon as possible. Claimants are put under pressure, pushed into inappropriate work and given support that focuses purely on work rather than health, all of which being detrimental to someone's mental health problem.

5.2. Whilst the term "work is good for your mental health" is constantly used as a justification of moving people back into work as quickly as possible, this is simplistic and misrepresentative of the research from which it is quoted. *Appropriate* work, with the right support can be very good for someone's mental health, but inappropriate work, without the right support, can be detrimental. Current back-to-work support fails to represent this nuance. Mental health problems are very individual. For some, moving back to work within a week may be very helpful, for others, they may need 6 months to focus on their health before even begin searching for work. Successful examples of back-to-work support (as shown in Appendix I) work at the customer's own pace.

6. Entrenched fear and negativity

6.1. There is an entrenched negativity and fear towards the Work Programme and the Department for Work and Pensions among people supported by ESA, and particularly people with mental health problems. Negativity exists because of the poor support that is offered, the pressure people are put under through conditionality, and the delays to support people face. The impact of this negativity means that people find it harder to engage and feel anxious about support. This in turn pushes them further from work. Small adjustments and alterations to the current model of support will do little to overcome this fear and negativity, again backing our call for more fundamental reform.

7. What should support look like?

7.1. Back-to-work support can work for people with mental health problems, as evidenced by examples in Appendix I. These examples are more successful than DWP provided support because they offer holistic support focused on the person's needs and health. The support is based on building a positive relationship between adviser and client, which is enhanced by knowledge and understanding of mental health. It works with the client at their own pace, looking towards their individual aspirations rather than pushing them towards inappropriate support or work. It doesn't put unnecessary and unhelpful pressure on clients through conditionality, as it understands that this can make someone's mental health problem worse. It also focuses on the health of the client, understanding that even if they take a while to find employment, if their health is improving that is a positive step forwards. In essence, support is based on the following principles:

- Understanding and trust
- Individual ambitions and aspirations
- Specialist and person-centred
- Proactive engagement with employers
- Continued support in employment
- Integration with health and other local services
- Focus on health outcomes as well as employment

7.2. The most successful employment model for supporting people with serious mental illness is Individual Placement and Support (IPS). [22] In IPS services, the percentage of job outcomes are

[22] See: Bond. G (2013) Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment, Bond at al (2012) World Psychiatry 11, 1, 32-29 (IPS studies outside the US), Burns, T., Whiste, S., Catty, J (2008) Individual Placement and Support in

significantly higher that DWP programmes, individuals work for more days in a year and achieve a higher pay.[23] More information on IPS can be found in Appendix I.

7.3. The role healthcare settings can play in supporting people back into work is also key. This is evident from the inclusion of evidence-based supported employment in recent updates to the NICE guidelines for both bipolar disorder and psychosis and schizophrenia.[24]

8. Our recommendations for reform

8.1. We believe these recommendations are commensurate to the scale of reform needed to improve back-to-work support for people with mental health problems:

1) The DWP should offer a new programme of support for the mental health cohort on ESA. This programme should be locally provided, with specialist providers at the forefront of delivery. This support should be integrated with other local services, such as IAPT, housing and other social care services and community groups.
2) The Department should pilot the use of personal budgets in back-to-work support. This would allow for more choice for the claimant, which in turn would create a more competitive and innovative market. It would also increase the claimant's ability to co-produce and take control of their own recovery which is so vital.
3) Support for this cohort should be delivered in association with a health setting, (primary secondary and social care), in a way that has proved effective in the IPS approach. This would lead to:
    a. a greater focus on supporting someone's health condition – the main barrier to work
    b. a break in the link between benefit eligibility and support which in turn leads to a heavy focus on conditionality
    c. more successful support, as evidenced by the IPS model and the programmes described in Appendix I

    Pre-existing employment indicators for health bodies could be used in conjunction with this support, as shown in Appendix II.
4) The current model of conditionality for people with mental health problems should be reviewed immediately, with a reduction in conditionality until the full impact over time of the policy is understood through independent research. Providers and Jobcentre Plus who continue to show high levels of inaccurate sanction referrals alongside poor success rates should be penalised.
5) Health and recovery-based outcomes should be used for this cohort. These outcomes should be used to acknowledge progress, but also used to hold providers and Jobcentre Plus to account where people's health and wellbeing is negatively affected by support.
6) People with mental health problems should be directly included in the design of any new back-to-work support.

Europe: the EQOLISE trial, Centre for Mental Health (2011) Doing what works: Individual placement and support into employment, Hoffman et al, "Long-Term Effectiveness of Support Employment: Five-Year Follow-up of a Randomized Controlled Trial" (May 2014): Study of 100 participants in Switzerland over 5 years and DWP and RAND Europe (2014) Psychological Wellbeing and Work

[23] Gary R. Bond, Kikuko Campbell and Robert E. Drake (2012) Standardising Measures in Four Domains of Employment Outcomes for Individual Placement and Support

24 NICE (2014) Psychosis and schizophrenia in adults: treatment and management (CG178) – recommendation 1.5.8.1 and NICE (2014) Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185) – recommendation 1.9.6

Appendix I

Individual Placement and Support (IPS)

IPS is significantly different from welfare to work programmes in that all the referrals come from people accessing NHS Mental Health services– therefore the individuals are already receiving mental health support whilst they are searching for employment and continue to have that support once they are in employment. All referrals to the service are voluntary - there is no obligation to the service.

The employment specialists are co-located within the clinical team and work jointly with clinicians to support the individuals into sustainable employment. The employment specialists work quickly with clients to get them into work rather than focusing on volunteering and training activities before job searching.

Unfortunately not all Trusts have IPS services so many people with SMI who want to work do not have access to this successful employment support. Reducing NHS budgets have hindered its implementation in other Trusts.

Most clients using IPS services have been found to be in the ESA support group. Joint working between NHS and Jobcentre has been piloted in a few locations whereby local job centres have successfully integrated a DEA into an NHS IPS service. Potentially extending these pilots to other areas will increase resource within IPS services, develop expertise within Jobcentre Plus in supporting people with SMI into employment and increase the number of people in the ESA support group supported into employment.

Principles of IPS

1. Every person with mental illness who wants to work is eligible for IPS support
2. Employment services are integrated with mental health treatment services
3. Competitive employment is the goal
4. Personalised benefits counselling is provided
5. The job search starts soon after a person expresses interest in working
6. Employment specialists systematically develop relationships with employers based upon their client's preferences
7. Job supports are continuous
8. Client preferences are honoured

Service user stories can be found here - http://www.centreformentalhealth.org.uk/individual-placement-and-support

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WorkPlace Leeds

Funding 2013/14

- CCG Leeds Funding (2013/14)
    - Employment support service - £337k
    - Job Retention service - £193K
    - Being Well at Work service - £25k
- Extra funding
    - Leeds City Council , Adult Social Care Funding - £173k

- DPULO funding - £47k

Total funding: £775k

Service referral routes 2013/14

Referrals come from:

- Community mental health teams, ICS and outpatient services
- LCC Adult Mental Health services
- Leeds Mental Health Housing services
- Leeds IAPT
- Specific Leeds GPs
- Jobcentre Plus advisors
- Access to Work

CCG contract numbers Supported 2013/14

- 343 people have received Employment support
- 233 received Job Retention support
- Average time in service – 175 calendar days (25wks/6 months)
- Ethnicity – 13 per cent BAME groups

Support Offered

Leeds Workplace offers an Employment support service, Job retention support, Group peer support workshops and courses (Being Well at Work), an IT service and is the lead for the City of Leeds in supporting employers to create mentally healthy workplace via the Mindful Employer initiative. The service is delivered in accordance with the key principle of Individual Placement and Support (IPS) approach to vocational services.

All support offered is voluntary and driven by the client need. It goes at the client's pace and can handle periods of client relapse. It is flexible and can meet clients at locations that are best for them. As clients are out of work because of their mental health problem, there is a focus on supporting this, including co-location and partnership with health services.

With a relatively low average caseload of 25-30 people, the experienced and motivated staff can better support their clients, building a trusting relationship.

Success of support 2014/15

- Employment Support
  - 110 gained paid employment (32% clients supported)
- Job Retention Support
  - 96% retained their jobs for 3 months
  - 84% retained their jobs for 6 months

Solent Mind

Funding
The service is funded by Portsmouth City Council, Solent Health Trust and local IAPT services.

Referral Routes
Clients are referred from primary and secondary mental health care.

Type of support offered
The support is focused around a person-centred approach with each client seen and treated as an individual. Where the client faces external difficulties that are impacting upon their employment or them gaining employment, they aim to solve these, or where possible signpost them to the appropriate services.

For those referred through secondary mental health services, they hold clinics in the local inpatient unit and the Adult Mental Health Service and offer advice and support in regards to job retention and exploring work, voluntary work or training upon discharge. For clients from primary health care settings they offer similar support, including attending IAPT services.

Whilst not co-located with health care services, Solent Mind uses the same patient management system as the local IAPT team, ensuring they are able to keep up to date with clients and share information. It is this open communication and information that helps make the service so successful.

Success rates
For those referred from Primary Mental Health Services (mild to moderate)

- 20.5 per cent found new work
- 61.4 per cent were able to retain their employment and resolve issues they were facing at work

For those referred from Secondary Mental Health Services (severe and enduring):

- 23.8 per cent found new work with the help of the service
- 19 per cent were able to retain employment and resolve issues they were facing at work
- 38 per cent engaged in a training or educational opportunity

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Solihull Mind
Statistics taken from 2013-14 Annual Report

Funding
Received from Solihull Metropolitan Council who funded the service for a number of years and have awarded a new contract for three years through their tendering process.

The employment part of this service receives £52,450pa. This pays for the one staff member and office and management costs.

Referral Routes

"Health Minds" – CBT Primary Care Provision	53
GP	29
Solihull Mind services	13
CMHTs	11
Jobcentre	10
Work of mouth	9
Website	9
Other	10

Numbers Supported and Demographics

- The service supported 177 people in 2013-14
- 133 of these were new to the service
- 13 per cent declared a disability over and above their mental health difficulties
- The majority of people were within the ages of 26-55 (89)
- 88 of the new people were employed and needed job retention support. 65 of these were off sick when joining the service
- 45 of the new people were unemployed
    - Of these, 6 had been so for less than 6 months, 13 had been so for 6 months to two years, nine for 2-5 years, and 17 for over five years

Type of support offered

- Job retention
    - The service provided information, advice and guidance to help clients choose their objectives and routes forward. They then supported, advocated, educated, mediated and represent clients with employers, union representatives, health professionals and colleges.
- Out of work support
    - The service provided information, advice and guidance, support to increase social confidence and reduce loneliness, practical help with job searching and interviews and support to access/retain appropriate benefits

Both support programmes helped people to take steps forward and achieve their goals by working in collaboration and partnership with a wide range of organisations and services. This includes working closely with Sustain, Jobcentres, occupational physicians, HR departments, unions, Job clubs, CMHTs, GPs, other Solihull Mind services and carers. The service also delivered awareness raising at two organised events for local employers, and delivered training to local therapists and CAB volunteers.

Success of support

- Client survey
    - 100 % felt they had been listened to and taken seriously
    - 99 % felt better informed
    - 99 % had a better understanding of their options
    - 82 % felt more positive about the future
    - 71% felt better about themselves
    - 83% found it easier to talk about their issues

- Job retention
    - 59 people retained their jobs and returned to work following sickness
    - 5 were redeployed within the same organisation
    - 2 gained promotion
    - 15 people chose negotiated exit settlements
    - 10 resigned on their own terms
    - 1 service user received the Boots National Award for Customer Service
    - 1 service user negotiated a sabbatical year
- Out of work support
    - 17 people were successful in obtaining new employment (38%)
    - 7 started their own business
    - 12 took up voluntary work
    - 6 went into training

Work Choice

Work Choice was created for people seen as having complex employment support needs related to their health or disability. The voluntary scheme has had far greater success than that of the Work Programme, although with a smaller cohort. [25] The most recent stats (page 15 of the Official Statistics) show that Work Choice is helping to support 44% of people with mental health problems into work. There are issues around referral routes (i.e. people closer to work are usually directed to this support meaning it is more likely to succeed) but it is extremely successful. However it is not clear at what cost this success has come. We recommend the DWP assess the cost/benefit of increasing mental health referrals to Work Choice considering its high success rates.

Appendix II

Employment outcomes within health

Whilst it is often assumed that support based in health and social care settings fail to focus on employment, this incorrect. Employment is a key indicator that many health bodies can be held accountable to. This includes:

- Public Health Outcomes Framework – Indicator 1.8ii Gap in employment rate of people in contact with secondary mental health services vs. unemployment rate
- Adult Social Care Outcomes Framework – Indicator I (F): Proportion of adults in contact with secondary mental health services in paid employment
- NHS Outcomes Framework – Indicator 2.5: Employment of people with mental health problems
- CCG Outcomes Indicator Set (C3.17 – Improving recovery from mental health conditions)

These indicators pave the way for more back-to-work support to be based in healthcare settings, or at more integration with the DWP with joint outcome goals.

[25] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425615/work-choice-statistics-may-2015.pdf