Royal College of Psychiatrists
Consultation Response

DATE: 20 February 2017

Submission of: THE ROYAL COLLEGE OF PSYCHIATRISTS

Submission to: *Improving Lives. The Work, Health and Disability Green Paper*

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

We are pleased to respond to this consultation. Our response was approved by Dr Adrian James, Registrar.

For further information please contact the Policy Unit on 0203 701 2546 or e-mail Masood Khan Masood.Khan@rcpsych.ac.uk

Royal College of Psychiatrists

Response to: Improving Lives. The Work, Health and Disability Green Paper

Introduction

The Royal College of Psychiatrists is pleased to have the opportunity to respond to the present Green Paper on Work, Health and Disability. This is a valuable and ambitious document which invites careful scrutiny.

We are aware of the importance of work and its relations to health, and acknowledge the need for close liaison between government departments to improve the quality of working environments and to offer valuable opportunities to people with all forms of health conditions and disabilities. We welcome the creation of the Work & Health Joint Unit which acknowledges the need to closely ally the two departments of Health and Work and Pensions for the benefit of these groups of people.

The Royal College of Psychiatrists has supported the need to ensure that people with mental health conditions and those with intellectual disabilities are given the opportunity to live full and satisfying lives, which may include the benefits of accessing and remaining in employment or engaging in other valued activities. We have also supported the need for parity of esteem between the availability of resources for people with physical and mental health conditions, as well as the need to counter prejudice, discrimination and for them to avoid the vicissitudes of poverty and exclusion.

In addition to providing this submission we have also contributed to a joint response from the main mental health charities from across the United Kingdom. The joint response represents a consensus of views from all these organisations and we have not repeated all the details of that joint submission in our individual response set out below. Our individual submission has focussed on areas of the Green Paper that have particular relevance to the work of psychiatrists and the people they see.

Tackling a significant inequality – the case for action

Needs and costs
The Green Paper is ambitious and offers a range of comprehensive proposals for the reform of the way people with mental health problems and other health conditions may be supported into work and to remain in work. Our overall concern is the reality and availability of funding to meet these goals. For example, the funding for the Work and Health Programme is £130m (Mirza-Davies et al, 2016), a small proportion of the £2.2 billion paid to Work Programme providers until December 2015 (Dar, 2016). In addition, there will be an estimated saving of £640m from the cut to the ESA-WRAG as a result of the Welfare Reform and Work Act: we would like know if this will be fully recycled into the services outlined in the Green Paper. (Department for Work and Pensions, 2015a).

Recommendation 1: We recommend that the government provides clarity on the availability of funding for the Green Paper's proposals

Disability Employment Gap
We are aware that the Disability Employment Gap is large and enduring; people with disabilities are more than twice as likely as non-disabled people to be without work. (All Party Parliamentary Group on Disability, 2016). People with mental health conditions and those with intellectual disabilities are disadvantaged in the open employment market. People with psychoses have particularly low levels of employment, lower than those with physical disabilities. People with common mental health conditions have significantly lower levels of employment than the general population (Marwaha & Johnson, 2004; McManus et al, 2016; Meltzer et al, 1995). In moving to close the Disability Employment Gap we need to be aware of the need to achieve a parity of esteem in both the health and employment sectors.

Overarching points
We wish to make three general points in our response to the consultation questions for this chapter which should be considered to apply to all other chapters. They can provide a set of principles and values that may underpin the measures used to improve the health and employment outcomes for those with disabilities.

1. *Supporting principles.*
The supporting principles of developments in work, health and disability should be based on those of fairness and justice. We need to develop a system of social security whereby people can receive out of work benefits when they fall ill and are unable to work, and disability benefits for those with long-term disabilities. This system needs to be supported by other opportunities to receive payments and exemptions to cover other essential living costs, such as housing. The assessment systems for these payments should be accurate, effective and fair to ensure that people who are eligible for benefits receive them on time and have access to a fair appeals process. The payments and exemptions should be sufficient to enable people to live above the poverty threshold. These principles acknowledge the historical experiences of many people with disabilities, including those with mental health conditions, who have lived in poverty and the current excess of people with disabilities who live in low income households (Elliott, 2016; Tinson et al, 2016).

In addition, we are aware that over recent years there has been a deterioration in public attitudes towards people who receive benefits which has been reflected in the media. This has led to increasing prejudice and discrimination towards people with physical disabilities, mental health problems and intellectual disabilities, including physical and verbal abuse (Disability Rights UK, 2012).

Providing access to work opportunities for people with mental health conditions and intellectual disabilities should be consistent with the above, necessitating a fair and effective support system for people when they are ready to access work, return to work and remain in work. Any movement from social security payments to regular wages should allow for a transition that supports a return to work and which lowers the risk of a benefits trap. Establishing a fair and effective system should have an emphasis on a voluntary process of support that is personalised, pays attention to individual preferences and is adapted to the needs of the individual. The aim is to improve both the process and outcome of work support which avoids punitive sanctions and increases the awareness of the needs and value of people with mental health problems and intellectual disabilities, alongside those of people with physical conditions.

One form of Supported Employment system is that of Individual Placement and Support (IPS), which this response will discuss in more detail later. One key feature of IPS is its set of eight principles, which guide its approach:
1. Focus on competitive employment as a primary goal
2. Eligibility based on the individual's choice – no exclusions
3. Use of rapid job search (minimal pre-vocational training)
4. Supported employment is integrated with the work of the clinical team
5. Attention to client preferences. Job finding and support tailored to individuals' needs
6. Proactive job finding – emphasis on building relationships with employers
7. Support available for unlimited period
8. Benefits counselling should be provided to support transition

These principles directly tackle the need for coordination of mental health care and employment services within an integrated system. These principles can be of use in planning and developing all employment support services and point to the need for a fair and effective system of social security benefits to back up employment support. They are consistent with other trends and policies in the NHS and social care including personalisation, person centred care and recovery-orientated services.

These principles could also assist in the training of staff who assess people for out of work benefits and who provide work advice and support. The principles could underpin many of the Green Paper proposals.

Recommendation 2: *We recommend that the government utilises the principles of fairness and justice, those of person centeredness and of Individual Placement and Support (IPS) as a means of guiding their welfare and employment policies.*

2. *Work as a health outcome.*
We are aware of the relationship between employment and health (Waddell and Burton 2006). Whilst, in very general terms, we acknowledge that work can have

a beneficial effect on health and well-being, we nevertheless believe that the statement 'work is a health outcome' is an oversimplification of the evidence linking health and work and that this needs to be given clarification and nuance. Our contention is based on the following:

a. Justification for acknowledging the health benefits of work mainly comes from the understanding that unemployment is bad for health. Unemployment is detrimental to people and bad for health, reducing their social networks and social functioning; and motivation and interest. People with mental health problems are especially sensitive to these negative effects of unemployment and this highlights the importance of structure and valued activity in their daily life (Bennett, 1970). In general, it is correct to suggest that employment provides a monetary reward, but also non-financial gains. These additional, 'latent' benefits include social identity and status; social contacts and support; a means of structuring and occupying time; activity and involvement; and a sense of personal achievement (Boardman, 2003).

b. However, jobs with poor psychosocial quality can be as bad for a person's mental health as unemployment (Butterworth et al, 2011) Poor quality jobs include those with high job demands and complexity, low job control, job insecurity and unfair pay. There is also a need to recognise that poor health and poor work outcomes are also determined by other social disadvantages (Marmot, 2015; Dorling, 2013). Many people with mental health problems tell us that good and appropriate work can be good for their mental health – this message may be more appropriate.

c. From the point of view of rehabilitation and inclusion in their communities, work can be an important part of a person's recovery journey and contributes to their opportunities to participate in their communities (Shepherd et al 2010; Boardman et al 2010). For mental health services, the key message is that helping people to gain or retain good and appropriate work is a valid recovery goal and that health services should play a role in facilitating this. Supporting people into employment or other valued activities can improve their sense of hope and agency as well as offering them important opportunities, all of which are key components in personal recovery (Shepherd et al, 2010).

d. In addition, stigma and discrimination play a significant role in producing the low employment rates seen in people with mental health problems (Manning & White, 1995). The workplace provides a useful environment for tackling stigma and public education on mental health.

e. Whilst open employment can be an appropriate goal, other related goals may also be appropriate. Many mental health conditions begin in adolescence or early adulthood and thus interfere with a young person's education, training and early attempts to enter the employment market. For these groups entering education or training may be an important first step. In addition, we need to recognise that some people with long-term mental health problems and intellectual disabilities may be too unwell to work and face complex barriers to achieving employment. For these groups important recovery goals may not include open employment but are better focused on achieving valued activities which allow them to lead a more satisfactory life. These may be facilitated by improving the rehabilitative and recovery foci of health and social services, which have often been overshadowed by our concentration on acute care. It is worth remembering that it is often difficult to predict in these who may be able to work at some point, thus implying that open employment should not be a closed opportunity in these cases.

The Green Paper pays particular attention to the need to reduce the size of the ESA Support Group in order to reduce the disability employment gap. The Government must ensure that the focus on health and work does not lead to a culture within healthcare and employment services where people with mental health problems are pressured to find unsuitable work at the expense of their mental health.

We recommend that:
Recommendation 3: *The Government clarifies its use of the term "work as a health outcome" to take into account the present evidence relating work to health, personal worth, stigma, recovery and rehabilitation.*
Recommendation 4: *The Government works with healthcare professionals' organisations to develop a common understanding of approaches to work and health.*
Recommendation 5: *The Government review current NHS services relating to the rehabilitation of people with long-term mental health problems.*

3. *Clarifying disability.*
In some aspects of medical practice we often rely on an 'illness model' which assumes that an episode occurs for which treatment is available and a cure achieved. This model may be useful when applied to acute mental illness, especially in the context of acute in-patient services, but may be inappropriate for many with long-term conditions. In contrast, the 'disability model' makes no such assumptions. People with long-term or relapsing conditions cannot normally expect a 'cure', but can adapt to changed circumstances and can increasingly expect adjustments in the world around them to enable them to participate. They can expect contributory action from others, rather than waiting to 'get better'.

Disability can be understood to mean the interaction between an impairment (being blind, unable to walk, or having long-term cognitive difficulties as a result of schizophrenia) and the social structures and barriers that exclude the affected individual from full participation. In this sense, 'disability', unlike 'illness', brings into focus the need to remove barriers in social attitudes, practices, policies and the built environment. This 'social model of disability' sees disability as an interaction between a person's impairment and the social barriers that he or she faces (Oliver, 1990). It offers a helpful conceptual basis for understanding and promoting employment opportunities for people with mental health conditions and offers more hope of recovery of social roles. It helps to capture the experience of discrimination and exclusion central to the lives of many mental health service users and addresses the barriers to employment. It is consistent with the views of users and people with disabilities and may assist in achieving dialogue between a range of people including clinicians, employment workers and employers. It is also consistent with current the Disability Discrimination components of the Equalities Act.

One aspect of this approach is its focus on functioning. In the World Health Organisation's *International Classification of Functioning, Disability and Health*(World Health Organisation, 2001),functioning is seen as a continuum covering:
- *Bodily functions and structures* e.g. energy and drive, motivation, appetite, sleep, attention, memory, psychomotor difficulties, agitation, depressed mood, worry and anxiety, stress, making decisions, pain, sexual activities;

- *Activities, and participation* e.g. communication, walking, washing oneself, independence in everyday activities, looking after one's health, informal relationships with friends, family and intimate relationships, education/work and employment, managing money, joining in community activities

Functioning is seen as being determined by the interactions between the health conditions and contextual factors, which consist of:
- *Environmental factors*, such as technology, the natural environment, support and relationships, attitudes of others, services, systems and policies;
- *Personal factors*, such as socio-demographic characteristics, position in the immediate social and physical context, personal history and biography, feelings, thoughts and beliefs, motives and patterns of experience and behaviour.

Here the WHO is providing a social model of disability which is particularly useful in the context of the Green Paper. It provides a useful heuristic device for people working across the health, social and employment sectors as it is readily understandable and offers a means of understanding the psychosocial difficulties experienced by people with mental health conditions. It offers a clear structure that can underpin the assessment of peoples' psychosocial difficulties in relation to their ability to work and their eligibility for out of work and disability benefits.

This WHO approach also provides a common link between mental health conditions and physical disorders. Work comparing psychosocial difficulties and their environmental determinants between people with mental health conditions (Depression, Schizophrenia, Substance dependency) and neurological conditions (Epilepsy, Migraine, Parkinson's, Stroke, Dementia) shows considerable overlap: 57 of the 64 psychosocial difficulties examined were experienced across the neurological and psychiatric disorders, and 17 the 20 environmental factors were common influences of psychosocial difficulties across the conditions(Cieza A et al, 2015; Sabariego et al, 2015; Hartley et al, 2014)

These commonalties have been examined between people with neurological and mental health problems, but they are likely to be seen across other physical conditions. This offers the possibility of bringing together the combined assessment of physical and mental health conditions in the Work Capability Assessment for ESA and assessments for PIP.

In addition, we need to take into consideration the assessment of functioning in people who have both a mental health and a physical health condition. People with mental health conditions experience significant physical co-morbidity (Naylor et al, 2012). The effects of this co-morbidity should be considered in further detail. We know from past research that mental health problems are at least as disabling as common physical conditions (Moussavi et al, 2007) and that mental and physical disorders are known to co-occur at greater than chance levels (Scott et al, 2009; Buist-Bouwman et al, 2005). There are two main ways of considering the effects of co-existing mental and physical disorders: first that their effects are additive i.e. that the individual components of these coexisting disorders have independent effects on functioning and thus the total effects are equivalent to the sum of the parts. The second view is that this co-existence is interactive and is associated with significantly greater levels of dysfunction than predicted by a

simple sum of the main disorders, i.e. the total dysfunction is greater than the sum of the parts.

By contrast there is no evidence that mental health and physical health problems add up to less than the sum of their parts, yet in the operation of the Work Capability Assessment (WCA) this is often how they are interpreted. There is evidence for both additive and interactive effects when mental and physical disorders co-exist. A large international survey (Scott et al, 2009) found that people with depression and anxiety are more likely to be severely disabled than those with physical disorders and that those with combined physical and mental disorders are more likely to be severely disabled than those with one condition alone. Those with combined disorders also had higher levels of disability than predicted by the sum of the disability attributable to the individual disorders.

Recommendation 6: *We recommend that the Government utilise the Social Model of Disability and the World Health Organisations approach to functioning in the training of staff working across the benefits and employment services and in their approach to assessment of people for benefits.*

Supporting people into work

Evidence-based support with treatment
Individual Placement and Support (IPS) is the approach that has the best evidence for its use in supporting people with serious mental health problems into open employment. There are now 17 international trials which provide positive evidence for the success of IPS (Modini, et al, 2016).

Individual Placement and Support schemes are cost-effective, have low drop-out rates and generate positive outcomes across several employment outcomes (into work quicker, work more hours per week, longer job tenure), give good personal outcomes, fewer hospital admissions, quicker recovery (Drake et al, 2012; Knapp et al, 2013). The IPS approach is based on a set of eight principles which this response has outlined above. It has been shown that working in line with these principles ('fidelity') results in better employment outcomes (Drake et al, 2012).

We are pleased to see the Government's intentions to support trials of IPS for people with common mental health problems and other back to work support trials. We would like to see the development of a series of evidence-based approaches to providing back to work support that may be developed into a model for supporting people with mental health conditions into work. We would like to see a system where evidence-based interventions of varying degrees of intensity are available to people with mental health conditions.

We are aware that IPS services can be successfully used in secondary care services, but that they are not widely available across the United Kingdom and that this is the result of their implementation being hampered by clinician and societal attitudes and the lack of awareness by commissioners (Boardman and Rinaldi, 2013).

We recommend that:
Recommendation 7: *The Government consider developing a clear evidence-based model for supporting people with mental health problems into work which is based on the principles of the IPS approach and offers people a variety of interventions depending of their needs and the barriers that they face obtaining employment.*
Recommendation 8: *IPS services are regarded as a standard intervention for vocational support and are developed in all NHS Trusts.*

Though the Government's current trial of in-work support focuses on increasing hours, for many people with mental health problems returning to work this may be inappropriate. Support should instead help people stay well and have in place any reasonable adjustments (such as reduced hours) they might need for their job.

Currently, the Access to Work Mental Health Support Service is intended to provide in-work support for people with mental health problems. Yet applicants are required to be in employment before they can access it.

To improve employment interventions for people with mental health problems the Government should:

Recommendation 9: *As recommended by the Five Year Forward View, greatly expand the provision of IPS.*

Recommendation 10: *Continue to develop the evidence-base for IPS for people with common mental health problems.*

Recommendation 11: *Commission back-to-work support based on IPS principles, which provides intensive support to employers and people with mental health problems as they return to work.*

Recommendation 12: *Refrain from extending in-work conditionality to people with mental health problems.*

Recommendation 13: *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.*

Training of staff

Following the end of the Work Programme and Work Choice in April 2017, more people with mental health problems will be supported directly through Jobcentres rather than through specialist provision. We are aware that Jobcentre staff, including Work Coaches do not currently have the training or skills to provide tailored and personalised support for people with mental health problems. We acknowledge that some effort has been taken to improve the Work Coaches' knowledge and understanding of mental health. Work Coaches require more than general mental health awareness training, and need a clear understanding of the relationship between health and work, a clear model of disability, the principles of IPS, a practical understanding of how to support people with mental health problems and how to respond sensitively to people who are experiencing distress

We recommend that:

Recommendation 14: *The training of Work Coaches should be improved and extended to include a clearer understanding of the needs of people with mental health conditions and the practical help that they require.*

Recommendation 15: *This training should be evaluated in relation to the behaviour of Work Coaches and the experiences of people with mental health conditions.*

Recommendation 16: *This should be extended to the training of all staff who assess people for benefits and support people to find work.*

Recommendation 17: *Commission trials that will allow the Department to understand how this training affects Work Coaches confidence and people with mental health problems' experiences.*

Integrating healthcare with back-to-work support

The right environment to join up work and health

It is useful to re-emphasise that the essential principles, and subsequent success, of IPS are that they integrate employment and health services. Good and appropriate work can be good for people's mental health. In order to halve the disability employment gap, 'health' needs to be carefully listened to in order for 'work' to work. A key barrier to smoother joint working between work and health is the need for local authorities and healthcare services to align themselves around Jobcentre Plus processes. The narrow focus on paid employment outcomes,

sanctions and conditionality and the physical set-up of Jobcentres are current challenges in the pursuit of integrating healthcare and employment support.

Many people with mental health problems find their experience at the Jobcentre stressful and often say that their engagement with support can make their mental health worse through pressure. For that reason we support the Government's aspiration that Work Coaches should be able to advise where to get help and signpost them to local voluntary provisions. However many of these people are fearful that they will be mandated to seek treatment, and we know from past DWP programmes that Work Coaches can fail to make clear when a suggestion is a voluntary one.

To encourage greater joint working between work and health, the Government should:

Recommendation 18: *Encourage Jobcentres to build trusting relationships with local healthcare services and voluntary sector organisations without the threat of conditionality and sanctions for people with mental health problems*

Recommendation 19: *Give Jobcentres greater flexibility in how they use staff resources.*

Recommendation 20: *Evaluate the devolved Work and Health Programmes with a view to replicating successful approaches with core Jobcentre Plus support.*

Recommendation 21: *Expand the Work and Health Innovation Fund to include a component dedicated to local innovation and partnership working.*

Recommendation 22: *Consider carefully how it communicates a signposting role to Work Coaches and individuals. It is absolutely vital that no-one feels pressured to receive treatment.*

Recommendation 23: *Examine means of promoting effective liaison between secondary care, primary care and employment support services.*

Assessments for benefits for people with health conditions

Work Capability Assessment

Over recent years we have seen many publications that have detailed the problems that people with disabilities face when going through the Work Capability Assessment (WCA) and we are aware of many media reports and individual testaments that reveal the inadequacy of the WCA process (e.g. Citizens Advice Bureau, 2006; 2010; 2012; Hale 2014).

The process falls short of the principles that discussed above. There are many reasons to suggest that the current WCA process is not fit for purpose. We are aware that people with mental health conditions may be particularly disadvantaged when applying for ESA. Reasons for this include:

1. *People with mental health conditions may find it difficult to report the nature of their condition or the way that this affects their functioning.*

One reason may be the degree of acceptance or awareness that they have of their mental condition (sometimes referred to as lack of 'insight'). Many people seen in secondary mental health services may be too unwell to work, but have limited awareness of the nature of their illness and who may complete the self-assessment ESA50 on the basis of this and thus not be found eligible for ESA despite being unable to work. For others they may be unable to organise their claim because they are too ill or because their life and behaviour has become chaotic. These people require help to complete forms and may not be able to do so even with support. In this particular circumstance, an appointeeship may be appropriate. Such individuals are commonly seen in daily clinical practice, for which the provision of written clinical evidence would be helpful as they are not able to accurately explain their conditions and circumstances. Some of these individuals may be subject to an appointeeship or be subject to a Community Treatment Order, but these are relatively uncommon.

This self-denial of a person's own condition or symptoms is a particular problem for people with psychotic disorders, but an underestimation of one's one symptoms is a feature across all diagnostic groups. It is common for individuals to under-report the degree of severity or impact of their conditions relative to a third party or an independent clinical assessment. For example, research on patient versus researcher or clinician assessment of needs shows consistently that patients will assess themselves as having lower levels of need or severity of disorders than the third party assessors when completing a reliable semi-structured assessment (Slade et al, 1996).

Other features of people's conditions may make self-reporting difficult. For example, those who experience delusions of persecution may be suspicious of the intention of official agencies and will therefore refuse to complete forms. Such suspiciousness is not confined to people with psychoses and can occur in other conditions. Some people have low self-esteem or confidence and will not feel themselves worthy of benefits. This may occur in any mental condition but is common in people with psychoses and those with depression.

People with mental health problems, particularly those with long-term problems, are likely to be disadvantaged in several social domains and are more likely than

the general population to have poor levels of education and literacy (Boardman et al, 2011). In addition, may have some learning difficulties and a poor understanding of formal procedures and written communications. All these factors will impair their ability to complete forms accurately.

2. *People with mental health conditions may find it difficult to attend interviews or find it difficult to express themselves there.*

A common complaint for many people is the difficulty they have attending interviews and appointments. This applies across a range of diagnoses and may be a result of anxiety (most clearly seen in people with agoraphobia), the presence of persecutory ideas, and social withdrawal (commonly seen in people with schizophrenia and depression). Many people with mental health conditions may be able to cope with familiar people, routes and environments, but find novel situations and people particularly anxiety provoking and avoid them. Attending interviews may be possible for many of these people if they are accompanied and it has become practice for a community psychiatric nurse, advocate, friend or relative to accompany an individual to the WCA interview.

The presence of certain symptoms may impair co-operation and communication with the assessor. The experience of anxiety or suspiciousness may present problems. Many people with psychoses may have difficulty communicating owing to their disorganised thinking or their idiosyncratic habits; they may not be able to concentrate for sufficient time to complete conversations.

For people with mental health conditions participating in an interview with an unfamiliar person can be a daunting experience. Given the symptoms and impairments experienced by people with mental health conditions these circumstances become hard to endure. In addition, many people will understate their symptoms and impairments, as they do to questionnaires, often in order to appear compliant or acceptable, or because they think the clinicians have access to their doctor's written assessments. This interaction of understatement of symptoms with any difficult interview conditions is one reason why people with severe mental health problems are being found fit for work. In addition, the impact of mental health problems may also be underestimated in the presence of coexisting physical problems, thus people's mental health difficulties are downplayed. The presence of a third party, for example an advocate or the availability of accurate clinical evidence can help to rectify this. The availability of further medical evidence in these circumstances would help to direct the assessor's attention to the nature, severity and impact of the mental health condition.

3. *The fluctuating nature of their mental health conditions, symptoms, impairments and functioning may be difficult to describe or to assess.*

Fluctuations of symptoms and conditions are a feature of all mental health conditions. Fluctuations can be experienced in several ways: through relapses and acute exacerbations; through less severe and lengthy exacerbations; and through variations of symptoms day to day or week to week, or within a 24-hour period. For example, some people may experience repeat acute episodes during the course of a year and over several years. This is often seen in people with psychotic conditions and this may be a central feature of their condition over several years; it is often recognised that this may 'burn out' over the years. For

people with affective disorders (depression and bipolar disorders) they may experience sub-acute fluctuations of their conditions during the course of a year, often related to the time of year, for example with low mood being experienced during the winter time.   Fluctuations of symptoms over shorter periods of time are common and there may be an added complexity as some symptoms may vary independently of others.   For example, a person with a mental health problem may find that 30% of the time their mood is low and at other times they cannot concentrate or at other times they are irritable or have FOR COMPANY to withdraw to deal with their auditory hallucinations.   Day to day variations are common in some conditions such as depression, when the individual may feel worse in the morning and improve as the day progresses (this is often termed 'diurnal variation of mood').   Some symptoms may be reactive to environmental changes, most obviously seen in people with agoraphobia whose anxiety symptoms worsen when they leave the home.   Others may vary in response to environmental stressors. All these types of variations can occur in all conditions.

This complexity and the variable patterns can make fluctuations of symptoms and conditions and their consequences for functioning difficult to assess.   They are difficult for patients to describe and it takes careful questioning and experience to evaluate them accurately.   This indicates a need to have competent assessors who can collect and assess all the relevant facts accurately and then rate or categorise them under relevant, clear and valid headings.   Factors influencing the accurate evaluation of fluctuations, and indeed any symptoms or impairments, include the ability of the person being assessed being able to describe them, the quality of the clinical interview and the availability of third party information.   The third-party information can be provided by a person accompanying the claimant to the assessment interview or can be provided through clinical reports which clarify the nature of the disorder and the symptoms and impairments experienced by the individual.

To evaluate fluctuations accurately any assessment needs to be sensitive to mental health needs and accurately reflect the impact that mental health problems can have on daily living.   It is likely that there is no single way of taking account of variable and fluctuating conditions but there are several methods that could be taken into consideration.   The assessment should be sufficiently robust to deal with either the variation of the conditions, or the variability of symptoms.   For example, in the case of day to day fluctuations of symptoms perhaps none of the symptoms, on their own, may be severely incapacitating, but together they are sufficient to affect their overall functioning. Any assessment of functioning should ask about severity, duration and frequency rather than simply trying to gauge an impairment based on simple and one-dimensional proxy measures. For those with variable conditions they may be less incapacitated on their better days, but on their bad days they may function poorly. Symptoms may be so severe on the minority of days that they need to be given greater weighting. A good assessment should be able to evaluate variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations.   These multiple ways could include not only the assessment of a 'typical day', but also a 'typical week'.   A judgement should also be made of the claimant's functioning at its worst, which should include what they are like during an acute episode of their illness. Whatever ratings are used could be assessed as to how often they apply, and the worst-case scenario could be used to provide a reliable judgement. The subjective components of their problems could be assessed in a similar way –

subjective experiences potentially include: overall distress experienced; chaotic thinking, difficulty organizing self or routine; feeling overwhelmed; tolerance for frustration; self-confidence; fear of others' expectations; debilitating side effects of medication; and difficulty coping with stress. The use of a semi-structured format to the interview as outlined above would facilitate this process.

Third party accounts supplied by the professionals who are providing ongoing treatment and support to claimants gives important evidence to help assess fluctuating conditions. A person's medical history can be taken into consideration; for example, information about recent hospital admissions is useful in capturing the true impact of a fluctuating mental health problem. To improve accuracy of assessment it is important to have a full understanding of people's individual circumstances. Useful further medical evidence may be obtained from a range of specialists who are familiar with the claimant, such as psychiatrists, community psychiatric nurses, occupational therapists who might see a claimant on a regular basis and can help to build up a picture of the day-day impairments and needs of the person. If the person is not in contact with secondary mental health services, then the reports can be obtained from the persons General Practitioner.

4. *The subjective nature of many mental health conditions.*
Mental health conditions are notoriously 'invisible' and assessors may not be able to rely on any obvious external features to assist their assessment. It is important that assumptions are not made about the person being assessed based on their appearance and behaviour on the day of the assessment. People's conditions can vary dramatically and experience suggests that they are far more likely to act to downplay their problems in an assessment than to 'play-up' their impairments. This can apply to any mental health condition.

The Citizens Advice Bureau (2012) report indicates that there was a significant level of inaccuracy in Atos medical reports and some of this may be accounted for by the invisible nature of many mental health conditions. In addition, poor interviewing may contribute to this and the tendency to ignore the personal accounts of a claimant's mental health problems and their impairment.

5. *The presence of co-existing physical health problems.*
There is also an increased likelihood that when people with mental health conditions experience physical problems, the mental health problem is more likely to be ignored in the WCA.   This tendency to overlook the existence of a mental health problem and give priority to the physical disorder(s) is also seen in other clinical setting (e.g. general practice consultations) and is sometimes referred to as 'diagnostic overshadowing'.

The masking of mental health problems by physical ones during an assessment deserves further mention. Earlier in our response we discussed the evidence for levels of disability associated with physical and mental health conditions and their likely interaction.

Decisions relating to making an appeal and dealing with it are difficult for many people with or without mental health conditions. But the factors considered above, particularly those relating to chaotic behaviour, low self-esteem and low self-confidence can make this process particularly daunting and difficult.   Some examples of this can be seen in the quotations given throughout this report.

6. *The negative effects on a person with existing mental health problems of going through the ESA claims process and/or the appeals process.*

The day to day experience of patients who have to go through the ESA claims process or appeals process suggests that they may find this stressful and detrimental to their mental health. They find the process confusing and threatening. This experience is reinforced by reports from benefits advisors and from reports by the Citizens Advice Bureau (2010; 2012). More recent studies have linked the WCA process to increases in completed suicide across England (Barr et al, 2014).

Recommendation 24: *We recommend that the Government undertakes a comprehensive review and reform of the WCA. This should include the underlying principles and evidence, and the nature of the descriptors. It should be modelled on a clear Social Model of Disability and should be done in collaboration and carried out with the involvement of clinicians, mental health and disabled people's organisations and charities.*

The importance of obtaining clinical evidence

One means of improving the accuracy of the WCA would be to improve the collection of third party evidence. We are aware that efforts to obtain written evidence from clinicians has fallen in recent years and lack of such evidence has hampered the WCA assessments, the conduct of appeals Tribunals, the recovery process of individuals and the work of many clinicians.

The collection of comprehensive, accurate and timely medical evidence that facilitates an effective Work Capability Assessment (WCA) to deliver the right decision the first time would significantly improve this process. As well as assisting assessors in identifying the most vulnerable clients in contact with mental health services, it would also aid WCA assessors in complex cases and lead to fewer unnecessary face to face assessments. The Green Paper considers how information can be more effectively shared across health and welfare systems. Good quality medical reports supplied by clinicians and team members who know them best can help within more formal information sharing between NHS and DWP.

Given the pressure and anxiety people with mental health problems experience in face-to-face assessments, gathering high quality information is particularly important. Often, any treating clinician 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 to poor decisions which are frequently overturned at appeal.

The Government has previously said that collecting evidence in every instance would place a heavy burden on healthcare professionals. However, we frequently see cases where people with mental health problems have struggled and incurred costs to collect evidence. This requires time from both the healthcare professional and from the person seeking evidence. Yet without the use of the ESA113, the evidence they collect is often generic and not taken into account as part of the assessment process.

We acknowledge how anxiety-inducing the process of completing detailed forms and gathering medical evidence is for people with mental health problems. We support eliminating the duplication of processes and energy, which would make this process easier to navigate. Any system that allows people to share data between assessments needs the full consent of individuals and their complete control about what and how information is shared.

In addition, more support is needed for people with mental health problems to secure an accurate assessment decision. A clinician's generic description of a condition does not often relate to the particular criteria on which ESA is awarded. An effective information sharing system needs to clearly communicate how assessments differ, and explain why someone might want to provide different kinds of information in order to address differences in their respective criteria.

We recommend that the Government:
Recommendation 25: *Set an expectation that assessors should always proactively seek evidence from the healthcare professionals of people with mental health problems.*
Recommendation 26: *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 27: *Extend the ESA113 process to include community psychiatric nurses, psychiatrists and other healthcare professionals.*
Recommendation 28: *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 29: *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 30: *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 31: *Use any new online system to improve the way evidence from healthcare professionals is collected and stored.*

The problems of Conditionality and Sanctions
Encouraging people to return to work is a key objective of Government policy. Most people with mental health problems want to work, but are aware of the barriers and risks that this entails. However, there is no evidence that sanctions are effective in bringing people with mental health problems nearer work. We remain concerned that they impede people obtaining open employment.

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" (Green, 2016). We also note that the National Audit Office's (NAO) recent analysis of the Work Programme sanctions data found that for people claiming ESA, a higher rate of sanctions was associated with poorer employment outcomes (National Audit Office, 2016).

As opposed to mandating treatment, in health settings it is accepted that it is vital to give people with mental health problems choice and control over their treatment. This is an ethical principle but it is also important because it is the most effective way of encouraging genuine engagement with and commitment to plans for recovery (Shepherd et al, 2010). The Behavioural Insights Team have noted that the anxiety caused by the possibility of sanctions may worsen people's attention, self-control and long-term planning (Gandy et al, 2016).

Work Coaches' incentives for tailoring their support may be reduced by sanctions. In a culture of compliance over meaningful engagement, mandation can urge Work Coaches to ensure that people with mental health problems comply with what they are being asked to do regardless if it is appropriate for their mental health. This adds to the fear of benefit sanctions and drives mistrust and disengagement with back-to-work support processes. It is 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 (Department for Work and Pensions, 2015b; 2015c).

We also know that Work Coaches' skills and experience around mental health vary considerably. In its recent investigation into benefit sanctions, the National Audit Office (2016) notes that the current system of sanctions results in a postcode lottery, where someone's likelihood of receiving a sanction depends on the attitude of the staff in front of them 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, variable and inconsistent decision-making.

People with mental health problems frequently report that the fear of losing their benefits makes them more unwell, less able to engage with support, and less likely to trust the support that they are offered. The Government needs to rethink how the current system affects people with mental health problems so that people are not subject to inappropriate pressure. To allow Jobcentres to build trusting relationships with claimants with mental health problems, local healthcare services and voluntary sector organisations, we recommend that the Government:

Recommendation 32: *Remove the use of conditionality and sanctions for people with mental health problems and focus on developing a tailored, voluntary offer of support.*
Recommendation 33: *Build on the existing 'yellow-card' trials in Scotland and 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 34: *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 35: *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 36: *Follows the call from the NAO for a wide-ranging review of the sanctions regime as a whole, including a specific focus on how it affects people with mental health problems.*
Recommendation 37: *Regularly publishes sanctions data broken down by health condition.*

Supporting employment through health and high quality care for all

Improving discussions about fitness to work and sickness certification
The recent development of 'Fit Notes' has had some limited success. For future developments we suggest considering the following:

- *Partial sickness absence.*
Partial sickness absence, which has some features of fit note, has been successfully tested in some Nordic countries and appears to be an effective way to improve a return to work (Kausto et al, 2014; Markussen et al, 2012). Unlike the fit note, partial sickness absence involves legislation which encourages the employee and the employer sign a fixed-term work contract for part-time work, which includes work solution. The fit note is a weaker instrument because there is no legislation to encourage employers to put recommended work solutions in place.

- *Inclusion of 'occupation type'.*
Inclusion of 'occupation type' on the fit note may facilitate conversations in primary care about the specific challenges patients face in the work place.

- *Further research on Fit Notes.*
The evidence suggests that maybe fit for work is typically not completed (Shiels et al, 2014; Shiels et al, 2013) and that maybe fit for work is less frequently completed in people with mental disorders (Gabbay et al, 2016). The reasons for these two findings are not known. There is an evidence vacuum about fit notes in general and for mental health in particular. Given the scale of the problem this lack of evidence is a matter of great concern. Ideally a new policy, such as fit notes, would have been implemented with prior research to show that they brought about the intended consequence – improved retention in the work place. As the fit note has been incompletely implemented without such evidence, it is still necessary that we demonstrate their potential efficacy through improved implementation.

Recommendation 38: We recommend a cluster randomized control trial (RCT) where GP practices are randomised to receive training and support to use fit notes more effectively, compared with a group with no intervention, could lead to improved return to work in the patients certified in this manner.

More generally for in-work health support, we note that there is a significant gap in the evidence base for Employee Assistance Programmes. Currently the evidence does not exist to show that EAPs are more effective compared to no intervention, in improving employee well-being or job-related outcomes.

Capturing data from health systems to look at occupational outcomes:
We support the broad goal of clinical services capturing occupational outcomes. However implementing this at scale across the NHS would be an immense task and should not be undertaken in isolation. We suggest that existing infrastructures which support the routine collection of patient reported outcomes involve uploading these into health records that could be piloted for this purpose. For example, the Integrating Mental and Physical Health: Research Training and Services (IMPARTS) programme at King's Health Partners uses e-tablets in waiting

rooms to collect mental and physical health outcomes, and health behaviours and functional/disability measures including occupational status for patients with long term conditions attending clinics in physical healthcare. Such information can be collected cheaply and at scale. Commissioners might in future require information on functional improvements as (KPI) Key Performance Indicator for clinical services.

Health and work indicators

The development of health and work indicators would support local commissioners to make better-informed decisions about mental health and employment provisions. This work can 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 (Improving Access to Psychological Therapies).

Investing in services that provide support to people with mental health problems and their employers would be beneficial to both groups. 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. There is a real need for local commissioners to invest in services that provide support both to people with mental health problems and their employers.

The role of healthcare professionals

Through recognising and acknowledging their work aspirations and sign-posting them to specialist services, healthcare professionals have a key role to play in supporting people with mental health problems. However, it is crucial that any new vocational training or programmes emphasise that work only brings health benefits when it is appropriate to someone's needs and circumstances.

We are concerned about recent reports of Jobcentre staff using 'work as a health outcome' to encourage people to take a job regardless of how appropriate it would be for their health. It is vital 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 evidence that shows the impact poor quality work has on mental health that for some people work will not be an appropriate option, and an appreciation of meaningful alternatives such as volunteering.

Access to mental health services

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. Therefore, if the Government is committed to halving the disability employment gap, then people will require appropriate treatment in tandem with employment support and other rehabilitative efforts. Mental health treatment needs to be in parallel with any work support. Government 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 important that people

with mental health problems can make use of specialist employment support, this is unlikely to be effective unless they are receiving appropriate interventions for their mental health.

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. Many children and young people find it particularly difficult to get the help they need, and most get no support for their mental health problem.

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.

The *Five Year Forward View for Mental Health* has set out appropriately ambitious plans to rectify this imbalance and improve mental health care in England. 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 this money reaches local services to achieve the turnaround needed. All current indications suggest that, as yet, this is not happening. It is essential that work moves to achieving a parity of esteem between mental and physical healthcare.

We welcome the Government and the NHS's commitment to investing £47.7million in increasing the number of Employment Advisors (EAs) in IAPT. They predict this to more than double the current capacity of EAs placed there. As we know from the CMO's annual report on public mental health, the majority of mental healthcare takes place in primary care. However we strongly believe that employment advisors should not be restricted to the IAPT programme. People should be able to access employment support in the place they are receiving mental health treatment.

We support NHS England's *Five Year Forward View for Mental Health* and would like to see its recommendations implemented to support the Green Paper. Consistent with the *Five Year Forward View for Mental Health*, we recommend that the Government drives:

Recommendation 39: *To double access to IPS enabling people with severe mental illness to find and retain employment.*
Recommendation 40: *To have at least 25% of people with common mental health conditions access psychological therapies each year.*
Recommendation 41: *To design and deliver person-centred healthcare, underpinned by evidence, which supports people to lead fuller, happier lives*
Recommendation 42: *To promote co-production between services and people with lived experience of services, their families and carers*

Also, the Government and the NHS Commissioning Board should work together to:
Recommendation 43: *Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS*

Summary of main points and recommendations

Introduction
The Royal College of Psychiatrists welcomes the opportunity to respond to the present Green Paper on Work, Health and Disability.

People with mental health conditions and those with intellectual disabilities must have the opportunity to live full and satisfying lives, including access to employment and engagement in other valued activities.

Tackling a significant inequality – the case for action
Our systems of support into work and assessment for social security need overhauling. We acknowledge that the Green Paper is ambitious, but are concerned about the reality and availability of funding to meet its goals.

Recommendation 1: We recommend that the government provides clarity on the availability of funding for the Green Paper's proposals

The Disability Employment Gap is large and enduring and people with mental health conditions have low levels of participation in the labour market.

We believe that three matters in require consideration and modification and should guide further policy on access to work for people with mental health conditions and their assessment for social security benefits: principles of fairness and justice, clarification of 'work as a health outcome', and a social model of disability. After considering these we recommend that:

Recommendation 2: The Government utilise the principles of fairness and justice, those of person centeredness and of Individual Placement and Support (IPS) as a means of guiding their welfare and employment policies.
Recommendation 3: The Government clarifies its use of the term "work as a health outcome" to take into account the present evidence relating work to health, personal worth, stigma, recovery and rehabilitation.
Recommendation 4: The Government works with healthcare professionals' organisations to develop a common understanding of approaches to work and health.
Recommendation 5: The Government reviews current NHS services relating to the rehabilitation of people with long-term mental health problems.
Recommendation 6: The Government utilise the Social Model of Disability and the World Health Organisations approach to functioning in the training of staff working across the benefits and employment services and in their approach to assessment of people for benefits.

Supporting people into work

Evidence-based support
Individual Placement and Support (IPS) provides a set of useful principles and an evidence base that supports it effectiveness in getting people with serious mental health problems into work. We recommend that:

Recommendation 7: *The Government considers developing a clear evidence-based model for supporting people with mental health problems into work which is based on the principles of the IPS approach and offers people a variety of interventions depending of their needs and the barriers that they face obtaining employment.*

Recommendation 8: *IPS services are regarded as a standard intervention for vocational support and are developed in all NHS Trusts.*

In addition, to improve employment interventions for people with mental health problems the Government should:

Recommendation 9: *As recommended by the Five Year Forward View, greatly expand the provision of IPS.*

Recommendation 10: *Continue to develop the evidence-base for IPS for people with common mental health problems.*

Recommendation 11: *Commission back-to-work support based on IPS principles, which provides intensive support to employers and people with mental health problems as they return to work.*

Recommendation 12: *Refrain from extending in-work conditionality to people with mental health problems.*

Recommendation 13: *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.*

Training of staff
Jobcentre staff, including Work Coaches do not currently have the training or skills to provide tailored and personalised support for people with mental health problems. We recommend that:

Recommendation 14: *The training of Work Coaches should be improved and extended to include a clearer understanding of the needs of people with mental health conditions and the practical help that they require.*

Recommendation 15: *DWP should commission a trial that will enable us to understand how training affects the behaviour and confidence of Work Coaches when working with people with mental health conditions.*

Recommendation 16: *This should be extended to the training of all staff who assess people for benefits and support people to find work.*

Recommendation 17: *Commission trials that will allow the Department to understand how this training affects Work Coaches confidence and people with mental health problems' experiences.*

Integrating healthcare with back-to-work support
We need the right environment to join up work and health. To encourage greater joint working between work and health, the Government should:

Recommendation 18: *Encourage Jobcentres to build trusting relationships with local healthcare services and voluntary sector organisations without the threat of conditionality and sanctions for people with mental health problems*

Recommendation 19: *Give Jobcentres greater flexibility in how they use staff resource.*

Recommendation 20: *Evaluate the devolved Work and Health Programmes with a view to replicating successful approaches with core Jobcentre Plus support.*
Recommendation 21: *Expand the Work and Health Innovation Fund to include a component dedicated to local innovation and partnership working.*
Recommendation 22: *Consider carefully how it communicates a signposting role to Work Coaches and individuals. It is absolutely vital that no-one feels pressured to receive treatment.*
Recommendation 23: *Examine means of promoting effective liaison between secondary care, primary care and employment support services.*

Assessments for benefits for people with health conditions

Work Capability Assessment
We are aware that over many years people with mental health problems and intellectual disabilities encounter considerable difficulties with the Work Capability Assessment (WCA). People with mental health conditions may be particularly disadvantaged when applying for Employment Support Allowance and Personal Incapacity Payments.

Recommendation 24: *We recommend that the Government undertakes a comprehensive review and reform of the WCA. This should include the underlying principles and evidence, and the nature of the descriptors. It should be modelled on a clear Social Model of Disability and should be done in collaboration and carried out with the involvement of clinicians, mental health and disabled people's organisations and charities.*

The importance of obtaining clinical evidence
The process of obtaining third party clinical evidence for the WCA is not adequate. Lack of evidence has hampered the WCA assessments, the conduct of appeals Tribunals, the recovery process of individuals and the work of many clinicians. We recommend that the Government:

Recommendation 25: *Set an expectation that assessors should always proactively seek evidence from the healthcare professionals of people with mental health problems.*
Recommendation 26: *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 27: *Extend the ESA113 process to include community psychiatric nurses, psychiatrists and other healthcare professionals.*
Recommendation 28: *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 29: *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 30: *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 31: *Use any new online system to improve the way evidence from healthcare professionals is collected and stored.*

The problems of Conditionality and Sanctions
The use of benefit sanctions is counterproductive and often punitive. We recommend that the Government:

Recommendation 32: *Remove the use of conditionality and sanctions for people with mental health problems and focus on developing a tailored, voluntary offer of support.*

Recommendation 33: *Build on the existing 'yellow-card' trials in Scotland and 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 34: *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 35: *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 36: *Follows the call from the NAO for a wide-ranging review of the sanctions regime as a whole, including a specific focus on how it affects people with mental health problems.*

Recommendation 37: *Regularly publishes sanctions data broken down by health condition.*

Supporting employment through health and high quality care for all

Improving discussions about fitness to work and sickness certification
The process of fitness to work certification needs improvement. We suggest considering the following: partial sickness absence; inclusion of 'occupation type'; further research on Fit Notes.

Recommendation 38: *We recommend a cluster randomized control trial (RCT) where GP practices are randomised to receive training and support to use fit notes more effectively, compared with a group with no intervention, could lead to improved return to work in the patients certified in this manner.*

Capturing data from health systems to look at occupational outcomes:
We support the broad goal of clinical services capturing occupational outcomes. Nevertheless, the scale of implementation implies an immense task and should not be undertaken in isolation. We suggest that existing infrastructures, which support the routine collection of patient reported outcomes involving uploading these into health records, could be piloted for this purpose.

Health and work indicators
The creation of health and work indicators could use the current indicators under development through the Five Year Forward View for Mental Health, such as: 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.

The role of healthcare professionals
Healthcare professionals have a key role to play in supporting people with mental health problems into work. Healthcare professionals and employment specialists need a shared understanding of what it means to think of 'work as a health outcome'.

Access to mental health services
It is good practice to give treatment and support to work in parallel. To facilitate this, we must improve access to mental health treatments. We support NHS England's *Five Year Forward View for Mental Health* and would like to see its recommendations implemented to support the Green Paper. Consistent with the *Five Year Forward View for Mental Health*, we recommend that the Government drives:

Recommendation 39: *To double access to IPS enabling people with severe mental illness to find and retain employment.*
Recommendation 40: *To have at least 25% of people with common mental health conditions access psychological therapies each year.*
Recommendation 41: *To design and deliver person-centred healthcare, underpinned by evidence, which supports people to lead fuller, happier lives*
Recommendation 42: *To promote co-production between services and people with lived experience of services, their families and carers.*

Also, the Government and the NHS Commissioning Board should work together to:
Recommendation 43: *Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS*

References

All Party Parliamentary Group on Disability (2016) *Ahead of the Arc – a Contribution to Halving the Disability Employment Gap*. London: All Party Parliamentary Group on Disability

Barr B, Taylor-Robinson D, Stuckler D, et al (2016) 'First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *Journal Epidemiology Community Health* 70:339-345.

Bennett, D. (1970) The value of work in psychiatric rehabilitation. *Social Psychiatry* 5: 224-230.

Boardman, J. (2003) Work, Employment and Psychiatric Disability. *Advances in Psychiatric Treatment* 9:599-603).

Boardman, J., Currie, A., Killaspy, H., Mezey, G. (2010) *Social Inclusion and Mental Health*. London: RCPsych publications.

Boardman, J., & Rinaldi, M. (2013) Difficulties in implementing supported employment for people with severe mental health problems. *British Journal of Psychiatry* 203, 247-249

Buist-Bouwman, M.A., de Graaf, R., Vollebergh, W.A.M., Ormel, J. (2005) Comorbidity of physical and mental disorders and the effects on work-loss days. *Acta Psychiatrica Scandinavica* 111, 436-443.

Butterworth, P., Leach, L.S., Strazdins, L., Olesen, S.C., Rodgers, B., 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. *Occupational Environmental Medicine* (published online doi: 10.1136/oem.2010.059030).

Cieza A et al (2015) Understanding the Impact of Brain Disorders: Towards a 'Horizontal Epidemiology' of Psychosocial Difficulties and Their Determinants. *PLoS ONE* 10(9):e0136271.doi:10.1371.

Citizens Advice Bureau (2006) *What the doctor ordered? CAB evidence on medical assessments for incapacity and disability benefits*. London: CAB.

Citizens Advice Bureau (2010) *Not working. CAB evidence on the ESA work capability assessment.* London: CAB.

Citizens Advice Bureau (2012) *Right first time? An indicative study of the accuracy of ESA work capability assessment reports.* London: CAB.

Dar, A. (2016) *Work Programme: background and statistics*. Briefing Paper Number 6340, 21 March 2016 House of Commons Library. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06340#fullreport.

Department for Work and Pensions (2015a) *Impact Assessment. Welfare Reform and Work Bill: Impact Assessment to remove the ESA Work-Related Activity Component and the UC Limited Capability for Work Element for new claims*. London: Department for Work and Pensions

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

Department for Work and Pensions (2015c) *Evaluation of the Telephone Support Psychological Wellbeing and Work Feasibility Pilot.* London: Department for Work and Pensions

Disability Rights UK (2012) *Press portrayal of disabled people. A rise in hostility fuelled by austerity?* London: Disability Rights UK.

Dorling, D. (2013) *Unequal Health*. Bristol: Policy Press.

Drake RE Bond GR, Becker DR. (2012) *Individual Placement and Support: An Evidence-Based Approach to Supported Employment*. Oxford: Oxford University Press.

Elliott, I. (2016) *Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy*. London: Mental Health Foundation.

Gabbay M, Shiels C, Hillage J. (2016) Sickness certification for common mental disorders and GP return-to-work advice. *Prim Health Care Res Dev* 1-11. doi: 10.1017/s1463423616000074 [published Online First: 2016/03/11]

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.

Green, D. (2016) *From welfare state to welfare system*. Speech delivered on 16 November 2016 by the Rt Hon Damian Green. Department for Work and Pensions. https://www.gov.uk/government/speeches/from-welfare-state-to-welfare-system

Hale, C. (2014) *Fulfilling Potential? ESA and the Fate of the Work-Related Activity Group*. London: Mind.

Hartley S, et al. (2014) Narratives Reflecting the Lived Experiences of People with Brain Disorders: Common Psychosocial Difficulties and Determinants. *PLoS ONE* 9(5): e96890. doi:10.1371/journal.pone.0096890

Kausto J, Viikari-Juntura E, Virta LJ, et al. (2014) Effectiveness of new legislation on partial sickness benefit on work participation: a quasi-experiment in Finland. *BMJ Open* 4(12):e006685. doi: 10.1136/bmjopen-2014-006685

Knapp M, Patel A, Curran C, Latimer E, Catty E, Becker T, et al. (2013) Supported employment: cost-effectiveness across six European sites. *World Psychiatry* 12: 60–8

Mirza-Davies, J. & McGuinness, F. (2016) *Work and Health Programme*. Briefing Paper Number 7845, 22 December 2016 House of Commons Library. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7845#fullreport

Manning, C. & White, P.D. (1995) Attitudes of employers to the mentally ill.*Psychiatric Bulletin*, 19, 541-543.

Markussen S, Mykletun A, Røed K. The case for presenteeism — Evidence from Norway's sickness insurance program. *Journal of Public Economics* 2012;96(11-12):959-72. doi: 10.1016/j.jpubeco.2012.08.008

Marmot, M. (2015) *The Health Gap*. London: Bloomsbury

Marwaha, S. & Johnson, S. (2004) Schizophrenia and employment. *Social Psychiatry and Psychiatric Epidemiology* 39, 337-349.

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Meltzer, H., Gill, B., Petticrew, M. & Hinds, K. (1995). *Economic activity and social functioning of adults with psychiatric disorders. OPCS Surveys of Psychiatric Morbidity in Great Britain. Report No. 3.* OPCS, Social Survey Division. London, HMSO

Modini, M., Tan, L., Brinchmann, B., Wang, M-J., Killackey, E., Glozier, N., Mykletun, A., Harvey, S.B. (2016) Supported Employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. *British Journal of Psychiatry* doi: 10.1192/bjp.bp.115.165092.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., Ustun, B., Depression, chronic diseases and decrements in health: results from the World Health surveys. *Lancet* 370, 851-858.

National Audit Office (2016)*Benefit sanctions. Report by the Comptroller and Auditor General.* London: National Audit Office

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., Galea, A. (2012) *Long-term conditions and mental health. The cost of co-morbidities*. London: King's Fund.

Oliver, M. (1990) *The Politics of Disablement*. Basingstoke: Macmillan.

Sabariego C, et al (2015) Determinants of Psychosocial Difficulties Experienced by Persons with Brain Disorders: Towards a 'Horizontal Epidemiology' Approach. *PLoS ONE* 10(12): e0141322. doi:10.1371/journal. pone.0141322

Shiels C, Gabbay M, Hillage J. (2014) Factors associated with prevalence and types of 'may be fit' advice on fit notes: a cross-sectional primary care analysis. *Br J Gen Pract* 14;64(620):e137-43. doi: 10.3399/bjgp14X677509 [published Online First: 2014/02/26]

Shiels C, Hillage J, Pollard E, et al. (2013) An evaluation of the Statement of Fitness for Work (fit note): quantitative survey of fit notes. London: DWP Research Report 841.

Scott, K.M., Von Korff, M., Alonso, J. et al (2009) Mental-physical comorbidity and its relationship with disability: results from the World Mental Health Surveys, (2009), *Psychological Medicine*, 39, 33-43.

Shepherd, G., Boardman, J., Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Slade, M., Phelan, M., Thornicroft, G. Parkman, S (1996) The Camberwell Assessment of Need (CAN): comparison of assessments by staff and patients of the needs of the severely mentally ill. *Social Psychiatry and Psychiatric Epidemiology* 31, 109-113.

Tinson, A., Ayrton, C, Barker, K., Born, T.B., Aldridge, H., Kenway, P. (2016) *Monitoring poverty and social exclusion 2016*. York: Joseph Rowntree Foundation.

Waddell, G. & Burton, A.K. (2006) *Is Work Good for Your Health and Well-being?* Norwich: The Stationary Office.

World Health Organisation (2001) *International Classification of Functioning, Disability and Health.*Geneva: World Health Organisation.