MRC/CSO Social and Public Health Sciences Unit Consultation Response

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<th>Title of consultation</th>
<th>Work, Health, and Disability Green Paper: Improving Lives</th>
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<td>Name of the consulting body</td>
<td>HM Government Department for Work and Pensions and Department of Health</td>
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<td>Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?</td>
<td>The Unit has research expertise on these key areas of public policy - which are key influences on health - covered by this green paper so it is an important opportunity to inform this consultation and respond directly to the government.</td>
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Our consultation response

1.3 How should we develop, structure and communicate the evidence base to influence commissioning decisions?

The emphasis on robust evaluation of new interventions within the Work and Health programme, including the use of RCTs, is to be welcomed. However, it is crucial that full and complete information on the methods used in these evaluations is made publicly available. Despite early commitments to provide this information for the in-work progression and Universal Credit RCTs (DWP 2012), what has been made available via the relevant DWP website (DWP 2016) and other publications falls short of that required to assess the robustness of the trials

For the credibility of the evidence obtained from such evaluations it is important that the design and conduct of the studies is transparent. It is now recognised as good practice in the conduct of clinical trials to publish the trial protocol in advance, so that the results can be appraised in the light of what was originally intended, and in particular to assess completeness of reporting and to guard against the risk of selective reporting of favourable findings.

The SPIRIT template (Chan et al 2013) provides guidelines to ensure transparency in reporting of trial methods. These guidelines stipulate that the following items should be reported: the rationale for the study and the specific research questions, a description of the trial design, study settings, inclusion and exclusion criteria for participants, experimental and standard interventions, the primary and secondary outcome measures, sample size, randomisation and allocation procedures, methods for data collection, management and statistical analysis, arrangements for trial management, monitoring of harms and adverse events, securing ethical approval, obtaining consent from participants, maintaining confidentiality of personal information, and dissemination of trial findings.

Publication of this information, ideally using a standard format, will enhance the credibility of any evaluations, and enable members of the public, parliamentarians, and researchers, to reach a
well-informed view of the key messages of the evidence, and its strengths and weaknesses.

REFERENCES


2.1 How do we ensure that Jobcentres can support the provision of the right personal support at the right time for individuals?

Personalised support delivered by well-trained advisors is likely to be effective for individuals both in and out of work and with a range of health conditions and disabilities. Staff with both an understanding of the impact of ill-health or disability on individuals, and a good knowledge of the local labour market, are required to support those who wish to return to work.

Disability employment advisors (DEAs) are popular and perceived as effective and helpful by service users and representative organisations (Scope 2013, Coulter et al 2012). JCP staff themselves believe that mainstream work coaches delivering support to ESA claimants via the ‘unipod’ model lack understanding of limitations imposed by health conditions and are unable to provide the specialist services required (PCSU 2015). As such, the HM Government’s plans to increase the number of DEAs to 500 are to be welcomed. However, it should be noted that the planned expansion will not increase the numbers of DEAs available above that which was provided prior to the cuts in DEA numbers implemented by this government (i.e. 491 DEAs available as at 7/12/10; HC Deb 7 Dec 2010).

Evidence from trials of in-work progression programmes for people without disabilities or health problems indicates that access to training which is relevant to the individual’s aspirations and abilities can improve employability, while generic training is unhelpful (Miller et al 2012). However, training provided via the Work Programme has often been found to be too basic or generic, and to fail to take account of limitations associated with illness or disability (Dwyer et al 2016, Hale 2014). Other services which are known to be effective in helping people with disabilities or health problems to return to or stay in work include Access to Work (Dewson et al 2009), the Independent Living Fund (DWP 2017), vehicles subsidised via the Motability scheme (Oxford Economics 2010), and the Condition Management Programme (Lindsay & Dutton 2013). All of these have been subject to severe spending cuts or abolished in recent years, in some cases removing the very support that was enabling disabled people to remain in employment (DWP 2017, Oxford Economics 2010). As such, it appears that there is evidence to support schemes which have previously operated in the UK, but no longer do so due to a lack of funding.

Above all however, there must be a recognition that employment or work-related activity may not be appropriate until the individual’s health problems have been resolved. Strict ‘Work First’ models involving conditionality and sanctioning have not been shown to be effective in promoting employment among people with disabilities or health conditions (Bloom et al 2007, Butler et al 2012) (see also response to 4.1).
REFERENCES


HC Deb 7 Dec 2010 vol 520 no. 86 c 166W
https://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101207/text/101207w0002.htm#10120753000380


2.2 What specialist tools or support should we provide to work coaches to help them work with disabled people and people with health conditions?
3.1 What support should we offer to help those ‘in work’ stay in work and progress?

See 2.1

3.2 What does the evidence tell us about the right type of employment support for people with mental health conditions?

Common mental health conditions such as anxiety and depression are continuing to increase in prevalence and have a serious impact on an individual's ability to function in the workplace. Mental health conditions account for as much as 91 million working days lost/year in the UK and estimates suggest that 3/10 employees will experience a mental health issue each year, mainly anxiety and depression (Health and Safety Executive 2015). Considering the impact of mental health conditions on an individual's ability to work it is important to know what types of interventions are helpful.

Depression characterised by low mood, feelings of hopelessness, inadequacy, sleep disturbance, fatigue and impaired concentration leads to lost productivity in the workplace due to presenteeism and increased levels of sickness absence (McClintock et al 2011 and National Institute for Health and Care Excellence 2013).

Evidence suggests that clinical interventions combined with workplace interventions are more likely to be effective in promoting and sustaining return to work, for those in work but at risk or absent from work, than clinical interventions alone. This suggests the need for more joined-up working between health and employment support. An occupational therapy intervention for those with long-term depression improved recovery and return to work rates for those on sickness absence (Hess et al 2013). Combining clinical interventions with work-related interventions creates opportunities for the health condition to be treated and due consideration given to the person’s work role, modification of work tasks, and the development of coping skills required in the workplace. A review evaluating the effectiveness of interventions aimed at reducing work disability in employees with depression found moderate quality evidence that adding a work-directed intervention to a clinical intervention reduced the number of days on sick leave compared to a clinical intervention alone (Nieuwenhuijsen et al 2014).

Despite high unemployment rates within this population, many people with more severe and enduring mental health conditions want to work (McQueen and Turner 2012). One model, the individual placement and support model (IPS), has been found to be twice as effective as traditional models (such as vocational training) in helping people with severe and enduring mental health issues to obtain competitive employment (Kinoshita et al 2013). Individual Placement and Support is the most intensively studied ‘place and train intervention’ and is open to those who express a desire to work (i.e. voluntary not mandatory). The emphasis is on ‘rapid job search’, reflecting individual preferences with employment support integral to mental health support. In this model links between rehabilitation and employment are integral components with employment support integrated with health, embedded within community mental health teams, rather than a separate service, with occupational therapists often forming the crucial link between employment and health (McQueen 2011). The search for competitive employment (based on the individual's preferences) is rapid and ongoing. Health, work, and employer support is provided once the individual is in work. The IPS model is most effective when delivered with good fidelity and this requires to be assessed by independent appropriately trained fidelity reviewers (Bond et al 2012). Whilst it is acknowledged that there is no so-called 'silver bullet' for comprehensively improving the employment outcomes for disabled people, the individual placement support model may provide an attractive alternative, enhancing the potential for those with long term health conditions to return to employment. To date research related to this model has focused on those...
with mental health conditions. The overall effectiveness of IPS is summarised in a Cochrane review containing 14 trials, with the results suggesting that those with severe and enduring mental health conditions offered IPS earned more and worked more hours overall (Kinoshita et al 2013).

REFERENCES


4.1 Should we offer targeted health and employment support to individuals in the Employment Support Allowance Support Group, and Universal Credit equivalent, where appropriate?

Health and employment support may be helpful for those who wish to explore return to work options, if the support is engaged with voluntarily (Weston 2012). If support is to be offered to individuals in the ESA Support Group, it should be on a voluntary basis, and should not involve sanctions or conditionality. The research evidence is clear that sanctioning of benefits carries high risks of damaging health further and pushing claimants even further from the labour market (Dwyer et al 2016, Barnes et al 2016). As the Green Paper states, individuals are assigned to the Support Group on the basis that they are “unable to engage with any type of employment-related support” (DWP & DoH 2016, p.40). Pressure to engage in work-related activity has been found to push ESA recipients in the UK further away from support (Dwyer et al 2016, Weston 2012), and, in a Danish controlled trial, to have negative effects on employment outcomes (Rehwald et al 2016). Trials of mandatory programmes in the United States have had limited success (Bloom et al 2007, Butler et al 2012). Conversely, returns to employment from ESA have been shown to be
primarily determined by resolution or improvement of health problems, rather than the application of conditionality (Sissons & Barnes 2013).

REFERENCES


4.2 What type of support might be most effective and who should provide this?

See 2.1

4.4 How can we best maintain contact with people in the Support Group to ensure no-one is written off?

See 4.1

6.1 Should the assessment for the financial support an individual receives from the system be separate from the discussion a claimant has about employment or health support?

It is unclear how separating assessments for financial and health support would be beneficial either to claimants or to government. It would seem to risk a duplication of bureaucratic procedures, and could lead to communication difficulties between systems. The proposed balance between mandatory and voluntary services is unclear in the Green Paper, although there is reference to work coaches requiring attendance at WFls, and to developing a Claimant Commitment within 4 weeks of a new claim for ESA, apparently prior to any assessment of health. Access to well-trained advisors with expert knowledge of both the impact of health and
disability and of local labour markets (such as DEAs) is likely to be helpful if accessed on a voluntary basis (Scope 2013, Coulter et al 2012, Weston 2012), and should not be arbitrarily denied to those who want it on the basis of their health assessment. However, if separation of financial and health assessments involves the extension of conditionality to individuals currently assigned to the Support Group, we would argue that such a move would be ill-advised due to the lack of evidence for the effectiveness of conditionality and sanctions (Bloom et al 2007, Butler et al 2012, Rehwald et al 2016), and the evidence that pressure to return to work too soon could have negative health impacts (Dwyer 2016, Weston 2012). Furthermore, the threat of sanctions has been found to engender negative reactions to offers of support, particularly where health problems precluded a rapid return to work (Weston 2012). See responses to Qs 4.1 and 14.6 for further discussion of these points.

REFERENCES


6.2 How can we ensure that each claimant is matched to a personalised and tailored employment related support offer?

See 2.1

8.3(i) Do you think there should be a different approach for different sized organisations and different sectors?

In relation to occupational health service provision for those in or out of work, and across a range of conditions, services should be easily accessible via a range of referral routes, including self-referral. It must be recognised that many employers, particularly at the lower end of the labour market, are unlikely to provide or engage with OH services (Shildrick et al 2012, Wilde 2016), and that services need to be available to those who are employed by such businesses.
REFERENCES


Wilde, J. (2016, 14 November). Precarious “gigs” are a perfect storm for occupational health

9.1 How can existing government support be reformed to better support the recruitment and retention of disabled people and people with health conditions?

See 2.1

10.1 What good practice is already in place to support inclusive recruitment, promote health and wellbeing, prevent ill health and support people to return to work after periods of sickness absence?

Sickness absence (SA) is a significant problem for employees, employers, the health care system, and society (Alexanderson and Norlund 2004; Henderson et al 2005; Ritchie et al, 1999, Wise 2011). The majority of workplace evidence-based return-to-work (RTW) interventions are focused on long-term SA (Carroll et al 2010; Elders et al 2000; Franche et al 2005; Palmer et al 2012; van Ostrom et al 2009), whereas there is a lack of evidence on interventions for the early stages of an absence event (Vargas-Prada et al 2016). Interventions demonstrated to be effective in reducing sickness absence often involve maintaining contact with occupational health professionals (Kant et al 2008; Taimela et al 2008), case management (Anema et al 2007; Smedley et al 2013, Demou et al 2016; Brown et al 2015), work modification (Steenstra et al 2006) and health promotion activities (von Thiele et al 2011).

In Scotland, there are a number of policy initiatives aimed at improving the health of the working-age population and assisting in the management of sickness absence (Healthy Working Lives 2005; Health Works 2009; Reetoo et al 2009]. The Sickness Absence Management (SAM) project was developed to further evaluate the utility of the software SA Recording Tool (SART) in assisting Small and Medium Enterprises (SMEs) manage sickness absence (Reetoo et al 2009).

The Scottish Government produced the Healthy Working Lives (HWL) policy and established the Scottish Centre for Healthy Working Lives (SCHWLs) (Healthy Working Lives 2005). The EASY sickness absence management service is a time contingent and generic very early telephone-based bio-psychosocial occupational health intervention for sickness absence, which was developed in in an NHS Scotland Health Board employing around 11,000 health care staff (Demou et al 2016). A four year evaluation of the impact on absenteeism showed that the EASY service was effective in significantly reducing sickness absence in the health board compared to the reduction across the rest of NHS Scotland Health Boards due to nonspecific tightening of sickness absence policies (Brown et al 2015).

An intensive case management sickness absence management system for NHS staff absent from work for more than 4 weeks in an English NHS Trust demonstrated a significant decrease in long term sickness absence as well as a decrease in mean absence duration, albeit the latter was not significant (Smedley et al 2013). Smedley et al (2013) reported that the intervention resulted in average savings of 1.6 days per 4-week absence, which across all absences at the intervention trust corresponded to an annual saving of c.1100 person-days, resulting in the intervention being cost-effective as well.
The Working Health Services Scotland (WHSS) programme was introduced in order to provide support to employees in small and medium sized enterprises (SMEs, <250 employees) whose health condition was affecting their ability to work. It was funded by the Scottish Government and HM Government’s Department for Work and Pensions (DWP). The programme offers telephone based case management and some face-to-face therapeutic support to those who were either off work due to a health condition, or at risk of becoming absent due to the condition (Hanson et al 2016). Participants' satisfaction with the service was positive and all health assessment tool scores (EQ-5D index, visual analogue scale (VAS), COPM and HADS) improved significantly from entry to discharge. Improvements in health and work ability were maintained at the three and six month follow-up post discharge from the service (Hanson et al 2016).

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Healthy Working Lives. A plan for action, Scottish Executive, Edinburgh, Available from:
http://www.scotland.gov.uk/Publications/2004/08/hwls/0. 2005


Kant I, Jansen NWH, van Amelsvoort LGPM, van Leusden R, Berkouwer A. Structured early consultation with the occupational physician reduces sickness absence among office workers at


von Thiele Schwarz U, Hasson H. Employee self-rated productivity and objective organizational production levels: effects of worksite health interventions involving reduced work hours and physical exercise. J Occup Environ Med. 2011;53:838-

Wise J. Audit finds large variations in NHS staff sick days. BMJ 2011;342.

11.2 How can we ensure that all healthcare professionals recognise the value of work and consider work during consultations with working-age patients? How can we encourage doctors in hospitals to consider fitness for work and, where appropriate, issue a fit note?

See 14.6

11.3 Are doctors best placed to provide work and health information, make a judgement on fitness for work and provide sickness certification?

Primary care teams are often patient person’s initial source of advice about fitness-to-work, but primary care staff generally lack adequate training or expertise in occupational health or disability evaluation and often do not understand or consider occupational issues or the consequences of long-term incapacity (Waddell and Burton, 2004; Coole et al 2010). Waddell and Burton (2004) identified specific gaps in health professionals’ understanding of the relationship between health and work and of alternatives to or options to minimise sickness (Waddell and Burton, 2004). Concurrently, Farrell et al (2006) reported that patients are often hesitant to ask GPs for advice relating to return-to-work.
A survey study of GPs' perceptions of their training needs - from one NHS Scotland Health Board - in relation to employability and vocational rehabilitation requirements of their patients, using a self-completion questionnaire, demonstrated that that general practitioners require further training to improve their ability to manage the vocational rehabilitation of their patients and provide competent advice about their fitness-for-work (Demou et al 2014). Categories in which GPs expressed the most training needs were 'Training needs related to Case/Condition Management', 'The Biopsychosocial Model', 'Legal & Ethical Issues associated with Employment and vocational rehabilitation', and 'Management Training' (Demou et al, 2014). The survey results also demonstrated that GP training does not appear to fully cover the practice of working with professionals outside the clinical sphere. The need for improved collaboration between different professional groups has been recognised with the aim of promoting a more holistic approach at improving health care, job retention and return-to-work following sickness (Sikorski et al 2012; Anema et al 2006; de Stampa et al 2006; Morales-Asencio et al 2008).

REFERENCES


14.6 What is the best way to encourage clinicians, allied health professionals and commissioners of health and other services to promote work as a health outcome?

There is clearly a relationship between work and health, but this does not imply that work is a health outcome in and of itself. If someone is well enough to return to work, this may confer
further health benefits (McKee-Ryan et al 2005). However, returning to work whilst unwell does not imply that the individual has recovered from their health problem. Indeed, there is evidence that attempting to return to work before one has fully recovered from a health condition has negative impacts on health and productivity, and leads to higher future levels of sickness absence (Gustafsson & Marklund 2011, Bergström et al 2009). Furthermore, attending work while unwell has serious economic impacts; it is estimated that the costs of presenteeism arising from reduced productivity are between 1.5 and 2.6 times those of absenteeism (ERS 2016). Crucially, there is strong evidence that while employment in general may be health-promoting, precarious or insecure employment is at least as damaging to health as unemployment (Kim & von dem Knesebec 2015, Butterworth et al 2011, Butterworth et al 2013, Scott-Marshall & Tompa 2011).

Given that a large and increasing proportion of the working-age population are in precarious employment (ONS 2016, CAB 2016), the potential for negative impacts on health is a serious issue which must be considered when discussing return to work with people with disabilities or health problems.

The causal relationship between precarious employment and health is bi-directional; people with health problems have an increased likelihood of moving into precarious employment (Dawson et al 2015), and precarious employment has negative effects on health independently of any existing health conditions (Scott-Marshall & Tompa 2011). Working conditions associated with precarious employment such as job insecurity and low autonomy are strongly linked with deteriorations in health (Scott-Marshall & Tompa 2011, Goh et al 2015). Unfortunately, the type of employment available to people with health problems who move into work is frequently at the lower end of the jobs market (Webber et al 2015). The evidence on the effects of conditionality and sanctions suggests that while exits from benefits are increased, this is very often into low quality, temporary employment (Finn & Casebourne 2012, Griggs & Evans 2010, Wu et al 2014). Thus, conditionality risks pushing people with health issues into precarious employment, which may further damage their health. For people in poor quality jobs, there is evidence of a cycle of moving into unsuitable, precarious work whilst still unwell, leading to a worsening of health and eventual involuntary job loss, either through inability to maintain employment or dismissal for taking sickness absence (Shildrick et al 2012).

REFERENCES


When was the response submitted?
17/02/2017

Find out more about our research in this area

Welfare reform and health:
http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/mrccsosocialandpublichealthsciencsu nit/programmes/policy/

Employability services for disabled people:
http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/mrccsosocialandpublichealthsciencsu nit/programmes/complexity/

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