

Editorials

A new therapeutic intervention

Alan Cohen FRCGP

Editor, *Primary Care Mental Health*, Professor of Primary Care, The Sainsbury Centre for Mental Health, London, UK

Over the last few years, there has been increasing interest in understanding the role that work can have in the recovery, and management, of people with mental health problems. Although there had been work undertaken for many years before this, the publication from the Office of the Deputy Prime Minister on Social Exclusion, brought together and summarised a lot of the data on the extent of unemployment amongst people with a mental illness, and some examples of best practice to improve their work opportunities.¹

In 2004 Lord Layard produced a report for the Government on mental illness and unemployment, that resulted in a Labour Party manifesto promise:²

Almost a third of people attending GP [general practitioner] surgeries have mental health problems, and mental health occupies approximately one third of a GP's time.

So we will continue to invest in and improve our services for people with mental health problems at primary and secondary levels, including behavioural as well as drug therapies.

Labour Party Manifesto

At the inaugural Sainsbury Centre Lecture, Lord Layard said:³

If you ask who are the most unhappy people in our society, the answer is the mentally ill. It is not the poor. You can see this from the National Child Development Study which shows that unhappiness is three times more closely related to mental health (measured ten years earlier) than it is to poverty (measured today). The cost to the economy in terms of lost output is around 2% of GDP [gross domestic product] and the cost to the Exchequer is similar – including some £10 billion spent on incapacity benefits and some £8 billion on mental health services.

At present most of public expenditure on mental health goes on people suffering from psychosis – who are roughly a quarter of a million people. But at any one time there are a million people suffering from clinical depression, and another four million

suffering from clinical anxiety states. For these groups, the depressed and the fearful, there is almost nothing except a few minutes with the GP and some pills. Many of these people do not want pills but they do want psychological therapy. According to the Psychiatric Morbidity Survey under a half of all the people suffering from depression were receiving any kind of treatment, and under 10% were receiving any kind of psychological therapy. For people with anxiety each of these figures should be halved.

Other statistics presented in his report to the Government make interesting reading:²

- 38% of all people on Invalidity Benefit have a mental health disorder, amounting to nearly 1 million people
- there are more people on Invalidity Benefit for mental health reasons, than there are unemployed
- less than 10% of people on Invalidity Benefit for mental health reasons are in touch with specialist mental health teams
- less than 5% of people on Invalidity Benefit for a mental health reason who have been off work for more than 12 months ever return to work.

Other work demonstrates the positive effect of employment on mental health, while unemployment has been found to adversely affect mental health.^{4,5} People with mental illness who are employed have significantly higher levels of self-esteem and also value work more highly than unemployed people with mental illness.⁶ Employed individuals reported that work was both a distraction from symptoms and a means of managing them. Furthermore, while mental health services seldom regard work as a health issue, use of support services and periods of ill-health decline when a person is at work.⁷

Elsewhere in this journal, papers describe in detail some of the issues associated with sickness certification, and mental illness. There are also a number of reviews, and other references that are included at the end of this paper to supplement the information available.

What can be done about helping people return to work? Quoting again from Lord Layard's lecture:³

So we desperately need a better NHS, delivering more help and understanding to patients. But for many patients, work is also a major route to recovery. And as taxpayers who pay for Invalidity Benefits, we can all say amen to this. There are at least three obstacles to overcome. First, doctors often find it easier to counsel against work: they do not have time to advise on employment problems. Second, the benefit system (at least until recently) has been a real problem: what if the job doesn't work out? And finally, employers and Job Centres have not wanted to know.

But the government, with immense courage, is trying to tackle these problems through its Pathways to Work pilots. When someone comes on to Invalidity Benefit, he sees an employment adviser once a month in months 3–8 for a work-focused interview. And the NHS has to offer him training in 'condition-management': how he would manage his condition if he was going out to work. Moreover GPs are lectured on the merits of work.

The result has been astonishing. In the pilot areas, the exit rate of people for Invalidity Benefit within the first 6 months of being on it has increased by one half – one of the most successful experiments I know of. On any assessment the economic benefits exceed the costs. The scheme should clearly go national. And employers everywhere should become more friendly towards the problems of mental illness – keeping people in work as long as possible and giving a second chance to those who have had a break. The Health and Safety Executive has a real role here.

What else needs to be done? We have a strong public health case, and a strong economic case, that of improving the employment opportunities of people with mental health problems. This is recognised by the Government. Have these political drivers been converted into changes within primary care, which is where some of the opportunities lie for change in behaviour?

The Sainsbury Centre for Mental Health, working with the Department of Work and Pensions, has submitted into the Quality and Outcome Framework (QOF) Review, a proposal that a new clinical domain should be included that incentivises a GP to refer people who are off work for mental health problems longer than three months, to a vocational rehabilitation officer. The outcome of this submission is not known yet, as the new QOF for April 2006 has not yet been published.

It would be a missed opportunity if this submission is not developed, since it expands the very effective Pathways to Work Programme, to include all GPs in a way that embeds this change in behaviour

into normal practice. The fear however is that the civil servants who negotiate the QOF review with the British Medical Association (BMA) do not have this as a priority topic. This is an opportunity for primary care to demonstrate that it is part of the wider NHS, and able to deliver holistic care; something that it has always prided itself on, but has been difficult to demonstrate. Without doubt, front-line clinicians wish to do the best that they can for their patients, and the negotiators of the new General Medical Services (nGMS) contract (from both sides of the contract divide) need to be aware of priorities other than those that relate purely to the delivery of primary care. Not to have included a worklessness clinical domain would be a missed opportunity, not for the profession, but for the people for whom we provide care.

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FURTHER READING

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