

**Department for Work and Pensions**

**Research Report No 593**

# **People with mental health conditions and Pathways to Work**

**Maria Hudson, Kathryn Ray, Sandra Vegeris and Sheere Brooks**

A report of research carried out by the Policy Studies Institute on behalf of the Department for Work and Pensions

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# Summary

## Introduction

In December 2007 the Department for Work and Pensions (DWP) commissioned the Policy Studies Institute (PSI) to undertake a qualitative study of how Jobcentre Plus Pathways to Work may better meet the needs of the heterogeneous mental health client group. The research explored the reasons why Pathways has yielded mixed results for clients with mental health conditions and what helps contribute to good outcomes. Fieldwork was carried out between January 2008 and February 2009 across three Jobcentre Plus districts. The research deployed an iterative qualitative research design including:

- 28 depth interviews with a range of Jobcentre Plus and non-Jobcentre Plus staff working with people with mental health conditions;
- 44 depth interviews with mental health clients, purposively sampled to capture a range of characteristics, including voluntary and mandatory;
- strategic and service provider workshops bringing together the different stakeholders (policy and practitioner, Jobcentre Plus and non-Jobcentre Plus) to discuss emerging findings and explore their relevance to improving services for mental health clients.

## Jobcentre Plus and non-Jobcentre Plus staff perceptions and experiences of working with people with mental health conditions and Pathways to Work

A recurring theme from staff respondents was the need to look at individual orientation to work and needs. To work effectively with mental health clients it is important to look beyond their health condition. However, client health is also important as the fluctuations of conditions and possibility of relapse has implications for working with the client group. There were mixed views on the compatibility of National Health Service (NHS) treatment and Work Focused Interviews (WFIs), with Incapacity Benefit Personal Advisers (IBPAs) sometimes

feeling that they were working against General Practitioners (GPs) rather than with them. Some Condition Management Programme (CMP) practitioners were reluctant to accept clients if they were already seeing an NHS counsellor to avoid the conflict that might be generated by multiple interventions. Respondents were often supporting an isolated client group, lacking in confidence. Talking to clients, and listening to what they have to say, was seen as an important enabler of progression. Several discussed how it can take time to build a rapport with mental health clients.

There was a range of views about the potential contribution of Pathways. Some respondents felt that it worked well for mental health clients while others were concerned about the influence of targets on working with this client group. Several health and voluntary sector respondents had a basic understanding of Jobcentre Plus Pathways, with visits from, or collaboration with, Jobcentre Plus staff helping to raise awareness. Constraints on support for mental health clients included:

- insufficient partnership working between Jobcentre Plus staff and other people and organisations;
- the adequacy of training and support for Jobcentre Plus staff;
- the influence of Jobcentre Plus performance targets on implementing client-centred ways of working;
- the persistent stigma surrounding mental health in wider society.

## Mental health clients' attitudes to and beliefs about work

The circumstances of Incapacity Benefit (IB) claims and client perceptions of their readiness for work are both pertinent to their engagement with Jobcentre Plus Pathways to Work. Depression was the most common condition reported by voluntary and mandatory clients in this study, arising for example, from workplace issues and pressures and family or relationship breakdown. Most mandatory clients had concerns about their health which made them question whether they could work. Other concerns included financial insecurity surrounding the prospect of returning to work, the need to find suitable work and work arrangements, a lack of qualifications, perceptions of discrimination and local labour market conditions.

## Client experiences and perceptions of Work Focused Interviews

This research has revealed a wide variety of experiences and views among clients about WFIs. Their experiences ranged from having relatively limited contact: one or two meetings followed by a deferral or by making a successful transition into work, to much more extensive and longer-term contact with an IBPA. Their views varied too, to a large extent reflecting the type of contact they had had: those who

were negative were usually those who had been deferred and had not established a relationship with an adviser, nonetheless, the traumatic experiences recounted by some of these respondents at their initial WFI meeting(s) has implications for whether these clients are likely to be receptive to the programme at a later date when their health or other circumstances have improved. In addition, there was also more general dissatisfaction with specific aspects of the WFI process, including the lack of privacy in WFI meetings and a lack of awareness of the flexibility in scheduling, particularly the first WFI.

Client accounts suggested that maximising their control over the back to work process, good adviser communication skills and the ability to address their health conditions sensitively and appropriately, were three key factors shaping positive advisory relationships. While clients who were positive about their WFI experiences and were receptive to Jobcentre Plus support sometimes had an ongoing relationship with their IBPA after the six mandatory WFIs, others did not, and there were some people whose journeys seemed to have stalled because of a lack of proactive contact from Jobcentre Plus. It thus seems that there was greater scope for more individual tailoring of meetings to clients' needs and circumstances.

## Client experiences and perceptions of referrals and other services

Only a small number of clients reported experience of the CMP. Perceptions were generally positive, with clients relaying improvements to their self confidence, social networking skills and attitude towards working, over and above other treatments they were receiving or had received in the past. However, most participants did not feel their condition had improved to a point where they felt ready for mainstream work. Clients as well as CMP managers and practitioners cited concerns about prolonged waiting times which could detract from the flow of services. The duration and continuation of CMP services were also called into question by key informants as well as by some participants. Negative perceptions of Jobcentre Plus could affect clients' willingness to attend an initial meeting with CMP at the jobcentre. IBPAs referred clients to Job Brokers, with the intensity and duration of support varying widely. Relatively more volunteers reported experiences with Job Brokers reflecting their readiness for work. Job Brokers were instrumental in helping clients find work placements and voluntary work as well as permanent positions.

There were some criticisms of services, including clients feeling pressurised to apply for any job vacancies that were available. Volunteer work was viewed as a practical bridge between paid work and benefits. It could be arranged by an individual's own connections as well as through Pathways. Clients reported similar benefits as those for paid work. There were few clients who took up Permitted Work. In these cases, work of less than 16 hours was preferred, as this fitted in with clients' health conditions and the impact of medication. Pathways clients also

accessed a range of other services which tended to be health-focused rather than work-focused support. It was not uncommon for Pathways clients to be receiving help from multiple service providers. However, partnership working and continuity of services that might contribute to effective case management was limited.

## Issues in entering and sustaining paid work

The therapeutic value of work was evident for several clients. The jobs clients entered tended to be low skilled and concentrated in the service industry. There was no evidence of down-skilling in the sample. Many worked part-time hours of between 16 and 20 hours per week. Initial feelings about starting work were generally positive as clients were achieving a goal they had set for themselves. Those moving into work were invariably voluntary clients. On the whole, clients who had moved into employment reported positive experience of disclosing their mental health condition to their employer. However, their route into employment was not always smooth. Clients who were not working at the start of their research interview conveyed many anxieties about disclosing their mental health histories to potential employers, fearing that they would see them as risky appointments.

Most clients who had moved into employment reported positive experiences of reasonable adjustments, linked to having a positive employer response to disclosure of their health condition. For those not in employment, anxieties about employer willingness and scope to make reasonable adjustments interacted with perceptions of job readiness. Return to Work Credit (RTWC) helped ease concerns about financial stability, particularly in the transition from benefits to wages and tax credits. Contact with In-Work Advisory Support was rare and there was little experience of other in-work supports available through Pathways. Clients reported on the need for employer compassion and flexibility, more provision of information on support services and the need to promote wider awareness of mental illness.

## Understanding people's trajectories

There was a strong association between patterns of participation in Pathways and outcomes. The facilitators of positive Pathways journeys included:

- getting the timing right for intervention;
- the importance of long-term support and case management and the right combination of support;
- support outside Pathways, including counselling and talk therapies, opportunities for group interaction and the presence of support workers;
- GPs embracing the ethos of Pathways;
- the presence of informal social networks of friends, particularly family, contributing to health improvements, practical and emotional support.

## Conclusions and policy implications

Many clients were satisfied with the help they received from Jobcentre Plus Pathways, though importantly, many mandatory clients felt that the opportunity to participate had not come at the right time for them. This was in contrast with voluntary clients who had experienced a health improvement and then felt better able to engage with Pathways and make the transition into work. Amongst the service gaps identified by clients was a need for more guidance and information about managing the transition to work, saving and budgeting and increased proactive contact at the end of the series of six mandatory WFIs, even for those further from work who still have health issues to address. There was also support for the development of a mentoring system where new clients could interact with former clients and learn from success stories. The range of suggestions for improvement to Pathways emerging in this research were wide-ranging, and included:

- a desire for more positive publicity about Pathways;
- a plea for greater empathy, understanding and tailored provision from IBPAs, including issues around training and support for IBPAs;
- better communication and information exchange between IBPAs and health professionals and better coordination of services;
- more private meeting rooms;
- choice of group or one-to-one sessions in training and counselling services;
- a need to improve availability of Jobcentre Plus interpreting support;
- flexibility in WFI and referral appointment dates;
- a wish for shorter waiting lists for CMP, skills training and NHS treatment.





# 1 Introduction

## 1.1 Background to the research

Mental health problems are widely recognised as a major cause of ill-health and sickness absence in the UK (Layard, 2004, 2006; SEU, 2004; Grove *et al.*, 2005) and people with mental health problems are over-represented among the unemployed and economically inactive. The Black Review (2008) of the health of Britain's working-age population has drawn further attention to the fact that the number flowing onto incapacity benefits remains high. In addition to those whose primary reason for claiming is a mental health condition, there are a large number of people who develop secondary mental health problems, such as reactive depression, low self-esteem or anxiety, following a prolonged period of ill-health and worklessness. For other clients, mental health problems are associated with other issues, such as problematic alcohol and drug use.

Waddell and Burton (2006) synthesised strong evidence that work can be therapeutic and reverse the adverse health effects of unemployment, in other words that work is generally good for well-being. It is now a well established research finding that people with mental health conditions '*are freer of symptoms and less prone to relapse if they have some constructive work activity to fill their days*' (Grove *et al.*, 2005: xvii). In the field of mental health there is also a rethinking of recovery that is gaining ground, '*seeing work as a significant stage in the journey to recovery, rather than recovery as a necessary precursor to work.*' (Secker *et al.*, 2005: 65)

The original design of Pathways was intended to screen in those with 'mild to moderate' mental health problems, but the extension to existing clients and the introduction of Provider-Led Pathways, and the removal of the screening process from October 2008, has eroded the distinction between this group and those with severe conditions. In reality, this has, from the outset, been less clear-cut in practice than expected.

Throughout the evaluation to date, the complex needs of clients with mental health problems (and the difficulties which Incapacity Benefit Personal Advisers (IBPAs) and other service providers may have in responding to them) have been

highlighted, but there has been no study which focuses specifically on the experiences of these clients. It is this gap which this study proposes to address. This chapter begins by providing a brief summary of the evaluation findings to date on clients with mental health conditions before introducing the research questions and design and outlining the structure of the report.

## 1.2 Evaluation findings to date

### 1.2.1 IBPA perspectives on clients with mental health issues

At various stages of research into the Personal Adviser role and practices, IBPAs have identified clients perceived to have 'moderate to severe' mental health conditions as being amongst the groups who were particularly difficult to progress, and Work Focused Interviews (WFIs) were often waived for this reason (Dickens *et al.*, 2004). This is consistent with survey data on the first seven areas which found that one in five people with mental health problems had no WFI, and a further fifth had only a single WFI (Bailey *et al.*, 2007). However, in a subsequent survey of existing customers in these areas a higher proportion of people with mental health conditions attended three or more WFIs compared with those without such conditions (Hales *et al.*, 2008: 106).

Dickens and colleagues found that the extent to which IBPAs felt able to work with these mental health clients depended on their perceptions of the severity of their conditions, their willingness to engage and the confidence of the IBPA. Where clients were receiving other support such as counselling or psychiatric care, some IBPAs said that they tended to defer until the client was in a better condition to consider work (Dickens *et al.*, 2004) or because of fears of unwittingly causing psychological damage to the client (Knight *et al.*, 2005: 96).

At stage two of the research study on personal adviser roles and practices, IBPAs continued to report concerns about dealing with clients perceived as having complex or severe medical conditions such as depression and a suggestion for improvement was that their training could have included a specific session or sessions on dealing with these cases (Knight *et al.*, 2005: 24). Some IBPAs found it difficult to get clients to open up, particularly those who seemed to see their depression as a personal failure or who refused to consider referral options (Knight *et al.*, 2005: 96). In later findings from qualitative research on the extension of Pathways to Work to some existing clients (Barnes and Hudson, 2006a), IBPAs across the participating districts again raised the issue of high rates of severe and enduring mental health problems among existing clients and emphasised that this was an area where they needed more support. Other bodies have also raised the issue of additional training in mental health issues for Jobcentre Plus staff (Sainsbury Centre for Mental Health, 2007).

Advisers also discussed the ongoing emotional pressure of listening to clients with 'severe' medical conditions, including mental health problems or other difficult and distressing personal issues and experiences. Both IBPAs and work

psychologists felt that there was a lack of support in place to help IBPAs deal with these issues, and workload issues can exacerbate the emotional strain for IBPAs (Knight *et al.*, 2005: 26). One suggestion for improvement was that time be set aside after potentially difficult WFIs for advisers to debrief (Knight *et al.*, 2005: 35). By 2005 there were signs that the Condition Management Programme (CMP) had taken on some of the responsibility for supporting certain clients taking *'some of the burden away from IBPAs'* (Knight *et al.*, 2005). CMP practitioners reported that as much as 80 per cent of the clients they saw had mental health problems, and this group was generally viewed as harder to help. A number of practitioners commented on the difficult circumstances and complexity of clients' lives (Barnes and Hudson, 2006b: 33-4). CMP professionals can also feel ill-equipped to work with people with mental health issues (Barnes and Hudson, 2007: 34).

Where clients are awaiting treatment, such as counselling for a mental health condition, IBPAs often feel that there is little they can do for them, and are likely to defer WFIs (Dickens *et al.*, 2004; Barnes and Hudson, 2006a). Mental health problems can lead to failure to attend Jobcentre Plus appointments and such problems are not always apparent in advance, for instance if this is not the condition noted on the medical certificate (Corden and Nice, 2006a; Barnes and Hudson, 2006a). In rural areas, clients were reported as sometimes being reluctant to attend CMP group sessions, because of concerns about confidentiality; the continuing stigma attached to mental health problems was a particular issue in this respect. In an effort to overcome this barrier there has been some experimentation with a computer-based Cognitive Behavioural Therapy (CBT) programme (Barnes and Hudson, 2006b: 37-8). In recent qualitative research exploring the Pathways to Work sanctions regime, mental health issues emerged as very common. Negative impacts on health were linked to the severity of the financial impact of the sanction and the additional stress and anxiety this caused, an impact that was more common among clients with mental health conditions such as depression, anxiety and panic attacks (Mitchell and Woodfield, 2008).

### **1.2.2 Client perspectives on Pathways to Work**

While the Pathways to Work evaluation has built up a body of information on the experiences of IBPAs in working with clients with mental health issues, to date less research has been undertaken to glean the views of clients themselves, although this is in part being addressed by the client survey work, which is ongoing (Bailey *et al.*, 2007). In addition, some insights have been provided by earlier phases of the evaluation. Clients with mental health conditions were recruited to the qualitative longitudinal panel of Incapacity Benefit (IB) claimants (Corden and Nice, 2006a, 2006b). Pain, fatigue and depression were common aspects of the lives of many people taking part, and medication to control symptoms often had a further effect on memory or concentration, or caused people to sleep during parts of the day. The authors noted that: *'People's different trajectories of recovery of health, deterioration or chronic unchanging conditions, and their different hopes and expectations of such trajectories are key to understanding experience of, and response to, Pathways interventions.'* (Corden and Nice, 2006b:58)

In the study of early findings on the extension of Pathways to Work to existing clients, there was a plea for greater understanding of mental health issues. For example, one client felt that there was a general misunderstanding of depression; with an emphasis on making people better and moving them into employment rather than full comprehension that depression might be a long-term mental health problem (Barnes and Hudson, 2006: 21). Generally, clients have conveyed a sense of employer attitudes and behaviour as a barrier to paid work that Pathways was unable to tackle. There are signs that clients with mental health needs are anxious about employer preconceptions of capabilities and staying power (Barnes and Hudson, 2006a: 19). Both clients and IBPAs feel that additional referral sources are required for people with mental health problems. Clients also express a desire for retraining where a return to previous employment, which may have been complicit in their mental health issues, would be inappropriate (Barnes and Hudson, 2006a: 36).

### **1.2.3 Evidence on what works for clients with mental health issues**

Impact study evidence on the effectiveness of Pathways for those clients who have a mental health condition is mainly positive (Bewley *et al.*, 2008; Bewley *et al.*, 2007; Bailey *et al.*, 2007; Hales *et al.*, 2008). The recent study exploring the impact of Jobcentre Plus Pathways on benefit receipt in the expansion areas (Bewley *et al.*, 2008) found that the programme had a strong impact on reducing claims for incapacity benefits by those whose main health condition was a mental or behavioural disorder over the early months following the start of their claim. The impact was significantly greater than for those with other health conditions.

The existing customer survey (Hales *et al.*, 2008) found that 19 per cent of clients with mental health conditions participated in the choices services. In addition, ten per cent of mental health clients took up CMP compared with six per cent of other customers (Hales *et al.*, 2008: 108). Almost 70 per cent of mental health clients who gave an assessment of WFIs indicated that the interviews had helped them to think about paid work in the future. Major barriers to work reported by clients included poor health, lack of confidence, concern about the number of hours they could work, other attitudes to work and lack of motivation to work.

Qualitative research has demonstrated employment outcomes in individual cases, and has also provided some insight into the low levels of recorded employment outcomes for this group. The CMP practitioners' study provided examples of clients who had been suicidal or self-harming at the start of the CMP programme, and who had not only managed to tackle this issue but had managed to return to employment (Barnes and Hudson, 2006b: 40). Practitioners emphasised that progress needed to be considered relative to the individual's own particular circumstances. Examples were also given of people, such as those who had left work because of stress-induced mental health problems, who needed to make a very gradual return to work if this was to be sustainable over the longer term. One practitioner commented that it was common for clients to move on to Permitted

Work or to begin with a very low number of hours, but this did not show up as an employment outcome in terms of the administrative data. This is borne out by the high use of Permitted Work in the survey data – over 40 per cent of those making use of this provision had a mental health problem (Bailey *et al.*, 2007). Transitions from out of work benefits to paid employment may take several years (Dewson *et al.*, 2004)

The qualitative strand of the evaluation has yielded some evidence on what makes Pathways to Work effective for clients with mental health needs (Knight *et al.*, 2005: 96-7). Explanatory factors for those clients who did progress included:

- an empathetic and understanding IBPA;
- timely advice from experts (e.g. work psychologists, CMP providers);
- CBT element of CMP;
- client motivation/willingness to move forward;
- making use of appropriate referral options.

A study on Social inclusion through Employment Support for Adults with Mental Illness (SESAMI, 2006) reinforces some of these themes. It seems to show that having confidence in your adviser, finding them empathetic, reliable and optimistic are all key elements of success. Negative factors are the attitudes of some others who, for whatever reason (and sometimes with good intentions) cast doubts on the Pathways to Work programme and its likely outcomes – including GPs, psychiatrists, family members and friends.

#### **1.2.4 Achieving sustainable job outcomes for clients with mental health issues**

People with mental health conditions/issues (clinical depression, anxiety, low self-esteem, confidence) are amongst the groups to whom In-Work Support (IWS) provision has been found to be most pertinent. While National Centre for Social Research (NatCen's) recent evaluation of IWS indicates that the biggest impact is on clients with mental health needs, it has yielded little detail on specific conditions. Providers seem to be working more with clients who have depression, anxiety, low self-esteem and confidence issues than with those at the harder-to-help end of the spectrum (Dixon and Warrener, 2008).

Amongst the findings of a recent study of mental health and employment is the need to widen understanding of mental health, with large employers being most aware of a broad range of health conditions. It also suggests a need for early and active involvement by Jobcentre Plus to facilitate returns to work (Sainsbury *et al.*, 2007). Elsewhere, concerns have been raised that Pathways is unable adequately to address one of the key barriers to the employment of people with mental health barriers, i.e. the attitudes of employers. Moreover, the contractual arrangements for Provider-Led Pathways are seen as having the potential to reduce incentives to work with this group (Sainsbury Centre for Mental Health, 2007).

### 1.3 The research aims and questions

The research addressed a number of related questions, in order to explore how Pathways may better meet the needs of the heterogeneous mental health client group. These included:

- What are the reasons why Pathways has yielded mixed results for clients with mental health conditions?
- Where good outcomes in terms of health improvements and employment outcomes have been achieved, what has worked well?
- What other services do people with mental health conditions want/need to help them back to work? Is there local provision that they can tap into to secure this help and support?
- What attitudes and beliefs do clients have about work? Do they feel able to work? How might working improve the quality of their lives? What anxieties do they have about making a transition into paid or unpaid work?
- What attitudes or beliefs do GPs, IBPAs, providers and family and friends have about the appropriateness of a transition to work for people with mental health needs?
- What challenges do IBPAs, CMP practitioners and other people involved in delivering Pathways face in providing services to this group, and what improvements can they suggest?
- How appropriate are mandatory WFIs for this group? What are their experiences of WFIs, including waivers<sup>1</sup> and deferrals?
- Is it possible to assess intermediate outcomes/create targets to better incentivise working with this group?

### 1.4 The research design

The study used a variety of methods, in order to draw on the findings of the evaluation to date and to ensure that the findings met existing gaps in knowledge. It was very much a qualitative study with a focus on generating examples of experience and exploring issues and processes rather than being representative. Clients were sampled to be representative of the range of conditions and characteristics of interest. The core development and fieldwork stages, conducted between January 2008 and February 2009, were as follows:

Stage 1: **Development work** to support the design of research instruments. This included a literature review on mental health and employment issues and secondary analysis of qualitative and quantitative data from earlier stages of the evaluation, to explore mental health issues in greater depth.

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<sup>1</sup> Since the introduction of Employment and Support Allowance (ESA) in October 2008, the ability to waive WFIs has been removed.

Stage 2: **Depth interviews with 28 key stakeholders** were carried out in order to ensure that the study reflected the diversity of issues involved. Three districts were sampled and interviews included Disability Employment Advisers (DEAs), work psychologists, CMP managers and practitioners and IBPAs, mental health services, community and voluntary organisations. Advice was sought from Jobcentre Plus key informants on potential non-Jobcentre Plus respondents (the topic guides used for this research are presented in Appendix A).

Stage 3: **Depth interviews were undertaken with mental health clients.** The 44 clients were purposively sampled to capture the following range of sampling characteristics (see Appendix B for some further detail on the sample):

- mandatory and voluntary clients;
- mental health condition as primary/secondary condition;
- severity of impairment, both less and more severe;
- type of mental health condition;
- gender;
- age;
- ethnicity;
- length of time economically inactive;
- work status;
- with children/childless.

Sampling across the three districts, the localities were chosen to capture a range of rural and urban localities, including areas of ethnic minority concentration. To facilitate the sampling of clients who had been on IB for varying lengths of time, the fieldwork area included an original Jobcentre Plus Pathways area as well as two expansion areas. The length of time that had elapsed between Pathways participation and the research interview varied across clients within the sample. This sometimes exacerbated issues of client recall of events and the timing of those events. (Issues in sampling and interviewing the mental health clients for this study are discussed in Appendix C.)

All interviews were conducted using a topic guide agreed with the Department for Work and Pensions (DWP), and were digitally recorded and transcribed verbatim. Initial analysis of key informant data was undertaken using *Framework*, a method facilitating the systematic analysis of qualitative data. The interviews were analysed with the assistance of an NVivo software analysis coding frame developed in the earlier stages of the study, to check consistency and dissonance with earlier concepts and findings, and to develop discussion themes for the fourth stage of the study.

Stage 4: **Finally strategic and service provider workshops** brought together the different stakeholders (policy and practitioner, Jobcentre Plus and non-Jobcentre Plus) to discuss emerging findings and explore their relevance to wider Jobcentre Plus agendas around health and wellbeing, as well as identifying specific ways in which Pathways can be tailored to better meet the needs of clients with mental health problems. One strategic level seminar was held presenting the emerging findings in some detail and inviting comments, questions and discussion. In addition in each of the three participating districts, service provider workshops were held again to present emerging findings and to provide participants in the research and other interested stakeholders with an opportunity to discuss them. The emphasis was placed on stakeholder participation in workshops to maximise potential for their engagement in the research and feed into the conclusions and recommendations chapter of the report.

## 1.5 Outline of the report

Chapter 2 draws on data from the key informant interviews to explore Jobcentre Plus and non-Jobcentre Plus staff perceptions and experiences of working with people with mental health conditions and Pathways to Work.

Chapter 3 draws on the client interviews to provide an overview of mental health clients' attitudes to and beliefs about work. It introduces a heterogeneous sample of people who have made claims for incapacity-related benefits in a range of circumstances. The chapter reviews the accounts they gave of their job readiness, in so doing drawing out issues they felt were pertinent to their prospects of returning to work.

Chapter 4 takes a close look at clients' experiences and perceptions of WFIs. It includes discussion of their first contact with Pathways to Work, issues in subsequent contact and factors at play in the quality of adviser-client interactions.

Chapter 5 reviews clients' experiences and perceptions of referrals and other services. It considers support provided by the CMP, job broker services, work opportunities and other services accessed.

Chapter 6 examines client issues in entering and sustaining work. It provides an overview of the nature of employment entered and clients' feelings and expectations. This chapter also considers perceptions and experiences of discrimination and disclosure, in-work support and reasonable adjustments.

Chapter 7 considers the factors at play in facilitating client outcomes. In so doing, the chapter maps client trajectories and outcomes.

Chapter 8 reviews some of the main themes arising from the research and considers the implications for policy through consideration of suggestions for improvement to Jobcentre Plus Pathways to Work outlined by the research participants.



Implicit in the chapters to follow is a dual model of disability (Berthoud *et al.*, 1993; Roulstone, 1998; Shakespeare and Watson, 2002). Roulstone (1998: 9) is among the writers who express concern that the separation of impairment and disability in the social model of disability can mean that important nuances in their relationship may be underplayed. He illustrates this by noting that a social barriers model needs to acknowledge that some disabled people will have absorbed able-bodied ideologies that present impairment as a personal tragedy. It has also been argued that people with mental health conditions can come to see it as a defining aspect of their core identity, reinforcing marginalisation and social isolation (Thornicroft, 2006: 155). Personal experience can have an impact on mental health client choices through negative experiences leading to the '*anticipation of failure*' (Thornicroft, 2006). Latterly the bio-psychosocial model of disability has been put forward as a framework to bring the medical and social models of disability together. This report recognises that both client health and societal barriers recognised in a social model of disability can interact and impact on individual actions and opportunity structures, including interactions with and journeys through labour market support programmes such as Pathways to Work.



## 2 Jobcentre Plus and non-Jobcentre Plus staff perceptions and experiences of working with people with mental health conditions and Pathways to Work

### 2.1 Introduction

This chapter introduces a range of themes arising from the initial key informant interviews with Jobcentre Plus and non-Jobcentre Plus staff. It begins by exploring the question of whether mental health clients form a distinctive client group for Jobcentre Plus Pathways to Work. Next it considers several issues in working with this client group: the compatibility of Pathways participation and the supporting of an isolated client group lacking in confidence. The chapter then moves on to consider the value of work in promoting well-being and Jobcentre Plus Pathways to Work. Finally it considers some of the main factors that may be constraining support for mental health clients in their potential journeys towards employment. The themes suggest the value of drawing on a dual model of disability in understanding the experiences of this client group, with both health and the configuration of social arrangements being relevant.

## 2.2 Mental health clients: a distinctive client group for Jobcentre Plus Pathways?

As noted in the previous chapter, this research was in large part generated by a desire to understand why Jobcentre Plus Pathways to Work has yielded mixed results for mental health clients. With this in mind, staff respondents were asked for their views on whether mental health clients are a specific group or some are harder to help than others. There were mixed views on this issue from both Jobcentre Plus and non-Jobcentre Plus respondents. However, a recurring theme was the need to look at individual orientation to work and needs. Several respondents reported that support needs tend to be dependent on the individual and not the health condition(s) they might have. To work effectively with clients it is important to look beyond their mental health condition. For example, whether they are young or older people, have childcare responsibilities, are refugees with English for Speakers of Other Languages (ESOL) needs, have had a long period out of work, are homeless or on probation, have a strong work orientation; all these characteristics have the potential to be pertinent factors in support needs of the individual client.

This is not to imply that mental health is unimportant. Respondents explained how mental health clients often have a fluctuating condition that varies over time, rather than the prospect of a return to the same level of wellness. In the words of one Disability Employment Adviser (DEA), it's *'not anything that will heal'*. With milder conditions, there is a strong possibility that symptoms will disappear. The fluctuation of conditions and possibility of relapse has implications for working with this client group, a theme explored from the client perspective in Chapter 4.

Respondents saw the easiest to help clients as those with a reactive mental health condition that had been acquired through a lengthy period out of work. While Jobcentre Plus Pathways is targeted at clients with mild to moderate conditions, Incapacity Benefit Personal Advisers (IBPAs) find themselves trying to work with clients with severe conditions. There was a consensus that it is those clients with more severe mental health conditions and for whom that condition is the main barrier to work that are the hardest to help, albeit that these clients were less likely to be screened into Pathways<sup>2</sup>.

As will be seen in the next chapter, some of the views on work readiness expressed by mental health clients with more severe mental health conditions reinforced this theme. To reiterate, severity of condition is not a barrier to engaging with Pathways to Work per se, as illustrated by the following quotation:

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<sup>2</sup> The screening tool was removed in October 2008.

*'We've got people who initially look from the records that...they've got maybe medium or severe mental health issues, when you look at them you can have two that are very similar but you can see from one record that the person's actually been looking for work previously, has been a bit more proactive and it might be a case that you...might waive them out of the process, but because of what they've actually been doing you can bring them in, so you can have two people with what appear to be the same conditions but...you've got to look at the wider picture.'*

(Key informant, Jobcentre Plus)

Clients with ESOL needs were also presented amongst the more challenging to work with due to the impact of language barriers. In two areas, both Jobcentre Plus and non-Jobcentre Plus staff respondents outlined the challenges posed in working with refugee and Asian communities with language support needs. In addition a voluntary sector discussed the multiple discrimination that clients experienced and for which they needed support. Some black and minority ethnic (BME) clients with mental health conditions were felt to need specialist support but waiting lists were an issue. Language support needs, and the quality of services to support them, can hinder interactions with employment programmes, a point reinforced by other evaluations (Barnes *et al.*, 2005; Hudson *et al.*, 2006).

## 2.3 Working with mental health clients

Respondents across a variety of Jobcentre Plus roles discussed how mental health clients have often been out of work for a long time and this can have a number of implications for working with them. Fear of the prospect of a return to work is perceived as a common feeling. Sometimes clients are not receiving medical support from a GP or are on a waiting list for treatment. Clients can need to have their mental health conditions stabilised before they are able to engage in a meaningful way with the Pathways to Work programme of support. This raises the issue of whether National Health Service (NHS) treatment is compatible with Pathways engagement.

### 2.3.1 The compatibility of NHS treatment and Pathways engagement

All Jobcentre Plus respondents had views on the compatibility of NHS treatment and Work Focused Interviews (WFIs). The views of Personal Advisers were mixed. Some spoke of advising their clients to tell their GP or therapist about what help they were receiving through Pathways. Several respondents clearly perceived that they were sometimes working against GPs rather than with them and expressed a desire for more sharing of information on specific clients. NHS treatment can be grounds for deferral and some clients feel that they are having too many NHS appointments to be able to absorb further commitments linked to involvement in Pathways. However, some clients are seeing crisis teams (Community Practice Nurses (CPNs)/psychiatrists) who have advised them that work can help. There

was some feeling that if a client is seeing a CPN (an emergency measure) they should not be engaging with Pathways. A particular source of concern amongst Personal Advisers was that in seeing clients with CPN support they might undo the CPNs' good work, while mental health workers in the health and voluntary sectors feared that clients might be forced into work when they were not well enough. This is indicative of a possible fine line between pressurising clients and not pushing them enough.

The interaction of medication with the timing of WFIs was an issue. For example, medication could affect engagement with the adviser whilst clients not taking their medication in order to feel able to attend an appointment could also become a cause for concern. Respondents commented on how clients forgetting appointments could contribute to high fail to attend rates amongst this client group.

Some IBPAs indicated that it was their standard practice that any WFIs should be deferred until clients finished treatment such as therapy or counselling. Condition Management Programme (CMP) respondents often had particularly strong views on the compatibility of Pathways participation with NHS treatment. Like the IBPAs, some CMP practitioners were reluctant to accept clients if they were already seeing an NHS counsellor as they want to avoid the conflict that might be generated through multiple interventions. Indeed, CMP managers and practitioners emphasised that parallel NHS treatment and Pathways CMP Cognitive Behavioural Therapy (CBT) (which is very work-focused) can be inappropriate. The rule of thumb appeared to be that where there are different treatment goals CMP participation would be deferred.

### **2.3.2 Supporting an isolated client group often lacking in confidence**

Mental health clients can find it difficult to mix socially so that just being in a room with other people, for example on a training course (accessed as part of the Pathways Choices package of support), can be a challenge.

On making contact with the Pathways programme of interventions many mental health clients often just want and need someone to talk to, as found in earlier studies (for example, Barnes and Hudson, 2006). With long waiting lists for counsellors, client options for securing the social and psychological support that they need can be limited, a theme reinforced by the comments of the following voluntary sector respondent:

*'I know that I see a lot of customers with mental health conditions and they're on waiting lists for months and months and months. And they need support now, but they just don't get it. Or I have seen customers in the past who have seen a variety of different psychiatrists, and each psychiatrist has given them a different diagnosis of what they have. So some people come into me with six or seven diagnoses. And I think there needs to be more consistency in the follow-up, because I think a lot of people do tend to fall through the cracks...'*

(Key informant, voluntary sector)

Talking to clients and listening to what they have to say, was seen as an important enabler of progression, IBPAs and others noting the importance of clients realising that they are going to be supported and not left to make a journey through provision on their own. A DEA also commented that the hardest-to-help clients are those who are not open about their mental health condition and open about the impact it has on their everyday life. This is an important point which reflects both the stigma that continues to be attached to mental health conditions in wider society which can be internalised (Thornicroft, 2006: 152) and the importance of working in a manner that builds client trust of support workers.

Several respondents discussed how it can take a while to build a rapport with mental health clients. A related, and recurring, theme was the need for these clients to take small steps to get into or return to work. Pathways was described as empowering for mental health clients, especially when they live alone. This is a point linked to the circumstances of claims for Incapacity Benefit (IB) as well as the range of factors at play in a client's 'job readiness' by the time that they enter Jobcentre Plus for their first WFI. There are often multiple, interacting enablers of and barriers to a positive engagement with Pathways provision.

## 2.4 The value of work in promoting well being and Jobcentre Plus Pathways to Work

Jobcentre Plus staff had a range of views about the potential contribution of Pathways. Positive views conveyed the feeling that Pathways services work very well for people with mental health conditions. As noted in Chapter 1, clients with mental health conditions are more likely to take-up CMP. CMP and CBT were perceived as very helpful interventions for those who were ready to benefit. Respondents often enthused that Jobcentre Plus is finally delivering something more for this client group, reaching out to people who would otherwise fall through the net. For example, providing more support for lone parents with depression and signs of building of trust with the Asian community. There was a group of respondents with more mixed views, which included staff concerned about the influence of targets on working with this client group. They described how clients' referral options had grown, but as implied earlier were, for example, concerned about *'referring people to things that maybe they're not ready to be referred'* and some clients being more severe than IBPAs can handle. Several staff were particularly negative about Pathways, and the capabilities of some mental health clients. This is illustrated by the adviser who said: *'if the medical profession can't help people to move on from their condition, we are limited as to what we can do to help them into work'*.

Several health and voluntary sector key informants had a basic understanding of Jobcentre Plus Pathways. What awareness there was had been raised through visits from, or collaboration with, particular Jobcentre Plus staff, or in some instances from clients who they had referred to Jobcentre Plus. Some information had also

been gleaned from the Jobcentre Plus website. One or two respondents were reluctant to give a view on the value of Pathways as they knew so little about it. However, those who knew more about the provision tended to empathise with the basic philosophy: that work can promote well-being and people can be supported into work. Respondents appeared keen for further information on Pathways provision, for example to help explain its value to their clients:

*'...from my point of view, the mental health team, sort of telling us what [the Jobcentre Plus] role is, what exactly is happening and stuff like that, I think that would go a long way. I know sort of a lot of the other sort of organisations do do that, and then we tend to work really well, and then we're more informed which means then the patients are more informed.'*

(Mental health nurse)

*'I've been seconded from the PCT to look at how we can improve the physical health of people with mental health problems. So although I'm looking at the...health promotion side, wellbeing, some of this comes into it because people only get motivated to look after themselves if they've got a purpose. And very often it's actually getting up in the morning to go to work.'*

(Occupational Therapist, Community Mental Health Services)

This mental health sector worker felt that healthcare provision was out of step with support needed to put mental health clients back to work.

## 2.5 Constraints on support for mental health clients

Respondent narratives indicated a perception of several constraints on their work with mental health clients. Below we present four of the main emerging themes. These include concerns about:

- insufficient partnership working between Jobcentre Plus staff and other people and organisations;
- the adequacy of training and support for Jobcentre Plus staff;
- the influence of Jobcentre Plus performance targets on implementing client-centred ways of working;
- the persistent stigma surrounding mental health in wider society.

### 2.5.1 Partnership working between Jobcentre Plus staff and non-Jobcentre Plus people and organisations

In keeping with the need to meet individual client needs, which could be multi-faceted, respondents discussed how it is a network of support that gets mental health clients into work. Partnership working is important in this and somewhat ad hoc and constrained by lack of resources, including time (see also Nice *et al.*, 2009). Work psychologists discussed the importance of follow-up with partners



describing how weak partnership working affects the standard of client care and ability to assess that they are getting the right support. For example, DEAs have referrals from a range of organisations but still highlight difficulties in obtaining named contacts and having sufficient time to network in the context of targets. There was some feeling that after an initial drive to raise awareness and build understanding of Pathways amongst providers and practitioners this has 'slipped'. Confidentiality issues were also presented as inhibiting partnership working.

More information from GPs about their patients would be useful for the Jobcentre Plus advisers working with them, but it is important that any information exchange respects confidentiality. In addition, a Personal Adviser reported that she would ask clients to give her phone number to support workers to try to make contact:

*'I don't know whether that's right or wrong what I am doing, to me, it's, if we all work together surely it's better than coming to see me once a month and then going off and seeing the mental health worker once a month, because I'm not convinced that they would let them know that they are working with me.'*

There were also some concerns that Jobcentre Plus has a poor reputation amongst mental health service providers, for example in one area an IBPA visited a voluntary organisation to find out more about its services and found that he was 'interrogated' on why his clients were being sanctioned. The need for greater GP involvement in Pathways to Work was raised by several respondents. Implicit was a wish for GPs to encourage a focus on work as a positive step, rather than health as a barrier. For example, work psychologists discussed how there was too much focus by GPs on what clients can't do, conflicting with the Pathways ethos of looking at what clients can do. They argued that GPs need to be educated to put a positive spin on Pathways services. Several Personal Advisers felt that GPs should be telling their patients about Pathways to Work and that it can be confusing for GPs and advisers to be presenting contrasting points of view on client readiness for engagement in Pathways. IBPAs perceive that the main gap in partnership working is with other NHS staff. Amongst participants in this study, only patchy connections seem to be being made to inform work with clients. The IBPA reporting the most contact had experienced some GPs/therapists recommending CMP to their patients and a couple of GP surgeries have phoned to say they have a patient interested in CMP. Most contact with NHS practitioners appears to be limited to CMP with both managers and practitioners reporting having contact with GPs on receiving referrals and those with moderate to severe health conditions are referred back to their GP. There was some concern that GPs are not seeing clients as often as they should.

In some cases and with client consent, work psychologists identify whether clients are working with any health professionals and get in touch with them. For example, one work psychologist asks for progress reports on clients working for an NHS outreach centre. They have experienced negative responses from Community Mental Health Teams that Pathways is 'meddling' with patients. While they have done some promotional Pathways work with them, and this has helped, they

feel that more work needs to be done to tackle negative views which can be transmitted to a client mindset that they can't work. To give more time to this kind of collaborative working, bringing it firmly into Department for Work and Pensions (DWP) and Jobcentre Plus ways of working, would be seen as a forward step. As implied earlier, health treatment can be the most prominent client need or one of several needs. The CMP is focused on addressing barriers to work and where clients need NHS psychological treatment this needs to be accessed.

### **2.5.2 Training and support for Jobcentre Plus staff**

Reinforcing themes from earlier Pathways evaluations (Knight *et al.*, 2005) concerns were expressed by staff in a variety of Jobcentre Plus roles around the adequacy of training for working with mental health clients, particularly for personal advisers. While it was never envisaged that Personal Advisers would be 'health experts', there was a feeling that Jobcentre Plus has not sufficiently acknowledged the significance of working with clients who are less visibly disabled. While advisers have intensive training in preparation for their role, there was widespread feeling that training on dealing with mental health issues is too little and not sufficiently ongoing. Advisers report a skewing of training to process issues (how to interview people and how to get the best out of them) but no training on how to cope with difficult situations.

There are additional layers of support in place, though this was not consistently reported. Some advisers have received written guidance on mental health symptoms but there is a lack of guidance on how to deal with mental health clients. Talks and short courses given by work psychologists and/or CMP therapists were also reported, but these are seen as too short in duration. While there was some use of the internet to find out about conditions before seeing a client, not all advisers are happy to access information in this informal way – though some have found mental health condition templates on the internet helpful. There is a feeling that training and support has not kept pace with the number and heterogeneity of mental health clients. Personal Advisers have not expected to see clients with more severe conditions and some report feeling nervous in working with them and insufficiently qualified to help them. Concerns include working with suicidal clients, for example, how to cope with the knowledge that one of their clients has killed themselves. Being able to talk about experiences working with mental health clients in a context where there can be some very distressing cases was a theme emphasised by work psychologists.

Advisers can phone Jobcentre Plus Care First to obtain counselling if they are finding it difficult to cope. It is beyond the scope of this research to comment upon how widely known or used this is<sup>3</sup>.

### 2.5.3 Jobcentre Plus performance targets

Respondents were asked whether client referrals to provision were being made because they are appropriate and because the client agrees. While some respondents emphasise that referrals are being made because they are appropriate and the client agrees, IBPAs frequently expressed concerns about the growing target culture that governs their work within Jobcentre Plus through an Adviser Achievement Tool (AAT)<sup>4</sup>. In so doing, they discussed targets for the number of WFIs conducted, referrals to provision and job submissions. Many were at pains to emphasise that the making of appropriate referrals is important and that a 'customer focus' is a valued ethic instilled by IBPA training. However, they were signs of concerns that focusing on targets has the potential to change this ethos and indications that this is happening already. The target of getting 60 per cent of clients into work does not sit well with the mental health client group as most, as noted above, are a long way off from work. Respondents described how targets have a bearing on every WFI, leading to giving people information that they don't need, for example, telling clients about better off calculations when they are not ready for this information. The WFI quota for the number of interviews to be conducted means that IBPAs can't give extra time to clients who need it. Some clients don't want to be referred on and just want someone to talk to – and they aren't getting support because of time constraints in IBPAs responding to this need. Furthermore, there were reports of the submission of mental clients to inappropriate jobs in order for IBPAs to meet their targets and a related concern that Jobcentre Plus does not value the time staff spends with providers and employers to ensure that support is in place. The potential for targets to lead to IBPAs pushing mental health clients too hard was also a fear expressed in the context of IBPA reports of the impending introduction of targets for referring clients to providers, monitored through an AAT.

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<sup>3</sup> It may be that other existing training tools are not widely known and sufficiently drawn on by staff. In 2008 Jobcentre Plus introduced a new training product called *Introduction to working with customers who have mental illness*. This provides a basic introduction to mental illness for advisers working with mental health clients. Learners gain a sound, preliminary understanding of mental illness. Advisers who have undertaken the specialist IBPA training will have covered this topic.

<sup>4</sup> Since the research interviews, Jobcentre Plus has undertaken a review of the AAT and this is under continual review. The AAT states that 60 per cent of WFIs should result in positive activity. Jobcentre Plus recognises that confusion surrounds the practice and meaning of targets.

It was not only IBPAs who expressed these concerns about a growing targets culture; DEAs and work psychologists raised similar fears. For example, a work psychologist commented on how support given to clients was too driven by contracts, through advisers having targets to refer to particular services. DEAs also have targets for getting clients into work and conveyed how they were mindful of issues around the sustainability of employment:

*'I'd rather get ten people into work who sustain that job, than 25 people into work who are back on benefits within two weeks.'*

(Disability Employment Adviser)

#### **2.5.4 The stigma society attaches to mental health conditions and the underestimation of capabilities**

There is considerable evidence that stigma and discrimination is both a consequence of mental illness and a barrier to provision of support (Thornicroft, 2006). Medication and counselling have sometimes been declined to avoid the stigma that can be felt to be attached to asking for help (Nice *et al.*, 2005). A commonly held view amongst staff respondents was that mental health clients face considerable discrimination on a variety of levels. Employees, employers and health professionals, are all amongst those who have a role. Mental ill-health was also perceived to interact with other characteristics associated with labour market disadvantage. The following quotations are illustrative:

*'The main barrier is stigma, that's about lack of understanding by the employee, sometimes it's about health professionals always...concerned about customers', clients' ability to cope...work doesn't have to be 37.5 hours per week, Monday to Friday, you can do two hours a day but you've got to have the foresight and the willingness of the employer to engage in that.'*

(Key informant, CMP)

*'Black people have to prove themselves twice as hard. If you have a mental illness you have to work three times as hard.'*

(Key informant, voluntary sector)

This concern about stigma and discrimination is a recurring theme to which we shall return both in the next and later chapters.

# 3 Mental health client attitudes to and beliefs about work

## 3.1 Introduction

The circumstances of Incapacity Benefit (IB) claims and client perceptions of their readiness for work are both pertinent to their engagement with Jobcentre Plus Pathways to Work. This chapter explores both of these themes, and in so doing provides insights into client mindsets on their prospects of working in the future at the time of their interview. At the time of interview, almost half of the clients reported that they had engaged with Pathways in the last year. A smaller proportion had engaged with Pathways in the last two to three years. Most clients interviewed appeared to have at least moderate mental health conditions. Several clients were in receipt of Jobseeker's Allowance (JSA) at the time of interview, two of whom were appealing. This chapter does not report on the clients whose contact with Pathways was unclear at the time of interview.

## 3.2 The circumstances of Incapacity Benefit claims

Depression was the most common condition reported by both mandatory and voluntary clients and the reason for claiming IB. Depression arose in a number of contexts including:

- as an outcome of physical impairment(s);
- as a response to bereavement;
- workplace issues and pressures;
- family and relationship breakdown;
- refugee resettlement and transition.

In addition, a small proportion of respondents had childhood mental health conditions which continued into adulthood. Others had a mental health condition linked with substance misuse.

### 3.2.1 Secondary mental health conditions

Some mandatory clients highlighted their experience of reactive depression as a response to physical impairments. This was noticeably the case among persons who were in the 30s to 50s age group category. The range of health conditions reported by Client 7 included diabetes, thalassemia and internal complaints. She attributed her depression to just staying at home:

*'It's difficult because it's like a vicious circle isn't it...you feel ill and then you end up staying home and then when you end up staying home you're not working, you're not meeting people so you feel depressed.'*

(Client 7, female, age 50s)

### 3.2.2 Bereavement leading to depression

For some clients depression occurred after the death of a family member or friend. Client 4, a voluntary client reported experiencing depression after his parents died in quick succession behind the other. Depression soon led to agoraphobia. He explained:

*'My mother and father passed away one after the other and this sort of wrecked me life for a long time...I was on anti-depressants for years and years.'*

(Client 4, male, age 50s)

Similarly, Client 7, a voluntary client in her 50s and who had never before claimed IB, recalled becoming depressed when her husband committed suicide. Her life seemed to fall apart:

*'I was drinking more and more, I was turning night into day, I was sitting up 'til two/three in the morning and then staying until about 11 thinking 'there's nothing to get up for...I am still taking anti-depressants.'*

(Client 7, female, age 50s)

### 3.2.3 Workplace issues and pressures

The on-set of depression was also linked to problems in the workplace leading to long periods of sick leave or job exit, in some cases on the advice of their GP. Client 29 had ongoing depression linked to harassment at work. She had been on IB for 18 months but at the time of interview was on statutory sick leave. The client described feelings of worthlessness, lack of confidence and hopelessness that triggered her depression. An Asian client, in his 30s had worked in the mental health sector as a nurse for a number of years, but was sacked. The onset of depression arose from having to come to terms with what had happened to him and having to contemplate doing another kind of job.

### 3.2.4 Family and relationship breakdown

Several respondents described how the cause of their depression was linked to a breakdown in family relationships or the break-up of a relationship with a partner, sometimes involving children. Some with on-going problems such as drug or alcohol misuse. The latter would in some cases surface following the emotional stress of these events. A male respondent, Client 17, described the onset of depression accompanying the breakdown of his marriage which led to a painful divorce and separation from his children. Sometimes relationship breakdown interacted with an existing mental health condition. For Client 31 a bad period in her bipolar mood disorder coincided with a breakdown in a relationship and after repeated periods of sick leave she left her job.

### 3.2.5 Refugee resettlement and transition

There were also examples of depression associated with the context and process of refugee resettlement in the UK. Both experience of labour market disadvantage and cultural attitudes towards depression characterised experiences. Client 41, a Kurdish refugee and lone parent described the frustration of not being able to find a job and lack of support from her own community:

*'The problem is with my community they are not open, no-one talk about individual problems, most of them they pretend they haven't got any troubles...the Arab community like that, they pretend something it doesn't show because they feel ashamed to talk about these things. That's why I felt lonely, I don't know what to do and this make me too much, I can't handle it anymore, make me very deep depression.'*

(Client 41, female, age 30s)

### 3.2.6 Childhood mental health condition which continued into adulthood

One or two respondents recalled their experience of depression was triggered during childhood and continued into adulthood. Diagnosis sometimes came late leaving support needs unmet and allowing the condition to escalate. Client 36, a mandatory client in her 20s could recall experiencing a recurring problem of agoraphobia which was never diagnosed or treated when she was a child, but became progressively worse as she moved into adulthood. Her experience is now considered severe, and at the time of interview she was unable to go anywhere unaccompanied.

### 3.2.7 Substance misuse

For most respondents reporting substance misuse, this had arisen from depression. One exception was a mandatory client who had been a drug addict for a decade but had only been on IB for between 12 to 18 months. His depression was largely spurred by the frustration of wanting to recover from his addiction and remain clean and a fear of leaving his house in case he turned to drugs again:

*'I'm a recovering drug addict and what I done was a couple of years ago I got clean and it was all the troubles that come with that, you know, just trying to stay clean. I struggled more to stay clean than I did when I was actually using so the first thing was just to stay clean, you know, and just taking small steps in trying to recover so I wouldn't have to go back.'*

(Client 33, male, age 40s)

The narratives of substance users were often complex. For example, Client 5 is a mandatory client and has been on IB for 14 years. A history of drug misuse led to her relationship with her partner breaking up and her children being taken into care. She later developed other health conditions, which ranged from bad nerves, lung disease and osteo-arthritis. Her ongoing depression is largely a result of these conditions but has also to do with the medication that she has been prescribed by her GP which creates suicidal tendencies.

Another client spoke about a series of events in her childhood, which she found difficult to deal with. She was diagnosed by her GP as having anxiety and depression, but her condition has recently been compounded by heavy alcohol abuse, *'I've had some counselling at the local hospital but they want me to drastically reduce my alcohol intake before they carry on with any counselling with them, because they're a little concerned at those levels.'* (Client 34, female, age 20s)

### 3.3 Client perceptions of job readiness

In assessing clients' attitudes and beliefs about the prospect of returning to work or in some cases actually doing a job for the first time, clients were asked how ready they were to move into work. This line of questioning enabled an assessment of barriers which clients considered prevented them from making a transition into work. Analysis compared responses between mandatory and voluntary clients, length of time on incapacity benefits, type and severity of health condition, age and gender differences and the experience of ethnic minority claimants.

In both the mandatory and voluntary client groups, there were clients who stated the main factor impeding them from returning to work was concern about their health condition. For the most part, most voluntary clients felt able to return to work on account of improved health. Apart from concerns about their health conditions, there were a number of other factors that impeded their readiness for work. For most clients, these were realistic concerns, and overcoming one concern did not necessarily eliminate or resolve others. Hence, the culmination of these made the prospect of entering the job market a distant prospect. This was particularly the case for those who had been away from the job market over an extended period of time. Their concerns were wide ranging, including:

- concerns about their health condition and about working linked to levels of confidence about going into work and being able to function in the work place;
- financial concerns surrounding the stopping of their benefits and not being able to meet the costs of housing, council tax and other payments;



- the type of work clients felt able to do, with some wanting to return to the same job they had before becoming ill, or not wanting to return to the same job, but needing to re-train. Related to this, a preference to do part-time work instead of full-time work, based on not wanting to disrupt their benefits, but also wanting to follow a process of 'trial and error' to assess the suitability of a job before gradually moving into full-time employment;
- concerns about lack of qualifications and feeling ill-equipped to enter the labour market without adequate skills and training;
- concerns about age discrimination, stigma attached to mental health conditions and fear of the repercussions of disclosure, hostility to people with criminal records;
- concerns about local labour market conditions.

### 3.3.1 Perceptions of mental health conditions as a barrier to working

Most mandatory clients had concerns about their health, which made them question whether they could return to work or take their first job. A substantial minority of clients discussed such feelings. Client 5, a mandatory client, who had multiple health conditions including lung disease, osteo-arthritis and drug misuse, said she could not return to work on account of her health condition:

*'I couldn't go back to work, I would love to, if I could get a magic tablet to make us walk properly and for me hands, I would, I would love to go back to work but health-wise I know I can't.'*

(Client 5, female, age 50s)

Other clients talked about the severity of their health condition and the effect that medication could have on their ability to work or emphasised the number of appointments that they could have in the space of a single week and/or the need to attend appointments on a regular basis. Mandatory clients such as Client 37 spoke about the difficulty she experienced in trying to maintain a proper sleep routine because of a cocktail of medication she was prescribed by her GP. The medication made it difficult for her to sleep at night and she would find herself waking up in the early afternoon of the following day. Other clients were concerned about continuing with the recovery process which meant having to attend medical appointments on a regular basis. The frequency and variation of these appointments determined whether they could take a job and whether an employer would accommodate this.

Another important theme was the assurance clients needed in ensuring that they were indeed well enough to return to work. Mandatory repeat claimants wanted to ensure they were well enough to enter work and avoid cycling between benefits and work. Client 35 had been on IB several times over a period of ten years and in the last year, returned to work having felt pressurised to do so, but had to leave his job as he found it difficult to manage his alcohol misuse. Within a year he

returned to claiming incapacity benefits and this experience had heavily shaped his mindset:

*'I've got to be careful, because when I was doing the last job, I just sort of like, "I'll be back in ten minutes" and I wasn't, I was down the boozier, down the pub.'*

(Client 35, male, age unknown)

Mandatory clients with single spells on IB made similar comments about their health condition and capacity to work. There were 11 clients who had been claiming IB from between one to five years who fell into this category. Client 33 had been on IB for between 12 and 18 months. He was positive about returning to work and had done a number of college courses in preparation for this. As he was a recovering drug addict, he felt his potential to get a job and retain it had to do with how far he had improved during the recovery process, *'For me, it's about rehabilitation and being of value.'* (Male, age 40s). On the other hand, there were clients who felt their illness would be a barrier to returning to work, as Client 21 (Female, Age 20s) said, *'I wouldn't be able to cope because I'm physically too poorly all the while, and mentally I can't take it.'*

Across the client sample it was largely voluntary clients who had pursued a return to work. Notably they had experienced improvements in their health condition. These respondents were amongst the clients who felt that working would promote their health and well-being, typically in the context of already having recently experienced an improvement in their health. Client 7 had never claimed IB, but throughout her depression had received support from her key worker and through Pathways. She told her support worker that she was ready to return to work and this was her choice:

*'I said, I think I'm ready to go back to work...it was to change my life, that's what it was for, otherwise, I don't think I'd have been here now.'*

(Client 7, female, age 50s)

Similarly, another female voluntary client said that having had a hospital operation, and the time to recover from this, she then felt it was time to return to work:

*'Once I got my operation and everything sorted, I was just helping my daughter and then I was saying, "I want to go back to work" and then you just need that little bit of push to get you there.'*

(Client 8, female, age 50s)

Client 43, a mandatory client, had also experienced a health improvement, had a desire to get better and felt that part of that process involved going back out to work:

*'It was not my sickness that stopped me from working, it was the depression, but once I get up and go out there and start back at work, it was a totally different thing...I was meeting a lot of people I wasn't meeting before, so it got us back into working with other people.'*

(Client 43, Female, age 40s)

### 3.3.2 Financial insecurity

Several clients, both voluntary and mandatory, reported that they had financial concerns about returning to work, in particular how they would cope with bills such as housing and council tax payments, if they were to sign off from IB. There were clients who cited a preference for doing part-time work (16 hours a week) as opposed to full-time work, based on a wish not to disrupt benefit payments such as housing and council tax benefits. Client 44 had been a mandatory client and had been on IB on two occasions; with each one lasting for between five and ten years. He was on his third stint of being on IB and had made enquiries about whether he would be better off in work:

*'Yes, I'd gone to see how I'd be better off and they explained about Extended Housing Benefit, etc...and its all very nice and rosy for the first year...after the second year, I find myself in a detrimental sort of financial situation...but the second year you find yourself eight pounds down.'*

(Client 44, male, age 50s)

Hearing negative stories about other people's experiences could also fuel concerns about movement into work. Another long-term mandatory client had been on IB consistently for between 14 and 16 years and likewise had concerns about meeting her expenses having learnt about the struggles others were experiencing in this respect:

*'I know people in my situation who have come off the sick and have gone back into work and they've struggled because they've had like their full rent to pay, their full council tax to pay.'*

(Client 5, female, age 50s)

Other clients feared having to leave a job if they found that they were unable to cope, then experiencing problems as new claimants:

*'Maybe when you're there, you might be alright one day, but you don't know if you could handle it, then you're afraid of chopping and changing your circumstances with your money and it's a just a big step after a long time.'*

(Client 1, male, age 40s)

There were concerns about problems that might arise in retaining a job. Narratives around the fear of disrupting existing financial arrangements indicated that benefits were providing a 'security blanket'. This was endemic to clients who had been on IB over a prolonged period of time.

### 3.3.3 Client views on suitable work and work arrangements

A variety of clients anticipated that a return to previous jobs might lead to a worsening of their health condition. Some clients recognised a need to re-train. However, preference for doing a particular kind of job was not necessarily based on the kind of job people would have liked to do. There seemed to be practical considerations, especially the need to avoid pressure and associated stress, and the scope for moving into jobs that were relatively easy to access and exit, if the need arose.

Among mandatory clients in the 20-40 age group, there were indications that clients had been in and out of a series of mainly low-paid, casual jobs due to their health condition. Most of these clients had been on IB for between one and five years and had no previous history of claiming IB. One client with depression and anxiety commented on his desire to avoid cycling between benefits and employment due to the interaction of his symptoms and work experience, thus he explained:

*'The problem is I never really struggled getting jobs, it's not getting the job or doing the work that was a problem, it was motivating myself to wake up in the morning...If I go and get a job when I don't feel ready, all I can imagine happening is me over-sleeping, me not being motivated to do the job and end up quitting and then I've got to go through that stuff again.'*

(Client 30, male, age 20s)

Client 20 had concerns about becoming ill again on account of experiencing pressure in a job and looking towards preventing this through the kind of work he could be doing, *'Its finding a job where there's not going to be too much pressure initially, where I can get into employment without putting myself under too much pressure'*. As if to avoid the concern of a pressurising job, the client stated a preference for doing voluntary work as opposed to paid work in the belief that he would have greater control and choice to leave if the job did not suit him, *'I would say because I'm in charge in that respect, I can just walk away if I don't like it.'* (Client 20, male, age 20s)

The decision not to return to the same job was influenced by its compatibility with a client's health condition. This was expressed by Client 27, a mandatory client, who felt the adverse reaction of her medication could affect her ability to continue doing care work and particularly if this affected the people she worked with:

*'I was doing care assistant work, so that's working with elderly people. I don't think I'm quite ready to go back to that environment. Sometimes I get tempered and I'm scared working with the elderly if my temper goes funny while I'm on medication...I want to come off my medication.'*

(Client 27, female, age 20s)

One or two clients wanted work that could fit around medical appointments. Client 20 wanted to ensure he had started psychotherapy treatment ahead of starting

a job and wanted a job where the hours fitted around his medical appointments, which were fixed:

*'The problem is the psychotherapy's fixed, which is unfortunate, I mean if it was in the evenings or whatever it would be fine...I could look for a job with some flexibility.'*

(Client 20, male, age 20s)

Some clients also had clear ideas about how hours of work and form of work (paid or unpaid) could be part of a strategic approach to minimise exposure to excessive pressure. There were clients who felt that part-time work was less pressurising in view of their health condition. Client 11 had worked full-time but reclaimed IB after her health deteriorated. She had worked in a 30-hour job and had resolved the next time to get a 20-hour job. The client's GP had expressed concerns in the past about the client's ability to return to work and this seemed to reinforce her sense of the validity of this decision:

*'I'd rather be working within my capability, like 20 hours if I could...I'm saying about 20 hours, whatever makes it worthwhile money-wise in the hours thing because yes if I work 30 hours I'm a lot better off but I'd rather be a little bit better off and have my peace of mind and work 20 hours, does that make sense?'*

(Client 11, female, age 50s)

The most common deterrent to employment cited by lone parents is their caring responsibilities and an inadequacy of childcare (Ray, *et al.*, 2007). Mindful of the strain that would be generated by combining work commitments with childcare responsibilities, a mandatory female client had a preference for paid work of 16 hours a week and finding the right kind of job:

*'I think if the right job came along, that suited me and the hours, you know, to fit around the kids then possibly I would.'*

(Client 14, female, age 40s)

However, like other clients, there were also financial concerns based on whether she would have been better off in the light of family commitments. This finding reaffirms the constraints associated with lone parents' participation in paid work. Those who had childcare responsibilities wanted part-time work that fitted around family commitments.

Having been out of work for some time, some clients saw this as an opportunity to change the kind of work they could be doing and secure greater job satisfaction. One or two clients wanted to try different jobs and experiment with the number of hours worked to find a manageable balance, and considered the future possibility of full-time hours. For example, Client 8, a voluntary client in her 50s who had been on IB for six years, wanted to do gardening. She had previously worked in a factory. In a similar vein, Client 32 was adamant at the prospect of not returning to his previous job considering the steps he had taken to improve his qualifications,

but wanted to 'sample' the market to check out the kind of jobs he could do based on his mental and physical condition:

*'I need the chance to find out and if I can't do it, I don't want to start from square one back on basic sickness benefit and losing my Income Support, losing my HB...I want the option to try.'*

(Client 32, male, age 50s)

### 3.3.4 Lack of qualifications

A lack of qualifications and the need for (re)training also featured in client narratives on job readiness and was another aspect that impeded clients' readiness to return to the job market. Client 9, a female mandatory client had made repeat claims for IB over a number of years and had recently been transferred from IB to JSA. A recovering drug addict, she provides another example of a client who wanted to return to work to aid in her recovery in giving her something to do while preventing her from becoming depressed. She wanted to do hairdressing, but needed the qualifications to do this and had been referred to a course lasting 26 weeks, though was concerned about whether her health would allow her to do the course.

From a different angle, refugees expressed a sense of frustration at not finding work in the UK, both due to language barriers and lack of recognition of overseas qualifications. The experienced engineer discussed earlier in the report had problems in translating her qualifications to the UK and in finding a similar job. While the client felt that her English for Speakers of Other Languages (ESOL) needs affected her job prospects she also felt that being in work, paid or unpaid, would help her English. Moreover, she felt that her depression was being reinforced by her inability to find work.

### 3.3.5 Perceptions of discrimination

Clients discussed the stigma attached to mental health conditions and related fear of disclosing their mental health history, their fear of age discrimination, a theme amongst older rather than young respondents, and one described employer hostility to criminal records.

Both mandatory and voluntary clients stated they had concerns about disclosing their illness or the duration of time they had been out of work to a potential employer. Client 1 had trepidations about getting a job in view of an extended period of absence from work and felt this could affect his chances of being employed:

*'A lot of people now ask for your CV or something like that and ask what you've been doing for the last 16 years and if you say that, then it's a risk for them to employ you.'*

(Client 1, male, age 40s)

Issues relating to disclosure are discussed at length in Chapter 6, but it is useful to note here how clients could internalise employer hostility. For example, a client who had been on IB for approximately 18 months talked about the negative impact

that alcohol misuse had on her capacity to work and was concerned whether an employer would be happy to have her considering the seriousness of her health condition:

*'Whose going to take an alcoholic, dependent, chronic asthmatic with a mental health condition?'*

(Client 18, female, age 30s)

Several clients were concerned about age discrimination. A long-term voluntary client on IB, Client 1 felt that multiple factors would impede his return to work; compounded by concerns about age discrimination:

*'Not at my age! I'm coming up to 54 next week and health-wise I think I'd be a hindrance in employment more than a help!'*

(Client 1, male, age 40s)

Client 44, a mandatory ethnic minority client in his 50s had applied for different types of jobs and had been encouraged by his Incapacity Benefit Personal Adviser (IBPA) to pursue 'care' jobs, but he lacked confidence in pursuing job applications based on his age:

*'I've applied for all different types of jobs, what seems to be happening is when I am having an interview on the phone, the minute I give my age, that goes against me. I don't get any further than that and it's happened on maybe 10 to 15 occasions.'*

(Client 44, male, age 50s)

### **3.3.6 Local labour market conditions**

There were also signs of concern about local labour market conditions. Client 44 is a mandatory client in his 50s, who has had two major periods on IB lasting from five to ten years and has been on JSA during the last six months. This client did not feel he could return to work, even though he had a varied work history, due to supply and demand side factors:

*'I think its highly unlikely in the present climate, because I've got no actual qualifications...I've done a wide variety of things and I was a Youth Worker for about three years as well.'*

(Client 44, male, age 50s)

The following quotation from another client that harsh economic conditions exacerbate the labour market disadvantage of people with mental health conditions:

*'I know a lot of people these days do understand anxiety, stress health problems but a lot of employers looking from a business point of view,... they're going to get an able bodied...able minded...because jobs are so hard to get they can pick and choose anybody they want, they don't need to get people with disabilities from their point of view.'*

(Client 11, female, age 50s)





## 4 Client experiences and perceptions of Work Focused Interviews

This chapter focuses on mental health clients' experiences of Work Focused Interviews (WFIs). For mandatory clients (new/repeat claimants), the Pathways programme entails a mandatory WFI eight weeks after making a claim for Incapacity Benefit (IB), followed by five additional WFIs at roughly four-week intervals, unless clients are waived or deferred.<sup>5</sup> Voluntary clients (stock claimants) do not have to undertake mandatory WFIs but are eligible for the full range of Pathways support and generally access this support via contact with an Incapacity Benefit Personal Adviser (IBPA). The experiences of both mandatory and voluntary clients are considered in this chapter. The chapter begins by looking at clients' first contact with Pathways and then the pattern and nature of their subsequent contacts. It goes on to look at the content of WFIs and adviser referrals, and finally examines client views on their WFIs and the factors facilitating positive relationships.

### 4.1 Participating in Work Focused Interviews

#### 4.1.1 First contact

##### *Mandatory clients*

For mandatory clients, their first contact with the Pathways programme came as a result of receiving a letter mandating them to attend a WFI at Jobcentre Plus. (See Appendix D for a copy of this letter.) Respondents' reactions to receiving this

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<sup>5</sup> In one of the study areas, longer-term IB claimants were also subject to mandatory WFIs as part of a pilot. These claimants were mandated to attend three WFIs at six-week intervals. As noted in Chapter 1, since the introduction of Employment and Support Allowance (ESA) in October 2008 the ability to waiver WFIs has been removed.

letter varied, however, a common response was one of anxiety. This was conveyed by respondents with a wide range of circumstances and not just those who were longer-term claimants. Clients were anxious about the possibility that their benefit might be stopped or they might be encouraged to move back to work sooner than they felt able to. The following comments were typical:

*'To tell you the truth...I thought, Oh God they just want me back in work and I can't do it, and I just didn't want to go.'*

(Client 33, male, age 40s)

*'I panicked...I thought, they're going to take me off it [IB], you know.'*

(Client 21, female, age 20s)

Some people referred to publicity in the media about Pathways making them nervous, because it suggested that the Government wanted to reduce the numbers of people on IB. Others had previous negative experiences of Jobcentre Plus and feared that they might be 'pushed' or 'forced' into work. Many clients had experience of claiming other benefits prior to IB, such as Income Support (IS) or Jobseeker's Allowance (JSA), and their participation in Pathways was not necessarily distinct in their mind from participation in other Jobcentre Plus programmes. Negative experiences in these programmes, such as the New Deals, impacted upon their receptiveness towards Pathways.

It was also clear that respondents' feelings of anxiety about the first WFI could be exacerbated by their mental health condition, thus resulting in considerable anxiety and distress, as the following respondent recounts:

*'...at the time I was very anxious about attending it. I had built it in my mind, because everything had gone so bad in sort of my life events at that time – I built it up into a massive thing in my head where I'm going to be cross-examined.'*

(Client 26, male, age 30s)

Some clients spoke of needing to take friends or family with them to the meeting for moral support and said that they would not have been confident enough to attend otherwise. Interviews with advisers also confirmed that many clients were extremely nervous when they attended their first WFI; one adviser noted:

*'You spend a lot of your time reassuring the customers, I think I must spend like half of my day doing that.'*

Reflecting this, most of those respondents who were initially anxious said that they felt reassured about the process after their first meeting.

There was variation in practice across districts and offices around whether clients also received a telephone call from an adviser prior to their first meeting. Some clients said that they would have preferred a telephone call in advance giving them more explanation about what the interview would involve in order to ease their

anxiety. IBPAs had mixed opinions about this, however, and noted the difficulties of getting hold of clients by phone. Nonetheless, they acknowledged that some people with mental health conditions had difficulty understanding the WFI letter. In addition, the length of time between the letter being sent and the appointment time could exacerbate the tendency for clients to forget, resulting in failure to attend.

Many clients also seemed to be unaware that they could have changed the time or date of the first WFI. Although this is stated on the WFI letter; it seems that it was not well understood. Some respondents were adamant that the letter did not state this, while others said that it was confusing:

*'It did say on the bottom of the letter, "ring up if it's not convenient". But it also said, "if you didn't attend your benefits may be stopped".'*

(Client 24, female, age unknown)

There was considerable dissatisfaction among both clients and Jobcentre Plus staff, about the current means of contacting mandatory clients about the first WFI, and a perception that this could be improved to both lessen the anxiety for clients and to improve the quality of the initial WFI interaction.

### *Voluntary clients*

Voluntary clients' first contact with the Pathways programme was quite different. The majority of these clients had contacted Jobcentre Plus themselves because they felt ready to start looking for work and had then been referred to an IBPA. However, even though they were mainly self-referred, some still expressed anxiety about attending Jobcentre Plus for the first time, especially if they had been on benefits for a lengthy period and were unsure about starting work. Again, fears were generally allayed following the first meeting.

There were also some voluntary clients who had only very minimal contact with an IBPA. These were people who had come into contact with Pathways via another provider and were either referred to Pathways services directly, without the intervention of an IBPA, or had only brief contact with an IBPA to find out about in-work benefits once they were ready to take a job. In some cases these customers were happy with the support that they had received from Pathways, however, in others it seemed that the clients might have benefited from ongoing support from an IBPA and access to other Pathways services such as the Condition Management Programme (CMP), but had not been offered this. This suggests that there may be some issues to address around the gateway onto the Pathways programme for voluntary clients.

#### **4.1.2 Scheduling subsequent meetings**

For clients who had regular ongoing contact with an IBPA (see Section 4.2 for more on patterns of attendance), subsequent WFI meetings were usually arranged at the preceding meeting and then followed up with a phone call or text message. Both IBPAs and clients concurred that these reminders were helpful for people

who had a tendency to forget about their meetings as a result of their mental health condition and/or their medication.

After the first WFI, clients generally found subsequent meetings easy to reschedule if they were inconvenient, because they had by then established a relationship with an adviser. Most had experience of ringing up to rearrange inconvenient appointments and a few had missed appointments without making contact, but had been contacted later by their IBPA and rearranged. IBPAs spoke about the importance of scheduling appointments to take account of the impacts of medication or alcohol/substance use on clients. Reflecting this, most clients found their advisers very accommodating; one respondent, a former drug-user, was very appreciative that his adviser had scheduled his meetings so that he didn't run into friends that he used to take drugs with; another that she could schedule meetings in the afternoon because her medication made her sleepy in the mornings.

A number of respondents also spoke of seeing or telephoning their adviser in between appointments to ask for advice, or being proactively contacted by their adviser. Most found their adviser's availability to be good, however, there was concern expressed that it was sometimes difficult to speak to advisers outside of appointments because of their heavy workloads, and one respondent referred to his meetings being cut short because of the adviser's schedule:

*'Now with the way the appointment structure works, sometimes you're just getting into the flow and you've got to stop because he's got another client coming in.'*

(Client 6, female, age 50s)

This mirrors accounts from advisers about the impact of growing performance pressures on their work. In particular, some IBPAs noted that quotas for the number of WFIs to be conducted in a day meant that they could not always give clients the time that they felt was needed.

Most clients reported that they had seen the same adviser at each of their WFI meetings and preferred this; they felt that it helped them to relax and be more confident in the meetings because they had established a relationship with the adviser.

### **4.1.3 The Jobcentre Plus environment**

A major complaint from respondents about their WFIs was holding the meetings in the open-plan Jobcentre Plus office. Many said that they would have preferred more privacy. Some respondents also said that it affected the quality of their interaction, because they did not want to talk about some things within earshot of other people:

*'...because I just felt certain things we were talking about, I had to lower my voice, and I remember keep like looking around because there's a lot of people.'*

(Client 5, female, age 50s)

In some instances this concern about privacy was also exacerbated by the client's mental health condition, which could make the meeting stressful and anxiety-provoking. In one extreme example, the client reported that she was so traumatised by the discussion of her condition in the vicinity of other people that she was not able to take in anything the adviser was saying, and subsequently asked her support worker to defer further meetings. The lack of privacy at Jobcentre Plus offices was sometimes contrasted to other mental health services (National Health Service (NHS) or voluntary sector services) where private rooms were available to talk to professionals in confidence.

## 4.2 Patterns of contact

Recent policy proposals have placed considerable emphasis upon 'personalised conditionality' where the support offered to individuals is tailored to their capability and built around their individual circumstances (see Gregg, 2008). While Pathways participation is structured around the six mandatory WFIs (for new/repeat claimants) as described earlier, within this there is discretion for advisers to tailor meetings and support to individual circumstances. In this section we examine patterns of attendance among the clients in the sample and the extent to which this was tailored to individual needs.

Following the first contact with an IBPA, subsequent patterns of attendance at WFIs or IBPA meetings varied considerably. Four main patterns can be discerned from client accounts:

- an initial interview (or small number of meetings) followed by a deferral.
- a series of six mandatory WFIs with no subsequent contact.
- ongoing regular contact with an IBPA for longer than six months.
- brief, focused contact with an IBPA prior to referral to other services or entering work.

### 4.2.1 Meetings deferred

A large number of people in our sample had had only relatively brief contact with an IBPA (one or a small number of meetings) and then experienced no further contact. They were not always aware of why this was the case (although there were also problems with their recall, particularly if the meeting(s) had taken place some time ago). However, the experiences they described suggested that they had had further meetings deferred because they were not able to participate in the programme at that time (because of their health or other life circumstances) or because they were undergoing some kind of NHS treatment. One client, for example, was deferred because he was undergoing intensive counselling; another because she was about to start an alcohol treatment programme. This is confirmed in discussions with advisers, some of whom said that it was standard practice to defer WFIs until clients had finished treatments such as therapy or

counselling because they felt that it might be too much for them to also engage in the Pathways programme at the same time.

As implied in Section 2.2, having a severe mental health condition is not a barrier to participating in Jobcentre Plus Pathways per se. As noted in Section 3.1, the client sample drawn for this study suggested that Jobcentre Plus Pathways was picking up clients with at least moderate mental health conditions. While some clients' experiences suggested that they were deferred but remained on the adviser's caseload, and were subsequently contacted periodically by their adviser to check if their circumstances had changed, others seemed to have been deferred and then had no subsequent contact. While some clients were content with this, others felt that at the time of the interview they were feeling better and potentially ready to take steps towards work and would have welcomed further contact. Some were confused or unclear about whether they were still on the Pathways programme.

#### **4.2.2 Mandatory WFIs only**

Some respondents had experienced the series of six mandatory WFIs, sometimes in combination with other Pathways services, and had had no further contact. These clients seemed to be characterised by having made relatively little progression during the course of their participation on Pathways and were not work-ready by the end of the six WFIs.

Some appeared to need further support with their health condition before they could participate in the programme any further. For example, this was the case with one respondent whose alcoholism had become worse towards the end of his WFIs:

*'I was hitting the beer bad...and they were saying at the end of the day they had no help at the moment, there's no job they can put you in at the moment because of the drink. ...they said, once the drinking is under control or whatever, then they would try and help out again.'*

(Client 35, male, age unknown)

Nonetheless, this respondent did not seem to have had any further support with his drinking, which raises questions around the adequacy of liaison between IBPAs and other services, which is discussed in more detail in Chapter 5. At the time of the interview the respondent would have liked further contact with the Pathways programme but was unclear whether he was able to contact his adviser or not:

*'I wouldn't know, because I've not spoke to him for...since I was last there and to be honest he's not got in contact with me. I never kept the forms, sort of thing, but I think...I know where it is and if need to, I think I could go.'*

(Client 35, male, age unknown)

There were also a number of other people who felt that they had started to make improvements and become more work-focused during the course of their participation on Pathways, although they were still a long way from being work-ready. It was often unclear why their Pathways participation had not been sustained after the six mandatory WFIs. Some were still receptive to receiving support, and while they generally understood that they could make contact with their adviser, it seemed that more proactive contact might have kept them focused and helped move them further along in their journey towards work. These clients did not seem to differ from those who continued to see their adviser on a longer-term basis, after the six mandatory WFIs, and it is difficult to unravel from client accounts why some seemed to have further contact and others did not. It is possible that this was due to different adviser practices across offices and/or to performance pressures limiting advisers' ability to maintain proactive contact with clients. This is discussed further below.

#### **4.2.3 Long-term contact**

Another group of respondents had finished the six mandatory WFIs and had continued seeing their IBPA on a voluntary basis. Even when clients had moderate to severe conditions they were not necessarily deferred if it was felt that employment was a realistic aim in the medium to long term. In all these cases the adviser had kept in touch with clients while they participated in other Pathways services, such as CMP, training courses, work trials, Permitted Work or voluntary work, reinstating regular meetings after their participation had ended. Thus the advisers were acting as overarching case managers (see Nice *et al.*, 2009) and in most cases clients assumed that they would remain in contact with their adviser until they had completed their journey into work.

Many of the people in this group were more work-ready and were 'trying out' labour market participation in the form of work trials, Permitted Work or voluntary work, although there were some who still had a long distance to travel and were in the process of learning to manage their condition better, eg through CMP. Practically everyone in this group, though, was positive about their adviser contact and receptive to an eventual return to work. The two people in this group who had not had adviser contact for some time when they were interviewed both seemed to have 'stalled' on their work journey, one because his health had become worse and he had had to leave his voluntary work, and the other because he felt that Jobcentre Plus were not able to offer him any further help in his goal of obtaining self-employment in his former occupation.

#### **4.2.4 Brief, focused contact**

Finally, there was a group of clients who had only brief, focused contact with an IBPA. These were predominantly voluntary clients but included one or two mandatory clients who were more work-ready and moved quickly into work. These clients with only brief contact were primarily work-ready clients, some of whom were referred to an IBPA from another provider simply in order to find out

about in-work services once they had already found a job, while others joined Pathways but then found work quickly.

As suggested earlier, there were also some voluntary clients who had only brief contact with an IBPA because they were referred directly onto other Pathways services, such as job brokers rather than being taken onto an IBPA's caseload. As we discuss more in the next chapter, some of these people felt that the service they received was too work-focused and they might have benefitted from access to the wider Pathways package of support.

Taken together, these patterns of WFI attendance suggest that contact with the programme was primarily shaped by the needs of clients: those who were more work-ready received brief, focused help; those who were too ill to participate or were undergoing treatment were usually deferred; while those who were starting out on a lengthier journey back to work usually had longer-term contact. Nonetheless, client experiences suggest that there was also scope for advisers to exercise greater flexibility in tailoring patterns of contact to the needs and preferences of clients, for example, some clients who were deferred were not subsequently 'picked up' by advisers when they felt more ready to participate in the programme, and some of those who completed six mandatory interviews were not encouraged to maintain contact or proactively contacted again, despite the fact that they were receptive to an eventual return to work and needed further support.

Discussions with Jobcentre Plus staff, in interviews and in the feedback workshops, suggested that generally they felt able to be flexible in scheduling meetings with clients, for example, by scheduling additional meetings in between mandatory WFIs where they were useful, as well as deferring for short periods of time while clients were undertaking NHS treatment. However, there were signs, particularly in workshop discussions towards the end of the fieldwork period, that performance pressures were limiting the scope for this flexibility on the part of advisers. This raises questions about the extent to which support is personalised and the extent to which advisers are able to act as longer-term 'case managers' overseeing and supporting a client's journey into work. This is discussed in more detail in the next chapter.

## 4.3 Content of Work Focused Interviews

### 4.3.1 Range of services

Respondent accounts suggested that the extent to which they were referred to or informed about other services differed widely. However, it is important to note that clients often had difficulty recalling the detail of what was discussed in their WFI interviews, especially if they had taken place some time ago.<sup>6</sup>

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<sup>6</sup> Therefore, this data should be treated with caution and viewed not as an accurate account of what was offered but what clients could recall retrospectively, which may have been influenced by their subsequent experiences.



Most respondents we spoke with were aware of the CMP; a number remembered being signposted to other providers that were contracted to Jobcentre Plus for the delivery of Pathways services; and some had been referred to job brokers and for work trials. Client experiences of these services are covered in more detail in Chapter 5. From respondent accounts, a potential gap seemed to be referral to community or voluntary sector mental health services that were not contracted to Jobcentre Plus.<sup>7</sup> A number of clients were using such services (and were overwhelmingly positive about them, see Chapter 7) but none had found out about them through Jobcentre Plus. Some expressed a desire to be referred to such services. For example, many wanted to be referred to community-based counselling services which they had not been able to access through the NHS. Advisers' practice of referring to appropriate services is discussed in more detail in the next chapter.

Many respondents could recall discussion with advisers about the financial implications of work and were aware of Return to Work Credit (RTWC), tax credits and Permitted Work. Most were positive about this information. Some, however, who could recall discussions of their finances, were still confused about their eligibility for different benefits and what the financial implications of working would be. Some also said that they would have liked discussion about financial issues earlier in the back to work process, before they were ready for work, in order that they could start thinking more concretely about work options. In contrast, advisers expressed concerns about performance pressures resulting in them conducting better off calculations too early in the back to work process, when they felt clients were not ready for the information. What seemed to be important, regardless of timing, was that the information was discussed fully with clients and revisited frequently to ensure that it was clearly understood.

Voluntary clients were particularly likely to have had WFIs focused primarily around discussion of financial help, because they were more likely to be work-ready, and indeed some first approached IBPAs once they had already found work. Most of these clients were very positive about their experiences and spoke of the reassurance provided by the financial support in enabling them to move back to work:

*'I sort of left thinking, well that's really good, you know, all this help's available that I didn't know about...I wasn't worried any more.'*

(Client 2, female, age late 20s)

While voluntary clients were generally more work-ready than mandatory clients, and it was, therefore, appropriate to focus WFI interactions on job searching or discussion of back to work financial help, there were a small number of cases, as noted earlier, which suggested that voluntary clients might not have had access to the full range of Pathways services. This is discussed in more detail in the next chapter.

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<sup>7</sup> This was also found in Nice *et al.*'s (2009) study of Personal Adviser referral practices in Jobcentre Plus Pathways.

### 4.3.2 Adviser referrals

While generally respondents preferred advisers to be non-directive and to feel that they were in control of the journey to work (see discussion in Section 4.4.2), some respondents felt that their adviser could have been more proactive in encouraging them to take up services. For example, one respondent said that she had been given information leaflets about services but might have been more inclined to take them up if the adviser had encouraged her and 'sold it' to her a bit more:

*'If the job centre were to say "There's this course here at so and so, why don't we make an appointment for you?" rather than saying "Here's a number should you ever want to call them".'*

(Client 34, female, age 20s)

This respondent also felt that the advisers she had seen were uninformed about the services on offer, hence making it difficult for her to decide if they were right for her. (This respondent did not appear to be seeing a single adviser regularly and may have had the series of six mandatory WFIs deferred.) Similarly, another respondent said that she was unlikely to proactively take up a service because of her depression, and would have liked it if the adviser had been more encouraging and perhaps made appointments for her.

Conversely, there were also a few cases where respondents felt that advisers were too 'pushy' about taking up services. One respondent recounted that she wanted to attend CMP but had cancelled a number of appointments because of fluctuations in her health condition and clashes with hospital appointments. She felt that her adviser was becoming too 'pushy' and she was starting to find her 'intimidating'. Advisers have a difficult balance to strike here. Referral to services seemed to work best in cases where clients felt advisers were 'encouraging' but not 'pushy'.

### 4.3.3 Action planning

Respondents were asked whether they were aware of having developed an action plan with their adviser during their WFIs. Those we spoke with were very rarely aware of having had such a plan. This is also confirmed in interviews with advisers: while some advisers said that they did share action plans with clients, most said that they used them to record client progress and as a reminder for themselves of previous discussions, but did not use them collaboratively with clients. It, therefore, seems that there was considerable scope to improve the use of action plans in the way envisaged in current policy proposals (see, for example, Gregg, 2008), as a means of generating co-operation and co-ownership in the back to work process between advisers and clients.

In the few instances where respondents were aware of having an action plan they were generally positive. For example, one respondent described the action plan as useful in order to monitor his progression and his 'journey' towards work:

*'It's good because I know what the next stage is and when it will be reviewed...so I know exactly what's expected of me and what will happen, so there's no uncertainty there.'*

(Client 20, male, age 20s)

## 4.4 Client views about Work Focused Interviews

### 4.4.1 Positive and negative client experiences

There was a wide range of different reactions to their WFI experience among respondents. While many clients were extremely positive about their experience, equally, many expressed very negative views. Respondents who were positive about their meetings tended to be either those who were more work-ready and had relatively brief contact prior to moving into work, or those further from work who had established a good relationship with their adviser and were in agreement over the course of action that they would take. Nearly everyone who had continued contact with their adviser after the six mandatory WFIs was positive about their experiences and the advisory relationship, although many of those who were no longer seeing the adviser at the end of the six WFIs were also similarly positive about the support they had received.

Many of the clients who were negative about WFIs were those who had only one or a small number of interviews and were then deferred because of their health circumstances. Many of these people felt that at the time of their WFI they were too unwell and should not have been called in to Jobcentre Plus. In addition there were also some people who felt they had received insufficient support from Pathways; for example, one young man, a voluntary client with a learning disability, felt that he had been offered little support and was 'passed on' to a contracted provider as quickly as possible. A few clients also felt that they had been unable to effectively participate in their WFIs, either because of medication or because of their health condition. This included a client with agoraphobia who was traumatised by having the interview in an open-plan office, referred to earlier, and a client with bipolar disorder who was moving into a depressive phase during his WFIs but said that he was obliged to participate in all six interviews. There were also some respondents who, while positive about some aspects of WFIs, disliked others, for example, the lack of flexibility over the timing of WFIs or the absence of a co-ordinating or overarching case manager role.

While those who were positive about their WFI experience tended to be those who were either more work-ready or were receptive to the idea of receiving Jobcentre Plus support with their journey back to work, it is difficult to tell from respondents' retrospective accounts whether this receptivity was evident from the outset, resulting in a positive WFI experience, or whether it developed during the course of their WFI experiences. The fact that many of those who had a positive experience said that they were initially apprehensive about attending Jobcentre Plus meetings suggests that receptivity might have developed over time, or that

a potential receptivity was reinforced by a positive encounter with an adviser. This was also the view of advisers who felt that WFIs were an opportunity for them to try and motivate clients, and could cite examples of cases where they felt that clients' receptiveness had increased over time. They noted that the six-month timeframe could provide an opportunity for people to get used to the idea of thinking about work and to start taking up services. At the same time, though, advisers felt that this was not possible with all clients. Existing clients with longer-term conditions and who were more 'settled' in their benefit status; people with more severe mental health conditions; and those who were unwilling to pursue prescribed treatments were amongst those who they felt unlikely to become more receptive to work over the course of WFIs. The analysis of client views also suggests that there are some people for whom it is 'the wrong time' to engage with the programme because of their health condition and/or involvement in other treatments.

#### 4.4.2 Factors influencing WFI interactions

In addition to differences in the respondents' receptiveness to back to work support, it also appeared, from respondent accounts, that the quality of WFI interactions were influenced by the skills of the adviser. The following factors emerged from respondent accounts as being especially important in facilitating positive interactions within WFIs:

- maximising client control over the back to work process;
- good communication skills;
- addressing health conditions sensitively and appropriately.

##### *Maximising client control over the back to work process*

One of the most important factors for clients was the extent to which the adviser allowed them to shape the nature, direction and the pacing of their journey back to work. For example, one thing emphasised as important by many clients was that they were treated by their adviser as 'an individual' and that the steps agreed were tailored to their needs. For example, commenting on why she valued his adviser's support, one client explained:

*'Because he sort of treated us like an individual...I wasn't just like a number and he didn't just say "Well we've got that and that, there you go", he actually took time and tried to help as best he could.'*

(Client 12, female, age 20s)

Clients also appreciated it when they felt advisers were listening to their own assessment about their readiness for work and were not too 'pushy':

*'I think she was in tune with the fact that I wasn't very well, I was depressed, but she was still trying to help without being pushy, see what I mean?'*

(Client 17, male, age 40s)

Similarly, clients also valued being able to determine the pace of the steps that they were taking to move towards work:

*'He says, "Look, there's no timetable here, it's in your own time, you don't have to do this by tomorrow or next week", he understood totally, he said, "In your own time, as you can cope with it".'*

(Client 6, female, age 50s)

Where clients felt that they were in control of the process in this way it promoted a sense of ownership over the back to work journey and thus, encouraged their commitment to it, as one client explained:

*'I was told about choices and I was allowed to make the decision. I think that's important, you know, because it makes you feel that you are in control and not being told what to do.'*

(Client 33, male, age 40s)

As discussed in Chapter 2, Pathways staff also subscribed to the importance of maximising client control over the back to work process and felt that WFIs should not entail any pressure on clients: *'just to explain to them we are here to help and we'll take it one step at a time'*, although they also expressed concerns about the extent to which this approach could be maintained with the growing performance pressures facing them, such as targets for referrals, better off calculations or submissions to jobs. Among the clients we spoke with, it was rare for respondents to feel that their IBPA was too directive.<sup>8</sup> However, one instance where the client felt the adviser was not allowing her to control the pace of the journey was viewed quite negatively. This respondent had had to reschedule a number of WFIs because of fluctuations in her health and had also been unable to attend CMP appointments that the adviser had made for her. Mental health conditions can fluctuate on a day to day basis and recede and recur over time, meaning that becoming well enough to take steps to move towards work may be a lengthy process with multiple interruptions, stops and starts on the way, rather than a one-off event (Seebom and Secker, 2005: 17). This highlights the importance of individually tailoring the back to work process to the needs of clients.

### *Communication skills*

Another key feature that was important to clients was the adviser's communication skills. As discussed previously, WFIs, particularly the first mandatory WFI, could be a traumatic experience for many clients and it was important that the adviser was able to make the client feel relaxed and at ease in order to facilitate discussion. When asked what they valued about their interactions with advisers, clients emphasised advisers who were able to make them feel comfortable and put them at ease:

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<sup>8</sup> It is possible that the concerns expressed by advisers had not yet filtered through into client experiences, since the clients interviewed for this study had participated in the Pathways programme prior to these changes taking effect.

*'I felt comfortable, I could open up to him, you know what I mean? I could actually tell him the problems I did have.'*

(Client 35, male, age unknown)

*'I was nervy when I first met him but after that it was just like talking to anybody, do you know what I mean?'*

(Client 8, female, age 50s)

While these adviser qualities are likely to be valued by all clients, they were particularly important for mental health clients because their conditions could make them very anxious about attending WFIs. In addition, some respondents were also quite isolated and had limited experience of social interaction.

A number of clients also talked about the prevalence of negative stereotypes about mental health in society and sometimes negative reactions that they had encountered from other service providers. It was important to them to feel that their advisers were not reflecting these attitudes:

*'...she didn't judge me and she didn't look down on me.'*

(Client 18, female, age 30s)

*'I think if you feel that somebody's trying to help you, you do confide in them and you do open up. There's other people maybe in other departments where I would feel they might look down on us because I have had different health problems, or not have the empathy there for whatever reason.'*

(Client 11, female, age 50s)

As discussed earlier, individuals who had a number of WFIs were generally positive about their relationship with their adviser, and this was often felt to be enhanced by the continuity of a relationship with a single adviser. Similarly, advisers noted how it sometimes took a number of meetings to build a rapport with clients and for them to be able to discuss their health condition openly, hence continuity of adviser was important.

Conversely, clients were negative about their interactions where they felt advisers were not listening to what they were saying and not providing a personally tailored interaction. There were criticisms of advisers who were felt to be 'sticking to the script' or 'ticking boxes':

*'I was just being passed along the line and I just didn't feel any kind of, I didn't feel that the person I was talking to wanted to help me, if you see what I mean, it was just like go through the motions.'*

(Client 17, male, age 40s)

These experiences were more common among those who had had just a single WFI and further interviews deferred and had, therefore, not developed a relationship with an adviser.

No clients interviewed for this research had a hearing impairment. The experience of people with both mental health conditions and hearing impairments may be a subject for future research.

*Addressing health conditions sensitively and appropriately*

A final factor that was important to clients was that their adviser addressed their health condition appropriately and with sensitivity. There were a range of different experiences among clients regarding the extent to which their health condition was discussed in WFIs and their feelings about this. The majority of the **voluntary** Pathways clients said that they had spent little, if any, time discussing their health condition in WFIs. This seemed to be because these clients had approached Jobcentre Plus in order to look for work because they felt that they were ready to do so. Therefore, for the most part, these clients felt that they did not need any further help in managing their condition before or during their search for work. From their accounts, it seems that advisers responded to this and did not seek discussion of their health condition in the WFI(s). Most clients were satisfied with this.

The picture differed for mandatory clients who had not taken proactive steps themselves to approach Jobcentre Plus to look for work and who mostly felt that their health conditions continued to pose a barrier in some way to their work readiness. These clients generally **had** discussed their health condition in their WFIs, and they differed in how they felt about this. Some expressed a concern that there was too much delving into issues that made them uncomfortable during their WFIs, either their mental health condition or traumatic events that had precipitated the condition (bereavement, relationship breakdown, etc.):

*'I felt stressed having to sit and explain it to him...they brought us into the interview so they would have had some kind of statistics off a computer, [about] why I was on the sick, you know what I mean, so...instead of having to go through it all.'*

(Client 5, female, age 50s)

*'...she did have some questions about what the matter is, and I didn't... it was the kind of wounds I didn't want to open, because they just kept putting me back.'*

(Client 26, male, age 30s)

Again, these clients were mostly those who had just had one or a small number of WFIs and had not developed a relationship with an adviser. However, as discussed earlier, a larger number of clients expressed some unease about having to discuss personal issues in the context of an open-plan office.

Other clients were more comfortable discussing their mental health condition with advisers. Generally, these respondents did not expect their advisers to display detailed medical knowledge, but it was important to them that their adviser took their condition seriously and empathised with the implications of their condition for daily life:

*'He was empathetic, he did say "I'm not qualified, you know, in these things", but that he could understand, do you know what I mean?'*

(Client 20, male, age 20s)

Respondents were more negative where they felt that advisers did not show empathy with their situation. Some described comments from advisers that suggested that they did not take their condition seriously. For example, one client who had an autistic spectrum disorder, as well as suffering from depression and alcoholism, said:

*'I told him about my condition and he says, "Well there's a lot more people out there that are a lot worse off", and I thought, "Yeah, but I've got my own problems too mate, you haven't seen me at my worst".'*

(Client 19, male, age 20s)

Another client with agoraphobia who found it difficult to leave the house on her own, said:

*'...he was nice enough to me, but I don't know, I felt that he thought I attended the interviews so "Oh well you're here, so you could be working".'*

(Client 36, female, age 20s)

Again, these were all clients who were generally dissatisfied with the WFI process and had not had a positive outcome from their Pathways participation.

Finally there were also a small number of respondents who felt that their WFI experiences would have been improved if their adviser had had more specialist knowledge of their condition. For example, the respondent with bipolar disorder, referred to earlier, who felt 'locked into' a series of six WFIs when becoming depressed, stated:

*'...this was a chap who was dealing with general Incapacity Benefit...but he didn't seem to have any understanding of what he was doing to me, which is turning the screws on. And it wouldn't feel like the screws to him, but to somebody who is just not quite right...'*

(Client 16, male, age 50s)

Similarly, a respondent who was on strong medication at the time of his WFIs also felt that the adviser should have recognised his inability to participate and deferred the interviews. In these instances, it seemed that the respondents had trouble communicating their discomfort to their adviser and they felt that the adviser should have been more responsive to their anxiety and lack of capacity to participate.

These concerns about adviser knowledge and understanding of mental health conditions mirror concerns expressed by IBPAs about the adequacy of their training for dealing with mental health clients, particularly those with more severe



conditions, as discussed in Chapter 2. While one adviser we spoke with mirrored the suggestion of the client, above, that there should be Pathways advisers who specialise just in mental health, others felt uneasy or ambivalent about acquiring too much information about mental health conditions, recognising that they were not health specialists:

*'I could jump in and say something completely wrong and send them off on the wrong track completely.'*

(Jobcentre Plus IBPA)

Instead, IBPAs generally felt that it was better to rely on the expertise of qualified health staff to gain a more informed understanding of individual clients' conditions and capabilities, and thus advocated more effective sharing of information with CMP staff, as well as Disability Employment Advisers (DEAs) and work psychologists, for example, through case conferencing.



# 5 Client experiences and perceptions of referrals and other services

## 5.1 Introduction

This chapter relays the experiences of those mental health clients who were referred to various Pathways services delivered by Jobcentre Plus or outside providers. In some of the cases, volunteer clients entered the Pathways programme by way of a partner provider. The chapter details experiences of the Condition Management Programme (CMP). It then turns to provision outside Jobcentre Plus: job broker services and participation in non-paid work such as volunteering and Permitted Work. The chapter ends with an overview on the other services clients may have been accessing, independent of the programme. Some of these services were accessed in parallel to Pathways provision and participation in multiple, sometimes overlapping activities raises questions about service coordination for mental health clients.

## 5.2 Condition Management Programme

The CMP, jointly developed by Jobcentre Plus with local National Health Service (NHS) providers, delivers work-focused rehabilitation, advice and guidance on topics such as pain and lifestyle management, confidence building and motivational support to help clients return to work. Specialist modules are designed to help clients overcome mental and physical conditions and different models of delivery are in operation (Barnes and Hudson, 2006). Clients are usually referred to CMP through their Incapacity Benefit Personal Adviser (IBPA) and participation is voluntary.

In the sample, only a small number had participated in CMP and most of them were male. Overall, reports on CMP experiences were positive. The range of experiences varied, with clients participating in individual and group counselling

sessions, Cognitive Behavioural Therapy (CBT), confidence building courses, assertiveness training, and relaxation techniques – singularly or in combinations. All participants rated improvements to their self confidence and social networking skills over and above other treatments they were receiving or had received in the past. One client, a recovering alcoholic who had been out of work for two years, contrasted the help he received from the group therapy sessions he attended through CMP with the counselling he was also receiving through his General Practitioner (GP) surgery. He viewed the two treatments as complementary, with CMP offering more of a work focus:

*[CMP has] given me something to start thinking about, which sectors I want to go into...I want a change of direction and this is the time to do it and it's a case of what drove me to become so ill and everything, and that's going to be dealt with, you know, hopefully by the therapy and through work and in parallel...it helped and I'd say in terms of structure and keeping me focused and motivated are the three words I would use.'*

(Client 20, male, age 20s)

Talk therapies were particularly important for people who had limited social contact. For example, one voluntary client who attended CMP sessions fortnightly over a six-month period said his attitude towards work greatly improved through talking about his condition:

*'It gave us a chance to talk with somebody...because at the moment we don't talk to anybody, we have no friends, no contact with other humans. This was a good chance to talk and get some feedback...'*

(Client 6, female, age 50s)

Another client (Client 17, male, age 40s ) who had felt suicidal in the recent past, attributed the CMP group sessions with giving him 'hope' and 'meaning' in life.

Most CMP participants did not feel their condition had improved to a point where they felt ready for mainstream work. For example, one client with a multiple personality disorder felt his CMP experiences over six months had greatly improved his work attitude, yet his condition made it difficult for him to interact with people in a work setting. He was contemplating self-employment as a work option.

There were, however, concerns about CMP waiting lists; reinforced by the views of CMP managers and practitioners. Those who accessed the support reported they needed to wait a number of weeks or even months for meetings to commence. One client who was accessing CMP at Jobcentre Plus felt the delay detracted from the relationship that had been established. Some IBPAs feel limited in what they can do for mental health clients.

### **5.2.1 Group sessions**

Some people appreciated attending group sessions and being with similar people who could empathise with the experiences of their condition. Hearing examples of other people overcoming difficulties helped motivate them and affirmed that, 'if

*they can do it, I can do it too*'. On the other hand, being exposed to more severe cases of mental illness could create feelings of unease. One client reported he felt as though he had been placed on a programme designed for people who are 'losing the plot' and felt as though he didn't belong (Client 44, male, age 50s)

### **5.2.2 Service discontinuity and setbacks**

The duration and continuation of CMP services was also called into question by staff respondents as well as by some participants who felt the need for regular contact after their sessions had ended. One client with a history of alcohol dependency and related depression, would have liked his CMP sessions to continue. He felt 'lost' when told the counselling had ended. This individual reported the benefits of the counselling began to dissipate after a few months and he felt he still needed more time to talk through his concerns before considering work:

*'...it would have made a big difference to me because I could have gone to somewhere to talk to somebody every week and just because I think that's one thing I miss, that's missing in my life, I don't have somebody to talk to about my problems.'*

(Client 19, male, age 20s)

After a few months, his IBPA signed him up for another round of therapy to help boost his confidence. However, while the first set of therapy combined group sessions with one-to-one therapy sessions, the second set consisted only of the group sessions. This change in delivery, combined with the change in his mental health did not result in a second positive CMP experience. The client said he felt detached from the different set of people who were in the group sessions and he subsequently stopped attending. At the time of the interview the client reported he was still waiting for his IBPA to get in contact.

### **5.2.3 Experience of inappropriate referrals to CMP**

Others who were referred to CMP were later screened out due to ill-health and the client being assessed as needing to prioritise NHS specialist support, or their participation was postponed due to hospital appointments clashing with CMP sessions. Key informant views reinforced the theme that some clients are reluctant to be referred to CMP because they already have a relationship with a GP or psychiatric nurse and do not want to see anyone else. Clients who were screened out on referral tended to be in agreement with the decision to postpone their involvement.

Jobcentre Plus staff, including CMP practitioners, felt that this provision was beneficial for clients with anxiety, depression, a need for confidence building, or a reactive mental health condition. Some personal advisers were concerned that if clients were not ready for CMP there was little else that they could refer them to. CMP staff who reported experience of inappropriate referrals of mental health clients who were not ready for CMP, said that this was often because of the severity of their condition or the complexity of the social issues that they

were experiencing. There was a tendency to report that the rate of inappropriate referrals had got better over time. Practitioners see their scope to signpost these 'not ready' clients onto appropriate support, where available, as a positive thing. One practitioner commented that some clients were not particularly motivated when they turn up for CMP creating the impression that they have only come to please the Personal Adviser. Another suggested that it would be helpful to have more information from Personal Advisers in referral forms as this information is needed to support staff in helping clients open up to them.

#### **5.2.4 Stigma attached to Jobcentre Plus**

Negative perceptions of the Jobcentre could also detract from clients' views about attending an initial meeting with CMP at the Jobcentre. For example, one client who had been referred to CMP, but was screened out due to the severity of his depression, expressed mistrust for the service because of its association with Jobcentre Plus. His attitude was partly fuelled by past negative experiences of signing on at the Jobcentre when he was cycling in and out of work. He also asserted a clear division between the services of the Jobcentre and the NHS, believing it was the role of the medical profession to advise on his capability to work. He did not see the point of attending group therapy sessions to discuss going back to work when it was his health that concerned him, stating, *'forcing yourself back into work when you're not ready is quite hard when you suffer from depression.'* (Client 30, male, age 20s)

### **5.3 Job broker services**

Pathways clients can also receive help towards employment from private companies and not-for-profit organisations. These providers, many of whom belong to the Employment Related Services Association (ERSA)<sup>9</sup> network, supply locally based services to address individual needs for health, training and employment support.

Clients were referred by their IBPA, or self-referred, to job brokers for work preparation services. Sometimes these services were delivered in tandem with Jobcentre Plus provision while in other cases, the job broker became the primary source of support. The intensity and duration of job broker support varied widely. Some clients experienced a single meeting with a provider while others followed through with multiple forms of help over time. Clients received help with CVs, job searches, interview techniques, confidence building courses, specialist advice on substance abuse, help with IT skills, financial advice about work and access to the Return to Work Credit (RTWC).

Relatively more Pathways volunteers reported experiences with job brokers, reflecting their general readiness for work. In several of these cases the IBPA referred

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<sup>9</sup> ERSA was established in 2005 to represent providers of publicly funded employment programmes.

the client to a contracted provider who then assumed the primary support role. Overall, individuals were generally positive about the different forms of help they received. For example, one female client who had a history of alcohol dependency and depression was referred to a job broker through her support worker when she expressed an interest in working. She was very positive about her experiences and felt the course in confidence building was the most helpful for addressing her inhibitions about returning to work. She did not feel pressurised to take a job she was not interested in and eventually started part-time work as a carer. Another voluntary client self-referred to a provider after reading about the Pathways job broker service in a local newspaper. She appreciated the support she received from an adviser who accompanied her to a job placement interview:

*'...it felt good that somebody was there but also she sort of explained to the employers that I was willing to work and I'd been off work for a while through illness and like they didn't sort of pity me but there was a little bit of leeway, where maybe if I just went by myself there wouldn't have been.'*

(Client 12, female, age 20s)

She also noted that her job broker adviser contacted her by telephone during the first few months of the job placement and this continued support was important to her adjustment.

In a few cases, referrals came from job brokers arranging for clients to meet with an IBPA to receive details about benefits, tax credits and other financial help available through Pathways.

There were very few instances where clients expressed dissatisfaction with waiting times for broker delivered training and other services and there were one or two instances where a client had moved into work in the interim.

### **5.3.1 Appropriateness of job matching**

Job brokers were instrumental in helping clients find work placements and voluntary work as well as permanent positions. However, there were some criticisms of services, mainly originating from individuals who did not secure work that met expectations. Feeling pressurised to apply for any job vacancies that were available was a repeated criticism. As one client who started a job in sales but left after a few weeks because she could not cope explained:

*'...there was a lot of pressure to apply for things that there was no way I was going to get, even if I was in employment at the time. ...A position asked for experience and qualifications in certain fields that I didn't have but the agency still pushed me to fill out the application form or send a CV...'*

(Client 34, female, age 20s)

In another case, a client who applied for a hotel receptionist job, which matched her previous work experience, only to find that the job vacancy was for cleaning staff (Client 39, female, age 20s) reported she was advised by her job broker to

take the position because, *'at least it was a job'*. She turned the job down and eventually found a work experience placement on her own initiative. Similarly, some clients reported they were encouraged to apply for full-time work which they felt unready for. For example, one voluntary client who was referred to a job broker by her psychiatric nurse had expected the agency to take a more holistic view of her condition, seeking how she could ease her way back into work, preferably through a part-time job placement in her field. Instead she found the support to be *'any job focused'* and did not feel they understood mental illnesses:

*'It would have [helped] to have been somebody who had a bit of specific awareness of mental health problems I think and I didn't get the feeling with the people I saw that they really had any kind of understanding of what the problem was...I think in the end it was more just, "Let's see if we've got any jobs on our books?"'*

(Client 31, female, age 50s)

Another voluntary client felt abandoned by her job broker because she already possessed appropriate qualifications and recent work experience. Although she expressed interest, the training opportunities in job preparation and confidence building that were offered at the introductory meeting with her job broker adviser were not followed up:

*'She was just sort of, "Oh well, your qualifications are all there I don't think you'll have any problem in finding work." And I just thought, "Okay great, that's fine", but I'm still like a little bit should I or shouldn't I?, if you know what I mean?'*

(Client 2, female, age late 20s)

The client eventually found a part-time job after sending out multiple applications on her own initiative.

## 5.4 Work opportunities

In addition to paid work (discussed in Chapter 5), clients took up other work-related opportunities like volunteering and Permitted Work. The former were more common among the sample.

### 5.4.1 Volunteer work

Volunteer work was viewed as a practical bridge between paid work and benefits. People volunteered their time and skills in various settings, e.g., charity shop, day centre, garden maintenance. Clients reported similar benefits as those for paid work (refer to Section 5.2), like improved self-esteem, improved health and, *'something to get up for'*. For one client who did not feel well enough to commit to a regular job with concerns that his illness would lead to absenteeism, volunteer work provided some structure and purpose to his life:



*'I want to be doing something meaningful and I guess, answering the question, "Why do you do voluntary work?"...It's because at least it's something, at least I'm making an effort.'*

(Client 17, male, age 40s)

Similarly, one individual who was easing back into her profession through a voluntary placement reported feeling stigmatised as a patient and as *'somebody a bit odd on the margins'* when she mixed socially. She felt her volunteer work gave her a hook to help define her identity when asked, *'What do you do?'*

Volunteer work could be arranged by an individual's own connections as well as through Pathways. A staff respondent noted that more services are needed providing voluntary work placements and places where people with mental health conditions can work in a really supportive environment; get into a routine and feel able to do a work placement with an employer. However, it was rare for a client to report difficulties with securing a placement. One exception was a volunteer client who approached a job broker for help with job re-entry. She requested work experience to regain accreditation in her profession after a nine-year absence while on Incapacity Benefit (IB), following a mental breakdown. She found the job broker did not have the capacity nor the appropriate networks to arrange the specific placement. Instead, she felt the job broker was steering her towards paid work outside her profession which she was not interested in. In the end, she managed to secure a placement on her own, after a six-month search. She justified her decision to be a part-time volunteer because of the time needed to feel ready for paid work:

*'...returning to work after a long period I think it is a gradual thing and I think it is a sort of a whole identity and confidence and process...I am going to go back to work but I'm quite glad that it's taking quite a long time...'*

(Client 31, female, age 50s)

#### **5.4.2 Permitted Work**

Staff respondents discussed how Permitted Work can be good for clients with mental health conditions who haven't worked for a long time because they can stay on benefits, thus minimising feelings of financial insecurity, and it provides social contact. However, they also felt that it could negatively impact on client finances depending on the benefits that they receive. In the sample, there were few instances of clients taking up Permitted Work. In these cases, work of less than 16 hours per week was preferred because the client's health condition was unpredictable while medication and restless nights made it difficult to work longer hours. Work trials were a means of achieving this balance. One client's experiences, however, illustrate the difficulties of taking on Permitted Work while at the same time coping with a mental illness. Client 21, who suffered from bouts of depression, appreciated the work experience she received while on Pathways but her condition made it difficult for her to continue. She took on a part-time job (14 hours a week) in door-to-door sales but found it difficult to cope and

had to give it up after six months, following her GP's advice. She was prescribed antidepressants which made her tired and affected her memory. She then went on a number of short-term work trials but was not offered a job. She felt the experience of being rejected by employers plus her health issues would make her reluctant to apply for permanent work.

## 5.5 Other services accessed

As discussed in Chapter 3 many clients felt that their health impacted on job readiness. The ongoing treatments through NHS services that clients were accessing while participating in the Pathways programme tended to be health-focused rather than work-focused support, including medical and counselling services.

Aside from medical and counselling services, mental health clients accessed support services independent of the Pathways programme to help them emotionally and practically prepare for work. Clients mentioned both mental health and work preparation-related supports like: mental health charities, support groups for chemical dependencies, self-help groups, qualifications and skills training, advice on self-employment and registration with employment agencies. There was a greater usage of back to work support by the volunteer clients.

A support worker was more often present for people with drug or alcohol dependencies. Individuals were grateful for the guidance they received from a case worker when dealing with Work Focused Interviews (WFIs) and referral agents. For example, one client, with a history of alcohol dependency and depression, reported she relied heavily on her support worker who referred her to Pathways, accompanying her to the handoff meeting with a job broker and to a subsequent enquiry about RTWC at Jobcentre Plus:

*'I was being led by me support worker but I was telling her what I wanted to do and she was leading me in the right direction. She sometimes spoke for me, but I mean I would just let her. It was easier for me that way, because I trusted her implicitly obviously and she knew what she was talking about. She knew what I wanted, she knew what me life was like because I saw her regularly, so she did most of the talking.'*

(Client 7, female, age 50s)

### 5.5.1 Coordination of Pathways and other services

It was not uncommon for Pathways clients to be receiving help from multiple service providers in the medical profession, adult social services, Jobcentre Plus, job brokers and related services. From the client interviews it was not clear whether IBPAs or job broker advisers were aware of the other services that ran in parallel to Pathways or if 'case management' was being practiced or what it really meant. As Nice *et al.* (2009) point out, the overall coordination of support for Pathways clients is often seen to be the role of IBPAs. However, this can be undermined by the demands and constraints of advisory tasks or it can be shared

with other service delivery agents who may take a 'case worker' role during their time with the client. *'Case management was thought to work best where case managers have sufficient knowledge, expertise, time and flexibility to engage in the tasks of building trusting relationships, identifying appropriate and timely support, monitoring client progress, collaborating with key actors and recording and sharing client information.'* (p 67)

Case management arguably involves an element of partnership working and as discussed in Chapter 2, concern was expressed amongst a range of stakeholders that while there was a range of activity in local areas, contact was limited and awareness was implicitly somewhat superficial. This is reflected in client narratives. For example, at the time of the interview, one client (Client 21) who had been on IB for a year due to depression, was awaiting the start of CBT sessions while at the same time her GP had referred her to a horticultural course in plant growing as a means of therapy. The client commented she was willing to *'try anything'* to get back in to work. She had not as yet decided if this combination of support was practical or indeed manageable.

For a good quality client experience, the importance of ongoing communication and networking amongst the various Pathways service agencies (both subcontracted and non-subcontracted organisations) has been identified in previous research (Barnes and Hudson, 2006; Nice *et al.*, 2009). Some clients expressed concern about being inundated with appointments for different services and a general lack of cohesion among the services. For example, one 45 year old client with clinical depression reported participation in a series of services over a span of 18 months. This included WFI meetings, psychiatric counselling, CMP courses (work preparation, confidence building), eight CBT sessions, local job broker provision, self-employment advice through a local scheme and a college IT course. At the same time he was receiving support from a key worker which was disrupted due to staff turnover. The client did not finish or follow through with much of the provision because he felt overwhelmed by the mix of services. He felt that the different agencies did not communicate nor coordinate a package of services for him, albeit that he struggled to complete tasks. After being referred to the other services, this client lost contact with his IBPA and did not feel he was part of Pathways any more. Although he felt buoyed after the counselling he received, his confidence suffered as time passed and he still had not found work.

In another case a Pathways volunteer in his late 50s, who was referred to multiple providers, felt that he was ultimately turned down for back to work services because of his age. Client 3 who had been off work for nine years was referred by an IBPA to a job broker who subsequently referred him to a specialist agency for self-employment advice. Before starting a business in home repairs, the agency referred him back to the jobcentre to enquire about test-trading. It was another adviser at the jobcentre who told him he did not qualify for the self-employment support because of his age. Now retired, he relayed how he felt let down by the programme. He felt the process lacked coordination as the various agencies were not informed of his circumstances:

*'And the one didn't know what the other was doing and all through this experience it seems that nobody knows what the other one is about so you're sent back to the first one again "Well tell me what's happened" and you have to go through it all because this one didn't inform that one...'*

(Client 3, male, age 60s)

Lack of continuity in services raises the issue of case management, which seemed to be lacking for some clients. There were also examples of people who took up services they were referred to and upon completion, were left 'hanging'. At the time of interview some clients were waiting to be contacted by their Pathways adviser or were unaware if they were still part of the Pathways programme. Again, case management is important for clients accessing multiple services. Towards this end, it would be useful to map client services accessed, reflecting medical and work-focused treatments, and include those services initiated by a GP, various support agencies and by the clients themselves. In their review of Pathways referral practices, Nice *et al.* (2009) have also highlighted the merit of mapping client service activity as a means for coordination.

# 6 Issues in entering and sustaining paid work

## 6.1 Introduction

Chapter 1 noted the work of Waddell and Burton (2006) in synthesising the positive effects of work to indicate why it is good for your health. However, they introduce a number of provisos, including:

- the need to take into account the social context;
- the nature and quality of work;
- jobs should be safe and should also be accommodating for sickness and disability;
- that a minority of people may experience contrary effects.

One-fifth of the clients interviewed for this research were in employment at the time of interview. Most of these were in part-time work, with one in full-time work and one in Permitted Work. In addition one respondent was about to start work and two had recently had a short spell in work. This chapter draws on their perceptions and experiences of entering and sustaining work. The therapeutic value of work was evident for several clients. In places the chapter also draws on the perceptions of those who had not yet made an into-work transition.

## 6.2 Nature of employment

The jobs people entered tended to be low skilled and concentrated in the service industry (e.g., community care, cleaning, retail sales, office support). Work generally reflected people's skills and qualification levels and there was no evidence of down skilling in the sample. Individuals tended to take up work with a different employer, rather than return to a previous one, reflecting the time they had been out of the labour market.

Most worked part-time hours of between 16 and 20 hours per week. This might be anticipated for people with a mental health condition as a means to enable them to manage the transition into employment, especially if their condition could be aggravated by work stress. One client felt that a full-time job would have 'compromised' her health. Two respondents reported they would like to work more hours than their employer was able to provide. In all cases where clients were able and willing to work full-time hours, perceived improvement in their health was key. For example, one client (Client 8, female, age 50s) who was working full-time as a community carer and had claimed IB for four years following a medical procedure that led to depression, said she volunteered for Pathways because she felt ready to return to work, *'I wouldn't take a job on until I was a hundred per cent fit for work'*. Unsurprisingly, a greater proportion of voluntary clients who initiated contact with Pathways because they felt ready and able to go back to work, were in paid employment at the time of the study.

### 6.3 Clients feelings and expectations in entering employment

Initial feelings about starting work were generally positive because clients were achieving a goal they had set for themselves. As one client who was returning to her field of work as a carer summed up her feelings, *'I was happy because that's what I did want to do'*. (Client 43, female, age 40s)

Concerns were mainly discussed in the context of being unfamiliar with the new work environment. It was less often the case that people were apprehensive about their health condition interfering with their work performance or the work tasks exacerbating their illness. However, this also depended on an individual's well-being. One client who was still seeking treatment for her medical condition when she was hired after a work placement as a nursery nurse, expressed concerns because of the volatility of her health:

*'...some days I felt great and then the next day I felt like I couldn't leave the house and I thought that no one's going to employ me when some days I'm great and then some days I couldn't.'*

(Client 12, female, age 20s)

For those who were in work at the time of interview, the transition into work was unanimously a positive one. This followed from a desire to return to work. Respondents reported benefits to their physical and mental well-being, being financially better off, increased social contacts, and they appreciated having a structure and purpose to life. The following quotations illustrate this sentiment:

*'...at least when I went back to work there was a reason to go out and to get up and it just makes you feel better about yourself and your confidence starts to build more.'*

(Client 2, female, age late 20s)

*'It makes me live what I call a normal life.'*

(Client 7, female, age 50s)

It was pointed out that financial well-being and feeling 'better off' in work also depended on outgoings. Upon entering work, one client incurred the added costs of transportation, childcare and housing expenses that were not entirely offset by tax credits, resulting in little improvement in her income. Still the social and health benefits justified her decision to remain in work:

*'I just hate to think what I would be like if I hadn't sort of pulled myself out of it and said "Right, that's it, I want to go back to work". I would just sort of be sat here by myself all day not talking to anybody and it would have made the depression worse.'*

(Client 2, female, late 20s)

## 6.4 Discrimination and disclosure

On the whole clients who had moved into employment reported positive experiences of disclosing their mental health condition to their employer though their route into employment was not always smooth. Typically, clients did not receive advice about disclosing and drew on their own judgement. In one case the client was told by a job broking adviser to disclose her condition to the firms, but was told by an Incapacity Benefit Personal Adviser (IBPA) not to do so.

Client 2 described how she had many interviews but found it *'really hard to find somebody who would take a chance on employing us'*. She was well aware that on occasion she did not fit the criteria for the job, but there were other jobs that she was qualified for, but made no progress. After telling her current public sector employer about her two years on IB with depression at the outset, they had been *'great'* in accommodating a working time pattern that would meet her work-life balance needs. Like several other respondents in this study, she wanted to be up front about her depression because *'people are more understanding if you tell the truth'*.

Some clients targeted employers who they knew had a good track record of recruiting disabled people, which in a sense represents a discrimination avoidance strategy. An example of this is provided by Client 4 who had seen a television news report on his prospective retail employer which helped prompt his application. This coincided with him being on a training course organised by his future employer and being supported in the job application process. On this course he was advised to disclose because it was easier for the employer to help if they were aware of his circumstances. Another client was prompted into talking about their health history when prompted to explain a gap in their CV in an interview for a care sector job which she subsequently obtained.

Two clients in particular had very negative experiences of disclosure. Client 12 had obtained a job with a large retailer but found that her colleagues lacked understanding. She is critical of people who think you should *'snap out of it'*.

After leaving the job she happened to meet the interviewer who apologised for the way she had been treated, having subsequently learnt more about mental health conditions. The following quotation illustrates the difference that employer awareness can make:

*'Since you've left one of my family members have suffered from it and I'm really sorry for, like, the way I didn't understand because I've never experienced it before.'*

(Client 12, female, age 20s)

Clients who were not working at the start of their research interview conveyed many anxieties about disclosing their mental health histories to potential employers. A common thread running through their narratives was their concern that employers would see them as a risky appointment, hinting at the process of 'self-stigma' explored by Thornicroft (2006). This involves making choices not to pursue a particular avenue, for example, job search, in anticipation of failure. Client 9 and Client 26 starkly convey how client anxieties reflected at least a degree of internalisation of the stigma attached to mental health conditions and a perception of employer concerns around employing them, when they said:

*'...with us being on drugs and everything because I mean in this day and age now people don't think like they can give people second chances, they always think they're going to be the same and that's not right.'*

(Client 9, female, age 20s)

*'Employers will tell you that they look at each person individually on their own merits but if I was an employer and I had a person who tried to take their life a couple of times and who was on medication.. would I take that individual on or if there was an alternative applicant who had none of those issues, who would you take on?'*

(Client 26, male, age 30s)

Peer pressure could reinforce such feelings: Client 13 asserted that he would not disclose to an employer because he would not want anyone to think of him differently. Lack of understanding from his friends, who did not seem to take his health condition seriously, seemed to reinforce this attitude: *'they'll be telling me take my tablets, you know, and these are my friends so I'm not going to push that on an employer'*. (Client 13, male, age 20s)

Some clients indicated that in previous job search activity they had disclosed to some employers and not others. In the case of Client 11 she had feared that disclosing her health condition would lead to a questioning of her capacity to do the job, but in the end felt that this backfired when she could not cope with the pressure. One client explicitly emphasised the importance of people having support, describing the big 'burden' of having to disclose, the challenge being felt all the more intently by people who were feeling unwell.



## 6.5 In-work support and reasonable adjustments

### 6.5.1 Reasonable adjustments

Most clients who had moved into employment reported positive experiences of reasonable adjustments commensurate with having a positive employer response to disclosure of their health condition. For example, Client 4 was able to go for medical appointments as long as some notice was given. Client 7 enthused about having a public sector employer. Having an employer with a positive attitude was felt to make a huge difference to job retention, particularly when their condition continues to fluctuate. As one client noted: *'...they've got belief in me and I think that really helps to think that.'* (Client 12, female, age 20s)

As seen in Chapter 3, many clients who were not in employment were concerned about the willingness of employers to be responsive to their mental health needs. This meant that anxieties about employer willingness and scope to make reasonable adjustments interacted with perceptions of job readiness. Just one client in the sample had learning difficulties, a young Asian man who was extremely frustrated that he could not find a job. He had applied for a job at a large retail company where he had recently done a work placement, but was not given a job. His mother, who sat in on his interview to provide support, expressed the view that some employers cannot be bothered to give *'that extra bit of time to somebody with a learning difficulty'*. She was concerned that neither Jobcentre Plus nor the job broker to which he was referred would be willing to support him.

### 6.5.2 Financial support

Financial stability, particularly during the transition from benefits to wages and tax credits was also a concern. This related to unease over financing the gap between the last benefit payment and the first pay cheque. To address this, Return to Work Credit (RTWC) provides Pathways clients with an extra £40 weekly bonus for up to one year, for those who enter work of 16 or more hours per week. RTWC was the most often cited form of in-work support mentioned. All reported positive experiences and appreciated the extra money that helped *'put your mind at rest'*.

RTWC also acted as an incentive to work. Client 11 relayed her concerns about the financial transition between benefits and earnings. She claimed the RTWC payments made all the difference between taking a job and not taking a job:

*'My decision to take the job was based on the fact that they were giving us a lot of extra benefits to get us back to work so, therefore, it was worth my while trying to do it, even though I might not manage because of me health, I'd give it a try...'*

(Client 11, female, age 50s)

RTWC was also seen to make part-time work financially more viable and this was appreciated by people who viewed part-time hours as a way to ease themselves

back into work. In addition, one working client reported that it was her intention to find work at a minimum of 16 hours per week so she could qualify for RTWC.

No one expressed concern about a drop in income once the £40 payments stopped and all working clients in receipt of RTWC reported their intention to remain in work after payments ended.

### **6.5.3 In-work advisory support**

Although clients reported they were informed that their personal adviser would be available if needed once they were in work, this contact was rare. There was some mention of an adviser getting in contact during the early stages of work but this was not systematic, and contact was generally left to the client's initiative. This was the case regardless of whether an IBPA or a job broker was the main point of contact prior to work entry. The few instances where working clients re-contacted their advisers related to enquiries about RTWC or tax credits. One working client described her hesitation about contacting her IBPA because she felt that he was preoccupied with seeing people who were not in work; she perceived that people who were already in work were less of a priority to advisers.

### **6.5.4 Other supports**

There was little experience among the sample of other in-work supports available through Pathways. No one in the sample took up Supported Employment and reactions to the service were mixed. While some welcomed the idea of having such support it was also pointed out that the support should not be necessary because the preference was to return to work well enough to do the job independent of help. As one client who did not feel ready for work stated, *'I think once I got back into work I'd prefer to feel that I was able and not need somebody coming in.'* (Client 34, female, age 20s)

## **6.6 Gaps in support and suggestions for improvement**

### **6.6.1 Employer compassion and flexibility**

A few clients experienced difficulties with job retention due to the unpredictability of their health condition. These people identified the need for occupational health support in the workplace to advise on flexible working hours and sick leave as well as fulfilling the role of a person to talk to about work-related issues. One client attributed her supportive employer who helped her identify flexible ways of working with her ability to remain in work. Another individual who had various spells in work while undergoing treatment for her condition, suggested that having a person in the workplace to talk to would have helped her deal with the job-related stress she attributed to worsening her anxieties. Her work history consisted of a series of short-term and temporary service sector jobs with small employers that did not have the capacity to offer support:

*'I think it's down to the employers, if they have a personnel officer where you can go to in confidence and confide in I think that would help anybody.'*

(Client 11, female, age 50s)

Likewise, other respondents had experience of work which they had to give up in a matter of weeks due to the hours and demands of the job which they found difficult to cope with. Two of these experiences related to sales positions where earnings were partly reliant on commission. These experiences also call into question the role of job matching and the need to consider the demands of the work environment as well as the appropriateness of skills when job searching for people who have a history of mental illness.

### **6.6.2 Reinforcing information on services**

It was evident that some clients were either unaware of the supports they were entitled to or they had poor recall of information provided on the various forms of assistance. This was demonstrated in the number of respondents who identified Pathways supports they were entitled to as services they found lacking. Respondents mentioned services such as information on the financial implications of work, advice about in-work financial support and tax credits; and in-work advisory support especially during the first few transitional months. Given that a client's job preparation and journey into work can occur over an extended period of time, these examples of misunderstandings and uncertainties about the programme suggest that clients would benefit from information being reiterated, and reinforced with printed materials, closer to the time of job entry.

### **6.6.3 Wider awareness of mental illness**

Finally, changing societal attitudes and understandings of mental health in general and reinforcing awareness of the prevalence of mental illnesses would help to ease work re-entry for people who are coping with a mental health condition. This would entail educating employees as well as employers. Clients talked about both themselves and co-workers feeling unease when discussing their time out of work and medical treatment for a psychiatric illness. In order to avoid the discomfort some clients chose not to disclose their illness. Wider dissemination of literature about mental illnesses in the workplace would help people with a mental health condition adapt to a new work environment.



# 7 Understanding people's trajectories

## 7.1 Introduction

As seen in Chapter 2, a recurring theme from key informants working with mental health clients was the need to look at individual orientation to work and individual needs. People with mental health conditions are a heterogeneous group. Chapter 3 outlined the wide-ranging circumstances giving rise to incapacity benefit claims as well as the diversity of factors that clients perceived to be pertinent to their readiness for work. Health barriers were a recurring theme but these were complex. Many spoke of the need for mental health conditions to have improved or stabilised before an into-work transition could be attempted, or even contemplated. The role of broader societal attitudes and unaccommodating social arrangements in potential labour market encounters also weighed heavily in clients' minds, however. In this chapter we look at the range of outcomes from the Pathways programme among the clients in the sample and explore what some of the facilitators and enablers, and conversely barriers, to successful outcomes were.

## 7.2 Client journeys and the importance of taking small steps – signs of progression

Jobcentre Plus Pathways staff respondents made reference to various signs of client progression through the Pathways programme. These reflected a range of intermediary outcomes along a continuum of client journeys towards and into work of some form. Identified signs of progression included:

Signs of change in individual receptivity to journeys towards work and the possibility of entry into work:

- How clients engage in Work Focused Interviews (WFIs) and whether they appear committed to action plans.
- Whether they show more drive and responsiveness to Incapacity Benefit Personal Adviser (IBPA) suggestions.
- Whether they start engaging in more activities.

Signs of personal growth:

- The clients 'open up' and explain how they are feeling.
- What the client discloses about their personal life, providing insight into how this has changed over time.
- Client confidence visibly growing over time.
- The client's appearance improves.

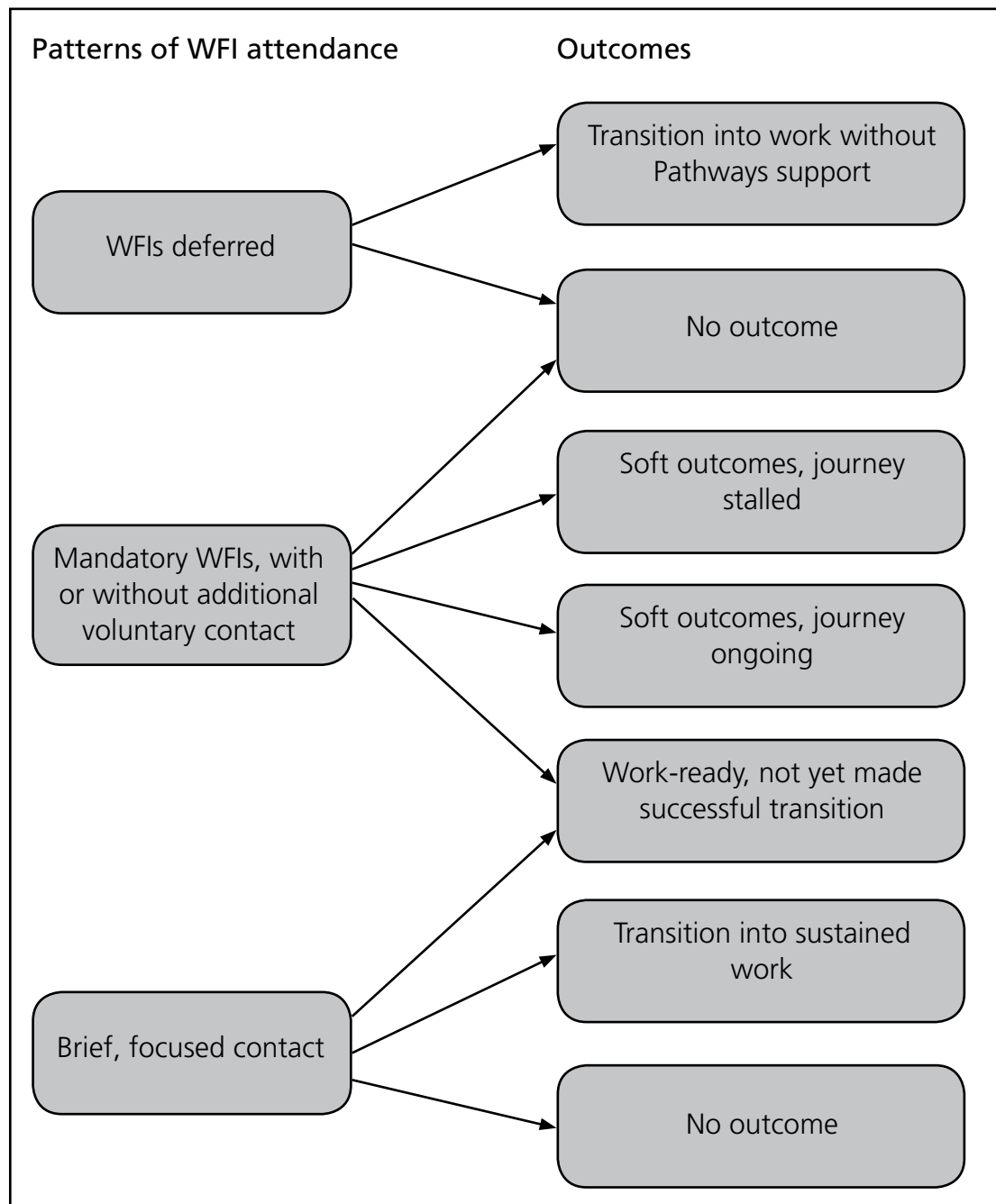
### 7.3 Mapping client trajectories and outcomes

Chapter 4 presented four different patterns of attendance at WFIs among the client sample:

- an initial interview followed by a deferral of further meetings;
- a series of six mandatory WFIs with no subsequent contact;
- ongoing regular contact with an IBPA for longer than six months;
- brief, focused contact with an IBPA prior to referral to other services or entering work.

These four patterns were also associated with different outcomes from the Pathways programme, as shown in Figure 7.1. The second and third patterns are presented and discussed together in Figure 7.1 and Section 7.3.2. This association between patterns of participation and outcomes is to be expected given that attendance at WFIs was related to varied client circumstances and needs, which also played an important role in shaping outcomes from the programme. It should be noted, however, that the outcomes in Figure 7.1 are not final outcomes for the clients concerned, but represent the stage that they had reached at the time of the research interview. As explained in Chapter 1, the length of time that had elapsed between Pathways participation and the research interview varied across clients within the sample, therefore the outcomes observed should be viewed as provisional.

Figure 7.1 Client trajectories and outcomes



### 7.3.1 An initial interview followed by a deferral of further meetings

As we discussed in Chapter 4, clients who had just one or a small number of WFIs and then had further meetings deferred tended to be those who were too ill to participate in WFIs or were undergoing National Health Service (NHS) treatment. Accordingly, as shown in Figure 7.1, most of these people were still attempting to manage or stabilise their health condition at the time of the research interview and, by their own assessment, had not moved closer to work. The majority of these people did not feel that it was the right time for them to think about work and were waiting for their health or other circumstances to change before they

could begin to start thinking about the prospect of work. Some, however, were using other services in the community to help manage their health condition and life circumstances and did see a return to work as an eventual possibility. An example of such a client is given in Box 7.1.

Some of the people in this group had engaged in Pathways in a limited way before being deferred, and had made very small steps towards thinking about work, for example, in one case preparing a CV with an IBPA, before withdrawing from the service due to a relapse in health condition. In addition, a small number of people in this group had made a successful transition into work, but without the help of Pathways support. For example, one man in his early 30s who had become depressed after losing his job in difficult circumstances was undergoing intensive counselling at the time of his first WFI and so was deferred. At the time of the research interview he was about to start work in a retail job, after receiving support from his General Practitioner (GP), a psychiatrist and a counselling service (Client 26).

**Box 7.1: Client 36: WFIs deferred, no movement towards work**

This respondent was a 23 year old woman who lived with her five year old daughter. She had experienced agoraphobia since she was 15, combined with depression, and was not able to leave the house on her own. She has not worked since leaving school, and until recently lived in supported accommodation. She had two WFIs at Jobcentre Plus before having further meetings deferred. She found having to speak to an adviser in an open-plan office about her condition extremely anxiety-provoking, due to her condition, and became very negative about the prospect of returning to Pathways for further support. She contrasts Pathways to her experiences of a young people's mental health support group which she was referred to by her GP:

*'...it's really good, especially for young people, it's absolutely brilliant...it's more your age group and you feel the people that you are talking to are more on your level, they can kind of understand where you are coming from...If you need to talk in private there's a room that she'll happily take you in away from all the crowd downstairs and that is great.'*

The respondent did envisage an eventual return to work but not in the near future:

*'I'd like to work in the future, you know, no one wants to be as I call it, crazy,...and I'd like my daughter to look up to me and stuff,...but at the moment it's just a no-go area. I physically can't...if I can't go out how am I supposed to get a job and stuff?...that's why I see a counsellor, because hopefully I'd like to get better one day and, you know, be so-called normal, so yes.'*



### 7.3.2 Series of six mandatory WFIs, with or without additional voluntary contact

Among those respondents who completed the series of six mandatory WFIs, some of whom made further additional voluntary contact with an IBPA, and some of whom participated in other Pathways services too, outcomes from the programme were diverse. The majority of people in this group had experienced some kind of 'soft' outcomes from their Pathways participation, but at the time of the research interview had 'stalled' in some way. The outcomes experienced were wide-ranging, similar to those identified by the staff respondents discussed above, including an enhanced sense of wellbeing by 'having someone to talk to'; gaining additional motivation and structure in their lives from attending regular WFIs; developing greater confidence as a result of interacting with others in group settings or through volunteering; or practical skills acquired through taking training courses. Their journeys towards work, or at least towards thinking about and preparing for work, seemed to have stalled after their participation in Pathways had finished. This was either because the mandatory WFIs had come to an end and it had been left to the client to proactively seek further contact, because a health condition had worsened, or because a client had become disillusioned with the support available to them through Pathways and had disengaged. As discussed in Chapter 4, it was notable that some of these clients were receptive to further contact and hoped for an eventual return to work, but seemed unlikely to make proactive further contact with services themselves and might have benefited from a further 'push' by their IBPA. One example of this is given in Box 7.2. Of course, it is possible that some of these clients would be subsequently contacted by their IBPA further down the line.

#### **Box 7.2: Client 38: Soft outcomes from Pathways but journey towards work stalled**

This respondent was a woman in her late 40s, who at the time of interview was a single parent with two children. She came to the UK as an asylum seeker and now has refugee status. She had been diagnosed with depression a year earlier after a long period of illness. She was trained as an engineer in Iraq but has not worked in the UK and was claiming Jobseeker's Allowance (JSA) prior to moving onto IB after she was diagnosed. She had six mandatory WFIs at Jobcentre Plus and was referred to the Learn Direct service to gain some work skills, where she undertook several courses. While she felt some improvements from taking the courses, she was struggling to complete them because of her depression:

*'It does help me...to make me, at least for one or two hours, to go on the computer to forget about my problems...that's helped, and when I start to gain a bit of progress...I felt a bit happier about myself. But the problem is...I supposed to finish two months ago or three months ago,... you know, when I feel again down, I can't go on,...I feel I repeat it again, again and again without concentration.'*

Continued

She felt that to progress further she would like to do some voluntary work, both to improve her language skills and also to build her confidence through interacting with other English people. It is unclear why she did not receive any help with finding this from the Pathways programme, but she spoke about needing her adviser to be more proactive and provide more support in encouraging her to take up services. When asked if she mentioned her desire for voluntary work, she said:

*'They told me, "fine, it's all right if you want to go to",...but they haven't done serious step [in other words, they had not helped her move forward as much as she would have liked]. ...When you are depressed you know everything, but you can't step, this is the problem, because you feel, you don't feel alive,...because you are ill you don't step yourself, you need somebody to help you.'*

After her final mandatory WFIs, she had no further contact from Jobcentre Plus and seemed to have stalled in her journey towards work.

There were also respondents in this group who had maintained contact with Pathways after the series of six mandatory interviews and while they were not work-ready at the time of the interview were still in contact with services and making further progress. The key in these cases seemed to be an IBPA who had adopted the role of case manager and had maintained proactive contact with the clients after the mandatory WFIs had finished. An example is given in Box 7.3.

### **Box 7.3: Client 33: Soft outcomes from Pathways and journey progressing**

This respondent was a man with a non-working partner and several children, all in full-time education. He had been on IB for around 18 months and a drug user for some ten years. When he came off drugs a couple of years ago, he started to experience mental health problems and left his job. At the time of the interview he had completed the cycle of six WFIs and was continuing to see his adviser. He got on very well with the adviser, and was most impressed by the fact that she listened to what he wanted to do and supported him to do it rather than directing him. He was referred to a specialist training adviser in Jobcentre Plus to discuss course options, which he found very helpful. He decided on a course in mentoring, stimulated by the fact that a local church had asked him to provide mentoring support to local children. His completion of the first year of the course was a major achievement to him, particularly as he had done no education or training since his school days and he credited his adviser with giving him the motivation to complete the course:

Continued

*'I did not want to go to college, that was the last thing, I was never one for school, [but] I had a Pathways to Work Adviser and she was really good, you know, and we looked into something and we looked into a course.'*

Having completed the course, he was not sure whether this was the right direction for him and, at the time of his interview for this research, was looking into construction courses, an area of work he has past experience in.

In addition to Pathways he has a range of other support which have enabled his progression: the tutor at college has been very encouraging and provided individual support; he has a drugs key worker who helps him set personal goals and follow them through; and he attends a day centre for therapeutic activity and personal development support.

Finally, there were also some people in this group who had progressed during Pathways so that they were almost at the stage of being work-ready although had not yet, at the time of the interview, secured a successful transition into sustained work. In these cases, clients had either engaged in Permitted Work, work trials or unsupported employment but had found the pressures of their job too much. An example is given in Box 7.4.

**Box 7.4: Client 11: Journeyed to work readiness but not yet experienced a successful transition into work**

This respondent was a woman in her 50s with a long-standing mental health condition (as well as other health conditions), who had had several spells in and out of IB between doing various jobs. Most recently she had taken a job for a charity, soliciting contributions from the public in a shopping centre, but had only stayed in the job for three months as she was not able to cope with the pressure and the long distance she had to travel to work. Her GP had advised her to stop working, although she was keen to work because she felt better when she was working and was financially better off. While she had a good relationship with her adviser, she seemed to have no awareness of In Work Support. She had not entered the kind of 'safe' job, accommodating of sickness and disability, that Waddell and Burton (2006) discuss.

**7.3.3 Brief, focused contact with an IBPA prior to referral to other services or entering work**

The majority of people in this group were much nearer to being work-ready at the time they came into contact with Pathways (many were voluntary clients) and either had contact with an IBPA before moving relatively quickly into work or were referred on to another service, usually a job broker service, for support with the into-work transition. Thus, the predominant outcome for people in this group was a sustained transition into work. The few exceptions comprised people who had disengaged from Pathways because they were dissatisfied with the

service received. For example, one man, who was 60, was turned down for self-employment support on the basis of his age and subsequently became disillusioned and lost contact with Jobcentre Plus; another young man with a learning disability was referred onto a job broker service but after an initial assessment had received no further contact and was seeking additional support outside Pathways at the time of the interview.

Among those who moved into sustained work, nearly all were voluntary clients who had proactively approached Pathways because they felt ready to look for work. The one mandatory client in this group was a woman who was suffering from depression following an operation when she went onto IB, but subsequently regained her health and felt herself to be work-ready after just a couple of WFIs. She then moved onto JSA before entering work. Of those who proactively approached Jobcentre Plus, some received most of their support from Pathways (for an example see Box 7.5), while others had initially approached another provider and were simply referred to Jobcentre Plus when they were ready to enter work in order to find out about in-work services, notably the Return to Work Credit (RTWC). In these cases, then, Pathways played only a small role in their transition into work; (an example is given in Box 7.6).

**Box 7.5: Client 4: Transition into sustained work with Pathways help**

This respondent, a man in his late 50s, had experienced depression triggered by bereavement and was on IB for over five years. He entered work in retail a year before his interview for this research and he had stopped his medication a year before taking the job, a sign that his health had improved. The last job he did, other than training schemes, had been almost 20 years earlier in a declining industry. This respondent praised the help that he had received from Pathways with whom he had contact for two years. He attributed his success to the IBPA, who he was still visiting at the time of his research interview, and Condition Management Programme (CMP). Describing himself as determined to get a job, he was working for an employer to whom he had disclosed his mental health condition and who was very supportive of him.

**Box 7.6: Client 12: Transition into sustained work with limited role of Pathways**

This respondent was a young woman in her mid 20s who experienced the onset of depression in her late teens. Symptoms of this included anxiety and panic attacks which got progressively worse and she stopped working on the advice of her GP. After two years on IB she felt as though she was in a vicious circle: not working and staying in the house a lot was making her feel worse. After contacting several job brokers, she began working with one that had a Pathways to Work contract. Extensive support was provided by the job broker, who found her a local work placement, accompanying her to the interview and helping her to disclose her condition. Eventually she was offered a part-time position. The combination of In Work Support for the first few months of work from the job broker, and an understanding employer, had helped her stay in work.

As is illustrated in the preceding discussion, there is a strong association between improvement in depression and improved capacity for work (Simon *et al.*, 2001; cited in Waddell and Burton, 2006). This is reflected in the fact that those people within our sample who achieved a sustained work outcome were nearly all voluntary clients who had contacted Pathways proactively when they felt ready to start looking for work. Nonetheless, there was also a range of outcomes for those people who were not initially job ready, or even ready to start thinking about work, but who engaged in the Pathways programme as mandatory clients. Their experiences provide insights into what the facilitators of positive outcomes are for mental health clients in the Pathways programme, as we explore below.

## 7.4 Facilitators of positive outcomes: Pathways support

### 7.4.1 The importance of getting the timing right for the intervention

A particularly strong theme emerging from this research is the importance of clients accessing Jobcentre Plus Pathways to work at a time that they are able to benefit from what the provision has to offer; both WFIs and referrals to other supports.

A number of respondents expressed the view that Pathways had not come at the right time for them. Explanations for this often centred on their health conditions, but not exclusively so. For example, Client 17 said that engagement in Pathways had not come at the right time for him as he was dealing with many issues in his life. While he could see what the programme was trying to do, he felt that it had no impact on him:

*'It wasn't the right time because I had all this other stuff in my head as well. I was doing it, if you like, and I was seeing the value of it, but I was going through the motions.'*

(Client 17, male, age 40s)

Not all clients who felt it was the wrong time had seen the value of Pathways involvement. A mother who had lost her child and was still going through the grieving process at the time of her WFIs, said of her experiences:

*'I personally didn't get anything out of them, just harassment basically because of having to fit them in and go to them. I didn't actually get anything out of them.'*

(Client 15, female, age 20s)

These accounts are from the client's perspective and it may be that IBPAs noticed changes in their clients during their contact with them, if only increased awareness of supports available.

The analysis above and in Chapter 4 shows that most clients who did not feel that it was the right time to engage because of their health condition did have further WFIs deferred by their IBPA. However, some found the experience, even if they just attended one WFI, extremely anxiety-provoking, either because they felt they lacked control over the timing, as was the case with the example above where the respondent felt obliged to attend a WFI shortly after her daughter died, or because they felt the circumstances rendered them unable to participate properly in the WFI, because of their state of mind or because of conditions such as a lack of privacy. Negative experiences of the first WFI can limit the extent to which clients are willing to re-engage with Pathways at a later date, once they feel that their health condition has improved sufficiently, as was seen in the example in Box 7.1.

#### **7.4.2 The importance of long-term support and case management**

As examples provided previously (and in Chapters 4 and 5) indicate, clients can complete the Pathways programme, both WFIs and referrals, and still require further support to continue a long journey into work. They can experience positive outcomes, for example through engagement with CMP, but not feel ready for work. This highlights the importance of long-term support from the Pathways programme. While this is important for all clients, it is particularly important for many mental health clients. Clients with mental health problems have a distinctive profile within Pathways, being further from work at the outset, less likely to enter paid work following Pathways, and much more likely than other clients to have a fluctuating health condition over the previous year (Bailey *et al.*, 2007). As noted in Chapter 2, key informants reiterated these themes as did clients falling within some of the trajectories outlined in Figure 7.1.

At present, the examples above suggest that some people had stalled in their journey due to the way the programme was structured: after completing six mandatory WFIs they were not encouraged to maintain contact. While all people we spoke with in this position had been given their adviser's contact details, hence in theory 'the door was still open', in practice it seemed that many would have required more proactive contact from their adviser to re-engage with the programme. While many of these people had started to take small steps on a long-term journey to work and were receptive, or at least not resistant, to further support, this had not been forthcoming.

In addition, some of those who were deferred due to their health received no subsequent contact from Jobcentre Plus, even though at the time of the interview they were feeling better and potentially ready to take steps towards work and would have welcomed further contact. While deferred clients were often in agreement with the IBPA decision to defer, not all clients were happy with the way this had been handled. For example, while Client 27 felt that it had not been the right time for her to engage with Pathways, she had wanted some advice and to be made to feel that there was an open door to contact the IBPA in the future. She was surprised at the lack of advice but did not express this:

*'I was surprised [at not getting any advice] but just left it, I never really said anything. I thought when I'm ready to go back to work, I'll get up and go!'*

(Client 27, female, age 20s)

While the Pathways programme envisages IBPAs having an overarching case manager role, overseeing clients' journeys all the way into work (see Nice *et al.*, 2009), there are signs that this might be being compromised by performance pressures facing IBPAs.

### **7.4.3 The importance of the right combination of support**

In order to progress it is important that the right support is available (both Pathways and non-Pathways) and advisers need to have the time to find out about it and access it. Several key informants expressed frustration that the right kind of support was not available for clients, some conveying that if clients were not suitable candidates for CMP, they had little else to offer them. Jobcentre Plus key informants were mostly aware of the range of Jobcentre Plus supports available. However, as discussed in Chapter 2, they were not always aware of non-Pathways support and expressed concern about the time that they had to find out about and engage with other potential support for their clients.

## **7.5 Facilitators of positive outcomes: Support outside Pathways**

As discussed in the last chapter, many clients were using a wide range of services that were unrelated to Pathways. This included both NHS-provided support for their mental health condition as well as a range of community services that

provided support with health, life skills or work preparation. It was also notable that this varied widely across the sample, a point reinforced by key informants who referred to access to support groups being 'a postcode lottery'. Where these types of support were accessed, they were seen by clients as vitally important in enhancing their well-being, potentially enabling them to engage in more work-focused support, either alongside or at some point in the future.

### 7.5.1 Counselling and talking therapies

Counselling, provided through the NHS or other providers, was viewed as very beneficial by the majority of clients. It was both in widespread use among the sample, but also widely sought after, with a number of clients making reference to long waiting lists and/or an inability to access provision. In some cases, it seemed that clients valued WFI meetings with their adviser because they wanted 'somebody to talk to' and had no other avenues for this support. Some clients described receiving this support through community-based services, for example, one woman described the support she received from a local community group, which also offered training courses for work preparation:

*'...you sit and basically have a chat, and plus if there's something really getting you down, you can go to the office and ask for a one-to-one and they take you away from everybody, and there's a person, a volunteer sits with you...and listens and you get it all off your chest, if there's anything she can advise you about, she'll advise you.'*

(Client 5, female, age 50s)

### 7.5.2 Group interaction

In addition to one-to-one support through counselling or other 'talking therapies', participants also highlighted the importance of being in situations where they were interacting with a range of other people, which was very important for some clients who had experienced isolation and a lack of social support. This was often felt to be necessary in order to build confidence before a move into work could be considered. Such support could take a number of forms. Group-based support sessions were welcomed by a number of people, for example one man referred to an informal support group he attended for recovering alcoholics:

*'...it was a really good fellowship, do you know what I mean, really good, and it gave me the sort of things, like a goal not to have had a drink by the next meeting, and we would have small group sessions, they would be single sex, and we'd sit round with a load of lads and you'd talk through whatever was brought up in the group, and I found that very helpful.'*

(Client 20, male, age 20s)

In addition, some people spoke about attending or volunteering at support centres for mental health clients which offered therapeutic activities and opportunities for interaction. For example, one young man who was autistic as well as suffering from depression, and who expressed a sense of isolation despite living with his parents, described volunteering at art classes at a day centre:



*'Well what I do is I'm an art volunteer...So that's what I do with my time usually to occupy myself...helping out or people helping me, sort of a very close group, you know like a family.'*

(Client 19, male, age 20s)

### 7.5.3 Support workers

One factor that seemed to be crucially important for many people was the presence of a key worker or support worker. This could be provided by the NHS, e.g. a drug or alcohol support worker, or through a voluntary organisation. Only a small proportion of people had such a worker, but those who did were unanimously positive about the support received. Examples include one older woman who had suffered from depression for five years since her husband died, and who had a support worker through a local voluntary organisation. Together they developed a plan of action for returning to work and the support worker accompanied her to meetings with the various agencies who could offer support, including Jobcentre Plus. At the time of the interview the respondent had sustained work for 12 months, and stated:

*'She was a godsend, she was, she was just nice and helped me a lot. Maybe without her I'd still be sitting here vegetating, so...she's brilliant.'*

(Client 7, female, age 50s)

Another example was a young woman with agoraphobia (discussed in Box 7.1) who had a support worker through a mental health support group for young people. The support worker was able to accompany her to counselling sessions, which was vital, since, because of her condition, she felt unable to leave the house on her own.

While family and friendship support was important (see below), clients with support workers spoke about how it was helpful to have somebody outside the family to talk over issues with and receive impartial advice. One man with an alcohol support worker (which he recognised to be 'a rarity'), said:

*'...if I say to my mum I'm feeling a bit down she'll get stressed out and worried about it so, but if I can say to [the support worker] oh I'm p\*\*\*ed off with this, it won't go any further, do you know what I mean, my concern is not to pass on worry to the rest of my family...they're there for me but it's, [the support worker] will give me sort of, well you could call it objective advice...'*

(Client 20, male, age 20s)

Respondents also viewed support workers as being 'on their side', which in some cases contrasted to their views of Jobcentre Plus staff, who they saw as there to do a specific job, i.e. getting them back to work. In these cases, support workers were seen as playing a more holistic role and taking a view of the client as a whole person. One woman, whose Community Practice Nurse (CPN)/psychiatrist played this key worker role, stated:

*'I did feel that she was on my side and I think she was, you know, she was very much backing me.'*

(Client 31, female, age 50s)

#### **7.5.4 GPs**

As discussed in Chapter 2, Jobcentre Plus Pathways staff had relatively little contact with GPs and were sometimes sceptical about whether GPs had embraced the ethos of Pathways. They felt that there was too much emphasis by GPs on health as a barrier and what the client can't do rather than what they can do. They were concerned that this could be confusing for clients if GPs and IBPAs were presenting contrasting points of view on their readiness for work or engagement in Pathways. In the client interviews, respondents were also asked about their relationships with GPs and how this related to their Pathways involvement. A mixed picture emerged.

Some clients, including some who had quite serious conditions and were seeing their GP as well as other NHS providers on a regular basis, said that they had not discussed their Pathways participation with their GP, nor with other NHS personnel such as CPNs or therapists. This could be potentially problematic and there was the potential for mixed messages to be presented to the client. In one case, a woman with schizophrenia who had been on IB for a year since leaving prison had regular contact with a CPN as well as a support worker linked to her accommodation, but had told neither of these people about her Pathways participation. While the client herself felt that she wanted to work, she noted that the CPN, her GP and other health professionals all felt that she was not ready for work. In this case, while the respondent was unclear about the status of her Pathways participation, it seemed that she may have been deferred after two WFIs pending further NHS support (Client 24).

While one client commented that she would never have time to talk to her GP about Pathways participation: *'they only have a few minutes to see you...so I think that's the last thing I want to talk to them about'* (Client 37, female, age 30s), other clients had very good relationships with their GPs and had found them to be very supportive, referring them to a range of NHS and community support services, and in one case even writing supportive references for employment. In this case, the respondent felt the GP to be a key element in the package of care that had allowed him to make a successful return to work (Client 26). After this man had had his WFIs deferred, he had made a successful return to work without Pathways support.

The examples where clients noted that their GPs were not in favour of them taking up work were usually cases where this was also the view of both the client themselves and the IBPA, for example, where WFIs had been deferred. Other cases were where respondents had taken up work (or Permitted Work) and found it too stressful. In these cases, both GP and IBPA were in agreement that this type of work was not best for the individual concerned. The only examples where there

seemed to be disagreement between GPs and Jobcentre Plus were cases where respondents were appealing decisions to be removed from incapacity benefit following a capability assessment, and GPs were supporting them in appealing the decision.

### 7.5.5 Informal social networks

Finally, the presence of informal social networks of friends, and particularly family, emerged from client narratives as very important in facilitating positive journeys. These networks and relationships were important in a number of ways. Firstly, some people in the sample spoke about the importance of relationships to their health improvement. For example, one woman in her 50s who had been on IB for nine years triggered by workplace stress, felt that a new relationship with a partner had been one of the triggers to her feeling well enough to start thinking about work and eventually to taking up a work placement and voluntary work. Another younger woman also spoke about a new relationship triggering an improvement to her health and encouraging her to think more positively about work, so that she proactively sought support from a provider organisation. Other women spoke of the importance of children or grandchildren in giving them the motivation to 'sort themselves out' and start thinking about work again.

Family networks also provided considerable practical and emotional support to clients. A number of respondents said that they wouldn't have been confident enough to attend their initial WFI on their own and took a family member (or a friend) with them for support. In one extreme case, one man who was an alcoholic, described how his 12 siblings, who all lived in the neighbourhood, provided extensive practical support by shopping and cooking for him and even managing his money so that he didn't resort to buying alcohol. This case also reveals the potentially negative impact that some types of social networks can have on client journeys too. While his siblings managed his money so that he did not buy alcohol, the respondent recounted how the presence of drinking friends in the neighbourhood exerted a negative influence on him:

*'...you see when I'm in the house people know I'm in so they're coming round, having a chat, sit here, bring cans round, and I've got to try and stop that.'*

(Client 35, male, age unknown)

He was considering moving house to avoid this social network, but did not want to move away from the support of his family. A similar predicament faced another respondent who was an ex-drug user. At the time of the interview he had recently moved house to break the ties with his former drug-using friends, but in his new house, although living with his partner and children, he feels quite isolated and it has been a big upheaval, especially settling the children into new schools. He worries about running into his former friends at WFI appointments and for this reason takes his brother with him who waits for him in the car because *'I was afraid of who I would bump into...I just couldn't trust myself.'* (Client 33, male, age 40s)



## 8 Conclusions and policy implications

The Pathways to Work evaluation synthesis report notes that: *'Given the prevalence of mental illness among the Pathways population, identifying ways of better supporting those with such a health condition would seem an important priority.'* (Dorsett, 2008: 86). While impact study evidence on the effectiveness of Pathways for those clients who have a mental health condition is mainly positive (see Section 1.2.3), the qualitative evidence presented in this report provides a grounded and mixed picture of client outcomes.

### 8.1 Summary of research findings

When asked about their feelings about work, a range of factors, often multiple and interacting, were evident in the mindsets of clients (Chapter 3). There were concerns about their health condition and about working linked to levels of confidence about going into work and being able to function in the workplace. Also evident were concerns around the stopping of benefits and the ability to meet the costs of household bills. Clients talked at length about the kind of work that they felt able to do with some wanting to return to their previous occupation and others wanting to retrain. Many clients wanted to work in the future and most also had views on the type of working arrangements that would be appropriate with frequent reference to part-time work and the need to test out job suitability. A further recurring theme was anxiety about age discrimination and stigma attached to mental health conditions linked to fear of the repercussions of disclosing health histories to prospective employers. Clients were also mindful of local labour market conditions and the economic climate.

On arrival for their initial Work Focused Interview (WFI), clients are often feeling anxious and vulnerable. This report has revealed a wide variety of experiences and views among clients about WFIs. Their experiences ranged from having relatively limited contact: one or two meetings followed by a deferral or by making a successful transition into work, to much more extensive and longer-term contact

with an Incapacity Benefit Personal Adviser (IBPA). Their views varied too, to a large extent reflecting the type of Pathways contact they had: those who were negative were usually those who had been deferred and had not established a relationship with an adviser, nonetheless, the traumatic experiences recounted by some of these respondents at their initial WFI meeting(s) has implications for whether these clients are likely to be receptive to engagement with the programme at a later date when their health or other circumstances have improved. In addition, there was also more widespread dissatisfaction with specific aspects of the WFI process, including inflexibility in scheduling, particularly the first WFI, and the lack of privacy in WFI meetings.

Client accounts suggested that maximising their control over the back to work process, good adviser communication skills and the ability to address their health conditions sensitively and appropriately, were three key factors shaping positive advisory relationships. While clients that were positive about their WFI experiences and were receptive to Jobcentre Plus support sometimes had an ongoing relationship with their IBPA after the six mandatory WFIs, others did not, and there were some people whose journeys seemed to have stalled because of a lack of proactive contact from Jobcentre Plus. It, thus, seems that there was greater scope for more individual tailoring of meetings to clients' needs and circumstances.

IBPAs held mixed views about their capacity to support people with mental health conditions. These raise the question of to what extent might adjusting the attitudes/beliefs of IBPAs regarding this capacity to support people be one of the keys to more effective support? Do IBPAs perhaps underestimate their capacity to help (so offer less) or underestimate the capacity of claimants to respond (if more 'optimistic' suggestions were made)? Clearly there is a fine line to balance here and client accounts suggest that they do not always get this balance right.

However, there is also a key issue of the context in which IBPAs support clients and the degree to which it is hospitable to meeting their needs. A very strong theme amongst IBPAs, both in individual interviews and at feedback workshops, was that their initial training had firmly set up an expectation that their role was to provide a tailored, individualised service to clients. Meeting their needs and respecting the varying length of time that clients might need to progress was all part of the service that they should be providing. However, they conveyed that the performance target culture was distorting this vision of support and having a negative impact on their job satisfaction (see Chapter 2). There was a broad consensus across participants in this research that a one-size-fits-all approach does not work, particularly for people with mental health conditions, who are a heterogeneous client group with many different issues. However, the attention that can be devoted to a single client is perceived by key informants/workshop participants to have been scaled back in Pathways.

The signs of positive progress described by key informants and outlined in the previous chapter provide some insight into the range of softer outcomes that might have a role to play in creating greater target sensitivity to client journeys and their

role in enabling them. Their narratives seem to reinforce the findings of Dorsett (2008) on new and repeat claimants, that *'the extent to which job targets might influence the nature of support provided to Jobcentre Plus Pathways customers should be carefully examined in order to ensure participants receive the assistance that best promotes their long-term position, and similarly that referral to voluntary provision should be dictated by the appropriateness of the service rather than the need to meet referral targets.'* (Dorsett, 2008: 99)

While relatively few clients reported experience of the Condition Management Programme (CMP) their perceptions were generally positive. Clients relayed positive changes to their self-confidence, social networking skills and attitude towards working, over and above other treatments they were receiving or had received in the past. However, most participants did not feel their condition had improved to a point where they felt ready for mainstream work. Clients as well as CMP managers and practitioners cited concerns about prolonged waiting times which could detract from the flow of services. The duration and continuation of CMP services was also called into question by key informants as well as by some participants (Chapter 5 and explored further below). It was not uncommon for Pathways clients to be receiving help from multiple service providers in the medical profession, adult social services, Jobcentre Plus, job brokers and related services. From the client interviews it was not clear whether IBPAs or job broker advisers were aware of the other services that ran in parallel to Pathways or if 'case management' was being practiced or what it really meant (Chapter 5). Voluntary work was viewed as a practical bridge between paid work and benefits.

On the whole clients who had moved into employment reported positive experiences; both in disclosing their mental health condition to their employer and in securing reasonable adjustments, though there were exceptions. Some clients targeted employers who they knew had a good track record of recruiting disabled people or persevered with job search until they found an employer who was willing to take them on. Those clients who were working emphasised the positive impacts that work had on their sense of well-being. Clients who were not working conveyed many anxieties about disclosing their mental health histories to potential employers. This reflected at least a degree of internalisation of the stigma attached to mental health conditions. There were some signs of a desire for social support within the workplace as well as a need to reinforce information on in-work support services, and clients had poor recall of information provided on the various forms of assistance. This research reinforces the need to change societal attitudes and understandings of mental health (Chapter 6). It also suggests a need for more work with clients around disclosure issues.

The facilitators of positive journeys emerging from this study (Chapter 7) include:

- getting the timing right for intervention. This point reflects how many clients did not feel that they engaged with Pathways at the right time for them, in contrast with voluntary clients who had experienced a health improvement;
- the importance of long-term support and case management;

- the importance of the right combination of support;
- support outside Pathways, including:
  - counselling and talk therapies;
  - opportunities for group interaction;
  - the presence of support workers;
- GPs embracing the ethos of Pathways;
- the presence of informal social networks of friends, particularly family. These networks contributed to health improvements, practical and emotional support.

Many clients were satisfied with the help they received from Jobcentre Plus Pathways, though importantly, many felt that the opportunity to participate had not come at the right time for them. The range of suggestions for improvement that emerge in this research are indicative of areas of dissatisfaction. Satisfaction for some clients was conditional on achieving a sense of accomplishment, often in relation to training or entering work. For those who felt ready for work, Pathways was seen to offer a balanced mix of soft skills and work-focused activities. This view was expressed by one client, with a history of alcohol abuse and depression, who experienced a gradual movement into voluntary work, after a series of WFIs and participation in CMP:

*'I think their approach is right, to build people's confidence and then you get them into some form of training or voluntary work...to me seemed the logical thing you know, learn some new skills, build up your confidence, meet new people, make new friends away from the friends I used to drink with and all of those things and it has helped me to do that.'*

(Client 20, male, age 20s)

## 8.2 The adequacy of Jobcentre Plus Pathways support

This report closes by reviewing suggestions for improvements to Jobcentre Plus Pathways support for mental health clients. Clients were asked about the adequacy of support they received, if services were lacking and what changes could be put into place to improve Pathways support. In the following sections client feedback is summarised, as exploring their perspectives on their experiences was one of the main aims of the research. Comments from key informants and workshop participants are also added at appropriate junctures.

### 8.2.1 Service gaps

Although most feedback from clients was related to adjustments to existing services that they had received, some identified additional services they would have liked.



Anxieties relating to the financial viability of working were common and some clients felt there wasn't enough **guidance and information available about managing the transition to work, saving and budgeting**. The interaction of Housing Benefit (HB) with the transition from Incapacity Benefit (IB) to wages and Working Tax Credit (WTC) was also seen to cause confusion.

A few clients would have appreciated guidance for setting up a business. Self-employment was seen to offer flexibility in terms of the quantity and timing of work, attractive options to people whose health conditions were less predictable. Similarly, running a business from home was considered a more viable choice for one individual with behavioural patterns that were not conducive to working in public.

Clients indicated that more proactive contact at the end of the series of six mandatory WFIs might be helpful – even for those further from work who still have health issues to address. Jobcentre Plus staff noted the resource constraints on this activity and how it can be a challenge to identify client barriers even after five WFIs. In addition, an **after care or follow-up service** was identified as something some clients would have preferred. This seemed to be more of an issue for people who had taken up referrals to services like CMP or training after having regular meetings with their IBPA. This is similar to the issue about the coordination of services, discussed in Chapter 5, but extends this to include a more proactive advisory model with a view to assessing the need for further support after the activity was complete. Several clients described feeling abandoned or in limbo after their time with a service had ended. One client described a window of time after completing his CMP sessions when he felt motivated to do a job search, but over time this diminished and he looked at this as a lost opportunity:

*'[I was waiting] for my adviser to contact me about work so I could take that next step, but at the time I couldn't take that next step because I felt as if I couldn't get to that next level I was stuck in this rut...I wanted to get out there but I couldn't and I had all this confidence and I felt better but I couldn't do anything about it.'*

(Client 19, male, age 20s)

Similarly, a few clients who were working said they would have liked to have been contacted by their IB or job broker adviser during the early weeks in the job as a form of reassurance and support. Greater individual tailoring of IBPA meetings within the fixed structure of WFI meetings.

Finally, a few clients suggested that Pathways include a form of **mentoring system** where new clients can interact with former clients, hear about solutions to the similar issues they face, and be inspired and motivated by success stories.

### **8.2.2 Suggestions for improvement to service delivery**

**Pathways publicity** – Generating greater positive publicity about Pathways, including more specific branding as a distinct programme, which would be helpful in reassuring people prior to their participation.

**Empathy, understanding and tailored provision** – Many clients commented on the need to distinguish mental health issues from physical conditions when designing back to work provision. Some felt that mental health clients required provision delivered by mental health specialists, as opposed to a generalist Pathways adviser. They felt advisers need to understand the dynamics of a condition in day-to-day living and the implications this has for job matching (see Chapter 4). As seen in Chapter 2, a range of Jobcentre Plus staff questioned the adequacy of training and support for IBPAs. At the feedback workshops there was further discussion which emphasised that IBPAs were never intended to be medical experts. This reinforced the view that there was need for more training and support for IBPAs in mental health conditions, as well as better communication and information exchange between IBPAs and health professionals, perhaps even prior to the first WFI.

**Privacy** – A private environment for WFI meetings was preferred by mental health clients and this issue was recognised by Jobcentre Plus staff. Some clients said they felt uncomfortable in the Jobcentre Plus open-plan office. They did not feel their confidentiality was being respected, nor did they like hearing other people's private conversations. As a consequence, they felt inhibited and reticent to divulge personal details during conversations with their IBPA (see Chapter 4). Given the negative experiences of the first WFI for many mandatory clients, including nervousness about approaching Jobcentre Plus and discomfort with the open-plan office environment, there may be a case to consider greater use of outreach services, perhaps delivering WFIs outside of the Jobcentre Plus environment in community-based settings that clients are more comfortable with. It is important that this issue is addressed as it can inhibit co-ownership of the back to work process as discussed in Chapter 4.

**Choice of group or one-on-one sessions** – Views on the composition of training and counselling sessions were mixed. Group sessions for counselling or training were preferred by some because they provided the opportunity to meet people, share like experiences, and empathise. A few clients suggested group sessions be organised for people of the same gender or age group. On the other hand, some clients mentioned a preference for one-on-one attention. Some felt uncomfortable in a group setting while others would have liked more focused help with IT, CVs, and form filling (see Chapter 5).

**Jobcentre Plus interpreting support** – Jobcentre Plus staff expressed concern about the availability of resources for the use of language interpreters crucial to engaging with some ethnic minority clients. A degree of interpreter awareness of mental health issues was viewed as important.

**Home provision** – A few clients described the difficulties they had with travel into the office to attend a WFI, either due to poor transportation links or anxieties related to their condition (e.g., agoraphobia, depression). They would have preferred it if the personal adviser had come to their home for at least the initial WFI.

**Flexibility in WFI appointment dates and arranging referral appointments –**

Some clients, particularly those accessing NHS treatment, suggested that they would benefit from provision of a range of alternative appointment dates to choose from. This was in order that WFI meetings could be scheduled around other appointments or around day to day changes in health condition.

One or two clients suggested they would have preferred that their IBPA made referral appointments for them rather than place the responsibility on them. Some felt unconfident initiating social contacts and needed the IBPA's intervention.

**Waiting lists** – Delays between referrals and the start up of provision were seen to detract from service continuity and the momentum of support. In particular, clients mentioned the need to shorten waiting lists for CMP and skills training (see Chapter 5). There were also concerns about the need to shorten waiting lists for National Health Service (NHS) treatment, perceived to reflect a lack of resources to provide more services (there were particular concerns about rural areas). At the feedback workshops, held in February 2009, participants were hopeful that Improving Access to Psychological Therapies<sup>10</sup> would make a difference and there were reports of early signs of this.

**Better coordination of services** – There seemed to be scope for further collaboration between IBPAs and other health staff, as well as for more signposting to community-based mental health services. Some clients who engaged with various Pathways provision felt lost or lacked instruction on what to do when sessions came to an end. This prompted one client to question, *'Am I with Pathways, or not?'* Clients felt the agencies did not communicate sufficiently in preparation for referrals nor were they fully aware of a client's service history, (see Chapters 2, 5 and 7). Greater coherence in client support packages is likely to help facilitate co-ownership of the back-to-work process. Workshop participants felt that a starting point for achieving better coordination of services in a locality was to map them, a task that one non-Jobcentre Plus participant had already embarked on. These views reinforce the conclusions of Nice and colleagues who argue that *'Jobcentre Plus advisers do not have time to develop awareness and in-depth understanding of all available service provision and would therefore benefit from help to compile this information.'* (Nice et al., 2009: 6). There is scope for improvement of case management that occurs between CMP and Work Psychologists; but, on the whole, not across other Pathways (and non-Pathways) provision. Workshop participants also reinforced the view that the NHS needs to help increase awareness of Jobcentre Plus clients. Amongst other things, this would seem to require a cultural shift allowing the NHS to embrace the principle of co-ownership of the back to work process. There were positive reports of IBPAs and Disability Employment Advisers (DEAs) working in GP surgeries.

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<sup>10</sup> This is an initiative that has been funded by Government to increase the number of trained psychological therapists and so improve availability and speed of access to 'talking therapies' for common health problems (namely anxiety and depression).

**A greater role for actions plans?** – Clients were more positive about experiences if they felt that they were progressing and at a pace they were happy with, and less positive if they felt they were being ‘pushed’ too quickly or if they saw very little progression. It is possible that better use of action plans could help with this, by making progression more transparent to clients and promoting co-ownership. The growing policy emphasis on personalised conditionality (Gregg, 2008) needs to be mindful of the importance of choice in the process of developing co-ownership of the back to work process.

# Appendix A

## Research instruments

## Key informant topic guides



Policy Studies Institute

Pathways to Work

Mental Health Focused Study

### Key Informants Topic Guide

**(version 2 – for community and voluntary sector and mental health services)**

Objectives of this first fieldwork stage of the research: to carry out interviews with a variety of stakeholders to ensure that the study reflects the diversity of issues informing and shaping the experiences of Pathways customers with mental health conditions.

#### 1. Introduction

- Introduce self and organisation/research consortium.
- Explain/reiterate independence of research team from DWP and the Jobcentre.
- Explain/reiterate purpose of the research and distribute information sheet (i.e. while the complex needs of customers with mental health problems have been highlighted in our previous evaluations, there has been no study which focuses on the experiences of Pathways clients with mental health conditions. It is this gap which this study proposes to address).
- State that there are no right or wrong answers, we are interested in the informant's views.
- Some questions may feel more relevant than others. We are interviewing people in different roles and their contribution will help shape the design of the next stage of interviews taking place with Pathways clients this spring/summer. This should help maximise the relevance and timeliness of the research.

- Indicate interview will last approx 45 minutes (and check that they are still ok for time).
- Explain/reiterate confidentiality and anonymity.
- Explain purpose of tape-recording (ask permission), transcription, nature of reporting.
- Check that respondent is happy to proceed – ask to sign consent form.

*If asked what we mean by 'complying with the Data Protection Act' explain that we will:*

- *keep all data in a secure environment;*
- *allow only members of the research team (including administrators and transcribers) access to the data;*
- *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
  - Check respondent happy to start the recording of the interview.

## **2. Background Information**

1. Confirm current post and length of time in this post and with organisation  
Probe:
  - o Previous roles
  - o Whether always worked in this geographical area
  - o Types of services and support involved in delivering

## **3. Barriers and support needs** *(Ask all questions and probe)*

1. In your experience, what are the main barriers to work for MH clients?  
Probe:
  - o Confidence, motivation, self-esteem, non-clinical depression
  - o Appropriate support services
  - o Awareness of support services
  - o Other barriers, eg. financial, age, work history, family circumstances
  - o Do the barriers vary for different kinds of mental health problem?
  - o Variations by solely MH compared with multiple impairments

2. In your experience, what tend to be the factors that enable people with mental health needs to have a positive journey towards paid or unpaid work?

Probe: (as appropriate *after respondents initial thoughts*)

- o Improvement in mental health
- o Access to psychological/psychiatric therapies
- o Empathetic and understanding support workers
- o Advocacy/pro-active support workers
- o Timely advice
- o Influence of family members, peer group, GP, employers
- o Appropriate referral options
- o Early intervention
- o Tailored support, taking into account individual circumstances
- o Do the enablers vary for different kinds of mental health problem?

3. Are there other influences that may affect customers' attitudes to working (either in a positive or negative way)?

Probe:

- o Views of other significant people, like *family members, peer support, GP, employers, any others?* (probe each in turn)
- o Reasons for answer (examples)
- o Any client perceptions of employer attitudes

4. To what extent are the kinds of support that you have indicated can be important being provided in this area?

Probe:

- o Contribution of Jobcentre Plus and Pathways to Work to this
- o Gaps/suggestions for improvements

#### **4. Working with other agencies and awareness of and contact with Jobcentre Plus and Pathways to Work** (*This is a key section – ask all questions and probe*)

1. How much, if any, partnership working between agencies takes place to support people with mental health needs in this area?

Probe:

- o Nature of partnership working? Examples?
- o How/why this partnership working came about?
- o What's working particularly well and why?



- o Whether would like more partnership working to take place? Why/why not?
  - o Any suggested areas for partnership working to improve support for people with MH conditions?
2. How aware are you of the Pathways to Work programme?
- Probe:
- o How did you first hear about Pathways to Work?
  - o What were your first impressions when you heard about it?
  - o Do you feel that more could be done to raise awareness of Pathways to Work outside of Jobcentre Plus, e.g. with health professionals, the community and voluntary sector?
3. How much contact do you have with Jobcentre Plus and the Pathways to Work programme?
- Probe:
- o Reasons for contact (examples)
  - o Regularity/mode of contact
  - o Whether on-going relationship(s) with particular offices and/or members of staff
  - o Contact (reasons, regularity, mode) with job brokers, CMP or other programme providers?
  - o Usefulness of contact
  - o Any partnership working with Jobcentre Plus, job brokers, CMP or other programme providers? (example(s))
4. How much contact do your clients have with Jobcentre Plus and the Pathways to Work programme?
- Probe:
- o Reasons for contact (examples)
  - o Regularity/nature of contact e.g. mandatory/voluntary WFIs, CMP, Job brokers (examples)
  - o Usefulness of contact (examples)

## 5. Reflective assessment

(\*\* indicates priority questions)

1. \*\*Overall, what are your views on the provision of support for people with MH problems in this area?

Probe:

- o Different mental health conditions
- o Subpopulations (e.g., BME groups, younger people, older people, women, men)
- o Any service gaps in provision
- o How could support be improved?

2. \*\*In particular, how well do you feel that Pathways is working for people with MH conditions?

Probe:

- o Different mental health conditions
- o Subpopulations (e.g., BME groups, younger people, older people, women, men)

3. Do you have any suggestions for changes or improvements to Pathways to improve support for MH clients?

4. Are there any topics/issues you would like us to include when we conduct interviews with MH clients?

5. *Is there anything else you would like to add about Pathways support for customers with mental health issues or about the study in general?*

*Thank you for your time and involvement in the study. You will be invited to practitioner workshops for Jobcentre Plus and non-Jobcentre Plus stakeholders working with people with mental health conditions (these are scheduled to take place early autumn). There will be one workshop per fieldwork area. Each workshop will discuss emerging findings from this study and explore their relevance to Jobcentre Plus agendas around health and well-being, as well as identifying specific ways in which Pathways can be tailored to better meet the needs of clients with mental health conditions.*

## Mental health client topic guide



S | P | R | U



Policy Studies Institute

Pathways to Work

Mental Health Focused Study

### Client Topic Guide

Objectives of this second fieldwork stage of the research: to carry out interviews with Jobcentre Plus clients (including new & repeat claims/voluntary existing) with a range of mental health conditions, demographic characteristics and Pathways/labour market trajectories. The interviews will explore:

- a) Client background (aspects of health/life/benefit & work history), to begin to set their experiences of Pathways in broader life context.
- b) Current feelings about work, for those who are/are not in paid work
- c) Views and experiences of Pathways/WFI contact, to begin to take a closer look at their interactions with the Pathways programme
- d) Referrals, take-up, experiences of services, gaps in provision
- e) Issues arising in entering and sustaining work and take-up of related services
- f) Perceptions of outcomes from participation in Pathways and suggestions for improvements to Pathways and other support and services.

There is likely to be variety in respondent experiences and **the topic guide is intended to be used flexibly**. On previous Pathways studies, interviews with mental health clients have provided rich and helpful information. However, interviewers should be mindful that there are some issues that may arise for some respondents, affecting the interview dynamics. These include:

- a) People may be hard to draw into conversation, giving brief answers only;
- b) People on medication may not always remember details, reinforcing routine problems of recall;
- c) People may become emotional & tearful, or sometimes agitated;
- d) People may find it difficult to focus on the topic of enquiry;
- e) People may appear confused or affected by deep depression or paranoia.

We have tried to design 'general' questions and minimise the necessity for detailed recall. Where recall is good, please do draw on the probes as fully as appropriate. **Where recall is poor, please use your judgement and move onto another question as appropriate.**

## 1. Introduction

- Introduce self and organisation/research consortium.
- Explain/reiterate independence of research team from DWP and the Jobcentre (if the client is in receipt of benefits the answers will not affect their benefit in any way)
- Explain/reiterate purpose of the research (i.e. we are interested in people with mental health problems' experiences of Jobcentre Plus services, so that the government can improve those services in the future)
- State that there are no right or wrong answers. We are interested in the respondent's views.
- Explain that participation is voluntary, they can change their mind about participating at any point or choose not to answer particular questions.
- Indicate that (as mentioned in letter/on the phone) interview will last **up to 1 hour, 15 minutes** (and they can stop and take a break at any point in the interview or we can do part of the interview now and part another time)
- Indicate that (as mentioned in letter/on the phone) respondent will be given [£20 voucher] for participating in the interview. This is to thank them for taking part and does not affect benefits or tax.
- Explain/reiterate confidentiality and anonymity.
- Explain purpose of tape-recording (ask permission), transcription, nature of reporting (all participants will be sent a research summary on publication).
- Check whether respondent has any questions and is happy to proceed – ask to **sign consent form**.

*If asked what we mean by 'complying with the Data Protection Act' explain that we will:*

- *keep all data in a secure environment;*
- *allow only members of the research team (including administrators and transcribers) access to the data;*

- *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
- Check respondent happy to start the recording of the interview.

**Please note that the priority areas are sections 4-7.**

## **2. Client background**

### **2.1 Can you tell me a bit about yourself and your current situation?**

*Probe as appropriate: personal circumstances:*

- o Length of time living in the area
- o Household composition (clarify if other earners)
- o Check current status: currently on incapacity benefit?/in paid employment?/undertaking some other activity?

### **2.2 Can you tell me (a bit more) about how you came to be on incapacity benefit?**

*Probe as appropriate: health status and benefits history*

- o Health condition(s) (onset/duration/symptoms/stability/taking medication/ in-patient, out-patient care)
- o Whether in regular contact with any services, eg.. GP, NHS, counsellor, support/key worker
- o Length of time on incapacity benefit/When most recent claim started/ finished/previous claims
- o Circumstances surrounding most recent IB claim

### **2.3 What's been happening with you since you went onto Incapacity Benefit? (Focus on most recent claim)**

*Nb. Interviewer begins to map client journey, with a timeline to help aid memory/ recall and show the timeframe for changes.*

*Probe as appropriate:*

- o Changes in health condition?, work, family
- o What has influenced these changes?
- o *(If saying nothing has changed)* What has been important to you during this time? Has anything helped you?

### 3. Feelings about work

*(Ask all not in paid work)*

#### 3.1 What are your thoughts about work at the moment?

*The following probes may be helpful:*

- o How working might improve or worsen their quality of life (eg.. household finances, other earners)
- o Perception of work as a possibility in the future/How likely
- o What needs to happen before they can get into work – or move closer to work
- o Current health situation and effect on capacity to work
- o Whether anticipation of discrimination is preventing job applications
- o Whether there is a paid job that they would particularly like to do in the future – Why/why not
- o What they would need to do to attain this
- o What support they may need from others to do this (prompt on support workers, counselling etc)
- o What flexibility or support they may need from employers eg flexible working, later start times, time off, mentoring etc
- o *(If indicated in 2.3 that moved into and out of paid work)* Nature of that work/reasons for leaving

*(Ask all in paid work)*

#### 3.2 How are you finding being in paid work?

*The following probes may be helpful:*

- o Current role (tasks and responsibilities)
- o Length of time in role
- o Expectations when they started the present job
- o Whether expectations being met: positives and negatives about work
- o Do they feel 'better off', include: impact on household finances, impact on health, other
- o Hours per week normally worked
- o Permanent or temporary job
- o Whether receive any in-work training
- o Whether their employer has done anything (whether routinely offered to all employees or not) that has made work possible eg flexible working, time off for (medical) appointments, disregarding time off from sickness absence (so no disciplinary action), enabling late starts or early finishing times etc

- o Whether they receive other support (eg from social care agencies eg including mental health professionals/peer support)
- o Whether want to stay in job/length of time & plans/hopes for future
- o Whether anticipation of employer discrimination has influenced job applications.

#### **4. Views and experiences of Pathways/WFI contact**

*(Say to all respondents...)*

As explained to you earlier we are very interested in how people with mental health conditions experience Jobcentre Plus services

##### **4.1 Can you tell me a bit about your experiences of the Pathways to Work programme?**

*Nb. If they seem unclear about the term 'Pathways', ask them if they have had any contact with Jobcentre Plus over [the period since their IB claim]*

*Probe as appropriate:*

- o Whether can remember the number and regularity of meetings (WFIs) at the Jobcentre
- o Whether still having interviews (*Nb. May be voluntary clients*)
- o Whether saw the same personal adviser or different ones – did this matter
- o Any constraints on attending eg childcare, caring; effects of condition or side effects of medication

##### **4.2 (Ask all mandatory clients) How were you asked to come into the Jobcentre (letter, telephone call and letter) – *Nb. May be issues of recall***

*Probe as appropriate:*

- o Feelings about being asked to come into Jobcentre/expectations/concerns
- o Any discussion with family/friends/GP/support worker – their views about them going back to work
- o Whether they were accompanied to the meeting (WFI)
- o Were they phoned in advance to remind them of the WFI?
- o If not telephoned, would it have been helpful to have received a telephone call as well
- o Whether they missed any meetings (WFIs) – if so, was this because the adviser cancelled/deferred/postponed (why?) or because they could not make it – what happened? Any sanctions experience (awareness that FTA might result in benefit being reduced, any contact with adviser before sanctioned, by phone, home visit so they had a chance to explain their absence?).

- o Any constraints on attending, eg.. childcare and other caring responsibilities; effects of condition or side effects of medication
- o Could anything about this process be improved?

#### **4.3 (Ask voluntary existing customers only) Why did you volunteer for Pathways?**

*Probe as appropriate:*

- o How heard about Pathways
- o Whether any specific part of Pathways influenced them to volunteer
- o Any expectations, hopes, concerns in entering Pathways
- o Any discussion with family/friends/GP/support worker – their views about them going back to work
- o Any influence of improvement in health condition/change in belief that they can manage their health at work
- o Any constraints on attending, eg., childcare and other caring responsibilities; effects of condition or side effects of medication

*(Ask all)*

#### **4.4 What sort of things did you discuss with the personal adviser during these meetings (Work Focused Interviews)?**

*Probe as appropriate:*

- o Services told about (eg. CMP, Permitted Work)
- o How did you feel about your adviser? How did you get on with him/her? What did you like about him/her?
- o Did they ask about your condition; if so was this appropriately done or did the adviser make assumptions
- o Did they make adjustments to enable you to take part in the interview(s) (if needed); did they make you feel comfortable?
- o Did you find him/her knowledgeable, eg.. about how health and work might interact, management of symptoms? What did you think of the advice that you received?
- o Overall, how did you feel about the meeting(s)?
- o What could have been improved?



#### 4.5 What types of work opportunities were mentioned at your Jobcentre meetings?

*Probe as appropriate:*

- o Paid Work, Permitted Work (*define as paid work for less than 16 hours per week*), Supported employment, Voluntary work, Work placement, training opportunities to update skills or change job goals, other
- o What did you feel about this? Why did you feel this way? (*Nb. health condition, length of time out of work, qualifications, labour market conditions and other potential obstacles might be mentioned here*)
- o Whether discussed the information provided about work with anyone else? Eg.. family, peers, GP, support worker/Advice given
- o Any influence of adviser on Job search goals
- o Rights at work – eg including pay, DDA, flexible working etc
- o If no work opportunities were mentioned – probe why (eg did the adviser not expect you to be in work?)

#### 4.6 Do you feel that the personal adviser understood your circumstances?

*Probe as appropriate:*

- o Feelings about work and whether paid work was realistic for them at the time
- o Understanding and awareness of health condition
- o Whether this mattered/How may have affected support offered/advice given
- o Whether agreement with adviser over how ready for work they were
- o Whether informed of how financially better off would be. Whether this information helped in making a decision about returning to work
- o (*If already raised by the respondent*) Cultural awareness (eg.. religious requirements, culturally appropriate jobs, cultural difference re: job search)
- o Need for an interpreter (non-English speakers or BSL)

#### 4.7 Did you develop an Action Plan with your personal adviser? (*Nb.if don't understand, explain that this would outline work goals and different kinds of support needed*)

*Probe as appropriate:*

- o Feelings about having/not having an action plan
- o Whether feels plan was agreed with adviser
- o Was it appropriate to your circumstances?
- o Main features of action plan (support services mentioned)

#### 4.8 How available did you find your adviser when you required advice?

*Probe as appropriate:*

- o Use of telephone contact between meetings/whether telephone contact worked well.

### 5. Referrals, take-up and experiences of services and gaps in provision

#### 5.1 Were you advised to see anyone else in the job centre? (*Nb. May be problems of recall*)

*As them to talk about all services advised to use and probe as appropriate on each one:*

- o Who was it? What for?
- o Did you go/take it up? Why/why not? What did you talk about? What did you do? For how long?
- o Whether they felt they were offered this support at the right time – why/why not
- o Feelings about the services they accessed
- o What services have worked well/how
- o What services have not worked well/how
- o Whether felt differently about work after accessing these services
- o Extent to which this support has helped to tackle obstacles to work mentioned earlier/How

*Nb. They may talk about Work psychologist, Disability Employment Adviser, Job Broker, access to financial assistance (such as Adviser discretion fund, Job Preparation Premium), Condition Management Programme*

#### 5.2 Did your adviser arrange for you to see anyone outside of the job centre?

*Probe as appropriate:*

Did you go? Why/why not? What did you talk about? What did you do? For how long?

- o Whether they felt they were offered this support at the right time – why/why not
- o Feelings about the services they accessed
- o What services have worked well/how
- o What services have not worked well/how

- o Whether felt differently about work after accessing these services
- o Extent to which this support has helped to tackle obstacles to work mentioned earlier/How

### 5.3 Is there any help or services that you would have liked to have received but did not?

*Probe as appropriate:*

- o Whether services for people with mental health problems or other
- o How might have helped
- o Gaps in provision

## 6. Entering and sustaining work and take-up of related services

*(Ask all who have worked since involvement with Pathways/currently in work)*

### 6.1 Were you offered any support by your adviser once you found work?

*Probe as appropriate clarifying type of support offered:*

- o In Work Support
- o Access to Work
- o RTWC
- o Managing your finances
- o Other

*For each received, ask:*

- o What they did/did not take up and why
- o What services have worked well/how (eg..what IWS helped with)
- o What services have not worked well/how
- o Whether felt differently about work after accessing these services
- o Perceptions of barriers to work now
- o Extent to which this support has helped to tackle obstacles to work mentioned earlier/How
- o Any other support that you would have liked?

### 6.2 Did you tell your employer about your mental health condition?

*Probe as appropriate:*

- o Why?/Why not?/What influenced this decision? Did you feel that you had a choice?
- o If told employer, who did they tell eg.. human resources, line manager

- o Do you think that [disclosing/not disclosing] has made any difference to your experiences at work? How?
- o Did the adviser advise you about this (either to disclose or not, who to tell)
- o Did the adviser mention the Disability Discrimination Act in this context? Whether learned about the DDA from other sources.

### **6.3 Would you have liked any additional support while in work?**

*Probe as appropriate:*

- o What kind of support? Eg.. adjustments in the workplace
- o Any difference support might have made to transition into/sustainability of work
- o Examples from what happened in the workplace

### **6.4 Have you experienced any problems while in work?**

*Probe as appropriate:*

- o Health condition or side effects of medication
- o Work organisation (eg.. workload)/job conditions (eg.. flexibility around sick leave and unpaid leave)
- o Reactions of colleagues/interpersonal difficulties (avoidance, prejudice)
- o Financial difficulties (whether RTWC helped)
- o Travel/transport
- o Child care or other caring responsibilities
- o Other

### **6.5 (Ask all experiencing problems) Did you receive any help or support in these difficulties?**

*Probe as appropriate:*

- o Family/peer support
- o GP support
- o Support from other mental health professionals
- o Mentoring/support from colleagues eg.. human resources, line manager, trade union
- o Debt management
- o Other

6.6 (*If no problems experienced*) Was there anything that you think helped you to stay in work?

## **7. Perceptions of outcomes from participation in Pathways**

*(Ask all)*

7.1 What role has Pathways played in helping you over [the last few years]?

*Probe as appropriate:*

- o Addressing some of the difficulties you talked about earlier
- o Contribution of Pathways to changing views about work
- o Moving closer to work
- o Moving back to work
- o Whether led to any improvement in health/recovery – how/why
- o Contribution of paid/unpaid work to any health improvement – how/why
- o How does the help from Jobcentre Plus compare with other help you have received? E.g., medical profession, social services, family/friends.

7.2 Overall, did Jobcentre Plus support meet your expectations?

*Probe as appropriate:*

- o Whether any other kind of help might have been helpful (with hindsight)?
- o Jobcentre Plus/non-Jobcentre Plus

7.3 Do you have any further suggestions for improving the support provided by Jobcentre Plus?

7.4 Do you have any further suggestions for improving other services for people with mental health problems in the area?

Thank you for your time and involvement in the study.

*Check that they are still happy for the information they provided to be used in the research.*

Please may I give you a £20 voucher for participating in the interview. This is a gift and does not affect your benefits or tax [*ask client to sign receipt*].

*If you have had to cut the interview short, ask if you may do a follow-up phone call. Record yes/no.*

## Feedback workshop questions



Policy Studies Institute

People with mental health conditions

and Pathways to Work

### Feedback workshop questions

#### Discussion 1

*Suggestions for improvement of services for mental health clients reflected some concerns about the availability of services.*

Are there enough services for the range of mental health clients in this area?

Do mental health clients need other services? Why? Why not?

*Some participants in the research reported a need for greater case management of mental health clients to increase the potential for them to attain positive outcomes from engagement in Pathways to Work.*

Does case management of mental health clients take place in this area?

What does case management mean? Is it important? Why?/Why not?

If it is important, how can it be promoted?

#### Discussion 2

*One of the emerging findings from this research project is the importance of co-ownership of the client-adviser back to work process.*

How important is co-ownership of the back to work process between people with mental health conditions and the staff supporting them?

What factors facilitate co-ownership?

What factors hinder co-ownership?

# Appendix B

## Overview of sample characteristics

### IB Mental health study sample statistics

#### Reported health conditions stated by clients

Health condition	Number of respondents reporting a health condition**
Depression	29
Type of mental health condition:	
Agoraphobia	5
Multiple personality disorders	1
Panic attacks	1
Bi-polar disorder	3
Paranoid schizophrenia	1
Manic depression	1
Anxiety disorder	2
Schizophrenia	1
Clinical depression	1
Insomnia	1
Mental health condition (specific condition could not be ascertained from client)	1
Internal ailments (heart problems, lung disease, angina, fatty liver (caused through alcohol abuse), diabetes, thalassemina/endocrine complaints; stomach ailments)	7
Muscular ailments (rheumatoid arthritis, osteo-arthritis, fractured spine, sciatica)	3
Alcohol abuse	3
Drug abuse	3
Visual problems (cataract and damaged eye-sight)	2
Dyslexia	1

\*\* (i) In most cases, clients reported suffering from a combined number of ailments such as physical ailments were combined with depression.

### Circumstance surrounding claim for incapacity benefit

Circumstance	Number of clients reporting this circumstance
Depression as a result of health condition	8
Work place issues and pressures (leading to mental health condition)	5
Depression linked to physical impairment arising while in work	4
Diagnosed with a mental health condition during childhood and continued into adulthood	4
Family breakdown/relationship break-up	4
Transition to the UK (linked to refugee re-settlement)	2
On-going drug/substance abuse and incapacity to work	2
Bereavement leading to depression	7
Depression (unclear about how this came about)	8
Learning difficulties	1
Alcohol abuse with depression	3

### Number of mandatory and voluntary claimants in the sample

Mandatory	Voluntary
27	13

Note:

- (i) There was one case where an interview was not included in the final analysis due to the interviewee not engaging with Pathways and had not claimed incapacity benefits.
- (ii) There were three cases where it could not be determined whether the clients were mandatory or voluntary because of problems of recall experienced by clients during the interview.

### Age group categories

Age categories	Number of clients
20s	15
30s	5
40s	9
50 and >	12

### Gender

Male	Female
18	26



### Ethnicity

<b>Ethnicity</b>	<b>Number of clients</b>
White British	31
Asian	7
Middle Eastern	1
Kurdish	1
Black Caribbean	3*
Mixed race	1

\* The interview from an ethnic minority client had to be excluded in the final analysis due to the respondent’s non-engagement with Pathways and not having claimed incapacity benefit

### Length of time on IB (most recent claim)\*

<b>Length of time on IB</b>	<b>Number of clients</b>
<6 months	3
7 months – 11 months	1
1-2 years	16
3-5 years	4
6-10 years	5
> 10 years	4

\* This data is not conclusive as there were instances where clients were unable to state how long they had been on incapacity benefit.

### Number of Work Focused Interviews attended by clients\*

Number of WFI interviews	0	1	2	3	4	5
Number of clients	4	9	6	4	1	9

\* Eight clients were unable to recall the number of meetings they had with an IBPA.



# Appendix C

## Interviewing people with mental health conditions

### The process of recruiting potential respondents

Claimant details, including telephone and address, were extracted from a database supplied by the Department for Work and Pensions (DWP). Overall, this was a hard to reach group. Telephone numbers were often not working, incoming calls barred or phones were not answered.

Once contact had been made with a claimant, the researchers would introduce the evaluation study by first making reference to the opt-out letter that was previously sent by DWP to potential respondents in September 2008. This was done both to prompt people's memory about their receipt of the opt-out letter and to set the tone for introducing and explaining what the study entailed before seeking their participation.

The experience of recruiting persons from this client group was a challenging one. Not all individuals recognised the name, 'Pathways' and there was also confusion surrounding whether individuals were on incapacity benefits or on another type of benefit. This was mostly the case among those individuals who had been cycling between Incapacity Benefit (IB) and Jobseeker's Allowance (JSA) over a long period of time, and could not name or remember their current benefit(s) at the point of being screened.

In many cases, individuals sounded depressed and quite low during this telephone conversation and would relate the problems they were facing and why they could not participate in the study. The extent of this was evident where some people would become traumatised or began to cry as they talked about their problems. For some clients, the telephone screening process was an outlet through which people could talk to somebody about their problems, and so some understanding and patience was required in those situations. One such case was a woman who

appeared to be overwhelmed at the prospect of possibly losing her home because she was in arrears with her mortgage as she had just been transferred from IB to JSA. The burden of this was quite clearly evident when she asked the interviewer where she might receive advice about her housing issues. Some clients sounded perturbed when they asked an interviewer how their names and contact details had been obtained. One man stated he did not think DWP had a right to circulate his name and contact details, but *'as he was receiving benefits from the state, they probably did not have a choice in the matter.'*

Some clients declined to participate due to work commitments. For one or two clients it was evident that they had moved on from receiving IB and Pathways and felt that they would rather put the experience behind them, than revisit it in the research. Other clients indicated that they were just about to participate in Pathways and so would not have been able to contribute meaningfully to the study, whilst others felt that they were too ill to participate or had just undergone an operation and were not looking to engage in Pathways or return to work for a while. Some clients with English for Speakers of Other Languages (ESOL) needs (not known before screening) were unable to engage with the interviewer or a family member spoke on their behalf; always indicating that it would not be appropriate for their relative to participate in the research. Others spoke enough English to convey that they did not feel happy about taking part in the study; and would have liked a member of their family to help them talk to the interviewer.

## The interview process

Respondents were largely welcoming towards interviewers coming into their homes and at times saw the interviewing process as therapeutic; providing somebody to talk to. They spoke of difficult periods in their lives and on-going struggles. All those who started interviews completed them, despite some people becoming emotional about the events and life journeys that they were recalling. In many cases, there were problems of recall and memory loss as people found it difficult to remember the precise time period when they were receiving different types of benefits. There were also difficulties in recalling the nature and sequence of contact with Jobcentre Plus.

Letters and phone calls reminding clients of their interview were often welcomed by those with problems of recall due to their health condition and/or medication. There were cases where despite being sent a letter of reminder and several telephone calls reminding respondents of the interview appointment, clients failed to turn up or were not at home at the appointed time. An understanding of what it means to be depressed and how best to work with clients had to be applied in working with this client group. Mood swings are a very common feature of a depressive disorder and so clients could at one stage appear to be 'upbeat' at the point of being screened into the study, but when the interviewers later sought to confirm the appointment, the client would be heavily depressed and reluctant to be interviewed. In such situations, the interviewers tried to be 'upbeat' and

positive whilst expressing concern for the client, who sometimes later agreed to be interviewed.

Clients were given the option of where their interview would be held and some opted to use a public place, especially if this was felt to be more convenient than in the home setting. There were a few cases, where after interviewing a client in their home, the client indicated they would have liked to be interviewed outside their home, as they considered this an opportunity to be away from the house for a while and part of the 'healing process' as one client described this.

In some cases, the trauma of coping with their mental health condition and daily life was expressed in condition of client homes. In particular, clients with agoraphobia would keep their home in a state of virtual darkness (during the morning or early afternoon hours) by keeping the curtains drawn and windows closed.

Amongst clients with alcohol and substance misuse issues, some clients appeared under the influence of alcohol during interviews. There were several situations where clients would behave erratically during the interview. For example, go off on a tangent or would suddenly lose concentration and find it hard to remember events; would take frequent breaks during an interview by going to make tea or go to another part of the house and return; drink lots of water or would chain smoke throughout an interview. In addition to this, some clients would be extremely fidgety or shaky and sweat a great deal; appeared extremely nervous and apprehensive about being interviewed. In some cases, to allay this nervousness, the interviewer would have a light hearted conversation and delay the start of the interview until the respondent appeared to be calm and ready as a way of relaxing them.

It was important for the research team to be aware of how mental health conditions might impact on interview dynamics. However, as noted above, respondents (like other Pathways client groups on previous studies) largely welcomed the interviewers into their homes. They shared their feelings and, often difficult, experiences and this is much appreciated.



# Appendix D

## Initial letter to mandatory clients

Jobcentre Plus

Telephone:                      Fax:                      Textphone:

[www.jobcentreplus.gov.uk](http://www.jobcentreplus.gov.uk)



Part of the Department  
for Work and Pensions

NINO:

Date: /       /

Dear

Your appointment details for your Pathways to Work Interview

On:

At:

With:

We are writing to let you know that we have arranged the above interview for you with one of our Personal Advisers to discuss the support available to you through our Pathways to Work service.

### **Do I need to come to the Pathways to Work interview?**

**Yes.** It is important you attend and take part in the interview or give an acceptable reason why you are unable to attend. Unless you have a good reason for not attending or not taking part in this interview, the amount of your benefit may be reduced. If you find you cannot attend at the date and time the interview is booked you **must** contact us as soon as possible, so that alternative arrangements can be made. Our telephone number is at the top of this letter.

### **What is Pathways to Work?**

Pathways to Work offers extra support to people who are claiming Incapacity Benefit (IB), Severe Disablement Allowance, Income Support (IS) because of incapacity in order to help them into work.



### **How Can Pathways to Work help me?**

We understand that it can sometimes be hard for people to get a job, particularly when they have health related issues or a disability. We also understand that there are many things to think about when starting work, particularly the effect that working can have on the amount people can receive in benefits. This is where Pathways to Work can help. Our Adviser who you will see, is specialist trained and has a great deal of experience in helping people receiving benefits due to an incapacity to take the first steps into work.

### **What will happen at the interview?**

The interview will last about an hour and is a meeting with our Adviser, to discuss the help that we may be able to offer you to take the first steps to returning to work. We will be able to tell you about the support that is available and discuss what is right for meeting your needs. At the interview we can offer advice on:

- the steps that can be taken towards getting paid or voluntary work;
- training to update your skills;
- programmes to help you manage your health condition;
- Job Brokers who help you look for work and give support once you are in work;
- Permitted Work – which could help you to try different kinds of work whilst still being entitled to benefit;
- Tax Credits to top-up low wages, a £40 per week Return To Work Credit and other financial support available;
- other help you may be able to access; and
- possible referral to specialist support provided by Disability Employment Advisers.

### **Can I get help to attend the interview if I need it?**

To help you get to the interview we may be able to provide help with:

- the cost of registered childcare if you have children and would prefer not to bring them with you but have no-one to look after them (Payment will be made direct to the childcare provider)
- travel costs (you will need to bring proof of these, e.g. travel tickets, with you to the interview)
- obtaining an interpreter, if English or Welsh is not your first language, or any other help you may need to attend the interview.

You need to contact us before the interview if you would like help with any of these.

**Can I bring someone with me to the interview?**

Yes, you can bring someone such as a friend or relative with you. Before deciding whether to do this, however, it might be helpful for you to know that Jobcentre Plus offices can get very busy and there is limited space in the waiting areas.

**If you want to know more**

If you want more information about Pathways to Work or you need to contact us about the interview, please get in touch with us using the telephone number or address at the top of this letter.

Yours sincerely,

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