

Health as a cross
cutting theme

Appendix A –
**The supporting
evidence for the
Performance
Management
Framework for
ESF providers**

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European Union
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Investing in jobs and skills

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MAYOR OF LONDON

Introduction

This appendix provides the supporting evidence for the performance management framework developed to support European Social Fund (ESF) providers in incorporating Health as a Cross Cutting Theme (HCCT) in their projects and in monitoring their impact on participants' health and well-being.

It has been compiled using information from published research exploring the links between health and employment. In particular, it looked for evidence about what support projects can offer participants in order to promote their health and well-being, and in turn maximise their chances of securing and retaining appropriate employment. It also explored the limited published research on the impacts on health and well-being of participants who have been supported to enhance their skills once in employment.

Where possible, the evidence has been supplemented with case studies kindly submitted by some of the ESF providers who participated in workshops to help develop the performance management framework – for which we thank them.

Following a brief overview of the policy context on health and work in relation to London, the supporting evidence is presented as follows, reflecting the structure and content of the performance management framework (PMF):

Section	Provides supporting evidence on:	Relevant to PMF
1.	The link between health and well-being and work for specific population groups.	'Target groups'
2.	Factors that Priority 1 projects can influence in order to help improve participants' health and well-being.	Table 1
3.	Factors that Priority 2 projects can influence in order to help improve participants' health and well-being.	Table 2
4.	Factors that projects can influence to help promote their participants' well-being as employees.	Table 3
5.	Specific interventions and activities that projects can offer participants to help promote their health and well-being.	Table 4
6.	Project development/partnership working practices that may help providers to integrate health objectives within their work.	Table 5

Policy overview: Why health and well-being in relation to work is a key issue for London

The Greater London Authority Act 2007 requires that the Mayor describes in a **Health Inequalities Strategy** the health inequalities among Londoners, the priorities for reducing them, and the role to be played by key partners in delivering the strategy's objectives.

Health inequalities are the differences in levels of health between people: a Londoner's well-being, how long they live and how well they are, is strongly influenced by where they live in the city, and such factors as their social and economic background, income, employment and education.

The London Health Inequalities Strategy 2010¹ sets out a framework for partnership action to:

- improve the physical health and mental well-being of all Londoners;
- reduce the gap between Londoners with the best and worst health outcomes;
- create the economic, social and environmental conditions that improve quality of life for all; and
- empower individuals and communities to take control of their lives, with a particular focus on the most disadvantaged.

One of its five objectives is focused on 'health, work and well-being' in recognition of the fact that employment is one of the most strongly evidenced determinants of health. There is clear evidence that 'good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages'.² A comprehensive review of more than 400 pieces of scientific evidence has also concluded that being in work is good for your physical and mental health.³

The strategy commits to 'reduce barriers to employment, improve conditions in the workplace, increase the recognition of unpaid work and create more volunteering opportunities'.

Linked to this, the **London Health Commission's** employer campaign: 'Good jobs – good for health and good for business', encourages London employers to be consultative, supportive and flexible with their employees with the aim of creating a healthier workforce and a more productive, effective and profitable workplace. Its website includes case studies, practical advice and support at www.london.gov.uk/lhc/goodjobs

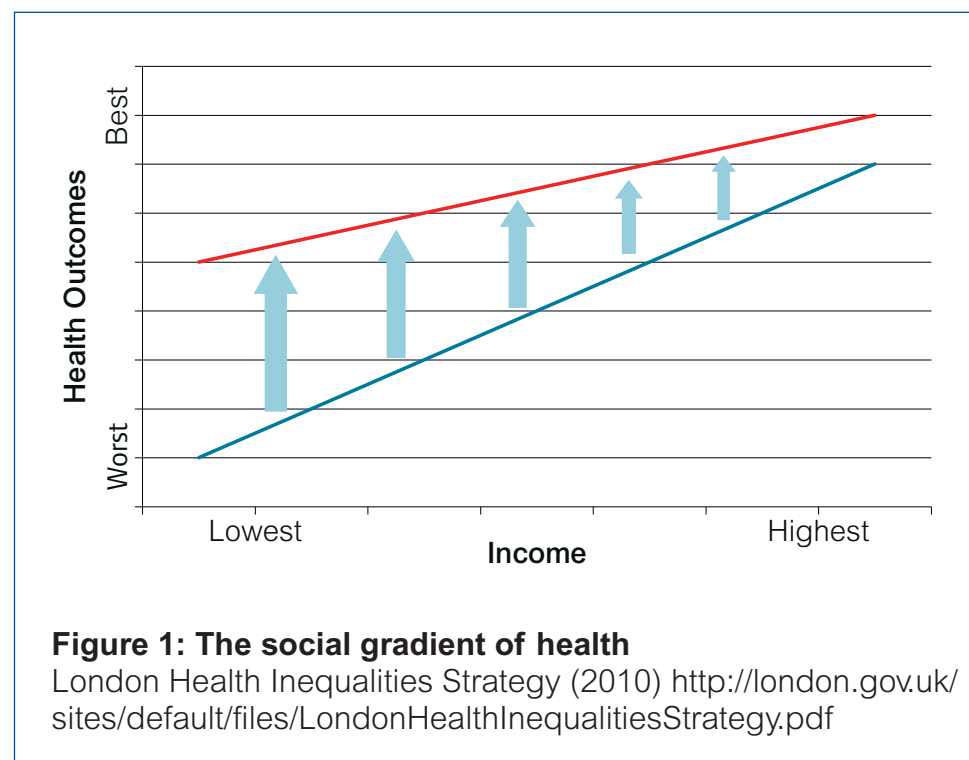
At the time of writing, the Coalition **Government's** policy concerning the delivery of employment-related support is in development, but it is clear that employment is the new Government's preferred approach to reducing poverty.

Section 1: Supporting evidence on the link between health and well-being and work for specific population groups

Population groups, communities and individuals have different needs and experiences that can affect their health and well-being. We know, for example, that those experiencing disadvantages such as language barriers, low level income, social isolation, discrimination in one form or another, certain ethnic groups and ages are more likely to experience poorer quality health. These groups include, for example: young people with substance misuse issues; young carers; older women (65+); carers; women offenders with children; and people who are homeless. Women in general are more vulnerable to poverty and unemployment; men are more vulnerable to completed suicide, drug and alcohol abuse, crime and violence.

Patterns of employment both reflect and reinforce the social gradient (see Figure 1) and there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.⁴

Research shows that, generally, the lower an individual's socio-economic position the higher their risk of ill-health. Therefore efforts to reduce health inequalities must address the wider determinants such as employment, income, the physical environment and education. People can be empowered to improve their own well-being, but they need to have healthy



home, work and learning environments, and access to the right opportunities, in order to make lasting changes to their daily lives.⁵

Socio-economic position (SEP) refers to the position of individuals in the hierarchy and is inherently unequal for different groups of people, shaping access to resources and every aspect of experience in the home, neighbourhood, and workplace. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation, support and inclusion. Social position also influences areas like identity and social status, which impact on well-being.⁶

People with mental ill health

There is now clear evidence that 'good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages'.² There is also compelling evidence that work has an inherently beneficial impact on an individual's state of health. Good quality and appropriate work is known to be 'good for mental health and to aid recovery even for those with the most severe of conditions. Unemployment is known to be bad for mental health and the longer people are out of the workplace the harder they find it to return and the greater the impact on their health and well-being'.⁷

'Mental ill health presents a major challenge to the well-being of our society and the strength of our economy. It blights lives, traps people in poverty and prevents the country in harnessing the talents and potential of hundreds of thousands of people'.⁸

- **Women are more at risk than men: around 15 per cent compared with 11 per cent.**
- **Adults in the poorest fifth of the population are much more likely to be at risk of developing a mental illness than those on average incomes: 20 per cent compared with 8 per cent for men, and 24 per cent compared with 15 per cent for women.**
- **People from manual backgrounds are at slightly higher risk of developing a mental illness than those from non-manual backgrounds.**

Poor mental health affects many Londoners and often goes hand-in-hand with physical health problems. Again, the burden of mental ill-health is not distributed equally. For example, the patient mix in London's mental health services includes much higher numbers of people from deprived communities. Specific groups of Londoners with high rates of mental health problems include refugees and asylum seekers, homeless people and those who misuse alcohol and drugs.

Just over three quarters (78 per cent) of people with a mental health condition require some support during the first six months of work. This falls to 35 per cent after 12 months and 18 per cent after 24 months. Some people will require unlimited support to sustain work.⁹

Long term sick and disabled people

The biggest group of people who are economically inactive but want paid work are the long-term sick and disabled, and the prevalence of such illness or disability is much greater among those on lower incomes than among those on higher incomes.¹⁰

Unemployment is a key measure of labour market disadvantage and is closely associated with poverty, poor educational attainment and poor health. It is also associated with injuries, poisoning, premature mortality (especially coronary heart disease), depression, anxiety, self-harm and suicide.¹¹ The longer people are out of the workplace, the harder they find it to return and the greater the impact on their health and well-being.⁷ Research undertaken by the Work Foundation on the health effects of unemployment found that cardiovascular mortality accelerates after two or three years, continuing for the next 10–15 years.¹²

Unemployment rates are particularly high for disabled Londoners (13 per cent).¹³ A study by GLA Economics found that 43 per cent of men with a health problem in London were workless, compared with 36 per cent elsewhere. Among women, 54 per cent of Londoners with a health problem were workless, compared with 49 per cent elsewhere.¹⁴

Disabled people face a range of barriers in accessing the labour market, and the employment rate for working age disabled Londoners is very low (45 per cent) relative to the rate for non-disabled Londoners (74 per cent). Disabled people are also much less likely to re-enter employment once out than other non-

employed people. Employment rates in London for people with musculo-skeletal problems (46 per cent) are more than twice that for those with a mental health problem (19 per cent).¹⁵ Of all people coming onto incapacity benefits in London, 43 per cent have mental health problems as their main disability, and mental health problems are a secondary factor for another 10 per cent or more.¹⁶

In August 2007, around one quarter of all London's children in families claiming benefits were in families where the main adult claiming was sick or disabled.¹⁷ Research by the IPPR found that 29 per cent of households with one or more disabled children live in poverty, compared with 21 per cent of households without disabled children.¹⁸

The Disability Discrimination Act requires employers to make 'reasonable adjustments' for disabled staff. These adjustments include supplying equipment and adapting the environment to enable disabled people to perform work tasks with the same level of ease as their able-bodied colleagues. Despite this, disabled people are more likely to be unemployed than able-bodied people with the same level of qualification.

Healthy workplaces

Healthy workplaces also have the potential to promote the health and well-being of employees. Stress in the workplace increases the risk of disease. People who have more control over their work have better health. In general, having a job is better for health than having no job, but the social organisation of work, management styles and social relationships in the workplace all matter for health too. Evidence shows that stress at work plays an important role in contributing to the large social status differences in health, sickness absence and premature death.¹⁹

'People with mental health conditions remain among the most excluded within our society. And nowhere is this exclusion more evident than in the workplace... a combination of prejudice and discrimination, low expectations and failure to provide the necessary support continue to deny many people with mental health conditions the opportunity to work'.⁷

Healthy employment policies have the potential to address health inequalities, not just by keeping people well, but also by helping employees to deal with health problems and supporting them to return to work after illness. Retaining and helping people through common health complaints, injury or impairment is a more sensitive and economical method of handling these situations than dealing with the costs of redundancy and recruitment.¹

Section 2: Supporting evidence on the factors that Priority 1 projects can influence in order to help improve their participants' health and well-being (relevant to PMF Table 1)

Health and well-being factors explained

An individual's health is affected by a range of factors as illustrated by Figure 2 below. They include individual genetics – age, gender, race, disability, for example – and lifestyle factors such as diet, exercise, drug and alcohol use and sexual behaviour. As important are the social and community networks that support us – our family, friends and social connections. Access to good quality living and working conditions – for example, education, housing, transport, employment and access to health and other public services – influence our health and the choices that we make. Finally, the



Figure 2: The main determinants of health
(Dahlgren and Whitehead 1991)²⁵

general socio-economic context, such as whether there is full employment, provides the framework within which we live our lives and make choices affecting our health.

Mental well-being has been defined as ‘...a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society’.²¹

ESF project participants may face multiple barriers to work, not all of which are directly employment-related; addressing their housing, health and transport needs, for example, may be essential in making individuals ready for work.²²

Unemployment has both short- and long-term effects on health. The immediate negative impact of being made redundant on a person's health outcomes has been frequently reported. Other studies emphasise the ongoing negative effects, proportional to the duration of unemployment, which progressively damage health; adverse effects on health are greatest among those who experience long-term unemployment.

There are three principal ways in which unemployment affects levels of morbidity (ill health) and mortality (death). First, financial problems as a consequence of unemployment result in lower living standards, which may in turn reduce social integration and lower self-esteem. Second, unemployment can trigger distress, anxiety and depression. Many psycho-social stressors contribute to poor health not only among the unemployed themselves, but also among their partners and children. Loss of work results in the loss of a core role which is linked with one's sense of identity, as well as the loss of rewards, social participation and support. Third, unemployment impacts on health behaviours, being associated

with increased smoking and alcohol consumption and decreased physical exercise.⁴

The nature of work is also important. Work characteristics that contribute to health and well-being include:

- work that is healthy and safe, and allows access to support such as from health, housing or transport services that help an individual to maintain their job;
- work that is appropriate to a person's ability to perform in the job – arising from their health (including mental health) status, as well as their skill level;
- work where an individual feels able to exert some influence over how they work;
- work that gives an individual a sense of self worth.

Supporting evidence for those factors highlighted in Table 1:

Provision of support to enable sustained quality employment for a person placed in work e.g. flexible or shorter working hours, childcare, good working conditions, meaningful work

There is strong evidence to suggest that it is not enough to place people into work. On-going support is required particularly for those who have been out of work for a while and / or who have on-going health needs.

Individual Placement and Support

There is much to suggest that Individual Placement and Support (IPS) is the most effective method of helping people with severe mental health problems to achieve sustainable competitive employment. There are seven key principles including: intensive, individual support, rapid job search, followed by placement in paid employment, and time unlimited in-work support for both the employee and employer. Also the employment specialists and

clinical teams work and are located together.²³ IPS participants were twice as likely to gain employment compared with traditional vocational rehabilitation alternatives (55 per cent compared to 28 per cent). The quality of partnership working between health and employment providers was a critical success factor, and it is particularly important to deliver integrated packages of vocational and clinical support.²⁴

Drake (2008) states: *'In following people for 30 years and then following patients who are in dozens and dozens of research studies that are sent around, it's totally clear to me at this point that there's nothing about medications or psychotherapies or rehabilitation programs or case management programs or any of the other things that we study that helps people to recover in the same way that supported employment does'*.²⁵

It is reasonable to suggest that the lessons and benefits from IPS are transferable to other people who have long term health conditions such as those with dual diagnosis (drug and alcohol misuse), and people who have been on Incapacity Benefit.

Working hours

Limitations on working hours may also be beneficial when pursued alongside job security and satisfaction. This is addressed by one of Marmot's policy recommendations to develop greater security and flexibility in employment by:

- prioritising greater flexibility of retirement age;
- encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

This is reinforced by Dame Carol Black's 2008 report² which, although referring specifically to helping people back to work after chronic disease or disabilities, says that *'the key factors often*

identified were early intervention when health problems develop and the provision of flexible working patterns’.

Supporting/providing access to education and skills development to enable access into work e.g. skills at completing a CV, being interviewed, skills for the job

In order to equip people for the work available, high standards of education and good retraining schemes are important.

A major study explored the lessons emerging from the New Deal for Communities programme regarding the most appropriate delivery models for providing neighbourhood-level services to tackle worklessness.²² It pointed to the importance of a holistic approach wherein a range of services is provided to tackle different barriers to employment. In order to make them work-ready, participants may need help with the job search process, access to information, advice and guidance, and opportunities for training, education and work experience as part a comprehensive package of support.

The Coalition Government’s welfare reform White Paper promotes training and skills development as a means of helping individuals to bypass low-paid, low-skilled work. This is a laudable ambition but not all workless individuals are willing or able to upgrade their skills; policymakers need to be realistic about the kinds of work residents in deprived areas are likely to accept. It maybe just as important to improve the terms and conditions attached to employment at the lower end of the labour market as it is to raise skill levels and aspirations.

Addressing transport access and options e.g. help with costs to attend interviews, training, clothing

There is very little published evidence specifically linking transport and access to employment. However, ESF providers were able to

illustrate how limited access to public transport was a barrier for their participants in accessing resources and services to support them back into work and to retain work. Case studies were used to illustrate how lack of funds prevented people attending for interviews.

Improving economic security e.g. access to secure employment (paid and unpaid), good working conditions, meaningful work and volunteering opportunities

Technological advances and economic growth in the context of globalised markets have resulted in new types of tasks (for example, information processing, personal services and service centres) leading to a demand for greater flexibility of employment arrangements and contracts, often combined with less job stability and security, more intensive work and longer hours. Related adversities include conflicts within workplace hierarchies, restricted participation of employees in decision-making, and covert or overt discriminatory practices. These types of psycho-social stress in the workplace can also cause ill health.

‘Toxic’ combinations of these factors are frequent in the current labour market, yet unequally distributed between occupations. They are most prevalent among the most deprived workers, specifically those in ‘precarious jobs’ that are defined by a lack of safety at work, by exposure to multiple stressors including strenuous tasks which the worker has little control over, low wages and high job instability.

There is ample evidence on the adverse effects on health and well-being produced by these conditions. A range of research relates issues such as job security, job satisfaction and supervisor and peer support to various psychological and physical health impacts, such as general ill health, depression, cardiovascular disease, coronary heart disease and musculoskeletal disorders.⁴

Job security

The effects of job security on health and well-being are as important as having paid employment. This is for both people in employment as well as for those entering employment either for the first time or after a spell of unemployment. Studies¹⁹ suggest that: *'The health effects start when people first feel their jobs are threatened, even before they actually become unemployed'*, showing that anxiety about insecurity is also detrimental to health.

Job quality

Very unsatisfactory or insecure jobs can be as harmful to health as unemployment – they have been shown to increase effects on mental health (particularly anxiety and depression), self-reported ill health, heart disease and risk factors for heart disease. Thus merely having a job will not always protect physical and mental health: job quality is also important.

Other factors

Outreach

Lessons can be learnt from projects which appear to have been successful in reaching more marginalised groups such as young people and certain black and minority ethnic groups. They tend, for instance, to place more emphasis on outreach work. Recruiting individuals through non-traditional channels such as sports and leisure activities or simply through 'hanging out' on the street seems to yield more positive results than relying on participants dropping into established facilities.

There is often a strong mentoring element to projects as is evident in the Community Mentor scheme in Knowsley and West Bowling Youth Initiative in Bradford, for example. The qualities of mentors matters too. Charismatic and well-respected individuals with roots in the local community can be especially effective in engaging individuals who might not consider using more conventional employment services.

Outreach work also appears to be more effective in recruiting participants or delivering services when based in well-established community facilities. But there are no simple short cuts in trying to engage some groups. Effective engagement work can be costly, time-consuming and resource intensive: interventions can take years to bear fruit.²²

Section 3: Supporting evidence on the factors that Priority 2 projects can influence in order to help improve participants' health and well-being (relevant to PMF Table 2)

Supporting/providing access to education and skills development to enable progress in work e.g. help completing applications, organising childcare if required, understanding what being on a training course involves e.g. studying, course work, assessments

Case study: Tomorrow's People Trust Limited: Working for Health

This project assists hard-to-engage income benefit claimants to overcome the barriers preventing them from accessing sustainable employment and training. Delivered in the community, support provided includes 1:1s, information, advice and guidance, employability skills development, job matching, mentoring, Skills for Life, access to specialist health and welfare support, and in-work aftercare.

Tomorrow's People has recently introduced a health questionnaire as part of their registration process and a Healthy Living Workshop. They have close links with ABITT, an organisation which promotes health and well being among participants. Advisors also talk to participants about the benefits of exercise.

Case Study: Pecan: Move On

With poor basic skills, few qualifications, limited work experience and often drug/alcohol problems, offenders are one of the most socially excluded groups in the community. Pecan provides an integrated programme of skills and employability training with specialist personal support to increase their inclusion and secure sustainable employment.

Pecan is very keen on ensuring that both staff and participants abide by health and safety regulations whilst on the premises, and this is also encouraged in their general lifestyle. On occasions staff have attended health-related training sessions organised by the NHS. Through the 'Move On' programme, participants are encouraged to ensure that their health is taken into account in their decision making, and issues such as cleanliness and tidiness are given emphasis.

Providing support to develop a learning development (LDP) plan for the course e.g. does it include a question on health needs?

There was no published research on the benefits of this to health and well-being. However, the evidence on mental well-being would suggest that by enhancing a person's sense of control over their learning, such as setting out a structure for learning, it is likely to have a positive impact.

Offering support to enable completion of qualifications (during the course) e.g. meet participant to review progress, helping solve any problems arising from review

Case study: Affinity Sutton: *Stepping Up*

The primary target group for this project is economically inactive homeless families, including those currently living in temporary accommodation, those who have recently been re-housed from homelessness or those otherwise vulnerably housed within the boroughs of Bromley, Lewisham and Bexley.

Educational attainment is a powerful determinant of health and well-being. Research shows that the longer an individual maintains education and the higher their attainment, the better their overall health and lifestyles. This project works to help reduce this health gap by making referrals to specialist support services, for example in relation to drug and alcohol abuse, debt counselling, mental health, GPs and other agencies which will positively impact on the families health.

Following-up if participant misses two or more training days

There is no published research to support this. However, feedback from ESF providers suggests that follow-up enables early identification of health or other problems that may be preventing people completing their training and to provide help to address them so that participants can complete their studies. This in turn is likely to have a positive impact on health and well-being.

Provision of support for people with disabilities, including learning difficulties, physical disabilities and mental health needs, to attend training

Again, there is no published research to support this. However, feedback from ESF providers suggests that some people who have health problems find they have additional support needs or need flexible working and training arrangements. By providing support it enables people to complete their training. This in turn is likely to have a positive impact on both health and well-being.

Section 4: Supporting evidence on the factors that projects can influence to help promote their participants' well-being as employees (relevant to PMF Table 3)

Factors such as personal resilience to life's challenges, participation in society and a sense of control over one's life have a significant influence on the well-being of individuals and communities.

Developing the ability to cope with challenges and change

e.g. problem solving, decision making, relationships with others, communication skills, self-esteem

Resilience is broadly defined as 'doing better than expected in the face of adversity'. Both individual characteristics (cognitive and social skills) and social context (peers, social networks, social support, and relationships) contribute centrally to resilience and may buffer the effects of material factors (low income, debt, lack of access to healthy products). However, economic adversity has a significant influence on factors that influence resilience; one hypothesis is that psycho-social resilience confers protection among equals, but is generally trumped by material advantage.⁶

One of the barriers that prevent people with mental health conditions from finding and keeping paid work is 'people's lack of confidence that they can cope with work'. A further is low self-confidence, reflecting low expectations in society in general of the abilities of people with mental health conditions (self stigmatisation).⁹

Promoting a sense of belonging e.g. connectedness to community, neighbourhood, family group, work colleagues

Support and good social relations make an important contribution to health. Social support helps give people the emotional and

practical resources they need. Belonging to a social network with communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns.

For individuals, social participation and social support are associated with reduced risk of common mental health problems and better self reported health. Measures of social integration are highly correlated with risk of coronary heart disease. Access to employment and the workplace can enhance access to social networks and support.

In schools, workplaces and other institutions, the quality of the social environment and material security are often as important to health as the physical environment. Institutions that can give people a sense of belonging, participating and being valued are likely to be healthier places than those where people feel excluded, disregarded and used.¹

There is very robust evidence that participation in employment, notably good quality employment, is good for mental health and, even more unequivocally, that unemployment is bad for mental health.³

Concerns are often expressed that a return to work might be damaging for people who have severe mental illness. However this concern is not backed up in the research literature relating to Individual Placement and Support. Actually a number of studies show that going back to work can lead to improvements in clinical and social functioning and none report any negative results.²⁶ There is also evidence, particularly from long-term studies, that increased employment has enduring benefits in terms of better self-reported quality of life, self-esteem and relationships with other people.²⁷

Enhancing a sense of control over their life and choices

e.g. choice of work, type of training, timing of access to work or training

The extent to which individuals and communities have control over their lives has a significant influence on mental health and overall health. In a major global report on inequalities in health, the Commission on Social Determinants of Health²⁸ identified 'control over our lives' as one of three key domains for action and empowerment:

- material resources;
- psycho-social (control over our lives); and
- political voice (participation in decision making).

Some of the evidence on the relationship between control and health⁶ comes from workplace studies which show that job control, effort-reward balance and social support have an independent influence on health outcomes:

- Work which provides fulfilment and allows individuals control over their working lives confers considerable health benefit.
- Types of job which are lacking in self-direction and control have far fewer health benefits, and people with such jobs have consistently higher rates of mortality and morbidity.
- High job control is associated with significantly lower risk of heart disease and markers of stress response e.g. lower levels of cortisol and blood pressure.
- Evidence from Sweden shows how changing employment conditions towards less job security and control are impacting upon people's health and well-being in a high income country, influencing rates of cardiovascular disease, alcohol misuse and suicide.

- Factors which diminish a sense of control, for example job insecurity, low pay and adverse workplace conditions may be more damaging than unemployment, notably where high unemployment is the norm.

Lack of control

Several European workplace studies show that health suffers when people have little opportunity to use their skills and low decision-making authority. Having little control shows a clear social gradient (see Figure 1, [page 3](#)) and is linked to increased rates of absence due to illness, mental illness and cardiovascular disease. This social gradient is also reflected in the metabolic syndrome, which is a combination of risk factors for diabetes and heart disease. Work stress, as measured by isostrain, has also been shown to increase the risk of this syndrome.⁴

Studies have also examined the role of work demands. Some show an interaction between demands and control. Jobs with both high demand and low control carry special risk. Some evidence indicates that social support in the workplace may be protective. Further, receiving inadequate rewards for the effort put into work has been found to be associated with increased cardiovascular risk. Rewards can take the form of money, status and self-esteem. Current changes in the labour market may change the opportunity structure, and make it harder for people to get appropriate rewards. These results show that the psycho-social environment at work is an important determinant of health and contributor to the social gradient in ill health.

Section 5: Supporting evidence on specific interventions and activities that projects can offer participants to help promote their health and well-being

This section explores actions that ESF providers could consider taking. As there is limited evidence in the literature on integrating health into employment projects, this section will draw on case studies from current ESF providers to illustrate actions that are likely to have a positive impact on the health and well-being of participants. It is not expected that all ESF providers would have the resources or opportunities to do all of these – they have been used to good effect by others and are intended as a guide.

Giving information about healthy lifestyles, services and social activities to participants

Giving information about other services such as housing to participants

Case study: Seetec

This organisation offers:

- Learners intranet 'Moodle', which is a resource for service users and has a section on health with information, handouts and questionnaires e.g. BBC mood gym, on self-esteem and healthy lifestyles.
- A community board in centres with local community and health information – people are prompted to look at it and consultants refer to it regularly.

- Consultants who have strong relationships with organisations in the community, including Salvation Army, Citizen's Advice Bureau, nurseries and play group facilities, MIND, RNIB, RNID etc and are able to sign-post these where appropriate.
- A 'work first' approach to health and well-being.
- A holistic service that addresses all barriers to work including housing, debt, health/mental health, basic skills, confidence, soft skills, social inclusion.
- Robust initial assessment, action planning, progress review and in-work support systems to ensure that issues are identified and addressed at any stage of the client journey.

Difficulties with child care, debt, benefits, housing and transport may also need to be addressed if individuals are to be supported back into work. Whilst it is not always possible to provide every service under one roof, there is a widespread sentiment that demonstrable advantages arise from a 'drop-in' one-stop local facility. Evidence from these case studies indicates that such facilities have been managed effectively by, in the words of one informant, 'good commissioning' on the part of the New Deal for Communities programmes to bring together a range of complementary services into a single workspace.²²

Case study: YWCA

This project focuses on personal and social development primarily for young women, but also some men (11-25yrs). They:

- Provide an initial holistic assessment which includes housing, education etc.
- Run accredited courses on personal and social development to improve confidence, communication skills etc.
- Do a 'ready, steady, cook' practical session, which includes cooking a meal for £5 and a nutrition talk.
- Address sexual health issues, including outreach in schools (e.g. on relationships, STIs etc).
- Work with teenage mums offering courses while they are not able to go to school, and parenting skills training.

Asking health related questions in initial assessment to determine health status for new participants and referring them into services if required

A report looking at the lessons from the past on the effects of recession²⁹ recommends that 'local worklessness assessments can be used to explicitly identify and address social barriers to employment (such as mental health, family and relationships breakdown and debt)'.

There is anecdotal evidence to suggest that a form of 'health needs assessment' may be useful with ESF project participants. This is not a clinical/medical assessment but can be a series of health related questions that might alert the ESF provider to issues on which the client may need advice or referral to specialist services such as health, social, housing, debt management.

Some ESF providers already do these and are referring participants into services which can help improve their health and well-being and increase the likelihood of gaining and sustaining employment.

Case study: St Giles Trust

- This project includes general health questions in their initial client assessments and set health related targets in individual action plans.
- Typical actions range from the straightforward, such as getting registered with a GP, through to the more complex, for example arranging a methadone prescription or engaging with a community mental health team.

Providing access to financial and debt advice – this is part of the IPS programme for people with mental health issues

One of the seven key principles of Individual Placement and Support (IPS) is that welfare benefits counselling will support the person through the transition from benefits to work.

It is essential that employment specialists or clinicians offer assistance to participants in obtaining individualised benefits counselling to understand the financial implications of starting work. This should include the process of managing the transition from welfare benefits to work and advice on in-work benefits such as Tax Credits. It is essential to have good relationships with specialist experts in Jobcentre Plus and other welfare benefit agencies, such as Citizens Advice Bureaux.

One-to-one support including advocacy and accompanying participants to health services

There is clear evidence that one-to-one support for people returning to work has positive impacts on health and well-being.

The effectiveness of local services depends on the nature of relationships advisers develop with clients, and the role they play in supporting them to find work. Building effective relationships has a number of components. First, according to beneficiaries, one of the key characteristics of good advisers is that they are receptive to the employment aspirations of clients. This consistently emerged as a crucial factor in distinguishing New Deal for Communities projects from Job Centre Plus services. Such an approach helps engender the trust needed to build confidence and broaden aspirations among clients.

Second, advisers can play a role in helping participants understand the benefits of returning to work. These include possible non-monetary benefits such as health improvements, increased self-esteem and greater quality of life as well as likely financial rewards. Equally, advisers can manage expectations especially in terms of potential wages, the ease of finding work and the distance clients are willing to travel. Clients may have unrealistic expectations of salaries they can command in the labour market and how close to home they can expect to find work.²²

IPS is focused on the individual who is looking for work. Far from being a rigid model that restricts services, the evidence suggests it actively encourages a thoughtful, supportive, flexible response to each individual. It promotes creativity and open-mindedness in employment specialists and mental health teams to help people to get good job matches and individualised support. It relies on employment specialists having excellent knowledge of local job markets and the needs of employers. It relies on effective team-working between employment specialists, health professionals and the individual, and it focuses on what is important and meaningful for those people.³⁰

Signposting participants to health related services e.g. physiotherapist, gym, psychologist

Dame Carol Black's report, chapter 5,² outlined a new Fit for Work service for those off work on sickness absence, the objectives of which are to help people recover from or manage their health condition to enable a return to productive employment. The same objective is necessary for those who are out of work, and many would benefit from the work-focused, case-managed, multidisciplinary approach offering services such as cognitive behavioural therapy, physiotherapy, and advice and counselling for wider social problems, such as debt management.

Other interventions

Healthcare provision

One of the most important aspects in enabling a return to work for people with health problems or disabilities is adequate provision of appropriate and targeted health services. In particular, vocational rehabilitation services address the specific health barriers to an individual's employment, as well as providing a source of information for the patient on the types of work which may be most suitable. The Government is currently reviewing vocational rehabilitation services and will be providing guidance for employers.

Healthcare professionals should consider a return to appropriate work as an important outcome in the treatment and support of patients. The NHS is currently considering patient pathways for those with major long-term conditions. For those of working age, this should, where appropriate, include a consideration of work-related health and the steps necessary to help the patient to move back into employment.²

Section 6: Supporting evidence on project development and partnership working practices that may help providers to integrate health objectives within their work

Discrimination

Working with employers

A common barrier preventing a return to work for those who are workless through ill-health is the attitude of others towards them. One of the changes required will be for employers to recognise the value and potential of disabled people and those with chronic health conditions.

Dame Carol Black argues: *'Too often employers believe, wrongly, that productivity would be lower and costs higher, whereas the majority will require little or no extra support to perform in the right job'.²*

Collaboration and links with health and or social services

Case study: St Mungo's

- Health issues are a key part of the lives of clients of St Mungo's, as are housing and employment. They believe that if you can tackle one it is likely to have a knock-on positive impact on the others.
- New clients have a health check including whether they are registered with a GP.
- They work closely with statutory providers such as community psychiatric nurses to support clients to access services.
- They have a health and mental health team who work directly with clients, also offering talking therapies, healthy living talks, smoking cessation groups.

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