



Predicting return to work from health related welfare following low intensity cognitive behaviour therapy



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ABSTRACT

The aim of this study was to identify predictors of return to work in the short and long term following condition management cognitive-behavioural therapy (CM-CBT). All participants ($N = 3794$) were disability welfare claimants, unemployed due to the presence of a physical or mental health condition. CM-CBT consisted of a seven session group cognitive-behavioural psychoeducational programme, with participants followed-up at 3 and 12–30 months. The primary employment outcome measure was a categorical measure of either returned to work, made progress towards work or remained on welfare. Results index an incremental progress and return to work rate, increasing from 34.41% at short-term follow-up to 53.07% at long-term follow-up. Clinically, 17.40% were classed as recovered following CM-CBT. Reliable psychological change during CM-CBT predicted successful return to work and remaining on welfare was associated with psychological regression over time. The results are discussed in terms of identified methodological weaknesses and the potential of CBT in enabling return to work for the health related unemployed.

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Introduction

High and increasing rates of health-related unemployment have made health and work a policy and service priority in high income societies (Harvey, Henderson, Lelliott, & Hotopf, 2009), particularly where the total cost of worklessness outstrips the total healthcare budget (Black, 2008). The majority of people who are unemployed due to poor mental health have depression and anxiety Schaufeli and Vanyperen (1993) and people unemployed due to physical health conditions often have unrecognised co-morbid mental health issues (Harvey et al., 2009). Long-term unemployment adversely affects physical and mental well-being (McKee-Ryan, Song, Wanberg, & Kinicki, 2005) and when poor health is the trigger for loss of work, a complex clinical picture emerges (Clay, Newstead, Watson, & McClure, 2010). Health related unemployment is conceptualised as a biopsychosocial phenomenon, whereby work readiness is restricted by the interplay of health condition, health related beliefs/attitudes and the social/cultural context Waddell, Aylward, and Sawney (2002).

Despite a strong desire to return to work amongst the health related unemployed (McQuilken et al., 2003), this group struggles to both attain and maintain employment and as a result has lower employment rates and earnings (Rigg, 2005). The likelihood of a return to work is only one-in-five after twelve months of incapacity welfare (DWP, 2002). The health related unemployed appear especially vulnerable to the negative effects of unemployment due to additional loss of life/social structure, personal purpose and work identity (Bennett, 1970; Grove, 2006). Length of time unemployed is associated with deteriorating psychological health (Freidl, Fazekas, Rami, Pretis, & Feistritz, 2007), physical de-conditioning (Waisak, Verma, Pransky, & Webster, 2004) and on-going financial strain (Price, Choi, & Vinokur, 2002).

Conversely, the therapeutic nature of work can reverse the adverse health effects of unemployment (Sainsbury et al., 2008; Waddell & Burton, 2006; Winefield & Tiggemann, 1990). Work reverses physical de-conditioning (Waisak et al., 2004) and habituation to unemployment (Black, 2008) and provides fiscal and physical security, daily structure, improved control and skill use, interpersonal contact and social standing/sense of purpose (Creed & MacIntyre, 2001; Fryer, 1995; Jackson, 1999; Jahoda, 1982; Warr, 1987). Return to work from health related unemployment is complex however, as it entails enhanced symptom management, increased motivation and behaviour change often via sustained

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interaction across a number of agencies (Frank et al., 1996; Krause, Frank, Dasinger, Sullivan, & Sinclair, 2001). Rick, Carroll, Jagger, and Hillage (2008) noted that there were few firm conclusions to be drawn from the evidence-base comparing interventions to enable a return to work for recipients of health related unemployment welfare. This is due to the extant studies lacking credible methodologies and, in particular, failing to access long term employment outcomes.

The current study is unique as it focuses on identifying factors that predict return to work in both the short and the long term from a 'low intensity' cognitive-behavioural intervention for the health related unemployed, i.e. the provision of a group psycho-educational intervention by trained health professionals acting in a generic practitioner role within a 'high volume, low contact' service ethos and design (Brown, Cochrane, & Cardone, 1999). Low intensity psychological interventions are defined by less intensive treatments (such as brief therapies, group treatments, assisted self-help, biblio-therapy and computerized treatments) for mild to moderate clinical problems, that enable rapid access to evidenced-based psychological treatments delivered by paraprofessionals, peer supporters or psychological well-being practitioners (Bennett-Levy et al., 2010; Rodgers et al., 2012). The clinical aim of the current study was to investigate the effectiveness and durability of CM-CBT and study the relationship with return to work rates in short and long term. We hypothesized that (1) reliable improvements in psychological functioning following CM-CBT would be associated with return to work in both the short and long term, (2) remaining on welfare following CM-CBT would predict deteriorations in psychological health over time and (3) effective return to work would produce longitudinal psychological benefits.

Method

Organisational context

Condition Management Programmes (CMP) were established in the UK as an aspect of the Pathways to Work (DWP, 2002) policy context. CMP provides disability management to recipients of health related unemployment welfare, with the explicit aim of facilitating a return to work, via more effective self-management of presenting health condition (Dorsett, 2008). The typical health conditions referred to CMP comprise mental health, cardiovascular, musculoskeletal and miscellaneous physical conditions, with mental health conditions predominating (Barnes & Hudson, 2006). All the present sample ($n = 3794$) were unemployed and claiming health related welfare (Incapacity Benefit or Employment and Support Allowance welfare) and were attending the publically-funded South Yorkshire CMP in the UK. Eligibility for health related welfare in the UK is initially determined by a General Practitioner in Primary Care providing a medical certificate of incapacity for work. Further independent medical examinations follow that assess the on-going eligibility for health related welfare. Eligibility is defined as the 'ability to perform work-related activities being substantially reduced' (DWP, 2009). Referrals for CMP originate from Department of Work and Pensions Job Centre Plus Incapacity Benefit Personal Advisors, who recognise the role of poor condition management impacting on ineffective job search strategies and the psychological well-being of health related welfare recipients. Participation in CMP is entirely voluntary.

Condition Management Programme

The South Yorkshire CMP offered a group-based, cognitive-educational approach to increasing employability and psychological

well-being (Grove, 2006). The programme drew heavily on Williams (2006a, 2006b) 5 areas approach with the emphasis on psychoeducation. The therapeutic aim of the CMP is the development of broader and more effective condition management strategies across mental and physical health conditions to enable an effective return to work (Grove, 2006). The group-based delivery approach was developed in response to evidence that a group approach can combat the isolating effects of worklessness (Sainsbury et al., 2008) and a non-condition specific approach was adopted to facilitate versatility of delivery (Waddell & Burton, 2006).

The '5 areas' self-help approach focuses on key areas in condition management; (1) life/situation and practical problems, (2) condition-related unhelpful cognitions, (3) condition-related altered emotions, (4) condition-related altered physical feelings/symptoms and (5) unhelpful behavioural patterns (Williams, 2006a, 2006b). The groups provided education and strategies for to apply in each of the identified five areas. Example topics covered in the group sessions are; assertiveness and practical problem solving, noticing and changing unhelpful or extreme thoughts, techniques to improve sleep and relaxation, goal setting, behavioural activation/pacing/balancing and overcoming cognitive and behavioural avoidance, via exposure. The programme is delivered via 7 consecutive four-hour weekly sessions, facilitated by two CMP practitioners to an average of 6 participants. Between-session tasks ('homework') are introduced each week, to aid the generalisation of the change techniques and strategies discussed in the groups. All of the mixed-condition group-based psychoeducational sessions were delivered in local community settings (e.g. leisure centres and voluntary organisations), with the aim of reducing any disabling effects of stigma and for ease of local access (Kellett, Clarke, & Matthews, 2007). The South Yorkshire region was covered by four CMP teams; Sheffield, Barnsely, Rotherham and Doncaster. This area of the UK has a higher proportion of health welfare claimants, due to previously been an area of high industrialisation and associated heavy industry (Beatty, Fothergill, & Powell, 2006). Each CMP team had a multi-disciplinary constitution of qualified health professionals from a variety of health backgrounds including mental health nurses, general nurses, occupational therapists, physiotherapists and assistant psychologists. Practitioners delivering the programme were trained on the 'five areas' model (Williams, 2006a, 2006b) and received regular supervision.

Design

In a prospective cohort design, employment and psychological data were collected via self-report at four time points (1) prior to CM-CBT (assessment), (2) immediately following CM-CBT (termination), (3) at short term follow-up (3 months following CM-CBT) and (4) at long term follow-up (12–30 months following CM-CBT). The psychological measures and employment data were collected at the beginning of the first CM-CBT group session, termination measures at the end of the final group session and follow-up data was collected via a mixture of telephone interview and postal return.

Sample

The present sample consisted of participants in the South Yorkshire CMP, who had participated in the intervention between 2006 and 2010. Health conditions were grouped into four categories by clinical opinion and claimant self-report at screening for CMP (DWP, 2002) and defined as the most dominant issue preventing return to work. The four CMP categories are defined as mental health conditions (61.7%; $n = 2352$, 1083 males with a mean

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