Evaluation of a Job Retention and Vocational Rehabilitation Pilot in Fife

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Full Report
Fife Pilot Project

JOB RETENTION AND VOCATIONAL REHABILITATION
FOR PEOPLE WITH MENTAL HEALTH PROBLEMS.

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<th>Description</th>
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<tbody>
<tr>
<td>CBI</td>
<td>Confederation of British Industry</td>
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<tr>
<td>COPM</td>
<td>Canadian Occupational Performance Measure</td>
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<tr>
<td>CORE-OM</td>
<td>Clinical Outcomes for Routine Evaluation - Outcome Measure</td>
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<td>EuroQOL</td>
<td>European Quality</td>
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<td>EVR</td>
<td>Enhanced Vocational Rehabilitation</td>
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<td>FEAT</td>
<td>Fife Employment Access Trust</td>
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<tr>
<td>GHQ-12</td>
<td>General Health Questionnaire - 12</td>
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<tr>
<td>HNC</td>
<td>Higher National Certificate</td>
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<td>HND</td>
<td>Higher National Diploma</td>
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<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IPS</td>
<td>Individual Placement Support</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>OHSAS</td>
<td>Occupational Health and Safety Advisory Service</td>
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<tr>
<td>OT</td>
<td>Occupational Therapy / Therapist</td>
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<tr>
<td>PA</td>
<td>Personal Assistant</td>
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<tr>
<td>SVQ</td>
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EXECUTIVE Summary

Introduction

This report provides a summary of the evaluation of the Job Retention and Vocational Rehabilitation project. The scope of this Fife-based pilot concerned the development of a model to enable individuals with mental health problems to avoid loss of their job or to attain employment.

There is increasing interest in the relationship between work difficulties and mental health problems, as the effect of mental ill-health on an individual’s ability to work becomes more widely recognised. Employers’ costs associated with mental health issues are most obviously noted in relation to sickness absence. Indirect costs, such as ineffective working, substantially reduced presenteeism must also be considered. A recent report has suggested that these costs amount to nearly £26 billion each year in Britain. Productivity reduction accounts for the majority of these costs (£15.1 billion), with an estimated £8.4 billion associated with sickness absence as a result of mental ill-health (Sainsbury Centre for Mental Health, 2007).

The cost of incapacity benefit for mental health-related illness is also significant, with as many as 121,850 people in Scotland with mental health problems, aged between 18 and 65, currently registered unemployed, but who are capable of work and keen to work (Framework for mental health services in Scotland, 1997). In addition to significant financial benefits, the effects of returning an individual with mental health issues to work, either after an episode of sickness leave or a period of unemployment, can have a positive impact on the individual’s mental health and wellbeing (Schneider, 1998).

A number of national initiatives and policies compliment the development of a job retention and vocational rehabilitation programme. One of the key priority areas of the Scottish Government Mental Health and Wellbeing Agenda outlines a programme for piloting job retention and vocational rehabilitation services for people who have developed mental health problems.

Existing services within NHS Fife and Fife Council encourage managers to refer employees experiencing mental health difficulties to the Occupational Health Service, supplied by OHSAS. There are no comprehensive procedures to actively encourage the recruitment and support of people with mental health problems within either NHS Fife or Fife Council, other than policies adhering to the Disability Discrimination Act (1995 amended 2005) and other relevant legislation (e.g. The Protection from Harassment Act 1997; Health and Safety at Work etc Act 1974).

The potential benefits of assisting individuals affected by both mental health and employment issues are many, including improvements to the mental health of the individual through the opportunity to work, reduced costs from a reduction in incapacity benefits, better support for employees and managers directly affected, and reduced sickness absence costs.

This pilot supports the need for a programme that supports individuals that are suffering from mental health issues to remain in, or return to, the workplace.
This pilot fulfilled this requirement through the provision of support for employed individuals at risk of losing their job as a result of mental health issues, coupled with assistance for job applicants who were currently unemployed and experiencing mental health issues.

The main aims of this pilot project were two-fold:

One: To develop and evaluate a model of service delivery designed to prevent job loss for employees of NHS Fife and Fife Council who are experiencing significant mental health problems.

Two: To develop and evaluate a model of Vocational Rehabilitation for unemployed people with mental health problems to enable them to attain employment in NHS Fife and Fife Council.

Evaluation Aims

The main aims of the evaluation of the pilot project are to:

- assess the extent to which the aims of the Job Retention and Vocational Rehabilitation pilot had been met;
- establish the effect of the pilot on the psychological and occupational health of the client;
- establish the effect of the pilot on sickness absence and performance in employment;
- evaluate the perceptions of the pilot project from a client’s and manager’s perspective;
- establish the success of the pilot in rehabilitating unemployed individuals with mental health problems back into employment.

Methods

A number of measures were used to evaluate the pilot project.

- a set of standardised measures to assess the significance of any changes in:
  - psychological functioning;
  - occupational performance and satisfaction;
  - confidence in job seeking abilities;
- questionnaires to collect client / manager perceptions of the project

Results

Participants in the project were generally experiencing anxiety and/or depression symptoms.

Significant mental health benefits were observed for participants in the project, through standardised measures, in terms of improved psychological functioning, increased occupational performance and satisfaction, and greater self confidence in terms of job seeking abilities.
A large proportion of the participants returned to work through the course of their involvement in this pilot project. The majority of this group returned from sickness absence to their existing post, with the remainder being redeployed within the employing organisation or commencing work after a period of unemployment.

In terms of perceptions of the project, both participants and managers reported positive experiences, suggesting that the addition of such a scheme to the range of employee benefits available to individuals is highly valued.

In March 2007, initial results from the pilot were presented to the National Employment and Health Innovations Network, a government supported group that exists to facilitate the exchange of ideas, experience and evidence across the area of work and health.

**Conclusions and recommendations**

The need for a programme that supports individuals who are suffering from mental health issues to remain in work, or get back in to work, has been identified both nationally through the Scottish Government Mental Health and Wellbeing Agenda and by local employers\(^1\), recognising that mental health issues relating to work are not given sufficient priority. The potential benefits of assisting individuals affected by both mental health and employment issues are wide: improving the individual’s mental health through employment (Schneider, 1998); reducing costs associated with incapacity benefits; support for managers tackling the issues; increased productivity at work; and reduced sickness payments.

The model developed for this pilot utilised a number of interventions to support individuals whose ability to work is affected by mental health issues. The efficacy of this pilot programme to support individuals in returning to their workplace after being absent with mental ill-health, and assisting unemployed clients with mental health problems in selecting, achieving and retaining employment, has been supported by this evaluation.

Health benefits for the individuals who participated in this pilot project were observed, in terms of improved psychological functioning, increased occupational performance and satisfaction, and greater self confidence in terms of job seeking abilities. In addition, a large proportion of the participants in this pilot returned to their workplace through the course of their involvement in this pilot project. It is anticipated that this would have an effect on the costs associated with poor mental health in employees, both directly through sickness absence and indirectly through a significant reduction in productivity, ineffective working and poor interpersonal relationships.

Significantly, both participants and managers reported positive perceptions of the project, suggesting that the addition of such a scheme to the range available as employee benefits, and the support for managers dealing with these issues on the front-line, is valued.

The model of job retention and vocational rehabilitation used for this pilot has been developed in such a way as to enable implementation across Scotland, utilising training, where necessary, to allow other similar community-based agencies and mental health professionals to develop the skills required for delivery of an effective programme. Since completion of the pilot project, FEAT have secured independent funding to continue provision of their service.
1. **INTRODUCTION**

**Background**

*A National Issue*

1.1. Awareness of the link between work difficulties and mental health problems is increasing throughout the public and private sector in the UK. The Health and Safety Executive (HSE) estimates that self-reported work-related stress, depression or anxiety account for an estimated thirteen and a half million reported lost working days per year in Britain (Jones et al, 2001/2002). In Scotland the prevalence of self-reported work-related stress, depression or anxiety is estimated at 1% of people ever employed (Jones et al, 2001/2002). The average length of time taken off work is greater for mental health related problems than musculoskeletal disorders, estimated at 29 days compared with 19 days (Jones et al, 2001/2002). Whilst mental health problems can therefore adversely affect work performance, work difficulties can also have negative effects on mental well-being. Staff surveys (Smith et al, 2000) indicate that 20% of employees find work stressful and believe it has an impact on their mental health. In addition to the direct costs of sickness absence due to poor mental health there are also other indirect important costs such as ineffective working, poor interpersonal relationships, and substantially reduced productivity. The number of people claiming incapacity benefit for mental health-related illness has an economic cost. In Scotland, it is estimated that as many as 117,000 people with mental health problems, aged between 18 and 65, who are currently registered unemployed are capable of work and want to work (Framework for mental health services in Scotland, 1997). It is important to bear in mind that evidence indicates that constructive employment can have a positive impact on an individual’s mental health and well-being (Schneider, 1998). Surveys have shown that people with mental health problems want a range of employment services and opportunities and up to 90% have indicated that they would like employment of some kind (Secker, Grove & Seebohm, 2001).

**Relevant Policies and Initiatives**

1.2. There are a number of national initiatives and policies that support the development of a programme to support individuals to remain in, or return to, their workplace. One of the six key priority areas of the National Programme for Improving Mental Health and Well-Being is to improve mental health and well-being in employment and working life. The Framework for Mental Health Services in Scotland (Scottish Executive, 1997) clearly identifies employment as a mental health issue whilst the Mental Health and Employment Policy for Scotland (Durie, 2003) addresses the exclusion of those with mental health problems from employment, tackling discrimination, improving the mental health of the working population and solving labour force shortages. Furthermore, Section 26 of the new The Mental Health (Care and Treatment) (Scotland) Act 2003 places a duty on local authorities to provide support into employment for people with mental health problems. The recently published ‘Healthy Working Lives’ (Scottish Executive, 2004) also outlines a programme for piloting job retention and vocational rehabilitation services for people who have developed mental health problems.
The Local Context

1.3. At present within NHS Fife and Fife Council, managers will refer employees experiencing mental health difficulties to the Occupational Health Service, supplied by OHSAS, via the Human Resources department. Services from Occupational Health Consultants and Nurses, Occupational Therapy, and Counselling and Psychology are accessible to all NHS Fife and Fife Council employees, free of charge. The processes of recruiting to NHS Fife and Fife Council are similar in that they use pre-employment health screening and abide by the legislation set out by the Disability Discrimination Act (1995).

1.4. A Fife survey looking into employers’ attitudes towards mental health problems (n = 70) found that, when recruiting staff, almost two thirds of employers require disclosure of medical information, half asked questions specific to mental health status and a number asked more general questions about fitness for work and disability. When asked how they would respond if an undisclosed mental health problem was identified after someone joined the company, 34% reported they would immediately consider dismissal, start disciplinary proceedings or refer the person for medical assessment. Of the employers surveyed, 73% considered that the presence of a mental health problem would affect their recruitment decision; their task is to recruit the best person for the job, as they see it. They thought that people with mental health problems might not be suitable for work involving customer contact, stressful occupation and work where there was a health and safety risk. The researchers did however find a willingness amongst employers to consider the employment of people with mental health problems. They consider that the current situation of covert discrimination and unhelpful perceptions of people with mental health problems results from a lack of understanding and awareness about the issues among employers, and the lack of priority given to mental health issues. This suggests that a service to support job applicants with mental health issues is not a current priority amongst local employers, but its importance is recognised.

Employment Support Programmes

1.5. Research on the outcomes of supported employment is limited in Britain. There has been far more comprehensive investigation of this area in the United States. A randomised clinical trial of two models of vocational rehabilitation by Drake and colleagues (1999) found that Individual Placement and Support (IPS) and Enhanced Vocational Rehabilitation (EVR) had a positive effect on employee outcomes such as measures of self-esteem, global functioning and quality of life. The IPS programme, which involved the unemployed client being placed in a normal workplace environment with additional support, was found to get the client back to work much quicker than the EVR programme and this was maintained at follow-up. The EVR programme involved using outside agencies that primarily helped the client to get sheltered employment, not in the mainstream employment market. However, participants receiving the two types of programme were equally satisfied with their employment.

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2 There are presently no Psychology Services available to Fife Council employees.
1.6. Currently there are no comprehensive procedures to actively encourage the recruitment and support of people with mental health problems within either organisations, NHS Fife or Fife Council, other than policies adhering to the Disability Discrimination Act (1995) and other relevant legislation (e.g. The Protection from Harassment Act 1997; Health and Safety at Work etc Act 1974). The main issues arising from the existing procedures are that they do not provide adequate opportunity for identification of someone with mental health problems and therefore can block essential communication. Without these elements there cannot be a planned programme of care of the individual put in place. In addition to these problems, the managerial/OHSAS system for people who are employed by NHS Fife and Fife Council does not easily lend itself to workplace intervention for people with mental health problems due to confidentiality concerns.

1.7. The majority of supported employment programmes for people with mental health problems who are unemployed are within the voluntary sector (e.g. Remploy, FEAT) and form part of a range of services for people with disabilities generally. These organisations do not provide services for people who have experienced or are experiencing mental health problems and are presently in employment. Moreover, it has been estimated that 14.5% of supported employment places in Scotland are occupied by people with mental health problems (Durie, 1999).

1.8. Within NHS Fife, the reported percentage of sickness absence that is related to stress and/or mental health problems is 4.65%, for 2003/2004. The Fife rates of sickness compare to a national average of 14% in the UK (ILO, 2000) with the CBI estimating that one-third of all sickness absence is actually due to mental health problems. For example, within the same period, at one Fife hospital with a nursing establishment of 282 staff, 22 individuals lost 984 days over 26 episodes. If the results of this sample were applied to NHS Fife’s total establishment of 7500 individuals, potentially 585 people may suffer mental health related illness in any one year. These figures demonstrate the need for services which help prevent people with mental health problems losing their jobs and provide support for those who are unemployed and have experienced or are experiencing mental health problems, with entering or re-entering employment.

Pilot Project

1.9. Interest and commitment to develop a job retention pilot in Fife rests on previous work undertaken by both Fife’s Multi-agency Mental Health Strategy Group and in particular it’s Employment Strategy Sub Group, which links into the Framework Sub-Group on Employment. These Groups identified a lack of services in Fife targeted specifically towards job retention for mental health consumers in Scotland, and gaps in vocational rehabilitation services for people with mental health issues wishing to enter or re-enter the workforce.

Overview of the Pilot Project

1.10. As a result of the growing awareness of the links between employment and mental health, and the duty of employers and local authorities owing to legislation and moral obligation, a pilot project has been developed as a model of job retention and employment re-entry services to be rolled out across Scotland.
The potential benefits of assisting individuals affected by both mental health and employment issues are universal: improving the individual’s mental health through employment (Schneider, 1998); reducing costs associated with incapacity benefits; support for managers tackling the issues at the front-line; increased productivity at work and reduced sickness payments. Taking this into account, this project proposes an approach that utilises a number of interventions to support individuals whose ability to work is affected by mental health issues, but where the individual has a desire to work.

1.11. The aims of this innovative project were to augment the existing OHSAS service with access to a case manager/rehabilitation consultant, combining occupational therapy and psychology. Work-related mental health issues were tackled within the workplace with managerial support. Joining this service to an external agency contracted to provide support for those experiencing mental health problems who are unemployed provided a robust approach to tackling mental health at work.

1.12. Combining this approach to promoting job retention with maximising the ability of those who are unemployed with mental health problems to attain employment allowed this project to be managed as a cohesive pilot, thus enabling the practice wisdom and innovation developed in the job retention strand to inform practice in vocational rehabilitation. These approaches added value to the existing standard procedures and offered a truly multidisciplinary approach to the issue. By so doing, the model developed offers a method of best practice to be disseminated across services.

**Project Aims and Objectives**

1.13. The main aims of this project were two-fold:

One: To develop and evaluate a model of service delivery designed to prevent job loss for employees of NHS Fife and Fife Council who are experiencing significant mental health problems.

Two: To develop and evaluate a model of Vocational Rehabilitation for unemployed people with mental health problems to enable them to attain employment in NHS Fife and Fife Council.

1.14. Common objectives across these two strands:

- To promote the service among the key stakeholders and identified catchment areas to ensure successful referral to the service.
- To establish an expert and community reference group to contribute to service development models.
- To develop an evaluation strategy, comprising ongoing quality improvement and final program evaluation.
- To provide regular reports as required to the steering or project management group of Employment Support Fife, including anonymous returns on individual outcomes as well as information on project activity.
• To ensure the dissemination of information regarding this pilot through a comprehensive communication strategy aimed primarily at public authorities with responsibilities under legislation for these issues, but including the wider range of stakeholders in this issue at national Scottish level.

Promotion of Job Retention and Vocational Rehabilitation Project

1.15. Leaflets to promote both the Job Retention service and the Vocational Rehabilitation service were distributed across NHS Fife, Fife Council, and throughout Fife in Opportunity Centres, Job Centre Plus, GP surgeries and libraries. Mental Health Teams throughout Fife raised the profile of the project through their service, and leaflets were included with all NHS Fife and Fife Council application packs.

1.16. Presentations to Human Resource teams and groups of managers were also offered, with the former offering the greatest opportunities to reach a wide audience. Where possible, the communication included both Job Retention and Vocational Rehabilitation representatives to give the audience a better appreciation of the totality of the project.

1.17. During October 2005, two Press Releases were issued regarding the project, and an article included in the Fife Employability Network newsletter.

Evaluation Aims and Structure of the Report

1.18. The main aim of the evaluation was to assess the extent to which the aims of the Job Retention and Vocational Rehabilitation pilot had been met, by:

• Establishing the effect of the pilot on the psychological and occupational health of the client.
• Establishing the effect of the pilot on sickness absence and performance in employment.
• Evaluating the perceptions of the pilot project from a client’s and manager’s perspective.
• Establishing the success of the pilot in rehabilitating unemployed individuals with mental health problems back into employment.

1.19. This report presents an evaluation of the Job Retention strand of the project (Chapter 2), followed by a separate assessment of the Vocational Rehabilitation pilot (Chapter 3). The conclusions and recommendations are then presented (Chapter 4), with considerations and limitations across the whole pilot project in the final section (Chapter 5),
2. **JOB RETENTION**

Aims of Job Retention Pilot Project

2.1. The specific objectives of the Job Retention pilot project were:

- to develop access to existing support services in the designated pilot area for individuals experiencing mental health difficulties at work;
- to provide rehabilitation case management for a minimum of 50 clients within this cohort over a two-year period averaged at 2 new clients per month.

Overview of Job Retention Pilot Project

2.2. A structured model was developed to facilitate introduction of the service to other organisations across Scotland. The model developed for the Job Retention aims of the pilot project was rooted in the Model of Human Occupation (Kielhofner and Forsyth, 1997). The selection of this professional model was based on its focus on the factors that determine individual occupational performance, and the associated tools it offered, such as the Worker Role Interview.

2.3. In addition to this, four options for intervention approaches, as illustrated in Figure 1, allowed rehabilitation to be tailored to the unique circumstances and requirements of each individual by selecting one, or a combination, of the following approaches for use. These options were based on occupational therapy delineation models, which focus on practice boundaries for particular client groups:

- Behavioural approach: Developing skills to support appropriate behaviour.
- Cognitive approach: Identifying and modifying negative cognitions affecting mood and behaviour.
- Rehabilitative approach: Improving function in the activities of daily living.
- Condition Management: Developing skills in dealing with a health condition and strategies to maintain a lifestyle in the context of this condition.

2.4. With the client’s permission, the rehabilitation consultant made contact with all key stakeholders to enlist them in the job retention process. Key stakeholders for the process were identified as the participant (Index Client), the manager, a Human Resources officer and an Occupational Health clinician, along with any other significant agents involved in the care and recovery of the client.
Methodology of Job Retention Pilot Evaluation

Referral Pathway

2.5. Referrals into the Job Retention pilot project were made to the project by OHSAS clinicians from October 2006, and were initially assessed by an evaluator (a psychologist) at a pre-intervention interview for suitability for the project. The inclusion/exclusion criteria used for this were:

- Participants must have had work-related issues that were affecting their mental health.
- Participants must have either been referred by their line manager or self referred for the job retention service.
- There must have been reduced performance or increased sickness absence as a result of mental health problems.
• The employee must have worked for the organisation longer than 6 months. It was possible, however, for clients who had been in contact with the recruitment aspect of the pilot to have earlier contact with the job retention portion if that was deemed appropriate.
• The participants must not have been experiencing additional problems that would be a barrier to job retention e.g. addictions, homelessness, physical disabilities, neurological disorders.\(^4\)
• Participants must not have been experiencing significant suicidal ideation.
• Participants must have given their informed consent and be willing to cooperate with the case-manager.

2.6. A number of self-report measures were also collected at the initial evaluation appointment. Following this meeting, arrangements were then made for the participant to meet with a second evaluator, an Occupational Therapist, to complete a standardised OT measure. Once all the pre-intervention assessments were complete, the individual’s details were passed to the Rehabilitation Consultant in order to conduct the intervention.

2.7. Following an initial appointment between the Rehabilitation Consultant and the client, contact was made with the individual’s manager by the Rehabilitation Consultant to arrange a workplace assessment, the output of which facilitated the formulation of an action plan agreed with the client, and informed the selection of appropriate interventions.

2.8. A number of options were available to the Rehabilitation Consultant within the project. Based on occupational therapy application models, these included:
• Referral on to a specialist service to provide service in the longer term.
• Target setting in re-engaging with work tasks identified as anxiety provoking for the client.
• Support in applying skills developed in therapy prior to contact with the project.
• Support in early stages of return to work.
• Relapse prevention planning.
• Assistance in accessing community services to offer support and activity in other aspects of the client’s life that have had impact on the client’s mental health.
• Modification of work practices to accommodate symptoms and / or medication regime.

2.9. A follow-up appointment was arranged once the intervention concluded, and a final report was issued to Occupational Health and Human Resources. The initial evaluation team (comprising psychologists and Occupational Health clinicians) were also informed to enable outcome measures to be recorded.

\(^4\) The rationale for this criterion is to be more targeted in the service delivery to those that would benefit the most from this form of approach. Participants experiencing significant additional problems may not be appropriate for the job retention pilot, but every effort would be made to source additional forms of support for their specific presenting problem.
2.10. The pilot project was evaluated by two professionals working independently of the Rehabilitation Consultant who provided the intervention, in order to reduce the potential for bias. When an individual was first referred to the project by OHSAS clinicians, this was directed to one of the evaluators (a psychologist) to arrange a pre-intervention interview at which suitability for the project was checked and a range of self-report measures were completed. Following this meeting, arrangements were then made for the participant to meet with an Occupational Therapist, the second evaluator, to complete a standardised OT measure. Once all the pre-intervention assessments were complete, the individual’s details were passed to the Rehabilitation Consultant in order to conduct the intervention.

2.11. When the intervention was complete the Rehabilitation Consultant informed the evaluators who then arranged to repeat the measures with the participant at a single follow-up session. The measures used are outlined below. With the participant’s permission, a questionnaire was also sent to their manager after the Rehabilitation Consultant’s first meeting with them and again when they were discharged by the Rehabilitation Consultant.

**Standardised Measures**

*The CORE Outcome Measure (CORE System Group).*

2.12. The CORE is a 34 item self-report questionnaire on which participants indicate the frequency with which they have been experiencing psychological states, problems and symptoms ‘over the last week’ on a 5 point scale. This then provides mean scores in the following domains:

- Subjective well-being.
- Problems & symptoms.
- Social functioning.
- Risk to self and others.

2.13. These are then combined to provide both a Global Distress mean score for all the 34 items and also a mean score for the total of all the items with the exception of the five Risk items (Non-Risk-29 items). In all cases higher scores represent greater impairment and lower scores indicate better psychological functioning. For all domains there are threshold scores (these differ for males and females) above which the individual’s scoring is classified as representing problems of a clinical magnitude. The measure has very good validity and reliability data in its support and is widely used in the mental health field, both clinically and for research purposes.

*The General Health Questionnaire-GHQ-12 (Goldberg, 1992).*

2.14. This is another well-established measure of psychological distress. It is a 12 item self-report questionnaire on which participants are asked to indicate the extent to which they have experienced certain problems and psychological states ‘over the past few weeks’ relative to their ‘usual’ state. The measure uses a four point scale and provides one total score. Again higher scores indicate greater psychological distress.

*The European Quality of Life 5D Scale (EuroQol Group, 1990).*

2.15. This is a brief measure which asks participants to indicate whether they have no, moderate or significant difficulties in five domains; mobility, self-care, usual activities, pain and anxiety/depression.
The individual is then asked to rate their overall health on that day using a visual analogue scale which then provides a score from 0-100. Because this group is characterised by mental health problems rather than physical health problems, the final two items; the anxiety/depression item and the overall rating of health are most likely to be informative.

_The Canadian Occupational Performance Measure (COPM) (Law et al, 2000)._  
2.16. This is a standardised occupational therapy assessment that is administered as a structured interview. The participant provides ratings of performance and satisfaction (0-10) regarding specific occupational problems which are identified in the first part of the interview. A mean score for both performance and satisfaction is calculated with higher scores indicating better functioning and greater satisfaction. A change score is then calculated when the measure is repeated.

**Non-standardised Measures**

_The Client Perception Questionnaire_  
2.17. The pre-intervention version of the Client Perception Questionnaire requires participants to respond to 13 items regarding their mental health, functioning in their current post, the relationship between the two and their relationships with managers and colleagues. Five of these items were Yes/No items and eight used a six-point Likert scale (1-6) to provide a rating. Participants were then asked to identify areas of their job in which they felt competent, areas where they struggle and possible modifications they thought could be made to their post to facilitate their functioning.

2.18. The post-intervention version of the Client Perception Questionnaire repeated three items from the pre-intervention questionnaire; ratings of current mental health, job performance and satisfaction using the same rating scale. Seven additional items asked the participant to rate various aspects of the pilot project and the support they had received. There was also room for additional comments.

_The Manager Perception Questionnaire_  
2.19. The pre-intervention version of the manager’s perception questionnaire contained many of the same items as the client questionnaire, rephrased to gain the manager’s perspective on the situation. They too were asked to rate the client’s current mental health, functioning in their work role and the relationship between the two and also the support received by the client at work. They were also asked to identify the difficulties the client was experiencing in their work role and any potential solutions to these. The manager was also asked to detail the support they receive to enable them to properly deal with the client’s difficulties and whether they feel they have been trained appropriately for this purpose.

2.20. In the post-intervention version of the manager’s questionnaire managers were once again asked to rate their employees functioning at work and also to make ratings on the same seven aspects of the project as are covered in the client version of the questionnaire to gauge their satisfaction with the service provided. There was also space provided for additional comments.

**Summary of the Results of the Job Retention Pilot Evaluation.**
2.21. Thirty five individuals completed both pre and post intervention assessments with the evaluators. Sixteen individuals either left the pilot before the intervention was completed or failed to attend for follow-up. Comparisons of the completing group with those who did not complete the follow-up confirmed that the two groups did not differ significantly either in terms of demographic variables or in terms of their scores on the standardised measures used at pre-intervention assessment. On this basis it was considered appropriate to analyse the outcomes for the completed group of 35 and treat these as representative.

2.22. The majority of participants were experiencing mood and/or anxiety problems and were receiving additional input from mental health and primary care services. Generally they had worked for the employing organisations for substantial periods of time and the majority were currently absent from their post at the time of entry into the pilot.

2.23. At the point of follow-up, the majority of participants had returned to their substantive post.

2.24. On the CORE, a standardised measure of psychological functioning and problems, there was significant reduction in scores from pre to post intervention, indicating improved psychological functioning.

2.25. On the General Health Questionnaire (GHQ-12) there was also a significant reduction in scores from pre to post intervention, indicating improved psychological functioning.

2.26. On the European Quality of Life Scale (EuroQOL-5D) there was also a significant improvement on both the anxiety/depression item and the overall quality of life rating.

2.27. Outcomes on the Canadian Occupational Performance Measure were of significant improvements in both occupational performance and satisfaction.

2.28. Clients provided moderately positive satisfaction ratings with various aspects of the pilot project.

2.29. Client comments were generally positive about the intervention provided but with some concerns about resourcing, timescales and speed of access to the service.

2.30. Managers expressed similar concerns and also provided moderately positive ratings of the service provided.
Results

Details of project participants

2.31. A total of 51 individuals took part in the pilot. Of these 51, 43 (84.31%) completed work with the Rehabilitation Consultant. However, 8 did not attend for the post-intervention follow-up appointment at which the outcome measures were repeated. Therefore we have complete sets of measures for 35 of the original 51 participants or 68.6% of the group. The pilot outcomes for the whole group of 51 who entered into work with the rehabilitation consultant are illustrated in Figure 2 below.

2.32. This rate of referral exceeded the target of 50 clients over a two-year period, as outlined in the project aims, with 2.9 new clients per month.

Figure 2: Pie chart of pilot outcomes for all participants who entered pilot.

2.33. The following report will therefore be based on the 35 participants for whom we have complete outcome data. However, it is essential to check for significant differences between the two groups; the 35 for whom we have complete data and the 16 for whom we do not, to ensure that the two groups do not differ systematically in any way that might compromise the reliability and generalisability of our findings.

2.34. The groups were therefore compared both in terms of their demographic composition and in terms of their scoring at pre-intervention assessment on the range of standardised measures used. The groups were found not to differ significantly on any of the variables; they were not significantly different in terms of age, gender composition, employing organisation, time in their current post, time working for the organisation or the amount of time they had been off sick. Nor did the groups differ significantly in terms of their scores on the CORE, the GHQ, the EuroQOL-5D or the COPM. Importantly, this demonstrates that the non-completers were not experiencing either significantly greater or fewer psychological and occupational problems that might have accounted for their leaving the study before completing the work (for additional details see Tables 14 to 18 in Appendix D).
2.35. It seems reasonable to conclude on the basis of these analyses that this loss of 16 participants from the project is due to normal processes of attrition and not due to a systematic difference between the two groups. Therefore it is considered reasonable and reliable to report the findings for the group of completers (N=35) and to treat these findings as representative.

**Demographics of the completers**

2.36. For details see Tables 19-23 in Appendix D.

2.37. The group who completed the project ranged in age from 27 to 60 with a mean age of just under 45 and a half years. The majority of the participants were female (24 or 68.6%), with 11 (31.4%) of the group being male. The majority were employed by Fife Council (27 or 77.1%) with the remaining 8 (22.9%) being employed by NHS Fife. This predominance of participants from council posts broadly reflects the size of the two organisations; NHS Fife employs just over a third of the number of staff as are employed by Fife Council. The participants came from a range of services within the two organisations with the largest two groups being the education and social work departments from the council. The job areas are illustrated in Figure 3 below.

**Figure 3: Job composition of the completing group.**

![Pie chart showing job composition of the completing group.](image-url)
2.38. The time that the participants had been in their current post ranged from just two weeks to 22 years, the mean average time in post for the group being 6 years and 3 months. The time that they had been working for the relevant employing organisation ranged from 30 weeks to just under 40 years with a mean average for the group of 12 years and 7 weeks. These statistics indicate that on average these employees have been working for the relevant organisations for a substantial period of time and are therefore likely to be of great value to the organisation in terms of their skills and expertise.

2.39. At the time that they attended for pre-intervention assessment, 27 of the 35 individuals in this group were absent from work, 24 of whom (68.6%) were receiving sick pay and 3 of whom (8.6%) were absent without pay. A further 5 individuals (14.3%) were at work but performing restricted duties and one individual was at work performing alternative duties. The remaining two individuals (5.7%) were the only ones of the 35 who were at work and performing their usual duties. The vast majority of the group (29 or 82.9%) were in full-time positions.

2.40. In terms of the time that the participants had currently been off for, this ranged from no additional time off to a year and a half with an average time of sixteen and a half weeks off. Participants were also asked, when they had been off for less than 6 months, if they had taken any other time off sick within the last 6 months. The average amount of additional time off was reported as 3 and a half weeks.

2.41. Participants were asked whether they were currently receiving treatment from a mental health professional and 19 of them (54.3%) stated that they were. In terms of the type of mental health problem they reported currently experiencing, the largest group was 40% who reported a mood disorder and an additional 17.1% reported experiencing a mixed anxiety and mood disorder. All together 68.5% of the participants were reporting current problems with either mood or anxiety problems or a combination of the two. The participant’s responses are illustrated below in Figure 4. Two individuals stated that they were not experiencing any mental health problem and four individuals (11.4%) described their current problems as ‘work-related stress’.

Figure 4: Pie chart to illustrate group composition in terms of current mental health difficulties.
2.42. A larger proportion of the group than were currently in contact with a mental health professional stated that they had received treatment from a mental health professional in the past (65.7%). This indicates that for the majority of participants there was a vulnerability to mental health problems which pre-dated the current period of difficulties. A much larger proportion stated that they had not experienced a mental health problem in the past (25.7%), than was the case for current status (5.7%). This would indicate that for twenty percent of the group, there was no significant history of mental health problems, although self-report of this may not be entirely reliable.

2.43. In terms of the support that participants receive from primary care health services, 88.6% confirmed currently receiving treatment from their GP in relation to their mental health difficulties. This was the case also for 71.4% of the group in their past. The vast majority of the group (31 individuals or 88.7%) were currently taking psychoactive medications; 28 individuals taking antidepressants, 1 person taking anxiolytics, 1 person taking antipsychotics and 1 person a mood stabilizer. Many individuals were taking a combination of psychoactive medications but these represent the primary medication according to self-report.

2.44. Participants were also asked to report their highest level of academic attainment in order to provide some basic indication of the skill level of the study group. The majority of participants involved (74.4%) had some form of further educational qualifications. The bulk of these (48.6%) were at the HND/HNC/SVQ level with a further 22.9% having a degree and 2.9% additional post-graduate qualifications.
2.45. For those who completed the project and follow-up reassessment, the average time they were active cases in the pilot project was 28.65 weeks or just over 6 months. This ranged from a minimum of 13 to a maximum of 50 weeks when their case was open to the Rehabilitation Consultant. The time elapsed between the Rehabilitation Consultant discharging a participant and that individual being seen for follow-up was on average 7.41 weeks. This ranged from one week to 34 weeks, the latter being the case where an administrative error lead to a significant time lapse in that individual being followed-up.

**Intervention Outcomes**

Attendance at work before and after completion of the intervention is shown below in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Absent – sick pay</td>
<td>33</td>
<td>64.7</td>
</tr>
<tr>
<td>Absent – no pay</td>
<td>5</td>
<td>9.8</td>
</tr>
<tr>
<td>At work – usual duties</td>
<td>6</td>
<td>11.8</td>
</tr>
<tr>
<td>At work – alternative duties</td>
<td>5</td>
<td>9.8</td>
</tr>
<tr>
<td>At work – restricted duties</td>
<td>2</td>
<td>3.9</td>
</tr>
<tr>
<td>Total n</td>
<td>51</td>
<td></td>
</tr>
</tbody>
</table>

2.46. The above indicates a shift of the majority of participants from being absent and in receipt of sick pay at pre-intervention to being back at work at post-intervention. The employment status pre and post intervention is illustrated in Figures 5 and 6.
Figures 5 and 6: Pie charts to illustrate employment status pre and post intervention.

2.47. There is a clear change from approximately two thirds of the participants being absent on sick leave at pre-intervention assessment to around a quarter of participants being absent at the post-intervention follow up.

2.48. In order to establish whether this change in attendance at work is statistically significant Binomial Sign tests were used, which indicated a significant change in attendance at work between pre and post-intervention. The details of these analyses can be found in Table 30 in the Appendix D.

Standardised outcome measures

CORE

2.49. The scores shown in Table 2 are mean scores for each domain. The possible range of scoring for each item of the CORE being 0-4 on a 5 item scale, the possible range for the mean scores is also 0-4 with higher scores indicating more significant difficulties.
Table 2: Group mean scores on the CORE subscales.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Group Mean Pre-Intervention (n=35)</th>
<th>Group Mean Post-Intervention (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>2.051</td>
<td>1.311</td>
</tr>
<tr>
<td>Problems/Symptoms</td>
<td>2.109</td>
<td>1.286</td>
</tr>
<tr>
<td>Social functioning</td>
<td>1.671</td>
<td>1.043</td>
</tr>
<tr>
<td>Risk</td>
<td>0.291</td>
<td>0.060</td>
</tr>
<tr>
<td>Global Distress (total)</td>
<td>1.620</td>
<td>0.974</td>
</tr>
<tr>
<td>Non-Risk (total with risk items removed)</td>
<td>1.920</td>
<td>1.194</td>
</tr>
</tbody>
</table>

*For a full table with standard deviations please see Table 24 in Appendix D.

2.50. The group mean scores for each domain of the CORE decrease from pre-intervention assessment to post-intervention follow-up. This would indicate that, on average, the participants who completed the study experienced some alleviation of their difficulties during this period. In order to establish whether these changes in scoring were of a sufficient magnitude and consistency to achieve statistical significance, Wilcoxon Signed Ranks tests were carried out on the data. The details of these statistical analyses are reported in Table 25 in Appendix D. (Significance values reported throughout these analyses are two-tailed). In all cases, for the four subscales and both of the total scores, the changes in scoring from pre to post intervention were statistically significant.

Clinical vs. Non clinical scoring on the CORE

2.51. For each subscale and total score on the CORE, a mean score is calculated for the individual based on the ratings of items which contribute to that scale. There are clinical threshold scores (which differ for men and women respondents, see Table 26 in Appendix D for details) for each scale, scoring above which indicates the presence of a clinically significant problem (See Table 26 in Appendix D for details of these).

2.52. As an illustrative example, above and below clinical threshold scoring for the total score (Global Distress) is illustrated in Figures 7 and 8 below. Details of the results for all the subscales in terms of the distribution of scores between clinical and non-clinical ranges can be found in the Appendix D.
Figure 7 and 8: Pie charts to illustrate the distribution of scoring on the Global Distress (total) scale for the CORE between the clinical and non-clinical ranges at Pre and Post Intervention.

2.53. There is a clear change from approximately two thirds of the participants scoring in the clinical range at pre-intervention assessment to around a quarter of participants doing so at the post-intervention follow up. This pattern is generally replicated for all the subscales of the CORE – see Table 27 in Appendix D – with the exception of the Risk sub-scale whereby two-thirds of the group are below the clinical cut off for risk to self and others at the outset of the project and this rises to just over 90% at follow up reassessment.

2.54. In order to establish whether the changes in the distribution of scoring between the clinical and non-clinical ranges is statistically significant Binomial Sign tests were used. The details of these analyses can be seen in Table 28 in the Appendix D. For all the subscales and total scores on the CORE, there was statistically significant change between pre and post-intervention assessment; i.e. there was a significant amount of movement from the clinical to non-clinical range from pre to post-intervention.
**GHQ-12**

2.55. The group mean scores on the GHQ-12 for pre and post intervention are shown below in Table 3. The possible range of scores using the 0-3 Likert method is 0-36. Higher scores represent greater psychological strain and problems.

Table 3: Descriptive statistics for the GHQ-12 at pre and post-intervention assessment.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Group Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Intervention</td>
<td>35</td>
<td>21.06</td>
<td>9.747</td>
</tr>
<tr>
<td>Post-Intervention</td>
<td>35</td>
<td>12.09</td>
<td>8.538</td>
</tr>
</tbody>
</table>

2.56. A decrease in the average score on the GHQ-12 between pre and post-intervention assessment is apparent. In order to establish whether this was a statistically significant change, further analysis was conducted using a Wilcoxon (T) Signed Ranks Test the results of which confirmed that the change in scoring was indeed highly significant \( (T(35)=92.50, p<0.001) \). This indicates a significant reduction in psychological distress from pre to post-intervention.

**The EuroQOL-5D**

2.57. Scoring (range 0-2) on each of the 5 domains was compared between pre and post-intervention assessment. As stated in the methodology; given the composition of the study group, their presenting problems and the inclusion criteria of the study, it is likely that some of the items (mobility, self-care and pain in particular but possibly also usual activities) will be of limited relevance in terms of outcomes. The anxiety/depression item and the global rating of health today are more likely to be informative and sensitive to change.

2.58. The modal average (most frequently occurring value) at pre intervention for the mobility, self-care, activities and pain items is 0. This remains the case at post-intervention. For the anxiety/depression item the mode is 1 both at pre and post-intervention; indicating that the most common response was to cite moderate problems in this domain at both times. However, the distribution of responses did shift somewhat towards ‘no’ or ‘some’ anxiety/depression from pre to post intervention- see Figure 9 below.
2.59. Wilcoxon (T) Signed Ranks tests were once again used to establish whether there were any statistically significant changes in scoring. The outcomes of these are reported more fully in Appendix D. There was no significant change in the scores for the items which asked about problems with self-care, usual activities or pain. There was a significant increase in the scoring on the item relating to mobility \((T(5)=0, p<0.05)\), which indicates presence of greater mobility problems in the group at follow-up. There was a highly significant decrease in scores on the item regarding problems with anxiety or depression \((T(25)=57.50, p<0.01)\) indicating fewer difficulties of this nature at post-intervention.

2.60. Looking at the rating of overall health today on the 0-100 visual analogue scale. The group mean score (see Table 4) increases by approximately 20 points from pre to post intervention indicating a clear improvement in perceived overall health on average. Further analysis confirmed this improvement in ratings to be highly significant \((T(33)=95, p<0.01)\) (See Table 29 in Appendix D for further details).

**Table 4: Group mean ratings of overall health on the EuroQOL-5D**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Group Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Intervention</td>
<td>33</td>
<td>48.48</td>
<td>23.51</td>
</tr>
<tr>
<td>Post-Intervention</td>
<td>35</td>
<td>68.69</td>
<td>20.28</td>
</tr>
</tbody>
</table>

2.61. Overall, the information provided by the EuroQOL-5D has reinforced the above findings of the CORE as it indicates a significant reduction in the experience of anxiety and depression and also indicates an improvement in overall self-rated health in association with this.
There are 34 complete sets of data for the COPM as one person who attended for follow-up did not complete the COPM due to an administrative error.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Stage</th>
<th>N</th>
<th>Group Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
<td>Pre-Intervention</td>
<td>35</td>
<td>3.64</td>
<td>1.40</td>
</tr>
<tr>
<td></td>
<td>Post-Intervention</td>
<td>34</td>
<td>6.22</td>
<td>2.02</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>Pre-Intervention</td>
<td>35</td>
<td>3.09</td>
<td>2.05</td>
</tr>
<tr>
<td></td>
<td>Post-Intervention</td>
<td>34</td>
<td>5.89</td>
<td>2.52</td>
</tr>
</tbody>
</table>

The average score clearly increases between pre and post-intervention assessment for both the performance and satisfaction domains. On the COPM an increased score is a positive indicator. Wilcoxon (T) Signed Ranks test confirmed that these changes in scoring were highly significant both for self-rated occupational performance (T(30)=25.50, p<0.001) and self-rated satisfaction with occupational performance (T(30)=26, p<0.001).

The outcomes using this specific measure of occupational functioning indicate that the intervention which is designed to address occupational problems associated with mental health difficulties, is associated with significant improvements in this area, based on self-report.

Non-standardised Measures

Client Perception Questionnaire

The group mean ratings (scale 1-6) for the three items that were repeated as part of this measure at both pre and post-intervention assessment; ratings of current mental health, job performance and satisfaction, show increases of just over 1 point (See Table 6 below).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-Intervention Group Mean</th>
<th>Post-Intervention Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=35</td>
<td>N=35</td>
</tr>
<tr>
<td>Mental health</td>
<td>3.17 (sd 1.32)</td>
<td>4.26 (sd 1.34)</td>
</tr>
<tr>
<td></td>
<td>N=24</td>
<td>N=31</td>
</tr>
<tr>
<td>Job performance</td>
<td>3.04 (sd 1.49)</td>
<td>4.29 (sd 1.35)</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>2.79 (sd 1.44)</td>
<td>4.00 (sd 1.51)</td>
</tr>
<tr>
<td></td>
<td>N=24</td>
<td>N=31</td>
</tr>
</tbody>
</table>
2.66. In this case higher ratings are desirable and further analyses using Wilcoxon (T) Signed Ranks tests confirmed that these improvements in scoring were statistically significant in all three cases (See Table 7 for full details).

Table 7: Summary of analysis of repeated items on client perception questionnaire using Wilcoxon (T) Signed Ranks tests.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>T value</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>31</td>
<td>65.50</td>
<td>&lt;.001</td>
<td>✓</td>
</tr>
<tr>
<td>Job performance</td>
<td>15</td>
<td>15.00</td>
<td>&lt;.01</td>
<td>✓</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>14</td>
<td>13.00</td>
<td>&lt;.05</td>
<td>✓</td>
</tr>
</tbody>
</table>

2.67. The numbers of participants responding to the job performance and satisfaction items are somewhat reduced as many participants felt unable to respond to these items if they were not at work at the time of assessment giving a reduced number of pairs of pre and post responses.

2.68. The post-intervention version of the client perception questionnaire also asked participants to rate their satisfaction with:
- The job retention pilot project as a whole.
- The help received from the Rehabilitation Consultant.

2.69. Participants were also asked to rate:
- How helpful they considered the intervention to have been.
- How worthwhile they considered the project to be.
- The impact of the project on their return to work.
- Whether they would recommend this form of intervention to others.

2.70. For all these items the group average ratings were very encouraging (See Table 8) with ratings for six of the seven items at or above 5 on a scale of 1-6 and the average rating for the remaining item, impact of the intervention on return to work just under this at 4.80. These average ratings indicate a reasonably high level of satisfaction with the approach of the project and the service received from the point of view of the client.

Table 8 – Average ratings on satisfaction items on the post-intervention client perception questionnaire.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Group Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>JRP</td>
<td>35</td>
<td>5.00</td>
<td>1.14</td>
</tr>
<tr>
<td>Rehab Consultant</td>
<td>35</td>
<td>5.23</td>
<td>1.17</td>
</tr>
<tr>
<td>Helpful</td>
<td>35</td>
<td>5.00</td>
<td>1.26</td>
</tr>
<tr>
<td>Involved</td>
<td>35</td>
<td>5.14</td>
<td>1.06</td>
</tr>
<tr>
<td>Worthwhile</td>
<td>35</td>
<td>5.34</td>
<td>1.21</td>
</tr>
<tr>
<td>Recommend</td>
<td>35</td>
<td>5.34</td>
<td>1.11</td>
</tr>
<tr>
<td>Impact</td>
<td>35</td>
<td>4.80</td>
<td>1.32</td>
</tr>
</tbody>
</table>
Client Responses to Request for Additional Comments

2.71. The post-intervention client perception questionnaire concluded by asking clients to “add any additional comments relevant to this pilot”.

2.72. Of the thirty five individuals who completed post-intervention assessment, nineteen chose to add additional comments to their questionnaire. Eight of these comments were wholly positive with respect to the project, such as:

“I felt the supportive nature of the pilot scheme and the Rehabilitation Consultant combined with the counselling I was receiving through my GP and enabled that counselling to be more successful and lasting in effect.”

“I found the JRP excellent in enabling me to gain self-esteem again in the working environment. It was helpful to speak to somebody who knew about work issues but was not directly involved in working for the council.”

2.73. Four comments were more negative in terms of content. Three of these, however, were commenting on the frustration with the timescales to come into the project and the view that earlier intervention would be desirable rather than criticising the content and approach of the intervention provided, such as:

“May have had more benefit from earlier support and more intensive support during initial return to work.”

“Only problem is time between visits and the time to get on the programme.”

2.74. The other individual whose comments were more negative in nature was quite critical of the project and of the Rehabilitation Consultant’s involvement with their case. However, comments supplied by the relevant manager indicate that this individual’s mental health difficulties were complex and the manager believed the individual was unfair in their attitude towards the JRP.

2.75. Six further individuals made comments that were mixed in content. These included some praise of the project but also identified some perceived shortcomings of the project. Examples are:

“The pilot was overall very helpful. The one problem I would point out is that I only saw the Rehabilitation Consultant a few times. I would have liked to see him a few more times,“

“As a whole, the pilot scheme gets twelve out of ten for me. Only one thing: the length of time it took to see the Rehabilitation Consultant was too long.”
2.76. The ‘mixed’ comments tended to express a generally positive experience but identified problems with timescales, a desire for earlier and more intensive input, some problems in coordinating with various other services and some concerns about the sharing of information between services. The main concerns were around timescales and resourcing of the service so that the Rehabilitation Consultant is able to provide the help required to all clients expediently.

Manager’s Perception Questionnaire

2.77. For the group of 35 individuals who completed pre and post-intervention assessment, there were 17 sets of complete pre and post-intervention questionnaires returned by their managers. Two of the rated items were repeated on the manager’s questionnaire at post-intervention;

- The rating of the employee’s current job performance.
- The rating of manager's satisfaction with the employee’s current job performance.

2.78. The group mean scores on these items were very similar at both times. The ratings were approximately 4 on average for both items on both occasions. This indicates that, on average the managers rated these items just to the positive side of neutral and that there was only very slight change, on average, from pre to post intervention. See Table 9 below.

Table 9: Average manager ratings of participants job performance and satisfaction.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-Intervention Group Mean</th>
<th>Post-Intervention Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
<td>4.06 (sd 1.25)</td>
<td>4.41 (sd 0.94)</td>
</tr>
<tr>
<td>(n=17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>4.12 (sd 1.27)</td>
<td>4.47 (sd 1.01)</td>
</tr>
<tr>
<td>(n=17)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.79. Further analysis using Wilcoxon Signed Ranks (T) tests confirmed what this observation suggests; the slight increases in the two groups mean scores are not sufficient to be statistically significant.

2.80. The managers also responded to the same seven satisfaction items on the post-intervention questionnaire as were used in the post-intervention client perception questionnaire.
2.81. The group mean ratings are reported in Table 10 below.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Retention Pilot (n=17)</td>
<td>4.47</td>
<td>1.13</td>
</tr>
<tr>
<td>Rehabilitation Consultant (n=16)</td>
<td>4.94</td>
<td>0.85</td>
</tr>
<tr>
<td>Feedback from Occupational Health (n=16)</td>
<td>4.50</td>
<td>1.21</td>
</tr>
<tr>
<td>Worthwhile (n=17)</td>
<td>4.82</td>
<td>1.13</td>
</tr>
<tr>
<td>Recommend (n=17)</td>
<td>4.59</td>
<td>1.28</td>
</tr>
<tr>
<td>Use Again (n=16)</td>
<td>4.81</td>
<td>1.28</td>
</tr>
<tr>
<td>Impact (n=17)</td>
<td>4.53</td>
<td>1.23</td>
</tr>
</tbody>
</table>

2.82. So managers are generally tending to rate their satisfaction with various elements of the project between 4 and 5 on a scale of 1-6 indicating mild to moderate positivity. Manager ratings are generally around half a point lower than those made by their employees.

Manager’s Responses to Open-Ended Questions.

2.83. As with the post-intervention client perception questionnaire, managers were also asked to add any additional comments regarding the pilot on the final page of the questionnaire. Altogether twenty managers of individuals in the completers group returned the post-intervention questionnaire (three of whom had not returned the pre-intervention questionnaire and so were not included in the above analyses). Nine of the twenty chose not to make any additional comments whilst eleven did add comments. One of those, whilst wholly positive about the individual’s recovery made no reference to any aspect of the pilot project itself and related only to the individual concerned, in positive terms. Of the remaining ten comments, five were wholly positive with regard to the project and its effect on their employee. For example;

“I think this scheme enabled the person referred to ‘help’ themselves, after the consultations received and because it was beneficial to them, it was beneficial to us.”

“The council has retained a very able member of staff who needed help and support on a temporary basis. This type of service has been invaluable in providing a bridge between work and the health service.”
"I am extremely pleased with the service. Without the help I am convinced that the employee would not have been able to return to work. It is more than likely that they would have been dismissed on the grounds of capability. The employee has not had any days sickness since they returned in XX."

2.84. Another manager made the valid point that their employee’s performance at work had greatly improved and that whilst this had coincided with their involvement with the JRP, it was difficult to know whether this was the cause of the changes observed but it was thought likely to have contributed.

2.85. Three comments were mixed; two stating that whilst the scheme was worthwhile and beneficial, they had some concerns about the timescales involved in responding to referrals, one of whom also thought their employee needed ongoing input. The third mixed response suggested that phased return plans etc were unaffected by the JRP but acknowledged that the client themselves might have found the support beneficial.

2.86. Of the two comments that indicated a more negative experience of the pilot project, one reflected a case referred to earlier where the client had a negative experience of the project which staff considered was largely due to the nature of the client’s problems. In retrospect, the suitability of the JRP to this client’s needs was questioned. The manager concerned thought that the project was probably not suitable for this individual. The other manager commented on what was an extensive delay to the follow-up meeting, which meant that due to a deterioration in the client’s functioning following the intervention, much of the benefit seemed to have been lost by the time the individual was reassessed. However, this manager’s comments seemed to indicate a degree of misunderstanding as to what elements of the project were intervention and which were purely for evaluation.

Comparison of Client and Manager Responses at Pre-Intervention.

2.87. Clients and managers were both asked to rate their own/their employees current job performance and their satisfaction with this as well as rating of how supportive the relevant colleagues were considered to be at the pre-intervention stage. In addition, the employee also was asked to provide a rating of how they believed their manager would rate their current job performance and satisfaction with this. The client and manager ratings were then compared as part of the analyses.

Table 11: Comparison of average client and manager ratings on the job performance and satisfaction items at pre-intervention.

<table>
<thead>
<tr>
<th></th>
<th>Job performance item</th>
<th>Job satisfaction item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client rating</td>
<td>3.19</td>
<td>2.94</td>
</tr>
<tr>
<td>Manager rating</td>
<td>4.10</td>
<td>4.10</td>
</tr>
<tr>
<td>Client rating of how</td>
<td></td>
<td></td>
</tr>
<tr>
<td>believe manager would</td>
<td>3.35</td>
<td>3.40</td>
</tr>
<tr>
<td>respond</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.88. Based on these group averages, managers rated client’s job performance and their satisfaction with this slightly higher than the employees rated themselves and also slightly higher than the employees thought the managers would rate them. Analysis using Wilcoxon (T) Signed Ranks Tests confirmed that the difference between client and manager ratings of the client’s performance \((T(12)=12.00, p<.05)\) and satisfaction \((T(14)=15.50, p<.05)\) were significantly different, with the manager’s ratings being more favourable.

2.89. With regards to the client and manager’s ratings of the support the client receives from colleagues, the clients on average rated this at 4.23, whilst the managers rated this at 4.96 on the scale 1-6. Further analysis confirmed that there is no significant discrepancy between these average ratings. Clients also rated the support they receive from their manager (although the manager was not asked to make a comparable rating of the support they provide) which was rated on average, fairly neutrally, at 3.82, only slightly lower than the average rating of support from colleagues.
3. **VOCATIONAL REHABILITATION**

**Aims of Vocational Rehabilitation Pilot Project**

3.1. The specific objectives of the Vocational Rehabilitation pilot project were:
   - To commission a community-based agency to provide the pre-employment and immediate employment-transfer support for Fife NHS and Fife Council.\(^5\)
   - To provide rehabilitation case management for a minimum of 20 clients, living within the chosen catchment area, over a two-year period, through applications to positions within NHS Fife or Fife Council.
   - To develop a training package which can be delivered to mental health professionals and community-based agencies to encourage skills-development in vocational rehabilitation for people with mental health issues.

**Overview of Vocational Rehabilitation Pilot Project**

3.2. Fife Employment Access Trust (FEAT), the external agency selected to assist in meetings these aims, has supported people with severe and/or enduring mental health problems in selecting, achieving and retaining employment since being established in 1994.

3.3. All NHS Fife and Fife Council applicants received information about the Vocational Rehabilitation service as part of the application pack. Clients therefore self-referred to FEAT for inclusion in this pilot project.

3.4. Client suitability for the project was assessed at their initial contact with FEAT, establishing that the service user was:
   - currently unemployed
   - experiencing a mental health problem
   - living within the project catchment area.

3.5. The applicant would then contact FEAT to be allocated an employment advisor. It was agreed that late applications for posts would be considered for individuals registered on the pilot, should the timescale prove unmanageable by FEAT.

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\(^5\) A copy of the tender document for the Vocational Rehabilitation portion can be found in Appendix C.
Methodology of the Vocational Rehabilitation Pilot Evaluation

Referral Pathway

3.6. An initial meeting between the FEAT Employment Advisor and the client was arranged to complete pre-intervention forms and registration of service. A vocational profile was developed over a series of regular appointments, establishing the client’s paid and unpaid work experience, skills, interests and any benefit implications of looking for work. This exercise developed an understanding of suitable work environments for the individual, taking into account the effects of the client’s illness and any medication, support needs and how these would be met, and overcoming barriers to gaining employment.

3.7. The vocational profile facilitated the development of an action plan, with specific goals, such as practical assistance in completing application forms, training in interview techniques, and support in making realistic, informed choices.

3.8. Once a client commenced employment, the employment advisor would:
   - Help the client make decisions regarding disclosure of their illness to colleagues
   - Provide support dealing with benefit changes
   - Help the client identify and use supports within the workplace
   - Ensure the person understood the job tasks and social rules in the workplace
   - Provide ongoing support to client and employer including in times of crises

3.9. In addition to the employment advisor, clients had access to a support worker and qualified counsellor throughout their contact with FEAT, to help them successfully tackle issues or problems in other areas of their life that affected their ability to sustain either involvement with the project or their employment.

3.10. When an individual first self-referred to the project, pre-intervention demographic information was collected by the employment advisor, and a range of self-report measures were completed.

3.11. On completion of the intervention, the employment advisor repeated the measures, and a questionnaire on the client’s perceptions of the service was also completed. The measures used are outlined below.
**Standardised Measures**

*The General Health Questionnaire-GHQ-12 (Goldberg, 1992).*

3.12. This is a well-established measure of psychological distress, also used in the Job Retention pilot. It is a 12 item self-report questionnaire on which participants are asked to indicate the extent to which they have experienced certain problems and psychological states ‘over the past few weeks’ relative to their ‘usual’ state. The measure uses a four point scale and provides one total score. Higher scores indicate greater psychological distress.

*Job Seeking Self Efficacy Scale – SES*

3.13. This scale measures perceived self-efficacy in job-seeking activities. The tool assesses an individual’s confidence in their ability to perform job-seeking activities successfully. Low levels of such self-efficacy are associated with low levels of searching for employment, and the use of ineffective techniques.

**Non-standardised Measures**

*The Client Perception Questionnaire*

3.14. The post-intervention Client Perception Questionnaire requires participants to respond to 10 items regarding their perception of the service they received from FEAT in relation to employment issues. All items used a six-point scale (1-6) to provide a rating. There was also room for additional comments.

**Summary of the Results of the Vocational Rehabilitation Pilot Evaluation.**

3.15. Eleven individuals completed both pre and post intervention assessments, with incomplete data for one further individual who lost contact with the pilot. Seven individuals completed the client perception questionnaire post-intervention.

3.16. The majority of participants were experiencing mood and/or anxiety problems and were receiving additional input from mental health services.

3.17. Four individuals had gained employment by the follow-up appointment.

3.18. On the General Health Questionnaire (GHQ-12) there was no significant reduction in scores from pre to post intervention, indicating no general effect on psychological functioning.

3.19. Outcomes on the Job Seeking Self Efficacy Scores were of significant improvements from pre- to post-intervention.

3.20. Clients provided very high satisfaction ratings with various aspects of the pilot project, irrespective of whether the individual was successful in gaining employment through the project.
Results of the Vocational Rehabilitation Pilot Evaluation.

Details of project participants.

3.21. A total of 12 individuals took part in the pilot. Of these 12, 11 (91.67%) completed both pre and post-intervention evaluations. This rate of self-referrals exceeded the target of 20 clients over a two-year period (10 per year), as outlined in the project aims.

Demographics of the completers

3.22. The group who completed the project ranged in age from 32 to 57 with a mean age of 43 years. The majority of the participants were female (6 or 54.5%), with 5 (45.5%) of the group being male. Previous jobs held were predominantly manual / unskilled, with 6 individuals previously holding full-time posts, and 5 with part-time posts in the past.

3.23. The period of time unemployed ranged from 8 months to 16 years, with a mean period of 5.5 years. Previous to this, 6 individuals held full-time posts, with the remaining 5 individuals previously in part-time posts. Previous work experience was predominantly manual / unskilled employment.

3.24. Participants were asked whether they were currently receiving treatment from a mental health professional and all of them stated that they were. The length of time they had been in contact with mental health services ranged from 8 months to 22 years, with a mean period of 8.8 years. In terms of the type of mental health problem they reported currently experiencing, the diagnoses cited were predominately mood and anxiety disorders, with the majority experiencing a mixed anxiety and mood disorder. Two participants indicated a diagnosis of Obsessive Compulsive Disorder.

3.25. In terms of the support that participants were receiving from primary care health services, most participants confirmed that contact with their GP was their most common contact in relation to their mental health difficulties. Five participants were currently seeing more than one professional. The majority of the group (7 individuals or 63.64%) were currently taking psychoactive medications, with 4 individuals taking a single medication and 3 people with a combination of medications. Some of the medications reported indicate fairly severe levels of psychopathology.

Intervention Outcomes

3.26. Four participants (36.36%) gained employment (3 part-time; 1 full-time). The 4 who gained employment had previously been unemployed for between 14 months and 16 years, with a mean period of 8.4 years. This mean period was higher than the total group mean (5.5 years), suggesting that the length of time unemployed does not influence success at gaining work.

3.27. Length of time with psychiatric problems for the 4 individuals successful in gaining employment ranged between 1 year and 22 years, with a mean period of 10.75 years. This mean period was higher than the total group mean (8.8 years), suggesting that chronicity of psychiatric problems were not linked to gaining employment.
3.28. The individual ages within the group successful in gaining employment ranged from 32 years to 45 years, with a mean age of 37.25 years. This was more than 5 years younger than the mean age of the total group (42.9 years), suggesting this may be a factor associated with a successful outcome.

**Standardised outcome measures**

**GHQ-12**

3.29. The group mean scores on the GHQ-12 for pre and post intervention are shown below in Table 12. The possible range of scores using the 0-3 Likert method is 0-36. Higher scores represent greater psychological strain and problems.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Group Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Intervention</td>
<td>12</td>
<td>15.75</td>
<td>8.36</td>
</tr>
<tr>
<td>Post-Intervention</td>
<td>11</td>
<td>11.45</td>
<td>9.47</td>
</tr>
</tbody>
</table>

3.30. A decrease in the average score on the GHQ-12 between pre and post-intervention assessment is apparent. Wilcoxon (T) Signed Ranks tests were used to establish whether this difference was significant. However, the change in scores from pre to post intervention was not shown to be a statistically significant change, (T(11)=11.00, p>0.05).

**Job Seeking Self Efficacy Scores (SES)**

3.31. The group mean scores on the SES for pre and post intervention are shown below in Table 13. The possible range of scores is 0-35. Higher scores indicate greater self efficacy for job seeking.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Intervention</td>
<td>11</td>
<td>19.9</td>
</tr>
<tr>
<td>Post-Intervention</td>
<td>11</td>
<td>24.2</td>
</tr>
</tbody>
</table>

3.32. An increase in the average score on the SES between pre and post-intervention assessment is apparent. Again, Wilcoxon (T) Signed Ranks tests were performed, and confirmed this difference to be statistically significant (T(11)=5.50, p<0.05), indicating increased confidence in job-seeking abilities following intervention.

**Non-standardised Measures**

**Client Perception Questionnaire**

3.33. Seven participants completed a post-intervention client perception questionnaire. The scores ranged from 48 to 60 (maximum score 60), with a mean score of 56.71, indicating very high satisfaction levels with the intervention.
3.34. Three individuals that were successful in gaining employment completed the questionnaire, with a mean score of 59. The remaining 4 individuals with complete scores showed a mean of 55, suggesting no significant difference in satisfaction with the intervention between those who succeeded in gaining employment and those who did not. Further analysis using an independent $t$-test confirmed the observation that the two group mean scores are not sufficient to be statistically significant.

3.35. The post-intervention client perception questionnaire concluded by asking clients to “add any additional comments relevant to this pilot”.

3.36. Favourable comments were found in the group that were not successful in gaining employment, as well as the group that were, such as:

“It would be a great loss if this scheme did not continue” (Person unsuccessful in gaining employment)

“Knowing I had support or could get help if I needed when beginning a new job made me feel safer/secure as I did not feel alone. If any problems arose I could get in touch with my advisor.” (Person unsuccessful in gaining employment)

“My advisor from FEAT has been very positive.” (Person successful in gaining employment)
4. CONCLUSIONS AND RECOMMENDATIONS

4.1. The need for a programme that supports individuals that are suffering from mental health issues to remain in work, or get back in to work, has been identified both nationally through ‘Healthy Working Lives’ (Scottish Executive, 2004) and by employers, recognising that mental health issues relating to work are not given sufficient priority. The potential benefits of assisting individuals affected by both mental health and employment issues are universal: improving the individual’s mental health through employment (Schneider, 1998); reducing costs associated with incapacity benefits; support for managers tackling the issues at the front-line; increased productivity at work; and reduced sickness payments.

4.2. The model developed for this pilot utilised a number of interventions to support individuals whose ability to work is affected by mental health issues. The evidence from this evaluation clearly supports the statement that this pilot effectively provided support for individuals in employment but at risk of losing their jobs as a result of mental health issues, and assistance for applicants with current mental health problems that are currently unemployed.

Individual Benefits

4.3. For the sixty three individuals that participated in this pilot project, significant health benefits were observed, through standardised measures, in terms of improved psychological functioning, increased occupational performance and satisfaction, and greater self confidence in terms of job seeking abilities. This reinforces previous evidence reporting a positive impact on the mental health and wellbeing of an individual through being engaged in constructive employment (Schneider, 1998).

Organisational Benefits

4.4. Significant costs are associated with the mental health of employees, both directly through sickness absence and indirectly through a significant reduction in productivity, ineffective working and poor interpersonal relationships. A programme that facilitates restoring individuals to be valuable employees is therefore a sound and worthwhile investment.

4.5. A large proportion of the participants in this pilot returned to their workplace through the course of their involvement in this pilot project. The majority of this group returned from sickness absence to their existing post, with the remainder being redeployed within the employing organisation or commencing work after a period of unemployment.

4.6. Significantly, both participants and managers reported positive perceptions of the project, suggesting that the addition of such a scheme to the range available as employee benefits, and the support for managers dealing with these issues on the front-line, is valued.

Nationwide

4.7. A key aim of this pilot was to deliver a model of job retention and vocational rehabilitation that could be implemented across Scotland.

4.8. The agency engaged for the provision of support and guidance for unemployed applicants has significant experience in this area. It is intended that a training package will be delivered that would allow other similar community-based agencies and mental health professionals to develop the necessary skills for delivering a vocational rehabilitation programme.
5. CONSIDERATIONS AND LIMITATIONS OF PROJECT

Limitations of the project

5.1. There are a number of methodological limitations which are important to consider with reference to the findings of this evaluation.

5.2. The study is correlational in nature and therefore, as is the case with all such studies, causal relationships cannot be determined with certainty. Whilst the evaluation has demonstrated clear evidence of improvements in participant’s functioning, it is not possible to definitively attribute these improvements to the intervention provided.

5.3. As is the case in a naturalistic study of service provision, some variables which may have relevance to the outcomes were not controlled. For example, the other interventions which a participant was engaged with such as medical, psychological and social interventions were not controlled. However, information was gathered regarding involvement of mental health and primary health care professionals as well as current medications.

5.4. Comparison of the employment outcomes from this study with those of a similar population (e.g. individuals absent from their post within the participating organisations from a time period previous to the project that did not receive job retention intervention) would provide further evidence for attributing participant’s improvements to the project intervention. However, it was not possible to address this within the timescales of this project.

5.5. One key limitation which perhaps could be addressed through further research in the area is the lack of a longer-term follow-up as part of this study in order to establish whether the improvements observed are sustained over a longer period of time. Given that the majority of participants reported having had previous mental health difficulties and therefore have a longer-term vulnerability, it would be particularly useful to look at the impact of the project and the interventions provided in the longer-term. This would be very powerful information in terms of efficacy.

5.6. The timing of some of the assessments may have diminished the accuracy of some of the outcomes in a few cases. For example, due to an administrative error in one Job Retention case there was a significant delay in conducting a follow-up assessment. In some cases the follow-up assessments were delayed due to initial non-attendance at a scheduled appointment or delays to the completion of discharge paperwork. This may have led to a reduced effect being observed on outcome measures.

5.7. In the Job Retention strand of the project, the initial questionnaire to managers was sent out after the Rehabilitation Consultant’s first meeting with the relevant manager in order that the context for the questionnaire had been established, which is important. However, one disadvantage of this may be that to some extent by virtue of the Rehabilitation Consultant having met with the individuals concerned and conducted some assessment, processes of change may have already begun prior to the completion of the pre-intervention questionnaire by the manager.
5.8. Additionally, a degree of bias in the participant’s responses to self-report measures may have been introduced by virtue of the fact that they completed these measures at a meeting with the evaluator or employment advisor. The participants may have been influenced by a perceived pressure to respond in a socially desirable way or they may have found it more difficult to give frank and honest responses. However, on balance it is considered an appropriate way to conduct the evaluation as response rates are much improved in this format and also it provides the opportunity for clarification about any of the items to be given, to facilitate accurate responding.

5.9. The Client and Manager Perception Questionnaires could perhaps have been improved in their design, both in terms of counterbalancing the items, ensuring consistency of the response scale, and perhaps including more of the pre-intervention items in the post-intervention version in order to be able to look at changes in responses.

**Strengths of the project**

5.10. Nonetheless, there are a number of aspects of the approach and methodology adopted for this study which are considered to be strengths of the research. Several well-established measures of psychological and occupational functioning which have good reliability and validity were used. The consistency of the findings across these measures supports the validity of the results observed.

5.11. In addition, the evaluators were not involved in providing the intervention, reducing the likelihood of biased responding by the participants, or influencing of this responding by the evaluators, in the Job Retention strand of the project. More than one source of data was used to improve the accuracy of findings in the Job Retention strand of the project; self-report and manager-report.

5.12. Crucially, baseline measures were taken pre-intervention so that outcomes post-intervention could be contrasted with previous functioning and well-being.

**Further research**

5.13. It is not clear if any of the benefits, in terms of psychological functioning, occupational performance and satisfaction, or employment outcome are long term, and so further research in this area is recommended.

5.14. Individuals participating in the Vocational Rehabilitation project appeared, anecdotally, to aim for lower-skilled jobs that did not necessarily match their actual skill level. Further research on the effect of self-esteem on expectations of appropriate jobs and perceived personal skill level is recommended. Additionally, the availability of such lower-skilled jobs in the locality was reduced, as a result of the uncertain financial climate, which is thought to have impacted the rate of referrals to the Vocational Rehabilitation project.

5.15. No demographic information on accommodation was collected. Research in this area may highlight if there is any correlation between this and an individual’s mobility for employment, and therefore their selection and expectations relating to jobs.
6. REFERENCES


The Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the Business Case*

Scottish Executive Health Department (1997) *A Framework for Mental Health Services in Scotland*, Edinburgh. HMSO


Scottish Office (1999) *Social Inclusion: Opening the door to a better Scotland*, Edinburgh: HMSO


ADVISORY COMMITTEE

A steering group has been established to oversee the project. Current members are:

Ken Laurie, Director of Strategic Change, NHS Fife – Project Lead
Moira Forrest, PA to Ken Laurie, NHS Fife
Barbara Anne Boyter, Head of Human Resources, NHS Fife
Beth Sparling, Head Occupational Therapist, NHS Fife
Catherine Kilfedder, Head of Service, Counselling and Psychology Service, OHSAS
Lisa Gordon, Assistant Psychologist, Counselling and Psychology Service, OHSAS
Malcolm Joss, Occupational Therapist, OHSAS
Simon Fevre, Employee Director, NHS Fife
Mark Dunlop, Scottish Executive representative
7. **APPENDIX A: PARTICIPANT INFORMATION SHEET**

**Employment Support Fife:**

Pilot of job retention services for people experiencing mental health problems.

**PARTICIPANT INFORMATION**

7.1. We invite you to participate in a pilot study that we believe to be of considerable importance. However before you decide whether or not you wish to participate, we need to be sure that you understand, firstly, why we are doing it, and secondly what it would involve for you if you agree.

We are therefore providing you with the following information. Please read it carefully and be sure to ask any questions you have and if you want to discuss it with others, you may do so. We will do our best to explain and provide any further information you may ask for now or later. You do not have to make an immediate decision.

**Background to the Pilot**

The aim of this Pilot is to develop and evaluate a model of service delivery designed to prevent job loss for employees of NHS Fife and Fife Council who are experiencing significant mental health problems. Currently there are no comprehensive fully integrated procedures to actively encourage the recruitment and support of people with mental health problems within either of the organisations, NHS Fife and Fife Council. The Pilot aims to demonstrate that involving a case manager will prove more effective and become recommended best practice.

**What does the Pilot study entail?**

It is up to you whether you take part or not but if you do consent then you will be assigned to a rehabilitation consultant/case manager. The rehabilitation consultant is uniquely trained in dealing with issues related to mental health and employment. They will carry out a workplace assessment, to examine whether there are work related factors contributing to your mental health problems, and then you will meet with them to formulate a plan of action. Part of the plan will involve the rehabilitation consultant liaising with your line manager to determine what can be done to facilitate a return to work. Your rehabilitation consultant will provide you with support and information regarding your rights as an employee as well as providing some interventions for mental health problems that are short-term. If you both agree that there are some longer-term problems the rehabilitation consultant will refer you to the appropriate person to help tackle them. Once back at work your rehabilitation consultant will follow up with you and your line manager to ensure that the changes that have been made are working.
So that we can evaluate the service, we will use a series of measures to assess:

- Your psychological health and well-being
- Your perceptions of your ability to do your job and the support you receive
- Your Line Manager’s perceptions of your ability to do the job
- Sickness absence and performance related data
- Your level of satisfaction with the rehabilitation consultant/case manager service

If you agree to take part you will undergo an independent assessment before and after the case manager/rehabilitation consultant intervention.

**What are my rights?**

You will receive an additional service in the form of intervention by a case manager/rehabilitation consultant. However, you are free to withdraw from the study at any time without giving a reason should you choose to do so. Should you choose not to participate or to withdraw, this will not affect your right to use the standard practice of care provided by OHSAS.

If you agree to participate in this research project you should know that your involvement is voluntary (you are free to withdraw at any time) and anonymous (all records will be identified by code number only).

**What will happen to the collected information collected in the study?**

All the information collected will be treated confidentially and in all research reports any information which could identify you as a participant will be removed. The storage of all files and records is in accordance with the Data Protection Act (kept in secure locked storage in OHSAS premises and only members of the Pilot service will have access to your file). All data collected will be stored on computer files that will be password protected.

If you wish, once the study is complete you may be provided with a summary of the overall results of this research.

Thank you for taking the time to read this.

If you have any questions about this study please contact:

Lisa Gordon (Assistant Psychologist)
Counselling and Psychology Service
OHSAS
Wedderburn House
1 Edward Street
Dundee
DD1 5NS
Tel: 01382 346016 Extension: 30258
Email: lisa.gordon@tpct.scot.nhs.uk
APPENDIX B: PARTICIPANT CONSENT FORM

CONSENT FORM

NB. This form must be completed and signed by the Participant in the presence of someone with knowledge of the research designated by the Principal Investigator. This may be a doctor, nurse, clinical research assistant or other member of the research team who must countersign the form as witness to the subject’s signature.

Please delete as applicable

Have you read and understood the Participant Information Sheet? YES/ NO

Have you been given an opportunity to ask questions and further discuss this Pilot? YES/ NO

Have you received satisfactory answers to all of your questions? YES/ NO

Have you now received enough information about this Pilot? YES/ NO

Who have you spoken to? Dr/ Mr / Mrs / Miss ………………………………………

Do you understand that your participation is entirely voluntary? YES/ NO

Do you understand that you are free to withdraw from this Pilot? At any time? YES/ NO

Without having to give a reason for withdrawing? YES/ NO

Without this affecting your right to use the Counselling and Psychology Service or Occupational Health and Advisory Service in the future? YES/ NO

Do you agree to take part in this Pilot? YES/ NO

Participant’s Signature……………………………………….. Date……………………..

Participant’s name in block capital letters………………………………………………

Signature witnessed by ……………………………………… Date ……………………..

Witness name in block capital letters…………………………………………………..

Position of the witness…………………………………………………..
8. APPENDIX C: PROCEDURAL FLOWCHART FOR JOB RETENTION PILOT PROJECT

Management Referral

Self-referral

Occupational Health

Screen for suitability (inclusion/exclusion criteria)

Consent (information sheet and signed consent)

Pre-intervention assessment (OT and Psychology)

Involvement of rehabilitation consultant/case manager

Post-intervention assessment

• Assessment of workplace
• Meet with client
• Meet with manager
• Joint client/manager meetings
• Possible short-term interventions or referral on
• Follow up

Total: 5 days
ALL RECORDED
9. **CASE STUDY**

**Background**
A 38-year-old care sector worker was referred to the pilot study having been on sick leave for eight months, having been diagnosed with Generalised Anxiety Disorder (GAD) as a psychiatric outpatient clinic. Prior to this, he had exhibited behaviour that was described as difficult to manage, and the individual reported feeling unsafe within his management structure. As he had been absent from work for more than six months, he was receiving half pay.

**Assessment**
Initial assessment indicated that the individual was motivated to return to his substantive post and gained rewards from this work beyond pay. He was recognised as having skills to contribute, and this all supported his return to work.

However, relationships at work had become strained and the working environment was stressful in its own right. This resulted in neither the individual nor the manager perceiving a successful return to work as possible.

**Intervention**
The target areas for intervention were established as:
- Symptom control and condition management
- Relationship with manager
- Phased return to work

Initially, relaxation training materials were introduced to the individual, and subsequently anxiety management. During this time a series of meetings were organised to reacquaint the individual and the manager and discuss concerns of both parties. These meetings were facilitated by the rehabilitation consultant.

A phased return was constructed that involved not only gradually increasing hours, but began from a different work base.

At the completion of the intervention, the individual had returned to the substantive post at full hours.
10. APPENDIX D: DETAILED ANALYSES FOR JOB RETENTION

I Comparisons between completers and non-completers.

Table 14: Descriptive statistics for interval variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Completers Mean (N=35)</th>
<th>Non-Completers Mean (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>45.46 (sd 8.651)</td>
<td>40.88 (sd 8.45)</td>
</tr>
<tr>
<td>Time in post (weeks)</td>
<td>324.97 (sd 317.75)</td>
<td>282.81 (sd 230.14)</td>
</tr>
<tr>
<td>Time in organisation (weeks)</td>
<td>631.03 (sd 473.64)</td>
<td>627.25 (sd 427.53)</td>
</tr>
<tr>
<td>Other time off in last 6 months.</td>
<td>3.49 (sd 6.21)</td>
<td>7.12 (sd 10.35)</td>
</tr>
</tbody>
</table>

Table 15: Results of independent samples t tests to compare the two groups on interval variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>t value</th>
<th>df</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.767</td>
<td>49</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>Time in post</td>
<td>.476</td>
<td>49</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>Time in organisation</td>
<td>.027</td>
<td>49</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>Time off</td>
<td>.664</td>
<td>49</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>Other time off in last 6 months</td>
<td>1.080</td>
<td>13.277</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
</tbody>
</table>

Details of composition of completers and non-completers groups – categorical variables.

Table 16: Gender composition.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Completer</th>
<th>Non-completer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>11</td>
</tr>
</tbody>
</table>

Analysis of the above distribution of gender across the two groups using a Chi-Squared test confirmed no significant difference between the two groups.

Table 17: Employing organisation

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Completer</th>
<th>Non-completer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>NHS</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Analysis of the above distribution of council/NHS workers across the two groups using a Chi-Squared test confirmed that the two groups did not differ significantly
according to the employing organisations. However, this was only narrowly non-significant.

**Table 18: Results of comparison of the completers and non-completers groups on pre-intervention scores on standardised measures using Mann-Whitney U Tests.**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Variable</th>
<th>N</th>
<th>U value</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE</td>
<td>Subjective well-being</td>
<td>15, 35</td>
<td>234</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Probs/Symps</td>
<td>15, 35</td>
<td>251</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Social functioning</td>
<td>15, 35</td>
<td>250</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Risk</td>
<td>15, 35</td>
<td>210</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Global Distress (total)</td>
<td>15, 35</td>
<td>252</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>GHQ</td>
<td>Total</td>
<td>15, 35</td>
<td>202</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>EuroQOL-5D</td>
<td>Mobility</td>
<td>15, 35</td>
<td>252.5</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td>15, 35</td>
<td>245</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Activities</td>
<td>15, 35</td>
<td>237.5</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Pain</td>
<td>15, 35</td>
<td>254</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Anxiety &amp; depression</td>
<td>15, 35</td>
<td>230.5</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Total health rating</td>
<td>11, 33</td>
<td>140</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td>COPM</td>
<td>Performance</td>
<td>16, 35</td>
<td>226.5</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Satisfaction</td>
<td>16, 35</td>
<td>265.5</td>
<td>&gt;.05</td>
<td>×</td>
</tr>
</tbody>
</table>

II Analysis of the completers group.

**Table 19: Descriptive statistics for interval variables.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Group Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35</td>
<td>45.46</td>
<td>8.65</td>
</tr>
<tr>
<td>Time in post-weeks</td>
<td>35</td>
<td>324.97</td>
<td>317.75</td>
</tr>
<tr>
<td>Time off – weeks</td>
<td>35</td>
<td>631.03</td>
<td>473.67</td>
</tr>
<tr>
<td>Other time off in last 6 months</td>
<td>25</td>
<td>3.49</td>
<td>6.21</td>
</tr>
</tbody>
</table>
Table 20: Frequencies for job groups

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Job group</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fife Council</td>
<td>Education</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Social work</td>
<td>5</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>Local office network</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>Finance</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Community &amp; Leisure</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Administrative</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>miscellaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childcare</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Development services</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Cleaning services</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Human resources</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Building services</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Criminal justice</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS</td>
<td>Nursing</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>PAMS</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Estates</td>
<td>1</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Table 21: Frequencies for mental health problem

<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Current</th>
<th></th>
<th>Past</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>14</td>
<td>40</td>
<td>11</td>
<td>31.4</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>4</td>
<td>11.4</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td>Mixed mood &amp; anxiety disorder</td>
<td>6</td>
<td>17.1</td>
<td>4</td>
<td>11.4</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1</td>
<td>2.9</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Work-related stress</td>
<td>4</td>
<td>11.4</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>11.4</td>
<td>6</td>
<td>17.1</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>5.7</td>
<td>9</td>
<td>25.7</td>
</tr>
</tbody>
</table>
### Table 22: Frequencies – current medication

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4</td>
<td>11.4</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>28</td>
<td>80</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Mood stabilizers</td>
<td>1</td>
<td>2.9</td>
</tr>
</tbody>
</table>

### Table 23: Frequencies – educational attainment

<table>
<thead>
<tr>
<th>Level of highest educational attainment</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications</td>
<td>4</td>
<td>11.4</td>
</tr>
<tr>
<td>Standard grade level</td>
<td>4</td>
<td>11.4</td>
</tr>
<tr>
<td>Higher level</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>HND/HNC/SVQ</td>
<td>17</td>
<td>48.6</td>
</tr>
<tr>
<td>Degree</td>
<td>8</td>
<td>22.9</td>
</tr>
<tr>
<td>Post-graduate</td>
<td>1</td>
<td>2.9</td>
</tr>
</tbody>
</table>

### III Analysis of outcome variables.

### Table 24: CORE Descriptive Statistics

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre/ Post</th>
<th>N</th>
<th>Group Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>Pre</td>
<td>35</td>
<td>2.051</td>
<td>1.0239</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>1.311</td>
<td>0.8973</td>
</tr>
<tr>
<td>Problems/ Symptoms</td>
<td>Pre</td>
<td>35</td>
<td>2.109</td>
<td>0.9195</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>1.286</td>
<td>0.8752</td>
</tr>
<tr>
<td>Social functioning</td>
<td>Pre</td>
<td>35</td>
<td>1.671</td>
<td>0.8587</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>1.043</td>
<td>0.6317</td>
</tr>
<tr>
<td>Risk</td>
<td>Pre</td>
<td>35</td>
<td>0.291</td>
<td>0.3973</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>0.06</td>
<td>0.1355</td>
</tr>
<tr>
<td>Global Distress (total)</td>
<td>Pre</td>
<td>35</td>
<td>1.620</td>
<td>0.7557</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>0.974</td>
<td>0.6075</td>
</tr>
<tr>
<td>Non-risk total</td>
<td>Pre</td>
<td>35</td>
<td>1.920</td>
<td>0.8595</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>35</td>
<td>1.194</td>
<td>0.7392</td>
</tr>
</tbody>
</table>
Table 25: Results of Wilcoxon (T) Signed Ranks Tests for The CORE

<table>
<thead>
<tr>
<th>Domain</th>
<th>N</th>
<th>T</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>31</td>
<td>87.50</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
<tr>
<td>Problems/Symptoms</td>
<td>35</td>
<td>89.50</td>
<td>&lt;0.001</td>
<td>√</td>
</tr>
<tr>
<td>Social functioning</td>
<td>33</td>
<td>78</td>
<td>&lt;0.001</td>
<td>√</td>
</tr>
<tr>
<td>Risk</td>
<td>20</td>
<td>18</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
<tr>
<td>Global Distress (total)</td>
<td>35</td>
<td>88.5</td>
<td>&lt;0.001</td>
<td>√</td>
</tr>
<tr>
<td>Non-Risk total.</td>
<td>35</td>
<td>99.5</td>
<td>&lt;0.001</td>
<td>√</td>
</tr>
</tbody>
</table>

*N varies as for Wilcoxon Signed Ranks Tests N refers to the number of cases excluding cases where there are ties between pre and post scores.

Table 26: CORE Clinical Cut-Off Scores

<table>
<thead>
<tr>
<th>Domain</th>
<th>Male Cut-Off Scores</th>
<th>Female Cut-Off Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>1.37</td>
<td>1.77</td>
</tr>
<tr>
<td>Problems/Symptoms</td>
<td>1.44</td>
<td>1.62</td>
</tr>
<tr>
<td>Social functioning</td>
<td>1.29</td>
<td>1.3</td>
</tr>
<tr>
<td>Risk</td>
<td>0.43</td>
<td>0.3</td>
</tr>
<tr>
<td>Global Distress (total)</td>
<td>1.19</td>
<td>1.29</td>
</tr>
<tr>
<td>Non-Risk total</td>
<td>1.36</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Table 27: CORE distribution of scores between clinical and non-clinical ranges at pre and post assessment.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Stage</th>
<th>Non-clinical</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>Pre</td>
<td>11 (31.4%)</td>
<td>24 (68.6%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>22 (62.9%)</td>
<td>13 (37.1%)</td>
</tr>
<tr>
<td>Problems and symptoms</td>
<td>Pre</td>
<td>11 (31.4%)</td>
<td>24 (68.6%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>23 (65.7%)</td>
<td>12 (34.3%)</td>
</tr>
<tr>
<td>Social functioning</td>
<td>Pre</td>
<td>11 (31.4%)</td>
<td>24 (68.6%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>25 (71.4%)</td>
<td>10 (28.6%)</td>
</tr>
<tr>
<td>Risk</td>
<td>Pre</td>
<td>24 (68.6%)</td>
<td>11 (31.4%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>32 (91.4%)</td>
<td>3 (8.6%)</td>
</tr>
<tr>
<td>Global Distress (total)</td>
<td>Pre</td>
<td>13 (37.1%)</td>
<td>22 (62.9%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>26 (74.3%)</td>
<td>9 (25.7%)</td>
</tr>
<tr>
<td>Non-risk (total-risk items)</td>
<td>Pre</td>
<td>12 (34.3%)</td>
<td>23 (65.7%)</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>25 (71.4%)</td>
<td>10 (28.6%)</td>
</tr>
</tbody>
</table>
Table 28: Results of Binomial Sign Tests For Clinical/Non clinical distribution of scores on the CORE at pre and post assessment.

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>s value</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective well-being</td>
<td>15</td>
<td>2</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
<tr>
<td>Problems &amp; symptoms</td>
<td>20</td>
<td>4</td>
<td>&lt;0.05</td>
<td>√</td>
</tr>
<tr>
<td>Social functioning</td>
<td>20</td>
<td>3</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
<tr>
<td>Risk</td>
<td>10</td>
<td>1</td>
<td>&lt;0.05</td>
<td>√</td>
</tr>
<tr>
<td>Global Distress</td>
<td>21</td>
<td>4</td>
<td>&lt;0.05</td>
<td>√</td>
</tr>
<tr>
<td>Non-risk total</td>
<td>21</td>
<td>4</td>
<td>&lt;0.05</td>
<td>√</td>
</tr>
</tbody>
</table>

For the purposes of these analyses a clinical range score was given a score of 1 whilst a non-clinical range score was given a score of 0. N varies as it indicates the number of non-tied scores.

Table 29: EuroQOL-5D Results of Wilcoxon (T) Signed Ranks Tests

<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>T</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>5</td>
<td>0</td>
<td>&lt;0.05</td>
<td>√</td>
</tr>
<tr>
<td>Self-care</td>
<td>3</td>
<td>0</td>
<td>&gt;0.05</td>
<td>×</td>
</tr>
<tr>
<td>Usual activities</td>
<td>17</td>
<td>48</td>
<td>&gt;0.05</td>
<td>×</td>
</tr>
<tr>
<td>Pain</td>
<td>14</td>
<td>52.5</td>
<td>&gt;0.05</td>
<td>×</td>
</tr>
<tr>
<td>Mental Health</td>
<td>25</td>
<td>57.5</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
<tr>
<td>Overall health today</td>
<td>33</td>
<td>95</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
</tbody>
</table>

Table 30: Results of Binomial Sign Tests for Change in Attendance at Work between pre and post-intervention.

<table>
<thead>
<tr>
<th>N</th>
<th>s value</th>
<th>p value</th>
<th>Significant difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>2</td>
<td>&lt;0.01</td>
<td>√</td>
</tr>
</tbody>
</table>

For the purposes of these analyses, participants attending work were given a score of 1 whilst those not currently attending work were given a score of 0. N varies as it indicates the number of non-tied scores.