Mental health and work

Supporting evidence and key findings for Lancashire-14

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Contents

1. Overview

This report focuses on mental health and wellbeing and the working-age population (WAP). Where possible, all data and statistics are quoted for the 16-64 population, when this is not available, the age range is clearly identified.

It complements the WAP JSNA, which provides analysis of the current and future needs for the WAP in Lancashire. It uses a wide range of data and resources that can be viewed on the publications section of the Lancashire Insight web pages.

Rather than take the form of a single document, the WAP JSNA should be regarded as a repository of health and wellbeing related data and intelligence available for all partners and the public.

2. Background information

There is strong evidence that good quality employment/work is beneficial for both physical and mental health, whereas unemployment and long-term sickness absence can have a harmful impact (Marmot 2012). Work can provide a sense of purpose, structure, dignity and an income, which enables people to support themselves and their families. It is also linked to other determinants of health such as housing and lifestyle choices. Employment can also provide social support, networks and social participation, which also contribute to good mental health.

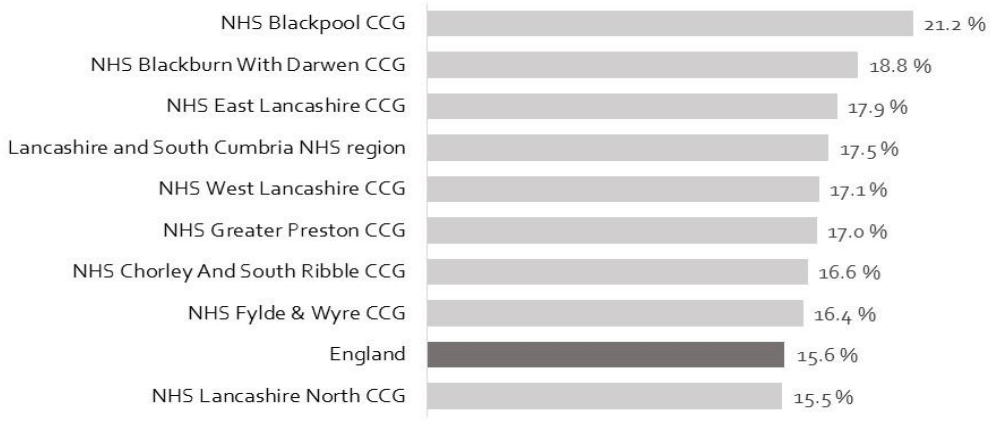
Mental illness covers a broad range of conditions, from affective (mood) disorders to psychotic disorders, such as schizophrenia. Mental illness can have a very different impact on people, and the intensity, severity and length of the illness can vary widely. The evidence shows unemployment relating to mental health conditions is longer lasting than other health-related work absence/unemployment. The longer a person with a mental health condition is unemployed, the chance of getting back into work is greatly reduced and the vulnerability to depression, anxiety and suicide increases.[1]

3. Prevalence of mental health conditions

The prevalence of mental health conditions varies and recent analysis from the Adult Psychiatric Morbidity Survey (2016) indicates that almost one in five (18.9%) of all adults aged 16-64 in England had experience of a common mental disorder (CMD) in the week prior to the survey (23.1% females and 14.6% males). From a regional perspective in the North West the figures are 15.9% of males and 22.3% of females. At a clinical commissioning group (CCG) level, data from Public Health England indicates the estimated prevalence of common mental health disorders is highest in

Blackpool CCG and Blackburn with Darwen CCG, with the lowest in Lancashire North (CCG).

Table 1: estimated prevalence of common mental health disorders by CCG, all people, 16-74, 2014/15



Source: PHE mental health profiles

Data from the Projecting Adult Needs and Service Information (PANSI) website estimates just over 153,300 people in Blackburn with Darwen, Blackpool and Lancashire-12 (18-64) will have a common mental health condition in 2017, with 3,800 having a psychotic disorder. Projections indicate all three authorities will see a decrease in common mental illness rates between 2017 and 2035, (Blackburn with Darwen: -8.3%, Blackpool: -9.0%, and Lancashire-12: -2.2%), while England is predicted to increase by 3.1%

Figure 1: Number of people (18-64) estimated to have a mental health condition (2017)

Common mental disorders

14,050	13,257	126,062	5,436,208
Blackburn with Darwen	Blackpool	Lancashire-12	England

Psychotic disorders

349	329	3,132	135,066
Blackburn with Darwen	Blackpool	Lancashire-12	England

Source: PANSI, 2017

Estimates from the Department of Work and Pensions suggest one in six adults of working age in the UK will experience some symptoms of mental distress (sleeplessness, irritability, worry) that can affect their ability to work, but does not meet the diagnostic criteria of mental ill health.[2]

In relation to employment status, those who are unemployed or economically inactive are more likely to experience a common mental disorder (CMD), compared to those who are employed (all people 16-64). A third of males and females who are economically inactive are likely to have any CMD, compared to 10.9% of males and 14.1% of females who are employed full time. It is important to note that a person can have more than one CMD.

Table 2: Common mental disorders by employment status for males aged 16-64 in England, 2014

Males	Employed full-time	Employed part-time	Unemployed	Economically inactive
Generalised anxiety disorder	4.1%	6%	6.5%	16%
Depressive episode	1.7%	0.6%	7.8%	13.4%
Phobias	1.1%	1.8%	3.2%	8.1%
Obsessive compulsive disorder	0.9%	1.3%	1.9%	2.8%
Panic disorder	0.1%	-	1.5%	0.9%
CMD – NOS[1]	5.1%	8.6%	9.1%	10.2%
Any CMD	10.9%	14.7%	24.5%	33.1%

[1] common mental disorders not otherwise specified refers to mixed anxiety and depression

Source: Adult Psychiatric Morbidity Survey, 2016.

Table 3: Common mental disorders by employment status for females aged 16-64 in England, 2014

Females	Employed full-time	Employed part-time	Unemployed	Economically inactive
Generalised anxiety disorder	4.8%	5.8%	7.8%	13.1%
Depressive episode	1.8%	2.0%	8.9%	10.8%
Phobias	1.4%	1.2%	5.5%	8.4%
Obsessive compulsive disorder	0.9%	1.3%	2.7%	3.4%
Panic disorder	0.2%	0.4%	2.2%	1.1%
CMD – NOS[1]	7.1%	8.5%	9.7%	12.2%
Any CMD	14.1%	16.3%	28.8%	33.1%

[1] common mental disorders not otherwise specified refers to mixed anxiety and depression

Source: Adult Psychiatric Morbidity Survey, 2016.

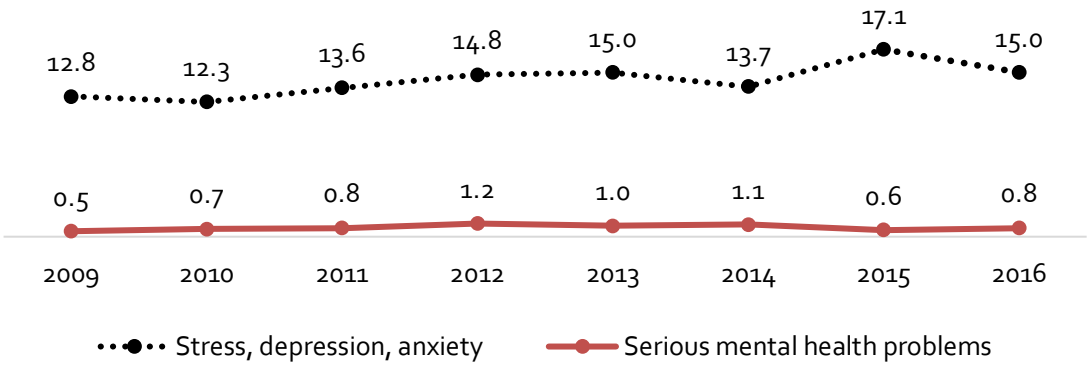
4. Cost of mental ill health

Unemployment puts a person at a major disadvantage with regards to health and wellbeing, with higher rates of mortality, morbidity and a lower quality of life. Unemployment and worklessness varies for men and women and across the age groups, with worse health outcomes for those from lower socioeconomic groups, those with little or no social support/networks and those for whom unemployment is a result

of poor health.[3] Being absent from work places significant costs on both employees, employers, and the economy – particularly if long-term sickness results in benefit payments, unemployment and future worklessness. Helping an employee to remain in work rather than having to start a benefit claim is estimated to save £3,000 per year, per person (Department for Work and Pensions, 2007). Moving people back into work traditionally focuses on economic outcomes (reduced benefit payments or receiving a salary), but factors such as self-reported measures of wellbeing and social capital are equally as important.[4]

Ill health among the working-age population (including working days lost and worklessness) costs the economy £100 billion a year, with sickness absence costing employers more than £9bn a year, with some estimates putting the cost at £15bn.[5] Data from the Office for National Statistics indicate of the 137.3 million days of sickness absence in the UK in 2016, 0.8 million are due to serious mental health problems, while 15.0 million are due to stress, depression and anxiety. Only back, neck and limb pain result in more days of sickness absence.

Figure 2: Estimated days of sickness absence (millions), 2009 to 2016 in the UK



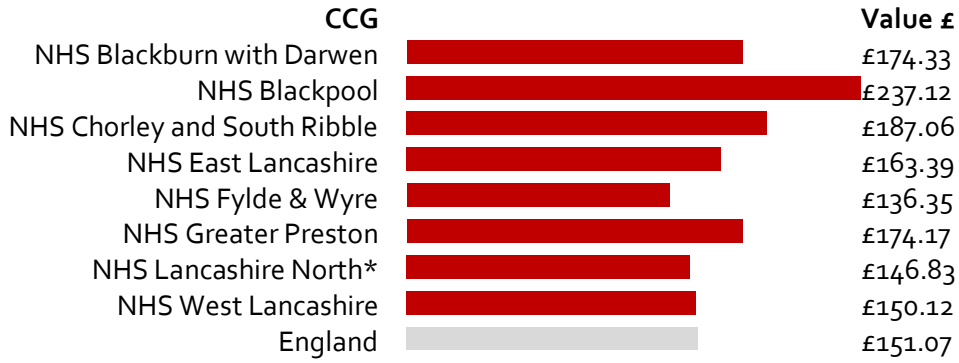
Source: Labour Force Survey (Office for National Statistics)

As noted above, people with a mental health condition are more likely to be unemployed, underemployed, or overrepresented among long-term recipients of disability payments, with depression being one of the leading causes of disability.[6,7] Although poverty and unemployment tend to increase the duration of episodes of CMDs, it has not been established as to whether they cause the onset of an episode or are a result of the CMD. Debt and financial strain are linked with depression and anxiety, and increasingly the evidence is suggestive of a causal association.

4.1 NHS spending on mental health services

Although CMDs are less disabling than psychotic disorders, their higher prevalence means more is spent on these and the cost to society is greater. The total spend on mental health services (per person) varies across the eight Lancashire CCGs, with the highest spend in Blackpool CCG and the lowest in Fylde & Wyre CCG.

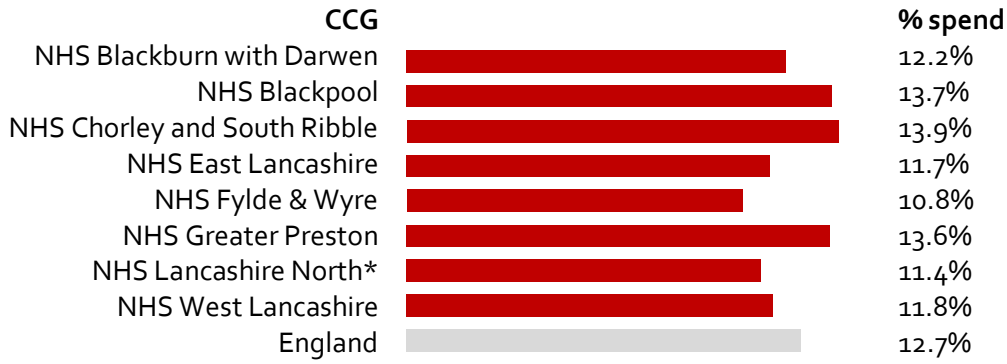
Figure 3: specialist mental health services spend – rate (£) per person (all ages) 2013/14



* Lancashire North CCG merged with the South Cumbria area in April 2017 to become NHS Morecambe Bay. This CCGs boundary covers both LCC and Cumbria County Council.
Source: Mental Health Dementia and Neurology profiles, Public Health England

When looking at this as a percentage of all CCG spending, Blackpool CCG, Chorley and South Ribble CCG and Greater Preston CCG all have a higher spend than England.

Figure 4: % spend of all CCG spending on specialist mental health services, 2013/14



Source: Mental Health Dementia and Neurology profiles, Public Health England

4.2 Benefit payments and common mental disorders

Respondents to the Adult Psychiatric Morbidity Survey who claim out of work benefits are more likely to have a CMD, compared to those who do not claim benefits, but have a CMD. Patterns of prevalence are similar for men and women (age standardised), with two-thirds of adults aged 16 to 64 in receipt of Employment and Support

Allowance (ESA)* having a CMD, compared with one in six adults not in receipt of this benefit (16.9%).

More than four in five women in receipt of ESA have a CMD (81.0%), compared with one in five (21.1%) of those not in receipt of ESA. General anxiety disorder (GAD) (41.1%), phobias (31.2%) and depression (28.5%) are particularly prevalent among female ESA recipients, as are GAD (24.3%) and depression (25.3%) for men.

Figure 5: % of ESA claims (all stages) for all people aged 18-59 due to mental and behavioural disorders.

52.6%	56.3%	56.9%
Lancashire-12	Blackburn with Darwen	Blackpool

Data from the Department of Work and Pensions (November 2016) shows that in the three upper tier authorities in Lancashire-14, over half of all ESA claims (all stages) are for mental and behavioural disorders. Across all three authorities the claimant figures are highest in the 25-34 age group.

People with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. In 2004 just 21% of people considered disabled by a long-term mental illness were in work compared to 47% of disabled people overall (Social Exclusion Task Force, 2006). The employment rate for the UK working-age population at that time was 74%. In Lancashire-12, approximately 21,895 people with a mental health condition aged 16-64 are economically inactive (Apr 2015-Mar 2016).†

5. Mental health in the workplace

While people with any disability may experience difficulties in the workplace, people with a mental health condition can face additional challenges. One of the main barriers is the stigma and discrimination associated with mental illness, with evidence showing that almost two out of three people who have received hospital treatment for a mental health condition stating they had experienced discrimination at work or when trying to gain employment.[8]

Presenteeism – when an employee is at work, but is not fully engaged, or is working at lower levels of productivity due to physical and/or mental ill health – can be more costly than absenteeism. Estimates from the Centre for Mental Health suggests

* ESA is a disability-related out-of-work benefit
† Mental health conditions includes depression, phobias and panic disorders, from the Annual Population Survey (2015-2016).

presenteeism from mental ill health costs the UK economy £15.1 billion per annum, while absenteeism costs £8.4 billion.[9]

Depression and anxiety are more likely to lead to presenteeism than absenteeism. Therefore, managing employees effectively rather than just reactively responding to ill health can provide benefits to both employers and employees.[10] Presenteeism can be influenced by a number of factors, including workplace and individual variables (family issues, financial situation and physical health for example), and while workplace and individual stressors cannot be totally eliminated they can be managed more effectively.

Other factors which can affect health and wellbeing in the workplace include stress and work pressure. While not always negative – some stress can be useful – it can be a major contributor to poor health, both in the workplace and personally. Much workplace stress can be associated with a lack of job control, lack of support, conflict, bullying and high demands. Organisational impacts include reduced productivity, lower job satisfaction and commitment to the business/employer. Therefore, helping employees to manage their work, having strong, clear policies regarding bullying for example, and having mechanisms in place to support good health and wellbeing will be beneficial.

6. Conclusions: developing a healthy workforce

With the rise in the ageing workforce, employers will have to effectively manage employees with a myriad of chronic conditions, including mental health issues. As noted above, developing a healthy workplace includes investing in employee health and wellbeing, which brings many benefits including increased job satisfaction, social support of the employee and company loyalty.

Table 4: Benefits of investing in employee health and wellbeing

✓	Increased productivity	✓	Reduced number of sickness absences
✓	Reduced staff turnover	✓	Increased retention of skills
✓	Improved staff morale	✓	Improved performance
✓	Reduction in accidents	✓	Reduced conflict at work

Sources: Improving health and work: changing lives, 2008. Mind 'Taking care of your staff', 2013.

The culture of a workplace has a massive impact on the employees, both in general terms and specifically in regards to mental health. One of the main ways to influence an organisation's culture is through building a resilient organisation, with an emphasis on treating employees well, and promoting health and wellbeing. In relation to mental health it can still be difficult for both employers and employees to be able to discuss issues, so encouraging a supportive workplace, keeping people well through early intervention, identifying signs of mental ill health and managing disclosure can be vital.

With regards to supporting individuals in the workplace many employees do not feel able to disclose or share details around mental health issues. This may be because managers are not trained in how to respond to such disclosures, or other employees are unaware how they can support a colleague with mental health problems. Training and awareness raising for managers and employees can help this.

Helping employees to have responsibility for their own health and promoting health and wellbeing can impact on both physical and mental health. Encouraging positive lifestyle behaviours can also improve engagement and productivity.

Identifying those most at risk can often prevent escalation of mental health conditions. This would require managers be trained to recognise and understand the signs of common mental health conditions to allow intervention at a timely point. In addition to this, providing specialist evidence-based interventions will be beneficial.

The ability to modify job tasks, work flexible hours or reduce work-related stress may be essential to maintaining long-term employment for people with a mental health condition. Therefore putting strategies in place to support the individual worker, and employer-led interventions to promote mental and physical health in the workplace to avoid work disability can be beneficial as people with untreated or unmanaged mental health conditions are also more likely to lose their jobs and/or claim benefits.[11]

As noted previously, having a long-term condition mental health condition leaves a person at risk of economic inactivity and unemployment. This can seriously affect an individual's quality of life in other areas, such as social exclusion, poor housing and other negative outcomes. Therefore, the recommendations in the working-age population final report around healthy people, healthy spaces and healthy workplaces are relevant, alongside the recommendations above.

7. References

Please note, due to difficulties in keeping links up to date in our documents, these references are not hyperlinked, apologies for any inconvenience this may cause.

[1] Department for Work and Pensions/Department of Health (2009). Working Our Way to Better Mental Health: A framework for action. [Accessed April 2017].

[2] Ibid.

[3] Norström, F., et al (2014). How does unemployment affect self-assessed health? A systematic review focusing on subgroup effects. BMC Public Health 2014, 14:1310. [Accessed May 2017].

[4] Murphy, G.C. & Athansaou, J.A., (1999). The effect of unemployment on mental health. Journal of Occupation and Organizational Psychology, March 1999. Volume 72:1 [Accessed May 2017].

[5] Department for Work and Pensions. 2016, Improving Lives. The Work, Health and Disability Green Paper. [Accessed February 2017]

[6] Lelliott, P., et al (2008). Mental health and work. [Accessed March 2017].

[7] O'Day, B., et al (2017). Preventing unemployment and disability benefit receipt among people with mental illness: evidence review and policy significance. Psychiatric Rehabilitation Journal, 40.2: 123-152.

[8] Department for Work and Pensions/Department of Health (2009). Working Our Way to Better Mental Health: A framework for action. [Accessed April 2017].

[9] Centre for Mental Health (2011). Managing presenteeim: a discussion paper. [Accessed April 2017].

[10] Ibid.

[11] Lerner, D., et al (2005). Work disability resulting from chronic health conditions. Journal of Occupational and Environmental Medicine. Mar, 47 (3):253-64. [Accessed May 2017].