South East England Development Agency

PREVALENCE AND ECONOMIC IMPACT OF MENTAL HEALTH CONDITIONS IN THE SOUTH EAST REGION.

Evidence to support the regional mental health partnership in developing employment strategies.

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1. INTRODUCTION

Data collation and analysis on the scale and impact of mental health conditions in the South East region was commissioned by SEEDA in February 2008 for the purpose of supporting the work of the regional mental health partnership to develop a regional mental health and employment strategy.

The brief focused on an overview of prevalence, geography and economic impact of mental health conditions in the region. Indicators of mild to moderate mental health conditions, which may not be presented to the primary care system, were seen to be of particular interest, and the brief also included analysis of demographic factors and geographical distribution, trends, current and potential impact on regional economy and identification of gaps in data and information.

Following the inception meeting it emerged that some of the analysis would be available from a report by the National Social Inclusion Programme on *Employment, Benefits and Education Data report: South East region*. It was agreed that the SEEDA report would not duplicate this work, but aim to add value by drawing together analysis from a range of reports to provide as comprehensive an overview as possible, including further exploration of the scale of mild to moderate mental health conditions.

An interim report was produced which focused on analysis at a regional level, while sign posting possible further demographic and geographic analysis. Following discussion with the steering group, it was agreed that the final report would incorporate analysis by locality where possible; commentary on gender and ethnicity where available, further analysis of key Health & Safety Executive data by industry and occupational group; commentary on 'visible' trends and further discussion on gaps in the data. The main report sections would be further developed to reflect the additional analysis.

The report is structured so as to provide 'the story' about mental health and employment in the region and, where possible, in localities, whilst also giving the reader a clear trail to the available sources of evidence, their scope and limitation, and potential for further use.

- Section 2 provides an overview of the scale of mental health conditions and its impact on employment and economy. The section also outlines some gaps in data to support development and monitoring of strategies, and concludes with a commentary on key issues for mental health and employment strategies .
- Sections 3 – 8 outlines sources and more detailed findings under different themes, including overall prevalence, mental health and the workforce, economic impact, incapacity benefit claimants and people in contact with mental health services.
- Metadata is provided for all sources to a standard template and sources are referenced for web links where possible.

2. OVERVIEW

2.1 The scale of mental health problems

Overall prevalence

The most comprehensive source on prevalence of mental health conditions is the ONS survey of psychiatric morbidity among adults (2000). Based on this, just over 1 million people aged 16-74 in the South East region at any one time are estimated to have a clinically diagnosable mental condition, representing almost 1 in 5 of this age group.[1] [Part II: 3]

- The majority of these , 820, 000 people or 1 in 7 adults in the South East, suffer from a neurotic condition, mostly anxiety and/or depression (broadly these would be people described as having *moderate to mild mental health conditions*). The rate is slightly lower than the average for Great Britain (14.2 compared to 16%).
- Some 23, 000 people (0.5 % of adults) suffer from psychotic conditions. (broadly these would be people described as having *severe mental health conditions*). The rate is the same as the average for Great Britain.
- Further, some 200,000 people (4.4% of adults) suffer from personality disorder to varying degrees.
- Women are more likely than men to suffer from neurotic disorder, while the reverse is true for psychotic disorders.
- Prevalence of neurotic disorder is higher than average amongst South Asian and 'other' ethnic groups, whilst prevalence of psychotic disorder is substantially higher than average for 'Black' groups.
- Compared to the general population people with a mental health condition are more likely to be aged 35-54, separated or divorced, living as a one person family unit or as a lone parents.
- In addition, people with *psychotic* disorders are also more likely to have low educational qualifications, be in social class IV or V and be economically inactive live in an urban area and in council/ housing association accommodation.
- The 2000 psychiatric morbidity survey is a repeat of a survey carried out in 1993. Comparisons show that there was no significant change in the overall rates of neurotic disorders or psychotic disorders for all adults. However there was a slight but significant increase in the prevalence of any neurotic disorder among men from 12.6% in 1993 to 14.4% in 2000.

Figure 1 shows the prevalence of different types of mental health conditions by localities in the South East . The numbers reflect the overall population sizes in the locality and range from 14,000 to 129,000 for neurotic disorders, 3,5000 to 31,000 for personality disorders and 400 to 3,600 for people with psychotic disorders. (Figures for all localities are in Table 1, Part II: 3)

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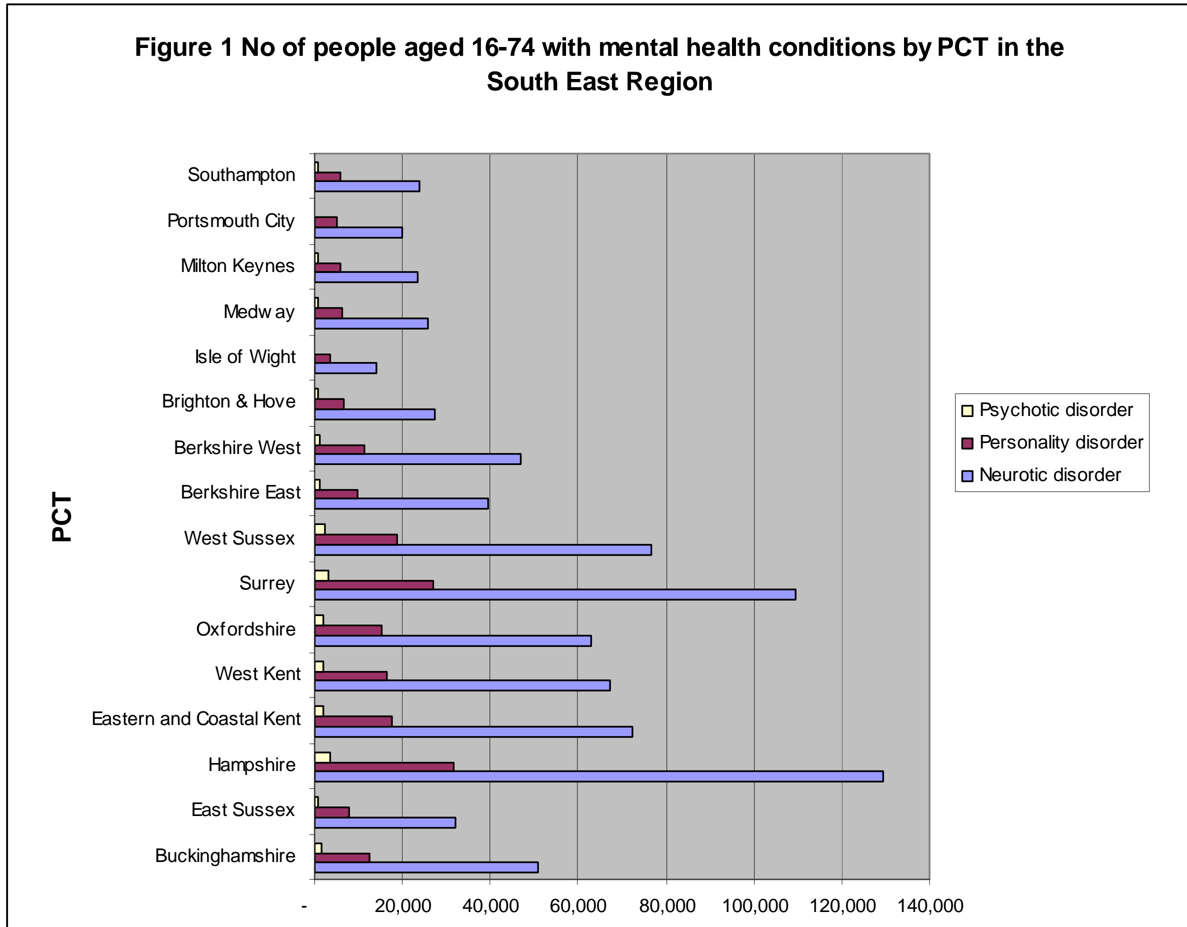
[1] Singleton et al (2001)



Source: Prevalence from ONS survey of psychiatric morbidity 2000 applied to 2006 mid year population estimates

Additionally, there will be people suffering from stress, who will not necessarily be included in the groups above, unless the stress had contributed to or was part of a diagnosable condition. There are no comprehensive figures on this, but a survey of people in employment indicates that 66,000 people in the South East Region (1% of people ever employed) believed they were suffering from *stress, depression of anxiety caused or made worse by work.*[2] [Part II: 4.4]

People known to services

Only a proportion of people with mental health conditions are *identified in primary care.* The Sainsbury Centre for Mental Health estimate that about half of people with neurotic conditons will present to primary care services and that, of these, only a further half will be identified as having a diagnosed mental health condition[3] - this would equate to some 200,000 identified in primary care in the South East region.

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[2] Health and Safety Executive (2007a)
[3] Sainsbury Centre for The Mental Health (2007a)

98,300 people in the South East were *claiming incapacity benefit on account of 'mental and behavioural disorders'* in February 2007. This represents 42% of all incapacity benefit claimants in the South East (similar proportion to England).[4] In other words, more people receive out-of-work benefits for mental and behavioural issues, than the total numbers receiving unemployment benefit[5] [Part 11: 6]

About 23,000 adults aged 18-64 with mental health problems (4.8 per 1000 adults[6]) were *helped to live at home* by councils in the South East region 2007.

2.2 Mental ill health and the workforce: work rates

Participation in employment varies by type of mental health condition and is comparatively high for people with mild to moderate conditions but low for people with severe conditions. Comparisons between the 1993 and 2000 surveys of psychiatric morbidity show a big drop in unemployment rates among those with neurotic disorders from 14% to 4%. A proportion of these (4%) moved from being 'unemployed seeking work' to becoming 'economically inactive', but there was an increase of 5% in those working full time. This partly mirrors overall reductions in unemployment in the general population. Among those surveyed who had no mental health condition, unemployment fell by 5% and full time working increased by 3%.

The ONS survey of psychiatric morbidity indicates a relatively high participation in employment by people with neurotic conditions (58%)[7]. Work rates are for people with mental health conditions are also available from the Annual Population Survey / Labour Force Survey and the comparative figure for this source is 43% for the SE region.[8] Differences between these sources are likely to be due to definitions and methodology, with the latter study relying on self-reporting of mental ill health and therefore less likely to pick up the milder conditions. [Part II: 4.1, 4.2]

People with more severe mental health conditions are much less likely to be in employment, though again estimates vary between sources: 28% in the psychiatric morbidity survey (ONS), 26% in the Health Care Commission (HCC) survey of people in contact with Mental Health Services (SE region), and just 18% (SE region) in the Annual Population Survey.[9] [Part II: 4.1, 4.2, 7]

The Annual Population Survey data allows for analysis at sub-national level and regional trends can be charted from year to year. Participation in employment is higher in the South East region both for the general population and for people with mental health problems. Overall the South East has shown an upward trend in work rates of people with mental health conditions between 2004 and 2006, in contrast with England as a whole. Work rates for people with moderate mental

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[4] National Social Inclusion Programme (2007)

[5] In February 2007, 82,300 people across the South-East were receiving Jobseekers Allowance (JSA). See DWP Tabulation Tool data - http://83.244.183.180/100pc/jsa/ccgor/ccsex/a_carate_r_ccgor_c_ccsex_feb07.html

[6] Social Services Performance Assessment Framework PAF C31 2006/7

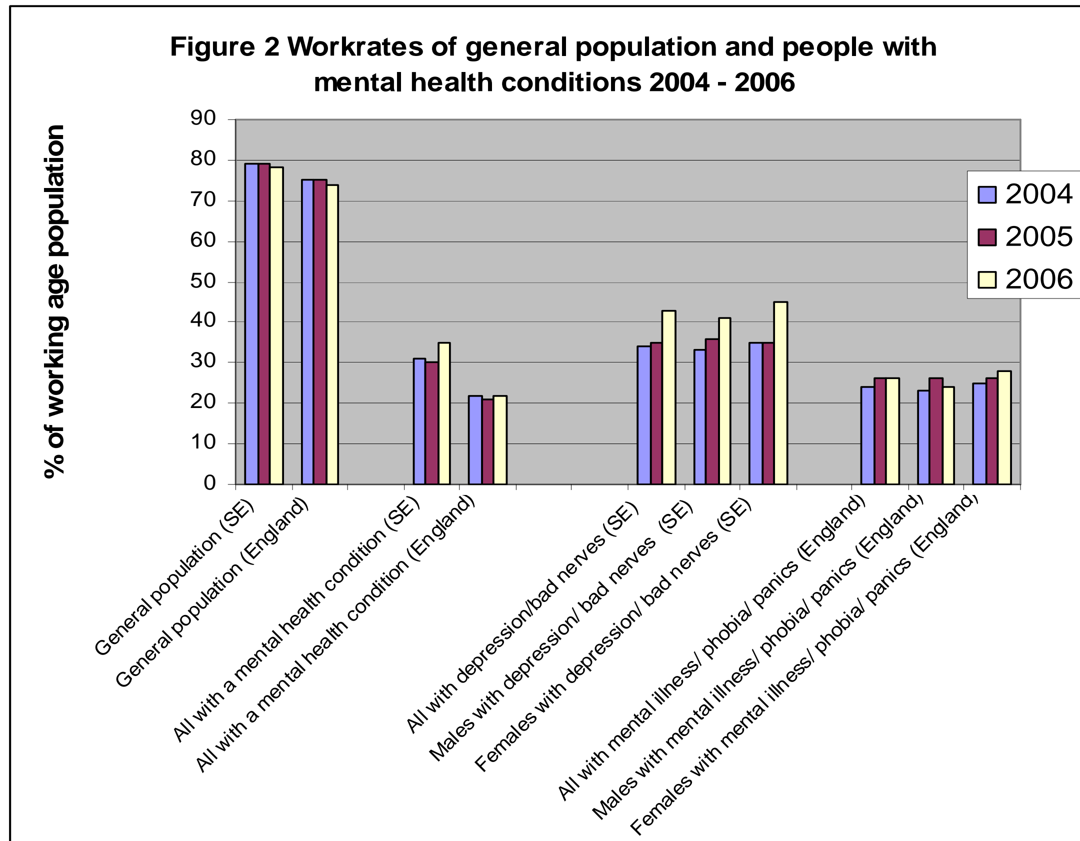
[7] Singleton et al (2001)

[8] National Social Inclusion Programme (2007)

[9] National Social Inclusion programme (2007)

health conditions have increased both for women and men between 2004 and 2006, and have been particularly notable for women. [Part II: 4.1, 4.2, 7][10]

These trends are illustrated in Figure 2.



Source: Annual Population survey/ Labour force survey 2004-06

Locality breakdowns of work rates for people with mental health conditions are available for upper tier authorities, but need to be treated with caution (see Part II: 4.2 Table 3). The erratic changes between years, likely to be due to small sample sizes, suggest that these figures should be treated with caution and are less suited to trend analysis than the regional figures. Based on an average for the years 2004, 2005 and 2006 the Labour Force Survey suggests that work rates for people with mental health problems were lowest in Southampton and East Sussex (just below England average), and highest in Buckinghamshire, Oxfordshire and Surrey.[11]

Looking at participation in employment from a different perspective, the ONS survey indicates a prevalence rate of 15.4 % for mental health problems among people in work. In other words, employers should expect to find, that on average nearly 1 in 6, of their workforce is affected by a mental health condition to a diagnosable degree. This is based on national rather than regional analysis, but the rate is not likely to be substantially different in the SE region as the

[10] ibid
[11] ibid

region has lower prevalence rate of mental illness overall, but higher proportions of people with mental health conditions in employment.[12] [Part II: 4.1]

Taken together, these figures suggests that, at the most conservative estimate, there are at least 400,000 people (1 in 10) with mental health problems in the workforce in the SE region[13], rising to 650,000 (1 in 6) based on the ONS survey estimate. Overlapping with these estimates, is the Health and Safety Executive finding that an estimated 66,000 people believed they were suffering from stress, depression of anxiety caused or made worse by work (1% of people ever employed).[14][Part II: 4.1, 4.2, 4.4]

2.3 Mental ill health and the workforce: sickness absence and work related illness

Sickness absence due to mental health problems

Best estimates suggests that 40 per cent of all time off work is attributable to mental health problems. This implies that approximately 10 million working days in the South East region are lost due to mental ill health, based on an average of 2.8 days off per (all) employee per year, or 1.4% of total working time. The ONS survey of psychiatric morbidity showed that the among all people taking time off for health reasons, the average amount of absence was 23 days, whereas the average for those with mental health problems was 33 days, and rising to 40 days for those with depression / anxiety.[15] [Part II: 4.3]

Work-related illness due to stress, depression and anxiety

Whilst there is limited information about sickness absence due to mental health problems overall, there is detailed analysis available about *work-related illness* due to stress, depression and anxiety from the annual surveys by the Health and Safety Executive (as part of the Labour Force Survey). This data gives an important insight into mental health problems that are likely to only partly figure in other mental health statistics. The latest survey indicates 66,000 people believed they were suffering from stress, depression of anxiety caused or made worse by work and that as a result of this 1.1 million working day in the South East region were lost, making this the largest single cause of absence attributable to work-related illnesses. There were no significant differences between the South East and England in incidence, prevalence or working days lost.

Those most likely to be affected tend to be in the age group 35 to 44 (males) and 35 – 54 (females), with a higher incidence for females. Prevalence varies between industry and occupational groups. The industries carrying the highest rates were public administration and defence; education; health and social work and financial intermediation. The occupational groups carrying the highest incidence of work related stress, depression or anxiety were professional

[12] Singleton et al (2001)
[13] Based on 43 % of all with mental health disorder
[14] Health and Safety Executive (2007a)
[15] Sainsbury Centre for Mental Health (2007)

occupations, managers/ senior officials and associate professional and technical occupations. [HSE graphs illustrating these differences are included in Part II: 4.4]

There was a downward trend in average working days lost per worker due to self-reported work-related stress, depression or anxiety from 2001/2 to 2005/6 followed by a statistically significant rise in 2006/07, taking it back to 2001/2 level. HSE notes that there is nothing to suggest that this is due to any changes in survey design and that further analysis is needed to understand this rise. [16]

Due to the rise in 2006/7 The *Revitalising Health and Safety* targets to reduce the number of working days lost per worker for **all** work-related illnesses and injuries are not on track.[17]

2.4 Employers awareness of mental ill health in the workplace

In spite of the evidence available on mental illness in the workplace , there is little awareness of these issues among employers, who have been found to badly underestimate the extent to which employees and fellow managers are suffering from stress, anxiety, depression and other forms of mental Ill health. In a survey of employers, almost three quarters thought the incidence of mental ill-health among their workforce would be 5% or less, and almost half thought that none of their employees would be suffering from any form of mental ill-health. Most companies do not have effective policies or provision in place to deal with mental health in the workplace. Workplace attitudes indicate widespread discrimination towards people with mental ill health, although this may not be conscious or intentional. The majority of directors believe industry needs significantly more support to deal with mental health in the workplace.[18] [Part II: 4.5]

Issues about health in the workplace are highlighted in the just published review Working for a Healthier Tomorrow (see section 3 – Conclusions).

2.5 Economic impact of mental ill health

Economic impact in the workforce

The Sainsbury Centre for Mental Health has calculated the economic impact of mental ill health in the workforce based on sickness absence (*Absenteeism*) , reduced productivity at work (*Presenteeism*)and *Staff turnover* as just over £1000 per year per average employee.[19] The total estimated cost to South East region's employers amounts to £4.6 billion per year. The highest proportion of cost is from lost productivity at work (58%). Absenteeism accounts for 32 % and staff turnover for 9% of total costs. [Part II: 5]

[16] Health and Safety statistics 2006/07

[17] ibid

[18] Shaw Trust (2006)
[19] Sainsbury Centre for Mental Health (2007)

Incapacity benefit claimants

As noted in section 2.1, 98,300 people in the South East were claiming incapacity benefit on account of 'mental and behavioural disorders' in February 2007. This represents 42 % of all incapacity benefits calimants in the South East, similar to the England figure of 40%. Whilst the overall trend for incapacity benefit claimants since 2004 has shown a gradual decline, the number of people claiming on account of mental and behavioural disorders have risen - in the South East by 7% (6200 people) between 2005 and 2007. A possible explanation for this increase may be that a diagnosis of mental health problems has become more acceptable and that stress and anxiety is more openly discussed. It may also be that changes in the labour market is putting more stress on employees leading to exclusion of people vulnerable to mental health problems. As noted in section 2.3, stress, depression and anxiety is the largest single cause of absence attributable to work-related illnesses

Two thirds had received benefits for at least 3 years and three quarters for at least two years.[20] The cost of incapacity benefit due to mental health conditions amounts to approximately £370 million per year in the SE region.[21] [Part II: 6]

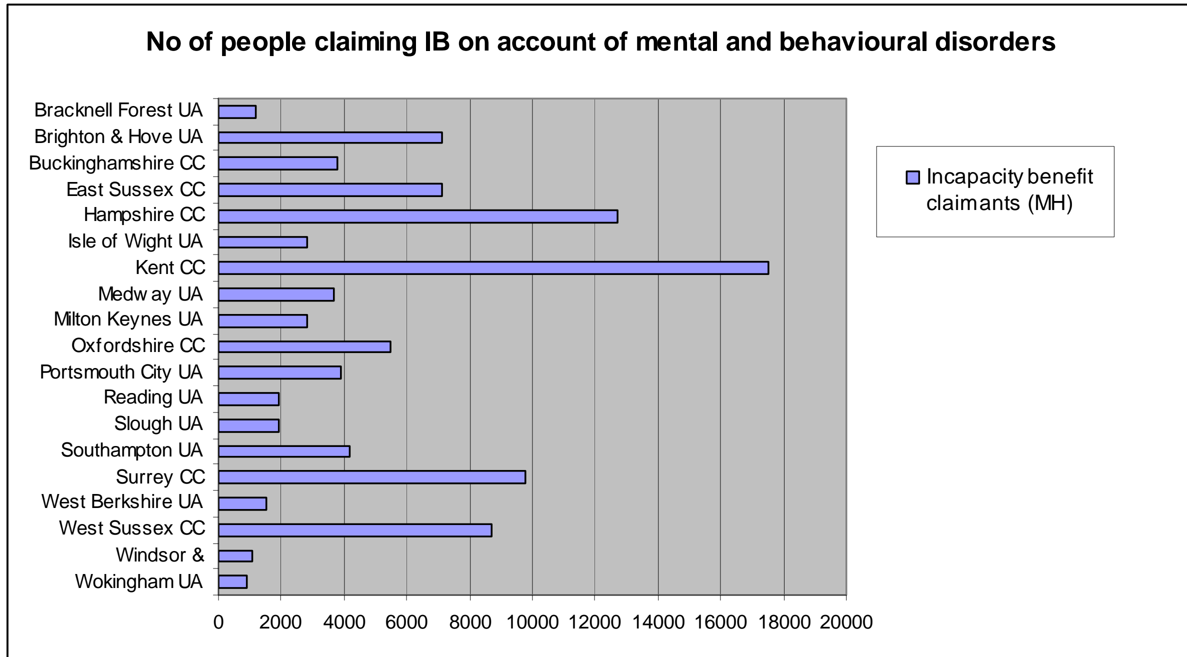
The ratio of men to women claimants is the same for South East as for England and has remained fairly static over time (57% male, 43% female).

Between February 2005 and February 2007 nearly all councils in the South East have seen an increase in the number of people claiming incapacity benefit on account of mental and behavioural disorders. In total the numbers rose by 7000, with the highest increases in Brighton & Hove (900), Hampshire (700) and Portsmouth, West Berkshire and West Sussex (each 500).

The overall numbers are shown in Figure 3. The differences in numbers reflect in the first instance the size of the working age population, but are also affected by differences in rates of claimants. [Part II:6]

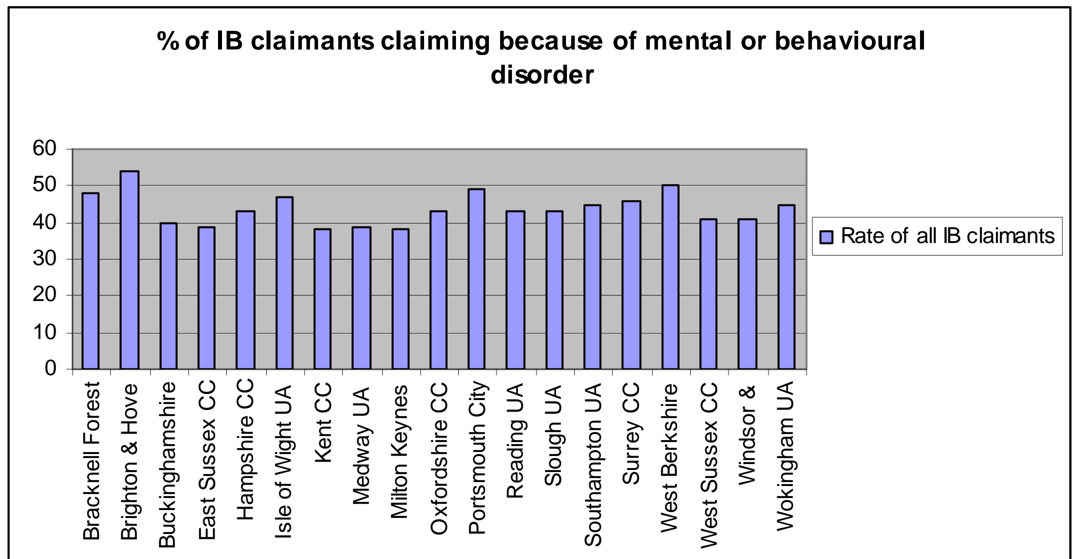
[20] National Social Inclusion Programme (2007)
[21] Based on mid level weekly payment of £72.55

Figure 3



Within the South East region the highest rates of people with mental and behavioural disorders claiming incapacity benefits (as a proportion of all claimants) were in Brighton and Hove (54%), West Berkshire (50%), Portsmouth (49%) and Bracknell Forest (48%). This is illustrated in Figure 4.

Figure 4



Comparisons with the ONS psychiatric morbidity survey suggest that there are at least as many people with severe mental illness who are 'economically inactive' but not claiming incapacity benefit.

The Government has announced major changes in the design and operation of Incapacity Benefit , with an associate aim of reducing numbers receiving the new Employment and Support Allowance by 1 million (DWP 2006), and *Pathways to Work* was introduced as a new approach to supporting incapacity benefit claimants into work. [22] The implication of the DWP target for the South East region is an approximate 50, 000 people who have experienced mental health problems re-entering the labour market. [Part II: 6]

However the recently published review of Review of the Health of Britain's Working Age Population[23] acknowledges that Pathways to Work has had a limited effect on people's mental health problems and that Pathways should therefore explore how better to target and meet needs of people with mental health problems.

2.6 Employment support to people in contact with community mental health services.

The Health Care Commission annual survey of people in contact with secondary mental health services, based on a sample of people on Mental Health Trusts CPA registers, asks questions about participation in work and employment support.

In 2007 the survey showed that 26% of service users in the South East were in paid work, slightly higher than for England as a whole, and that a further 5% worked on a 'casual or voluntary basis'. There has been a very slight upward trend in work rates for this group from 2005 to 2007.

Half of the service users in the South East region said they were unable to work because of their mental health problem. 8% of service users had received help with finding work in the last 12 months, and a similar proportion (9%) said they would have liked to.

Detailed results are availabe for Mental Health Trusts in the NSIP report. However the response rate to this survey is patchy and data is missing for some Trusts.

The development of effective employment services for people with mental health problems is central to the social inclusion agenda. Collection of this data will need to improve if the new national indicator 'Adults in contact with secondary mental health services in employment' (NI 150) is to be effectively monitored. The Sainsbury Centre for Mental Health is developing a framework for key indicators for development of evidence based employment services, with pilots being undertaken in 2008.[24] [Part II: 7]

Data on the provison of employment schemes and services provided through Mental Health Trusts is available from the Department of Health Adult Service Mapping. The dataset is not mandatory and there are some concerns about the comprehensiveness of the data and interpretation of staff categories. Detailed results by Mental Health Trusts are available in the NSIP report, though data is

[22] Sainsbury Centre for Mental Health (2007)
[23] Dame Carol Black (2008)
[24] Project lead Professor Geoff Shepherd, geoff.shepheard@scmh.org.uk

missing for some Trust. In March 2007 the data set identified 49 Employment Schemes with a total of 250 staff. [Part II: 8]

2.7 Potential developments in data collections and analysis

This report shows that there is a wide range of data sources that can be used to provide a picture of mental health conditions in the population and its relationship to employment. Each data source approaches the subject from a specific angle, using different sub-categories for mental health (or none), and the possibility for regional, locality and demographic analysis varies by source. Nevertheless, together the data provides insights into the prevailing patterns and highlights some key issues. However, there are a number gaps and areas where improvements to scope and/or quality is desirable.

- DWP benefit datasets are coded by ethnicity. It is potentially possible therefore for DWP Incapacity Benefit datasets to be made available with breakdowns by ethnic group of claimant. However at present only Jobseekers Allowance claimants are released broken down by ethnic group.
- Although it is inevitable that the self-reporting of mental health conditions in the Annual Population/ Labour Force Survey will mean a certain degree of under reporting, the survey is a reasonable regular source of data on mental health and employment, particularly at regional level. Consideration could be given to including a question to capture short-term or episodic metal illness; currently questions are framed in the context of long-term limiting illness.
- Analysis for sub-groups at locality level from the APS/LFS should be treated with caution as sample sizes for the sub-group mental health may become too small to give reliable estimates. Where year to year figures vary widely, averaging out values over a three year period is advisable.
- The APS/LFS collects data on employment status of non-white groups – a regional breakdown of this data for people with mental health conditions could usefully be made available.
- Sickness absence due to mental health conditions currently has to be estimated from a range of different sources. Comprehensive regular data (as done by HSE for *work-related* illnesses) would enable monitoring the impact of new 'fit for work' initiatives.
- The new national indicator NI 119 'Self reported measure of people's overall health and well being' has the potential for monitoring mental health in the population.
- There is a need to ensure that arrangements for collecting and reporting data to monitor the new National Indicator 'Adults in contact with secondary mental health services in employment' are effective and produce comprehensive and reliable information. Current datasets based on the HCC surveys are patchy in terms of quality and coverage.
- There is scope for improvements to the Adult Service Mapping Data set. This is not mandatory, and there are some concerns about the

comprehensiveness of the data provided and that it may underestimate employment resources.

- A review was commissioned by the NHS Information Centre in 2006, *Making Sense of Mental Health Information,* to make recommendations for ways of supporting more meaningful approach to information collections in the context of health and social care joint working arrangements. The review found that information collections and reporting on mental health were largely driven by external demands (core returns such as RAP for social care and MH MDS in health care) and localities tended to define their information requirements in this context. Future information needs were consistently seen in terms of achieving a better understanding of outcomes for service users within the broad context of social inclusion. The main recommendation emerging from the review was "the need to develop a single set of central information requirements for adult community mental health serviced, reflecting the delivery of local services by locally integrated teams"[25]. A strong implications of the findings of the review is that information collections relating to employment of people in contact with mental health services, must be seen as meaningful by practitioners in order to ensure quality of data.

Conclusion

Inclusion of people with mental health problems in the workforce is a key policy focus for tackling exclusion. A new national indicator to monitor 'Adults in contact with secondary mental health services in employment' is included in The New Performance Framework for Local Authorities & Local Authority Partnerships. Whilst there is a need to ensure that effective arrangements for collecting and reporting data to monitor this indicator, it is also important to recognise that it only affects the minority of people with mental health problems are known to mental health services.

The analysis in this report indicates that there is as much a need for mental health strategies to focus on the wider workforce and occupational health, in order to prevent people with mental health problems from being excluded from work. Nearly 1 in 6 of the workforce is affected by a mental health condition to a diagnosable degree, and stress, depression and anxiety is the highest single cause of sickness absence due to work-related illness. Mental health problems in the workforce thus has a major impact on individuals and the economy, while remaining largely unrecognised by employers.

The publication of the first ever review into the health of the working age population – *Working for a Healthier Tomorrow* is therefore timely. The review calls for urgent and comprehensive reform and a new approach to health and work in Britain. It spells out key challenges which include insufficient access to good work-related health support in the early stages of sickness including mental health conditions. The review commissioned a report into *Mental Health and Work* from the Royal College of Psychiatrists, and includes a ground-

[25] The Information Centre (2006) p5

breaking consesus statement signed by more than 30 health professional bodies, pledging to help people enter, stay in or return to work.

"We, the undersigned, will work with government, other healthcare workers, the voluntary sector, employers and trades unions, to promote and develop ways of supporting individuals to achieve the socio-economic and health benefits of work. This pledge includes a commitment to continue to educate the healthcare community, employers and people of working age about the benefits that work can provide; and, as appropriate, to do all we can to help people enter, stay in or return to work."[26]

Findings from the review include:

- Acknowledgement that Pathways to Work has had a limited effect on people mental health problems. Pathways should therefore explore how to better target and meet needs of the mental health group..
- Recognition that more needs to be done for the mental health group if Government is to meet the 1million off the Incapacity Benefit target and 80% employment aspiration.
- Mental health and employment strategy will need to urgently look at how to meet the needs of people with mental health problems who are workless.
- Specialist mental health provision should be available as part of employment programmes for all working age benefit groups
- A multidisciplinary 'Fit for Work' work related health service should be available in early sickness absence. It should be available for all people needing help and open to those on out of work benefits

Recommendations include

- A new Fit for Work service to be piloted in early stages of sickness, and if successful extended to those on incapacity and out of work benefits.
- Government should fully integrate health support with employment and skills programmes, including mental health support where appropriate.
- Government should expand the provision of Pathways to Work to cover all incapacity benefits claimants as soon as resources allow, including appropriate provision for those with mental health conditions.
- To support the development of its proposed mental health employment strategy, Government should review mental health support within current policies and seek to determine the most effective method of assisting this group of people back into work.
- Government should consider offering advice and limited funding to help local partnerships kick-start health and work activity.
- Occupational health should be brought into the mainstream of healthcare provision.

[26] Dame Carol Black (2008) p 67

Good quality data will be needed to support mental health strategies, identification of specific target groups and monitoring of developments and trends. Developments should strive to achieve a balance between sound data collections for people who are known to services and robust monitoring of mental health of the wider population and its impact.

Part II

3. PREVALENCE OF MENTAL HEALTH CONDITIONS

Data Source	ONS Survey of Psychiatric Morbidity
Dates	2000 [repeat of previous survey 1993]
Report	Singleton N et al (2001) *Psychiatric morbidity among adults living in private households 2000,* London ONS http://www.statistics.gov.uk/statbase/Product.asp?vlnk=8258
Sample	Representative population sample of 8,800 people aged 16-74
Basis for identifying MH condition	Assessed by clinical interview schedule and (for personality disorder and psychotic conditions) second stage interview.
Scope	Most comprehensive UK source of information on prevalence of mental health conditions among adults • Prevalence of all major forms of mental ill health by diagnostic category • Age 16-74 • Analysed according to wide range of demographic and socio-economic variables, including employment status.
Mental health sub-categories	• Neurotic disorders (depression, anxiety, obsessive compulsive disorder, panic disorder) • Personality disorders • Psychotic disorders • Drug and alcohol misuse/ dependence
Geography	Great Britain. Prevalence by gender provided for South East Region
Demographics	Analysed according to wide range of demographic and socio-economic variables: Age, gender, ethnicity, marital status, family unit type, qualifications, intellectual functioning, employment (see below), social class, housing tenure, no of accommodation moves, type of locality [Note only gender analysed at regional level]
Gaps / limitations	• Some demographic variables are not analysed at regional level. • Some of the findings may be dated.

What is the story?

Regional level

- In the SE Region just over 1 million people aged 16-74 at any one time are estimated to have a mental condition that would be clinically diagnosable [27],

[27] The ONS Survey also included alcohol and drug dependency as mental health conditions, but these have been excluded in these figures

representing almost 1 in 5 (19.1%) of this age group. The vast majority will be being people suffering from a neurotic disorders (mostly anxiety and/or depression).

- 820,00 people aged 16 – 74 (14.2%) suffer at any one time from a neurotic disorder. The proportion in the South East is lower than the national average of 16.4 %. Neurotic disorder is more common among women than men (16.4% compared 12%), and highest in the age-groups 40-54 (approx 20%).
- An estimated 29,000 people aged 16 – 74 suffer from personality disorder (4.4 % same as for the Great Britain average).
- An estimated 250,000 people aged 16 – 74 suffer from psychotic disorder (0.5 % Great Britain average).

Demographics

- Women are more likely than men to suffer from neurotic disorder (16.3% (female) 12.0% (male) , while the reverse is true for psychotic disorders 0.3% (female) 0.7% (male).[28]
- Neurotic disorder is highest in the age-groups 40-54 (approx 20%) and psychotic disorder is highest in the age-group 30-44 (approx 1%)[29]
- Prevalence of neurotic disorder was higher than average amongst South Asian (19.2%) and 'other' (20.4 %) ethnic groups, whilst prevalence of psychotic disorder was substantially higher than average for 'Black' groups (1.8% compared to 0.5%)[30]
- Compared to people with no neurotic disorder those assessed as having a neurotic disorder are more likely to be aged 35-54, separated or divorced, living as a one person family unit or as a lone parents.
- Compared to people with no psychotic disorder those with a psychotic disorder are more likely to be separated or divorced, living as a one person family unit or as a lone parents, be separated or divorced, have low educational qualifications, be in social class IV or V and be economically inactive. They were also more likely to live in an urban area and in council/ housing association accommodation.

Visible Trends

- The 2000 psychiatric morbidity survey is a repeat of a survey carried out in 1993. Comparisons show that there was no significant change in the overall rate of neurotic disorders or psychotic disorders for all adults. However there was a slight but significant increase in the prevalence of any neurotic disorder among men from 12.6% in 1993 to 14.4% in 2000.

Locality analysis

There are substantial numbers of people with a mental health condition in each locality; the numbers reflect the overall population sizes and range from 14,000

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[28] Singleton et al (2001) Tables 2.9, 2.13 [SE prevalence]
[29] ibid Table 2.7, 2.11 [GB prevalence]
[30] ibid Tables 2.8, 2.12 [GB prevalence]

to 129,000 for neurotic disorders, 3,5000 to 31,000 for personality disorders and 400 to 3,600 for people with psychotic disorders.

Table 1 Number of adults aged 16-74 estimated to have a mental health condition by local authority and PCT

Local Authority	PCT	Neurotic disorder	Personality disorder	Psychotic disorder
Buckinghamshire CC	Buckinghamshire	50,748	12,423	1,430
East Sussex CC	East Sussex	32,168	7,874	906
Hampshire CC	Hampshire	129,612	31,728	3,651
Kent CC	Eastern and Coastal Kent	72,450	17,735	2,041
Kent CC	West Kent	67,324	16,480	1,896
Oxfordshire CC	Oxfordshire	63,090	15,444	1,777
Surrey CC	Surrey	109,472	26,797	3,084
West Sussex CC	West Sussex	76,749	18,787	2,162
see note 1	Berkshire East	39,484	9,665	1,112
see note 2	Berkshire West	46,886	11,477	1,321
Brighton & Hove UA	Brighton & Hove	27,442	6,718	773
Isle of Wight UA	Isle of Wight	14,245	3,487	401
Medway UA	Medway	25,989	6,362	732
Milton Keynes UA	Milton Keynes	23,335	5,712	657
Portsmouth City UA	Portsmouth City	20,037	4,905	564
Southampton UA	Southampton	23,788	5,823	670
South East Region		**822,820**	**201,417**	**23,178**

Source: Based on regional prevalence rates from Singleton et al (2000) applied to ONS 2006 mid year population estimates

Note 1: Berkshire East PCT covers Bracknell Forest UA, Slough UA, Windsor and Maidenhead UA

Note 2: Berkshire West covers Reading UA, West Berkshire UA, Wokingham UA

Further breakdowns of prevalence by diagnostic sub-category is available at PCT area level from *The Mental Health and IAPT Workforce Estimate Tool* produced by Sainsbury Centre for The Mental Health.

4.1 MENTAL ILL HEALTH AND THE WORKFORCE: WORK RATES (a)

Data Source	ONS Survey of Psychiatric Morbidity
Dates	2000 [repeat of previous survey 1993]
Report	Melzer H et al (2002) The social and economic circumstances of Adults with mental health Disorders, London, ONS http://www.statistics.gov.uk/downloads/theme_health/PMA_S&E.pdf
Sample	Representative population sample of 8,800 people aged 16-74
Basis for identifying MH condition	Assessed by clinical interview schedule and (for personality disorder and psychotic conditions) second stage interview.
Scope	Most comprehensive UK source of information on prevalence of mental health conditions among adults • Prevalence of all major forms of mental ill health by diagnostic category • Age 16-74 • Analysed according to wide range of demographic and socio-economic variables, including employment status.
Mental health Sub-categories	• Neurotic disorders (depression, anxiety, obsessive compulsive disorder, panic disorder) • Personality disorders • Psychotic disorders • Drug and alcohol misuse/ dependence analysed by whether Employed, Unemployed [but looking for work] or Economically inactive [not looking for work].
Geography	Great Britain
Demographics	Employment status analysed by gender [GB analysis]
Gaps / limitations	Work rates not analysed at regional level No breakdown by age

What is the story?

Regional level

Employment status varies by MH condition, and is comparatively high for people with neurotic conditions but low for people with psychotic conditions.

- The ONS survey suggests that people at the moderate end of mental health conditions are almost as likely to be working as anybody else: 63 % of people with mixed anxiety and depressive disorder (the largest group) are employed, and of all people with neurotic conditions, 58% are employed, 39 % economically inactive and 4% unemployed/ seeking work. For people with no MH condition the comparative figures are 69% employed, 29 % economically inactive and 2% unemployed/ seeking work.

- For people with psychotic conditions, the picture is very different. Only 28% are employed, 70% economically inactive and 2 % unemployed/ seeking work.

Table 2 Employment status of people with mental health conditions (%)

	Neurotic condition	Psychotic condition	No MH condition	All
Employed	57	28	69	67
- Working full time	*40*	*9*	*50*	*49*
- Working part time	*17*	*19*	*19*	*18*
Unemployed	4	2	2	3
Economically inactive	39	70	29	30

Source: Melzer et al (2002) Table 2.2

- The ONS study also shows that 22.3% of all people in paid employment have some kind of mental health problem as defined in the survey (including drug and alcohol dependency). Omitting the latter category, the survey indicates a prevalence rate of 15.4 % for mental health problems among people in work. **In other words, employers should expect to find, on average that nearly 1 in 6, of their workforce is affected by a mental health condition to a diagnosable degree**. [31]This is based on national rather than regional analysis, but the rate is not likely to be substantially different in the SE region, as this has lower prevalence rate overall, but higher proportions of people with mental health conditions in employment.

Demographics

For people with neurotic conditions there was some difference between men and women in terms of employment status. Women were more likely to be economically inactive than men and men more likely to be employed.

Gender analysis was not available for psychotic conditions

Table 3 Employment status of people with neurotic conditions by gender (%)

	Male	Female
Employed	61	55
Unemployed	4	3
Economically inactive	35	41

Visible trends

Comparisons between the 1993 and 2000 Psychiatric Morbidity Survey showed a big drop in the unemployment rate among the groups with neurotic disorders from 14% to 4% . In contrast there was an increase in the proportion

[31] Sainsbury Centre for Mental Health (2007),

economically inactive by 4% but also an increase of 5% in those working full time.

To some extent this reflected changes in overall unemployment rates, Among those with no neurotic condition, those unemployed and seeking work fell by 5% and those working full time rose by 3%.

4.2 MENTAL ILL HEALTH AND THE WORKFORCE: WORK RATES (b)

Source	Annual Population Survey / Labour Force Survey (APS/ LFS)
Dates	Data drawn from the annual population survey (APS) 2004, 2005, 2006
Report	Secondary analysis from report by National Social Inclusion Programme (NSIP): Employment, Benefits and Education Data Report (February 2008)
Sample	170,000 households (2006)
Basis for identifying MH condition	Self-reported on the basis of a brief set of questions to assess if people have a longstanding illness or health problem (including mental health problem) and whether this disables or limits respondents as a result.
Scope	Population survey
Mental Health Sub-categories	Two MH categories • 'Depression, bad nerves or anxiety' • 'Mental illness or suffer from phobia, panics or other nervous disorders'
Geography	England Analysis available for South East region Analysis available at LA level (but not by MH category)
Demographics	Analysed by gender
Gaps / limitations	Likely to underestimate mental health problems, because of self- reporting. Additionally, questions focusing on long term limiting illness may miss episodic mental health problems.

What is the story?

Regional level

- The work rate for people with 'depression/ bad nerves/ anxiety' is considerably higher in the South East than for England – 43 % compared to 26%. [NB. This category may be compared with the result for the category 'mixed anxiety and depressive disorder' group in the ONS Psychiatric Morbidity study 2000; the latter showed a much higher work rate for this group – 63 %]
- The work rate for 'mental illness/ phobias/ panics' is also somewhat higher in the South East than for England – 18% compared to 14%. [NB. This category may be compared with the result for the category 'psychotic conditions' group in the ONS Psychiatric Morbidity study 2000; the latter also showed a higher UK work rate for this group – 28 %]
- The work rate among the general population is higher in the South East than for the rest of England, which can account for some, though not all, of the higher work rates among people with mental health conditions in the region. The work rate in the general population according to the LFS is

74% in England and 78% in the South East, whilst the comparative figure for people who report any kind of mental health condition is 22% and 35% respectively.

Demographics

The data suggests that there has been a notable increase in the SE region between 2004 and 2006 in the work rate amongst women with mental health problems in the category 'depression/ bad nerves' from 35% to 45%, and a similar increase among men from 33% to 41%.

Visible Trends

Overall the South East has showed an upward trend in work rates of people with mental health problems between 2004 and 2006, (from 31% to 35%), in contrast with England figures which have remained stable.

Locality analysis

Breakdowns of work rates for people with mental health problems (all levels) and for the general population by upper tier local authorities in the South East are shown in Table 4. [32]

The LFS results for 2006 suggest that work rates were lowest amongst people with mental health problems living in S*outhampton* (11%) followed by *Portsmouth* (24%) although the latter work rate is higher than the national average. Conversely, the data suggests that work rates were highest amongst people with mental health problems living in *Buckinghamshire (64%),* followed by *Surrey* (47%). However, the erratic changes between years suggest that these data should be treated with caution. For example, between 2005 and 2006, the estimated work rates for people with people with mental health problems living in *Southampton* drops from 30% to 11% and in contrast *Buckinghamshire* increases from 34% to 64%

[32] Table and commentary NSIP (2007) p 16

Table 4 Work rates by Local Authorities in the South East. Source: Labour Force Survey

Work rate for working age people with mental health problems (MHP) and for the general population (GP) in the South East government office region						
	Annual 2004		Annual 2005		Annual 2006	
	MHP	GP	MHP	GP	MHP	GP
Isle of Wight	18%	76%	26%	77%	37%	75%
Berkshire	46%	79%	31%	80%	36%	80%
Hampshire	30%	82%	30%	81%	37%	82%
Southampton	17%	75%	30%	71%	11%	70%
Kent	29%	77%	29%	77%	34%	76%
Medway	21%	75%	31%	75%	27%	77%
Milton Keynes	37%	80%	35%	81%	*	77%
Buckinghamshire	22%	81%	34%	82%	64%	79%
Oxfordshire	51%	79%	45%	81%	31%	81%
Portsmouth	31%	72%	25%	74%	24%	76%
Surrey	45%	80%	36%	80%	47%	80%
Brighton and Hove	15%	76%	*	73%	34%	74%
East Sussex	22%	78%	20%	78%	*	76%
West Sussex	19%	80%	26%	80%	53%	79%
Average work rate for South East government office region	**31%**	**79%**	**30%**	**79%**	**35%**	**78%**
Average work rate for England	**22%**	**75%**	**22%**	**75%**	**22%**	**74%**

Source: Secondary analysis of LFS in NSIP 2008

4.3 SICKNESS ABSENCE DUE TO MENTAL HEALTH CONDITIONS

Data Sources	Health & Safety Executive (2005) - Survey of Workplace Absence Sickness and (Ill) Health (SWASH) www.hse.gov.uk/sicknessabsence/swash2005.pdf ONS Survey of Psychiatric Morbidity (2000); CBI in association with AXA (2007), Attending to Absence: Absence and Labour Turnover Survey CIDP (2007) Absence Management, Annual Survey report
Dates	Various – as above
Reports	Secondary analysis in: Sainsbury Centre for Mental Health (2007), Mental Health at work: Developing the business case
Sample	Various
Basis for identifying MH condition	Various
Scope	Workforce
Metal health Sub-categories	NA
Geography	UK
Demographics	Analysed by Gender, Age
Gaps / limitations	Each of the sources have their own strengths and weaknesses, but taken together should give reasonable broad brush estimates. No data on ethnicity.

What is the story?

Regional level

- The starting point for the analysis is a broad average of seven days sickness absence a year per employee from the four surveys.
- 40 percent of all time off work is estimated to be attributable to mental health problems (mid point figure).
- This indicates an average of 2.8 days off per employee per year due to mental ill health, or 1.4% of total working time.[33]
- This implies 70 million working days a year are likely lost because of sickness absence due to mental ill health in the UK, equating to approximately 10 million working days in the South East region.
- The ONS survey showed that among all people taking time off for health reasons the average amount of absence was 23 days, whereas the

[33] Based on average assumed working time of 200 days per year taking into account paid leave and public holidays, and adjusted downwards to take account of part-time working.

average for those with mental health problems was 33 days, and rising to 40 days for those with depression / anxiety.

Demograhics

Demographic breakdowns for sickness absence due to mental illness is not available. Overall sickness rates were found in the HSE Survey of Work Place Sickness and Ill Health to vary by size of organisation, gender and age. Mean numbers of days sickness absence in the last twelwe months were higher for women than men (7.3 and 5.5 respectively) and increased by age. Small and medium sized business had less sickness absence han larger businesses.

4.4 MENTAL ILL HEALTH AND THE WORKFORCE: WORK-RELATED ILLNESS DUE TO STRESS, DEPRESSION OR ANXIETY

Data Source	Health and Safety Executive (HSE), Surveys of self-reported work-related illness (SWI) [part of the Labour Force Survey] Detailed analysis from 2005/06 [Tables STRGOR1E, STRGOR1W12, STRGOR3] http://www.hse.gov.uk/statistics/lfs/index.htm Headline tables from 2007/06 http://www.hse.gov.uk/statistics/swi/index.htm
Dates	Annual Survey
Reports	Self-reported work-related illness and workplace injuries in 2005/06: Results from the Labour Force Survey http://www.hse.gov.uk/statistics/lfs/lfs0506.pdf Health and Safety statistics 2006/07 http://www.hse.gov.uk/statistics/overall/hssh0607.pdf
Sample	50,000 households
Basis for identifying MH condition	Self reported stress, depression or anxiety caused or made worse by work
Scope	The LFS provides the single most comprehensively reported data source for information about work-related illness and workplace accidents, and a main HSE source of information on working days lost.
Mental Health Sub-categories	'Stress, depression or anxiety' treated as one category
Geography	Great Britain. Regional analysis available.
Demographics	Analysed by Age, Gender
Gaps / limitations	No data on ethnicity

What is the story?

Regional level

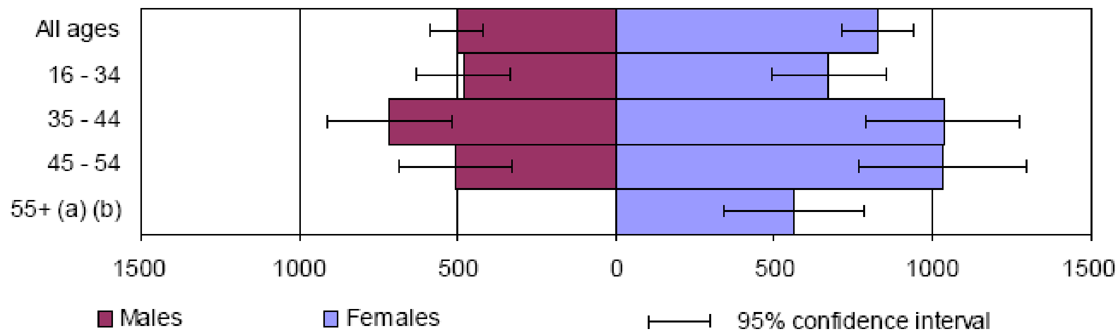
- In 2005/6 in the South East region an estimated 66,000 people believed they were suffering from stress, depression of anxiety caused or made worse by work (1% of people ever employed),
- 55,000 of these had been working in the last 12 months.
- An estimated 1.1 million working day in the South East region were lost from work related stress, depression or anxiety, making this the largest single cause of absence attributable to work-related illnesses.

- There were no statistically significant differences between The South East region and England in prevalence, incidence or working days lost.

Demographics

- For people who worked in the last 12 months, the incidence rate for females (0.83%), was statistically significantly higher than the corresponding rate for males (0.50%).
- For males, the 35-44 year age group carried the highest incidence rate of work-related stress, depression or anxiety. Its rate was statistically significantly higher than that for males as a whole. Sample numbers were too small to provide a reliable estimate for males aged 55+ years.
- For females, the youngest (16-34 years) and oldest (55+ years) age groups carried the lowest rates. Both rates were statistically significantly lower than those for the 35-44 and 45-54 year age groups and that for females as a whole.

Figure 64: Estimated 2005/06 incidence rates of self-reported stress, depression or anxiety caused or made worse by work, by age and gender, per 100 000 people working in the last 12 months



Notes:
(a) Estimates for females based on fewer than 30 sample cases.
(b) Sample cases for males too small to provide reliable estimates.

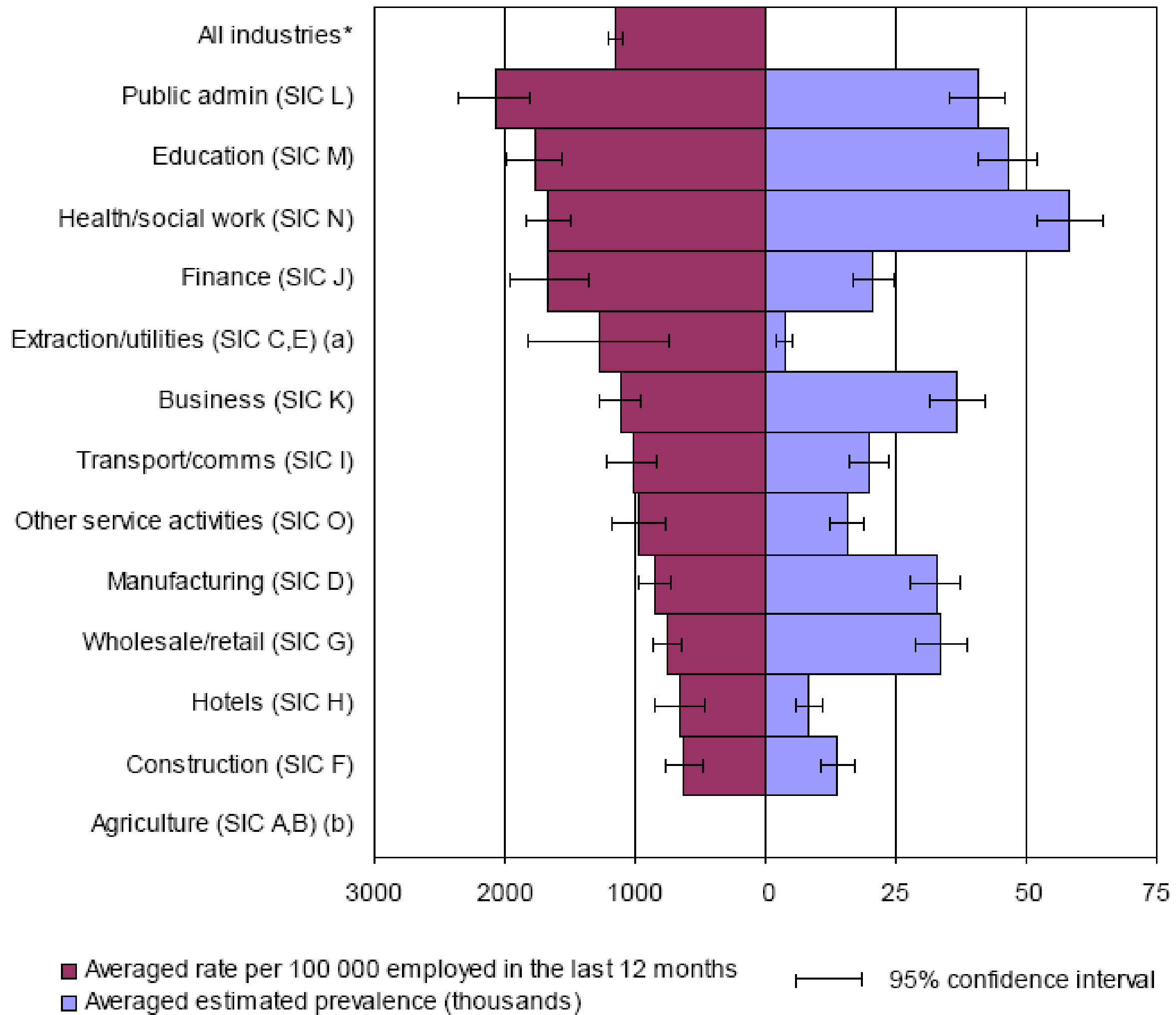
Source: HSE: Self-reported work-related illness and workplace injuries in 2005/06: Results from the Labour Force Survey p58

Self- reported work-related stress by Industry

- Figure 69 (from the HSE report) presents the estimated prevalence and rates of self-reported stress, depression or anxiety associated with the current or most recent job, by industry section, for people working in the last 12 months. Results have been presented as three-year averages using three successive years of data (2003/04, 2004/05 and 2005/06).
- The industries carrying the highest rates, where sample sizes are large enough to provide reliable estimates, were: public administration and defence; education; health and social work and financial intermediation. All four rates were statistically significantly higher than the rate for all industries.

- At the other end of the scale, again where sample numbers are large enough to provide reliable estimates, industries which carried the lowest rates were construction; hotels and restaurants, wholesale and retail trade and manufacturing. The rates for these industries were statistically significantly lower than the rate for all industries.

Figure 69: Estimated prevalence and rates of self-reported stress, depression or anxiety caused made worse by current or most recent job, by industry, for people working in the last 12 months averaged 2003/04-2005/06



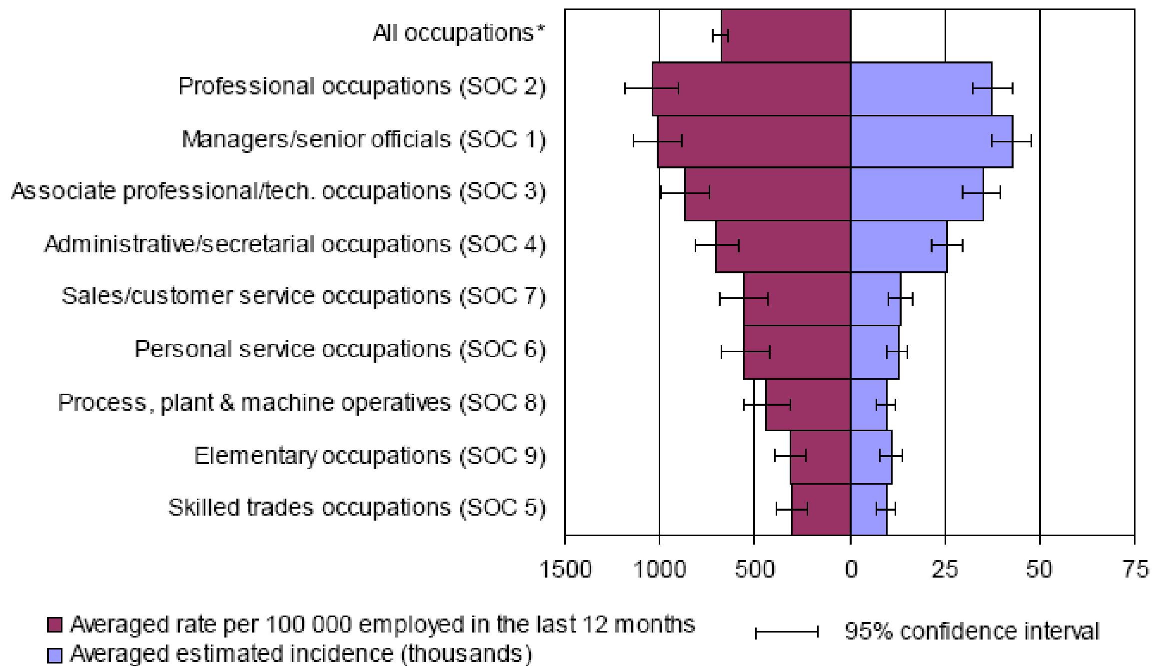
Notes:
(a) Estimates based on fewer than 30 sample cases.
(b) Sample cases too small to provide reliable estimates.
** The national averaged estimated prevalence of 333 000 (CI: 318 000 to 349 000) is too large to be shown here.*

Source: HSE: *Self-reported work-related illness and workplace injuries in 2005/06: Results from the Labour Force Survey p61*

Self-reported work-related stress by occupation

- The occupational groups carrying the highest incidence of work related stress, depression or anxiety were professional occupations, managers/ senior officials and associate professional and technical occupations.
- Figure 67 (from the HSE report) gives an occupational breakdown for those who became aware of their work-related stress, depression or anxiety in the last 12 months, and attributed their condition to their *current or most recent job* in that period. Results have been presented as *three-year averages* using three successive years of data (2003/04, 2004/05 and 2005/06).

Figure 67: Estimated incidence and rates of self-reported stress, depression or anxiety caused or made worse by current or most recent job, by occupation, for people working in the last 12 months, averaged 2003/04-2005/06



Note: **The national averaged estimated incidence of 197 000 (CI: 185 000 to 209 000) is too large to be shown here.*

Source: HSE: *Self-reported work-related illness and workplace injuries in 2005/06: Results from the Labour Force Survey p62*

Visible trends

- There was a downward trend in average working days lost per worker due to self-reported work-related stress, depression or anxiety from 2001/2 to 2005/6 followed by a statistically significant rise in 2006/07, taking it back to 2001/2 level. HSE notes that there is nothing to suggest that this is due

to any changes in survey design and that further analysis is needed to understand this rise. [34]

- Due to the rise in 2006/7 The *Revitalising Health and Safety* targets to reduce the number of working days lost per worker for **all** work-related illnesses and injuries are not on track.[35]

[34] ibid

[35] Health and Safety statistics 2006/07

4.5 MENTAL ILL HEALTH AND THE WORKFORCE: EMPLOYERS' PERCEPTIONS

Data Source	Shaw Trust Survey of CEO's and HR professionals in British Businesses
Dates	2006
Report	*Mental health: the Last Workplace taboo*. London, Shaw Trust http://www.shaw-trust.org.uk/mentalhealth/downloads.php
Sample	550 senior managers
Basis for identifying MH condition	Managers were asked: "What percentage of employees do you think will have a mental health problem at some point during their working life?"
Scope	Expert interviews
Mental health Sub-categories	NA
Geography	UK
Demographics	NA
Gaps / limitations	

What is the story?

National level

- Employers badly underestimate the extent to which employees and fellow managers are suffering from stress, anxiety, depression and other forms of mental Ill health. Almost three quarters of employers (71%) thought the incidence of mental ill-health among their workforce would be 5% or less, and almost half (45%) thought that none of their employees would be suffering any form of mental ill-health. The under estimation was particularly marked among small businesses.
- Most companies don't have effective policies to deal with employee's mental health and don't know enough about their legal position.
- Most companies don't have effective provision to identify and manage mental health in the workplace.
- Workplace attitudes indicate widespread discrimination towards people with mental ill health, although this may not be conscious or intentional.
- The majority of directors believe industry needs significantly more support to deal with mental health in the workplace.
- Detailed discussions of attitudes to mental illness available in the report.

Visible trends

- Not available

5. ECONOMIC IMPACT OF MENTAL ILL HEALTH IN THE WORKFORCE

Data Sources	Health & Safety Executive (2005) - Survey of Workplace Absence Sickness and (Ill) Health (SWASH) www.hse.gov.uk/sicknessabsence/swash2005.pdf ONS Survey of Psychiatric Morbidity (2000); CBI in association with AXA (2007), Attending to Absence: Absence and Labour Turnover Survey CIDP (2007) Absence Management, Annual Survey report
Dates	Various – as above
Reports	Secondary analysis in: Sainsbury Centre for Mental Health (2007), Mental Health at work: Developing the business case
Sample	Various
Basis for identifying MH condition	Various
Scope	Workforce
Metal health Sub-categories	NA
Geography	UK and international
Demographics	NA
Gaps / limitations	Broad brush estimates with possible wide margins of error

What is the story?

National and regional level

There are three main components of cost associated with mental health problems in the workforce:

- *Absenteeism*: Cost based on analysis of sickness absence outlined in 4.3 above linked with average employee costs of £28,850 per year
- Reduced productivity at work, '*Presenteeism*' : Based on a review of international studies and adjustments to refine figures and take account of UK differences, the SCMH report suggests that 'presenteeism' attributable to mental health problems in the UK accounts for 1.5 times as many working days lost as absenteeism. The international literature suggests that this is a conservative figure, and it should therefore be emphasised that it is subject to a wide margin of error.
- *Staff turnover*: Based on figures from CIDP (2007), the SCMH report suggests that " a reasonable estimate might be that, at most, mental health problems including stress account for five percent of total staff turnover" (p16). The average unit cost of labour turnover is assumed to be £11,625, which represents an average cost of £95 per average employee per year.

The combined costs as calculated for UK in the SCMH report are shown in the table. An estimate for the South East region has been added, based on a workforce of 4,200,000, as reported in ONS Labour Market Statistics, February 2008. [NB the UK figure does not include self employed people (13% of all in employment at UK level); this adjustment has not been made for the South East figures].

	Cost per average employee £	Total cost to UK employers £ billion	Total cost to SE region employers £ billion	Per cent of total
Absenteeism	335	8.4	1.5	32.4
Presenteeism	605	15.1	2.7	58.4
Turnover	95	2.4	0.4	9.2
Total	**1035**	**25.9**	**4.6**	**100.0**

Note: Details of assumptions and figures used for estimates available in the SCMH report.

6. INCAPACITY BENEFIT CLAIMANTS WITH 'MENTAL AND BEHAVIOURAL DISORDERS'

Data Source	Department for Work and Pensions (DWP) administrative data set
Date	2007
Reports	Secondary analysis from report by National Social Inclusion Programme (NSIP): *Employment, Benefits and Education Data Report (February 2008)*
Sample	100% sample of cases from DWP administrative data set
Basis for identifying MH condition	Data collected from people claiming benefit. The category 'mental and behavioural disorders' includes people with a mental health problem, learning disability and mental disorders due to drug or alcohol use. Previous analysis of the national data has indicated that just over four fifths of people in this category have primary mental health problems.
Scope	People claiming incapacity benefit aged 16-64
Mental health Sub-categories	No subcategories for 'mental health problem' Breakdown by length of time receiving benefit
Geography	Regional and LA analysis
Demographics	Gender
Gaps / limitations	No age or ethnicity breakdown. The data represents a relatively small proportion of all people with mental health problems, who are likely to be at the more severe end of the spectrum. Comparisons with the ONS prevalence study suggest that there are at least as many people with severe mental illness who are 'economically inactive' but not claiming incapacity benefit.

What is the story?

Regional level

- 98,300 people in the South East were claiming incapacity benefit on account of 'mental and behavioural disorders' in February 2007 [approx 79, 000 with primary mental health problems – se above]. This represents 42% of all incapacity benefit claimants in the South East (similar proportion to England)
- Whilst the overall trend for incapacity benefit claimants since 2004 has shown a gradual decline, the number of people claiming on account of mental and behavioural disorders have risen - in the South East by 7% (6200 people) between 2005 and 2007.
- Most of these had received benefit long-term - two thirds (65%) for at least 3 years and three quarters (74%) for at least 2 years. The national picture is similar – 68% have been claimants for three years or more.

Demographics

The ratio of men to women claimants is the same for South East as for England and has remained fairly static over time (57% male, 43% female).

Visible trends

Between February 2005 and February 2007 nearly all councils in the South East have seen an increase in the number of people claiming incapacity benefit on account of mental and behavioural disorders. In total the numbers rose by 7000, with the highest increases in Brighton & Hove (900), Hampshire (700) and Portsmouth, West Berkshire and West Sussex (each 500).

The Government has announced major changes in the design and operation of Incapacity Benefit , with an associate aim of reducing numbers receiving the new Employment and Support Allowance by 1 million (DWP 2006). The implication is that nationally 0.4 million people with mental health problems currently in receipt of Incapacity benefit will in time re-enter the labour market. (Source: Sainsbury Centre for Mental Health 2007). As 12 % of claimants are in the South East , the implication for the region is an approximate 50, 000 people with mental health problems re-entering the labour market.

Locality breakdowns

Within the South East region highest rates of people with mental and behavioural disorders claiming incapacity benefits (as a proportion of all claimants) were in Brighton and Hove (54%), West Berkshire (50%), Portsmouth (49%) and Bracknell Forest (48%). The figiures for each authority are set out in table 11c from the NSIP report – as shown below.

Table 11c: Estimated numbers of incapacity benefit/SDA claimants with mental and behavioural disorders and rate of claimants with mental and behavioural as a proportion of all claimants (2005, 2006, 2007) in the South East region
Source: DWP benefits admin data

	February 2005		February 2006		February 2007	
	Est. No.	**Rate**	**Est. No.**	**Rate**	**Est. No.**	**Rate**
Bracknell Forest	800	38	1,000	43	1,200	48
Brighton and Hove	6,200	50	6,700	54	7,100	54
Buckinghamshire	3,500	38	3,600	39	3,800	40
East Sussex	7,000	39	7,200	40	7,100	39
Hampshire	12,000	40	12,100	41	12,700	43
Isle of Wight	2,600	42	2,600	42	2,800	47
Kent	17,600	37	17,700	38	17,500	38
Medway	3,300	35	3,400	37	3,700	39
Milton Keynes	2,600	37	2,700	38	2,800	38
Oxfordshire	5,400	41	5,400	42	5,500	43
Portsmouth	3,400	45	3,900	48	3,900	49
Reading	1,500	38	1,700	40	1,900	43
Slough	1,700	43	1,800	43	1,900	43
Southampton	4,200	42	4,200	46	4,200	45
Surrey	9,300	43	9,900	45	9,800	46
West Berkshire	1,200	46	1,300	46	1,500	50
West Sussex	7,800	38	8,100	39	8,700	41
Windsor and Maidenhead	1,000	37	1,100	41	1,100	41
Wokingham	800	42	900	45	900	45
Total for the South East government office region	91,900	40	95,300	42	98,100	42
Totals for England	**827,300**	**39**	**832,100**	**40**	**840,700**	**41**

7. WORK STATUS OF PEOPLE IN CONTACT WITH MENTAL HEALTH SERVICES

Data Source	Healthcare Commission Survey of Users of Community Mental Health Services
Date	Annual from 2004
Report	Secondary analysis from report by National Social Inclusion Programme (NSIP): *Employment, Benefits and Education Data Report* (February 2008)
Sample	Sample of approx 16,000 people aged 16-74 from CPA register of Mental Health Trusts
Basis for identifying MH condition	People on MH Trusts CPA registers
Scope	As above
Mental Health Sub-categories	NA
Geography	England, South East region Mental Health Trusts (can map to [groups of] LAs)
Demographics	Gender
Gaps / limitations	Patchy response rate (average 38%, range by Trust 7% - 79%). Data missing for several MH trusts.

What is the story?

Regional level

- 26% of service users in the South East are in paid work compared to 21% for England. [NB this is similar to the 28% work rate of people with psychotic disorders in the ONS 2000 survey, but lower than the overall workrate of people with any mental health in the APS survey (35%.) Service users are likely to represent a mixture of people with neurotic and psychotic disorders, but with an emphasis at the severe end.]
- A further 5 % of service users in the South East worked on a 'casual or voluntary basis'.
- Half of the service users in the South East region said they were unable to work because of their mental health problem.
- 8% of service users had received help with finding work in the last 12 months, and a similar proportion (9%) said they would have liked to.

Locality breakdown

Results by Mental Health Trusts available in the NSIP report (data missing for some)

Visible trends

Very slight upward trend in work rates (2005 to 2007)

'Adults in contact with secondary mental health services in employment' is part of the new Single Set of National Indicators (NI 150)

8. EMPLOYMENT SCHEMES

Source	Adult Service Mapping (DH)
Date	March 2007
Report	Secondary analysis from report by National Social Inclusion Programme (NSIP): *Employment, Benefits and Education Data Report* (February 2008)
Sample	All Mental Health Trusts
Basis for identifying MH condition	NA
Scope	Information about specific employment services, other services that provide employment support and the numbers of employment and education staff
Mental health Sub-categories	NA
Geography	England, South East region Mental Health Trusts (can map to [groups of] LAs)
Demographics	NA
Gaps / limitations	Data set is not mandatory, some concerns about the comprehensiveness of the data provided and interpretation of staff categories. May underestimate employment resources.

What is the story?

Regional level

The data set identified 49 Employment schemes, with a total estimate of 250 staff.

Locality breakdown

Results by Mental Health Trusts available in the NSIP report (data missing for some)

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