SAMH

DISMISSED? SAMH

Centre for Mental Health
*Realising a better future*

# What's it worth now?

## The social and economic costs of mental health problems in Scotland

### Full report

# FOREWORD

What's it worth? That was the question SAMH posed in 2006, when we published the first figures on the social and economic costs of mental health problems in Scotland. The answer was £8.6 billion: a figure that at that time was greater than the entire NHS budget in Scotland.

Dismissed? That's a question we've been asking recently. It's the title of our current campaign for fairness in mental health and employability, and it came about for two reasons. The first and most important reason is that our service users and members told us they wanted us to campaign on employment and on welfare benefits. The second reason is that the statistical evidence told us that our service users and members were right: employability is the crucial issue of the moment.

- Forty-five per cent of Incapacity Benefit claims are made on the basis of a mental health problem[i]
- Seventy-nine per cent of people with serious, long-term mental health problems are not in employment[ii]
- Less than 40% of employers would employ someone with a mental health problem[iii]

That's why, as part of our Dismissed? campaign, we chose to revisit the What's it Worth? research, this time with a particular focus on employment. SAMH has always been clear on the moral and legal drivers for including mental health in employability. This new research makes clear that there is also an economic driver.

The social and economic costs of mental health problems in Scotland are so great that we simply cannot afford to ignore them any longer. With major welfare reform taking place at the same time as cuts to services on a scale unseen for generations, we must take these research findings seriously.

Mental health is fundamental to our identity. We can now see that it is also fundamental to our economy.

That's why we commissioned this report to answer the question: what's it worth now?

**BILLY WATSON**
**CHIEF EXECUTIVE, SAMH**

i. Brown J, Smith J, Webster D et al. (2010) *Scotland Incapacity Benefit Claimant Profile*. University of Glasgow: Scottish Observatory for Work and Health

ii. Riddell S, Banks P and Tinklin T (2005) *Disability and employment in Scotland: a review of the evidence base.* Edinburgh: Scottish Executive

iii. 'see me'. General Public Omnibus Survey (2004)

# EXECUTIVE SUMMARY

## THE SOCIAL AND ECONOMIC COSTS OF MENTAL HEALTH PROBLEMS IN SCOTLAND

Mental health problems impose very high costs, both on individuals and their families and on society as a whole. These problems are extremely common, with a strong tendency towards persistence and recurrence throughout the life course, and they adversely affect many different aspects of people's lives.

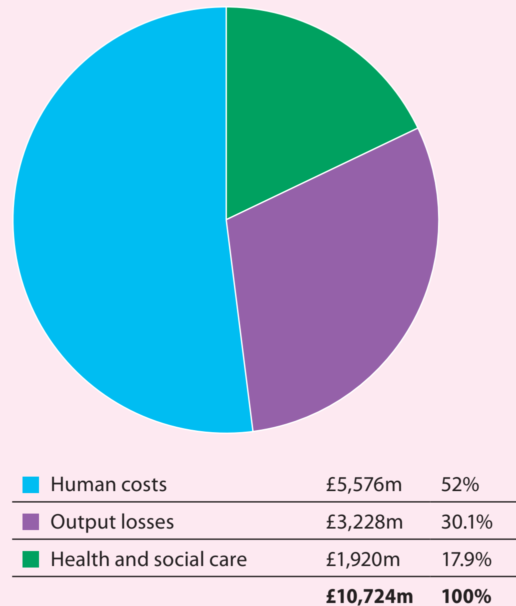
The costs of mental health problems can be described and evaluated under three headings:

- The costs of **health and social care** for people with mental health problems, including services provided by the NHS and local authorities
- The costs of **output losses** in the economy that result from the adverse impact of mental health problems on work and employment
- The less tangible but crucially important **human costs** of mental health problems, representing their negative impact on the quality of life

In a report published in 2006 we estimated that the total cost of mental health problems in Scotland in 2004/05 amounted to £8.6 billion. A straightforward updating of this estimate to 2009/10 indicates that the aggregate cost has increased by nearly a quarter, to £10.7 billion. Within the total, the costs of health and social care are estimated at £1.9 billion (17.7% of total), output losses at £3.2 billion (30.1%) and human costs at £5.6 billion (52.0%).

Between 2004/05 and 2009/10, spending on mental health services by the NHS and local authorities increased by 26%. In comparison, spending by the NHS on all health conditions combined rose by 39%, while spending on all social care by local authorities increased by 36%. The share of mental health in aggregate public spending on health and social care thus declined, from 10.6% to 9.7%.

TOTAL COSTS 2009–10



| | | |
|---|---|---|
| Human costs | £5,576m | 52% |
| Output losses | £3,228m | 30.1% |
| Health and social care | £1,920m | 17.9% |
| | **£10,724m** | **100%** |

## MENTAL HEALTH AND EMPLOYMENT

Mental ill health is now the dominant health problem of working age. Its impact falls mainly on people during their working lives, whereas most of the burden of physical ill health falls in the post-retirement years.

There is compelling evidence to show a positive link between employment and mental health. People enjoy better mental health when they are in work and worse mental health when they are out of work. The longer they are workless, the more damaging the consequences for their mental health.

For people with mental health problems, work can be therapeutic. A return to work improves mental health as much as the loss of employment worsens it. Some aspects of the work environment can pose a risk to mental health, but the overall balance of evidence is not in doubt: work is good for mental health.

## MENTAL HEALTH PROBLEMS AMONG PEOPLE IN WORK

Contrary to popular belief, the majority of people with a mental health condition have a job and are almost as likely to be working as anybody else. On average, employers should expect to find that at any one time nearly 1 in 6 of their workforce is affected by a mental health condition such as depression or anxiety. Only a small proportion of this ill health is directly caused by work or working conditions.

The high prevalence of mental health problems in the workplace imposes a substantial financial burden on employers, although much of this could be avoided through effective action. Better management of mental health at work makes good business sense, but few organisations recognise this or give it sufficient priority.

Many employers underestimate the prevalence of mental health problems at work and many of the costs associated with these problems take hidden forms such as presenteeism (people coming to work even when unwell and consequently functioning at less than full capacity) rather than the visible form of sickness absence.

New estimates prepared for this report suggest that mental health problems at work cost Scottish employers over £2 billion a year, broken down as follows:

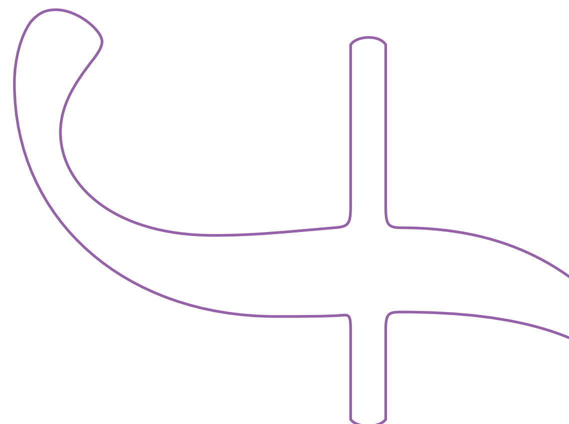
| | TOTAL COST | COST PER AVERAGE EMPLOYEE |
|---|---|---|
| Sickness absence | £690m | £310 |
| Presenteeism | £1,240m | £560 |
| Staff turnover | £220m | £100 |
| **Total** | **£2,150m** | **£970** |

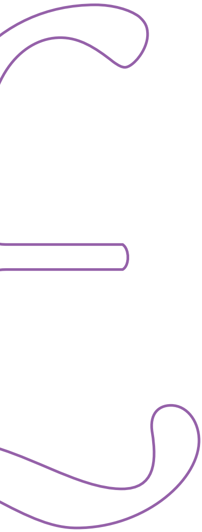
The large scale of these costs highlights the fact that mental health is – or should be – important to all employers as a business matter, and there is now an increasingly strong body of evidence to support the business case for intervention.

For example, BT has reported that its mental well-being strategy has led to a reduction of 30% in mental health-related sickness absence and a return-to-work-rate of 75% for people absent for more than 6 months with mental health problems.

Financial modelling of a workplace health promotion and well-being programme undertaken in the UK offices of a large multi-national company suggests that every £1 spent on the programme has generated savings of nearly £10 in terms of reduced sickness absence and presenteeism.

Research on an Australian programme of early identification and treatment for depression at work shows financial benefits in terms of higher productivity which are nearly five times the annual cost.





Evidence suggests that the key ingredients of an effective workplace programme are:

- **Recognition** by employers that work is good for mental health and also that people do not have to be entirely symptom free to work successfully
- **Prevention** of mental health problems, including the provision of mentally healthy working conditions and access for all employers to generalised health promotion and well-being programmes
- **Early identification** of emerging problems, with any unexplained change in an employee's productivity at work being treated as a possible warning sign
- **Awareness training** for line managers, to increase their knowledge and understanding of mental health issues
- **Better access to professional help**, which wherever possible enables people to carry on working at the same time as receiving support
- **Effective rehabilitation** for those who need to take time off work, including regular contact with employees during periods of absence

Common to most if not all of these ingredients is that they essentially involve no more than good management. Implementation does not require the availability of costly or specialised resources such as a large in-house occupational health department. Perhaps the most important first step is simply better understanding of mental health issues among senior managers.

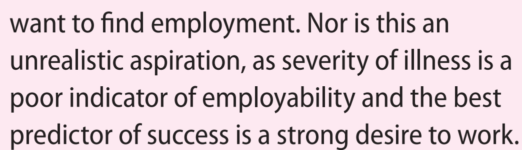
## MENTAL HEALTH PROBLEMS AMONG PEOPLE NOT IN WORK

There are currently around 1 million people of working age in Scotland who are not in work and the numbers in this group have increased by 125,000 since 2005, largely because of a sharp rise in unemployment caused by the recent recession. Ill health is the single most common cause of worklessness and mental ill health accounts for about 45% of all people not working for this reason. It is estimated that social security spending on workless people in Scotland who are in receipt of health-related benefits because of a mental health condition amounts to about £800 million a year.

One way of reducing these costs is to improve job retention, as much long-term unemployment can be avoided if the right steps are taken when employees' health problems are first identified at work. Early intervention is particularly important, as the longer a person is off sick, the lower the chance of a successful return to work and the higher the risk of permanent job loss.

More emphasis should also be given to helping people to stay in work with health problems and to return to work as soon as possible after any spell of absence. This means overturning traditional views, e.g. that it is inappropriate for people to be at work unless they are 100% fit or that being at work usually impedes recovery from a health problem.

Only about a fifth of people with severe and enduring mental health problems are in work, the lowest employment rate of any of the main groups of disabled people. This is not because of an unwillingness to work, as most people with severe mental illness



want to find employment. Nor is this an unrealistic aspiration, as severity of illness is a poor indicator of employability and the best predictor of success is a strong desire to work.

There is now very strong evidence from around the world that the best way of helping those with severe mental illness is by models of supported employment such as Individual Placement and Support (IPS) which emphasise getting people into competitive employment as quickly as possible, with training and support being provided on a continuing basis after job placement, not before (as in more traditional approaches). Research shows that IPS not only gets more people into work, it also leads to long-term savings in health spending, as stable employment promotes recovery for people with severe mental illness, leading to a better quality of life and reduced use of mental health services.

The prevalence of severe mental illness is relatively low and the great majority of workless people with poor mental health suffer from the so-called common mental health problems such as depression and anxiety. Many in this group have been out of work for long periods: more than two-thirds of all existing Incapacity Benefit claimants have been claiming for five years or more and after such lengthy periods of detachment from the labour market people are more likely to retire or die than to work again. It will be particularly important to ensure that those who have lost jobs during the recent recession do not suffer this fate.

Workless people with mental health problems need coordinated support from a range of services and agencies, and a key requirement is the development of better links between health and welfare-to-work services.

It remains to be seen whether the new Work Programme being introduced by the coalition Government will be more successful than previous mainstream employment programmes in helping people with mental health conditions into work. Also of critical importance are reforms in the social security system, including the replacement of Incapacity Benefit by Employment and Support Allowance, with eligibility determined by a new work capability assessment, and the proposal to replace all existing means-tested benefits for people of working age with a single Universal Credit, aimed at ensuring that work always pays.

All of these changes raise concerns for people with mental health problems who are currently out of work, but they also offer opportunities. Employment is a realistic goal for most people with mental health conditions and a very desirable one, given the many benefits of work including better mental health. The challenge now is to ensure that these opportunities are taken.

# WHAT'S IT WORTH NOW? THE SOCIAL AND ECONOMIC COSTS OF MENTAL HEALTH PROBLEMS IN SCOTLAND

## INTRODUCTION

In 2006 the Scottish Association for Mental Health published a report, "What's It Worth?", which presented high-level estimates of the social and economic costs of mental health problems in Scotland for the year 2004/05[1]. These included estimated costs of the output losses in the Scottish economy that result from the adverse effects of mental health problems on people's ability to work.

As part of SAMH's "Dismissed?" campaign for fairness in employability and mental health, the Centre for Mental Health was commissioned to produce this follow-up report. "What's it Worth Now?" updates the estimates of social and economic costs given in the 2006 publication, with a particular focus on the employment-related costs of mental ill health, both in work and out of work. The report also reviews the main policies, interventions and other actions that the available evidence shows to be effective in reducing the scale of these work-related costs. Greater use of these measures would enable more people with mental health problems to find and stay in employment and to work productively; they would generate significant financial benefits for employers; and they would reduce the burden of worklessness falling on taxpayers.

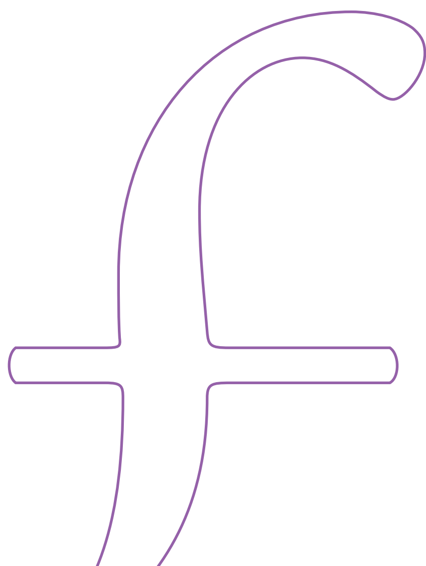
DISMISSED? SAMH

**Dismissed?** is a campaign that focuses on the employability journey of people with mental health problems. From claiming benefits to which people are entitled when they are sick or disabled, to applying for, getting and keeping a job, people with mental health problems are currently disadvantaged in employability.

The "Dismissed?" campaign:

- Works with employers to help them learn about mental health, and about equality law
- Helps employers to recruit and retain staff who experience mental health problems
- Aims to influence the benefits system to make it fairer and easier to navigate
- Empowers individuals to campaign for themselves

There are many ways to get involved in our campaign. Visit www.samh.org.uk to get involved on our action page, find out how your employer can support the campaign, watch our videos or read our easy-to-use factsheets all about rights and responsibilities in employment and benefits.



# THE SOCIAL AND ECONOMIC COSTS OF MENTAL HEALTH PROBLEMS IN SCOTLAND

## THE COSTS OF MENTAL HEALTH PROBLEMS IN 2004/05

The costs of mental health problems were described and evaluated in our 2006 report under three headings:

- The costs of **health and social care** for people with mental health problems, including services paid for by the NHS and local authorities and also the informal care provided by family and friends
- The costs of **output losses** in the economy that are linked to the impact of mental health problems on work and employment, as described above
- An imputed monetary valuation of the less tangible but crucially important **human costs** of mental health problems, representing their negative impact on the quality of life

We estimated that the total cost of mental health problems in Scotland in 2004/05 amounted to £8.6 billion, broken down by category of cost as follows: health and social care £1.5 billion (17.7% of the total), output losses £2.4 billion (27.7%) and human costs £4.7 billion (54.6%).

To place the total of £8.6 billion in context, our report noted that it was more than the total amount spent in Scotland by the NHS on all health conditions combined, which was £7.7 billion in 2004/05. It was also equivalent to nearly 9% of Scotland's Gross Domestic Product (GDP) in the same year, although this comparison needs to be treated with care, as the figure for the costs of mental health problems includes a number of components which are not included in national income as conventionally defined; most obviously, this applies to the human costs of mental health problems. The aggregate measure does however demonstrate the great importance of mental ill health in public policy, economic and social terms.

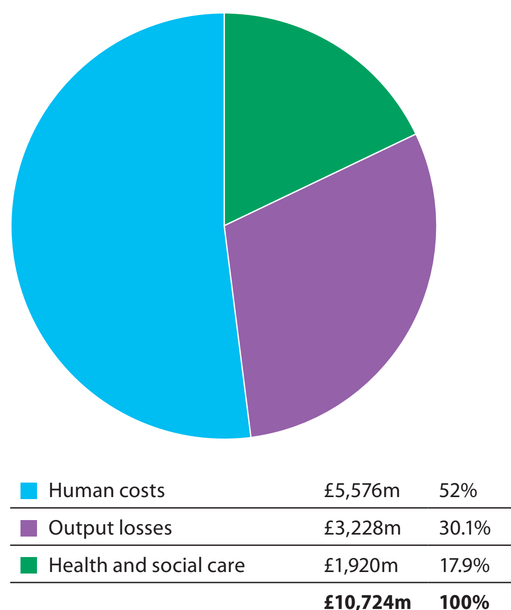
## THE COSTS OF MENTAL HEALTH PROBLEMS IN 2009/10

A straightforward updating of the above figures to 2009/10 indicates that the total cost of mental health problems in Scotland has increased to around £10.7 billion, broken down as follows:

## COSTS OF MENTAL HEALTH PROBLEMS, SCOTLAND, 2009/10

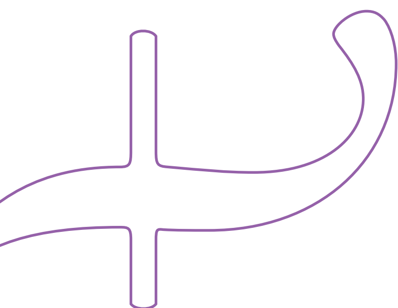
| | £ BILLION | % OF TOTAL |
|---|---|---|
| Health and social care | 1.9 | 17.9 |
| Output losses | 3.2 | 30.1 |
| Human costs | 5.6 | 52.0 |
| **Total** | **10.7** | **100.0** |

TOTAL COSTS 2009–10



| | | |
|---|---|---|
| Human costs | £5,576m | 52% |
| Output losses | £3,228m | 30.1% |
| Health and social care | £1,920m | 17.9% |
| | **£10,724m** | **100%** |

The aggregate cost of mental health problems thus rose by 25% between 2004/05 and 2009/10, including increases of 26% in the costs of health and social care, 36% in the costs of output losses and 19% in human costs (see below for more detail on these individual changes).

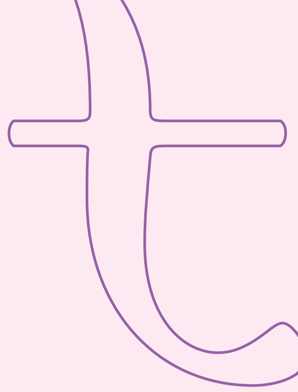


In calculating the costs of mental health problems in 2009/10, no changes have been made in the methodology used in our earlier report. This is so as to allow direct comparisons between the estimates for the two years. One consequence of this is that any shortcomings in the figures for 2004/05 are carried through into the later estimates. For example, the costs of health and social care are under-estimated in both years, as data shortages mean that they exclude the costs associated with people with mental health problems in the criminal justice system and specialist addiction services.

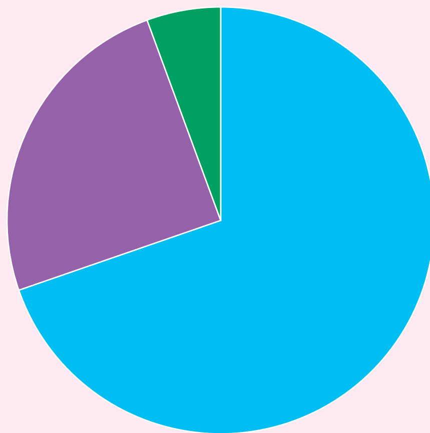
A comprehensive re-working of the figures would also need to take into account recent developments in costing methodology. To give an example, the estimates given above for the costs of output losses are too low: first, because recent research suggests that the costs of sickness absence were under-estimated in our 2006 report, particularly by using too low a figure for the average cost of a day's absence; and second, because they do not make any allowance for the costs of "presenteeism", defined as the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity. Adjusted estimates taking into account both these factors are given below. As will be seen, they substantially increase the overall cost of output losses attributable to mental health problems.

The updating of costs assumes that there was no change in the overall prevalence of mental health problems between 2004/05 and 2009/10. The cost estimates for 2004/05 were based on estimates of prevalence given in a survey of psychiatric morbidity undertaken in 2000 that covered England, Scotland and Wales, with separate figures available for each country [2]. This survey was repeated in 2007, but its coverage was restricted to England only [3], and no new national data on psychiatric morbidity in Scotland have become available since 2000. The recent survey for England showed no significant changes in prevalence between 2000 and 2007. For example, the prevalence of common mental health problems such as depression and anxiety was 17.5% in 2000 and 17.6% in 2007, the prevalence of probable psychosis was 0.5% in both years, and the overall proportion of the adult population in England with any kind of mental health difficulty was also unchanged at 23%. In the absence of more detailed information, it is assumed that the same pattern of unchanged prevalence also applied in Scotland.

In preparing the estimates for 2009/10, the total cost of health and social care has been increased in line with the growth of expenditure since 2004/05 on all services provided for people with mental health problems by the NHS and local authorities. This is easily the largest single component of care costs, accounting for about 70% of the total. Spending on these services increased by 26% between 2004/05 and 2009/10 [4]. In comparison, spending by the NHS on all health conditions combined increased by 39% over the same period, while spending on all social care by local authorities increased by 36% [5]. The share of mental health in aggregate public spending on health and social care thus declined, from 10.6% to 9.7%. As noted in our 2006 report, mental ill health accounts for about 20% of the overall burden of disease in Scotland, as measured by the WHO using a composite indicator which includes both premature mortality and morbidity/disability, and it must be a cause for concern that the already low share of mental health in health and social care expenditure has fallen further since 2004/05, relative to its share of the disease burden.

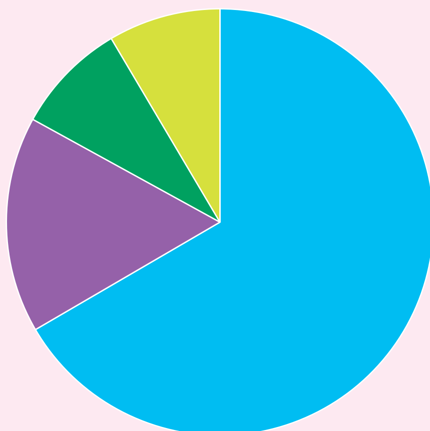


THE COSTS OF HEALTH AND SOCIAL CARE



| | | |
|---|---|---|
| NHS and social care services | £1,338m | 69.7% |
| Informal care | £475m | 24.7% |
| Other | £107m | 5.6% |
| | **£1,920m** | **100%** |

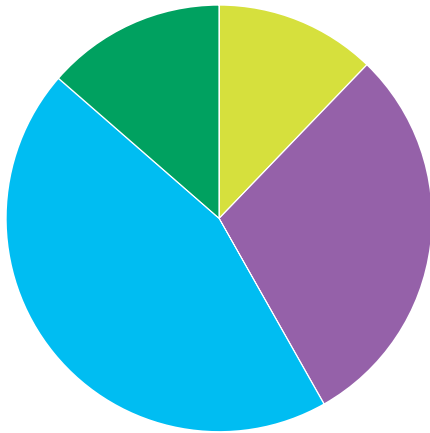
THE COSTS OF NHS AND LOCAL AUTHORITY CARE IN SCOTLAND 2009/10



| | | |
|---|---|---|
| NHS hospital and community services | £891m | 66.6% |
| GP consultations | £219m | 16.4% |
| Drug prescriptions | £114m | 8.5% |
| Local authority social care services | £114m | 8.5% |
| | **£1,338m** | **100%** |

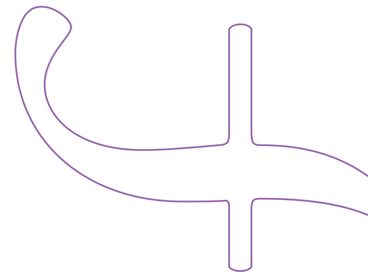
Output losses are employment-related and the estimates for 2009/10 take into account two main factors: first, the growth of average earnings in Scotland since 2004/05, which directly increases the value of lost employment and working time associated with mental ill health; and second, an increase in the total numbers of people of working age not in employment, which rose by 14 per cent in Scotland between 2004/05 and 2009/10 (6). The combination of these two factors implies an increase in the overall cost of output losses of 36 per cent over the period concerned.

THE COSTS OF OUTPUT LOSSES

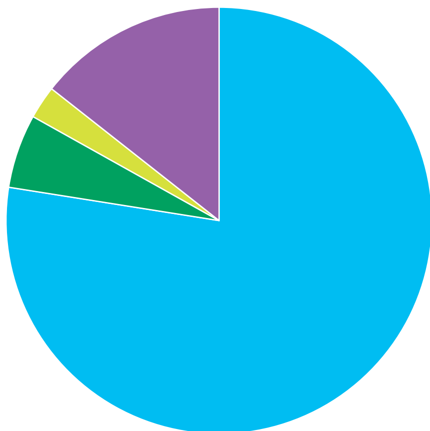


| | | |
|---|---|---|
| Worklessness | £1,440m | 44.6% |
| Losses of unpaid work | £954m | 29.6% |
| Sickness absence | £439m | 13.6% |
| Premature mortality | £395m | 12.2% |
| | **£3,228m** | **100%** |

Finally, human costs have been increased in line with the growth of money GDP in Scotland. This takes into account changes in population size and rising incomes, and incorporates the conservative assumption that the value people attach to health, including mental health, increases in step with their income. On this basis, human costs rose by 19% between 2004/05 and 2009/10 [7].



THE HUMAN COSTS



| | | |
|---|---|---|
| Household population - adults | £4,321m | 77.5% |
| Premature mortality | £803m | 14.4% |
| Household population - children | £314m | 5.6% |
| Institutional population | £138m | 2.5% |
| | **£5,576m** | **100%** |

## LIFETIME COSTS

All of the figures given above measure the costs of mental health problems as they arise in a single year. As an alternative perspective, there is growing interest in measuring costs on a lifetime basis, building on a substantial body of evidence from longitudinal studies in Britain and elsewhere that, in the absence of effective intervention, many mental health problems tend to be highly persistent and recurrent. There is a particularly high degree of persistence or continuity between adverse mental health states in childhood and those in adult life. Most children who have mental health problems will also have mental health problems as adults, and conversely most adults who have mental health problems will also have had mental health problems as children.

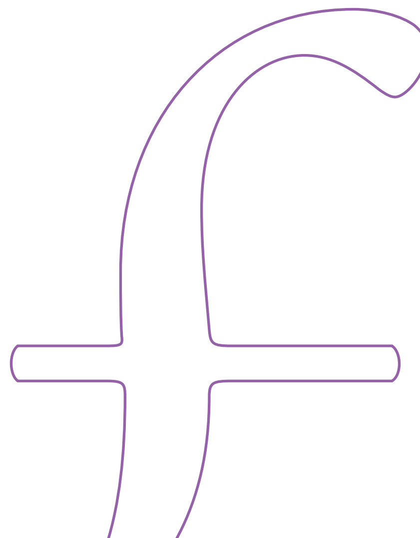
To illustrate, a British study using data on symptoms of depression and anxiety measured in the same sample of individuals at various ages between 13 and 53 has shown that the population can be divided into six groups as follows [8]:

Looking forward from childhood to adulthood, the figures show that 41.1% of the sample displayed symptoms of depression or anxiety during childhood, i.e. all of those in groups 4–6 combined. Symptoms persisted into adulthood in all but the relatively small number in group 6. It can thus be calculated that, among all children with depression or anxiety, as many as 85.9% continued to have these problems in adult life.

Looking back from adulthood to childhood, the figures show that 45.9% of the sample displayed symptoms of depression or anxiety during adult life, i.e. all those in groups 2–5 combined. Among these people, groups 2 and 3 represent those with adult onset and groups 4 and 5 those with childhood onset. The latter are much the larger number. Thus, of all adults with depression or anxiety, 71.3% first manifested symptoms in childhood.

The importance of continuity as shown by these figures suggests that a valuable way of analysing the costs of mental health problems

| | PER CENT |
|---|---|
| 1. No symptoms in childhood or adulthood | 44.8 |
| 2. Adult onset, moderate | 11.3 |
| 3. Adult onset, severe | 2.9 |
| 4. Repeated moderate symptoms over the life course | 33.6 |
| 5. Repeated severe symptoms over the life course | 1.7 |
| 6. Childhood onset with good adult outcome | 5.8 |
| **Total** | **100.0** |



is over the lifetime, as a supplement to the annual measures given above. To illustrate this approach, some broad estimates of the lifetime costs of conduct disorder are given below.

Conduct disorder is the most common mental health disorder in childhood, affecting 5.5% of all children in Scotland between the ages of 5 and 16 [9], and there is strong evidence to suggest that prevalence has increased significantly over the last 30 years [10]. Longitudinal studies show that the condition is predictive of a wide range of adverse outcomes in later life, including not only continuing mental health problems (uniquely, childhood conduct disorder is associated with increased risk for all types of adult psychiatric disorder), but also poor educational and labour market performance, substance misuse, criminality, disrupted personal relationships and even reduced life expectancy [11].

Because of this wide range of adverse consequences, the long-term costs of conduct disorder are very high. One study has shown that by age 28 the costs incurred by the public sector on services for individuals diagnosed with conduct disorder at age 10 were nearly 10 times higher than for those with no conduct problems at the same age (£70,019 against £7,423, at 1998 prices) [12]. More recently, a broader but less detailed study drawing on a range of secondary sources has suggested that the lifetime costs of childhood conduct disorder, relative to individuals with no conduct problems, may be of the order of £225,000 per case, taking into account such factors as reduced lifetime earnings, poor mental and physical health and costs relating to crime [13]. Such figures graphically illustrate the enormous potential benefits of effective early intervention.

In sum, whether measured on an annual or lifetime basis, it is clear that mental health problems impose very high costs, both on individuals and their families and on society as a whole. The scale of these costs reflects three key features of mental ill health:

- Mental health problems are extremely common, affecting more than one in five of the adult population at any one time; many of these problems go undiagnosed and untreated
- Mental health problems often have their origins in early life, with a high tendency towards persistence and recurrence throughout the life course
- The consequences of mental ill health are often pervasive, adversely affecting many different aspects of people's lives, and these adverse consequences are often compounded by stigma and discrimination

The remainder of this report focuses on an area where the consequences of mental ill health are particularly important, namely the world of work.

# MENTAL HEALTH AND EMPLOYMENT

## INTRODUCTION

It is no exaggeration to say that mental ill health is now the dominant health problem of working age. This is partly because mental health problems are very common, but also because the burden associated with these problems falls mainly on people during their working lives. The prevalence of mental ill health is highest when people are in their twenties and thirties and then declines steadily with age. This is in striking contrast to physical health, which for all major conditions shows a very pronounced age gradient going the other way. Indeed, the great bulk of the burden of physical ill health increasingly falls in the post-retirement years.

Poor mental health is therefore very common among people of working age and has a major impact on individuals and the economy. For individuals, it can mean difficulties in finding employment, increased risk of losing a job, frequent or prolonged periods of sickness absence and, at worst, long-term unemployment and detachment from the labour market, leading to a downward cycle of low income, worsening health and social exclusion. The longer people are out of work, the lower their chances of ever getting back. For the economy, there are enormous costs because of the lost production of people who are unable to work or whose attendance and performance at work are disrupted by their mental health condition.

There is compelling evidence to show a positive link between employment and mental health [14]. People enjoy better mental health when they are in work and worse mental health when they are out of work. The longer they are workless, the more damaging the consequences for their mental health, even leading in some cases to suicide. For people with mental health problems, work can be therapeutic. A return to work improves mental health by as much as the loss of employment worsens it. Some aspects of the work environment can of course pose a risk to mental health and well-being, for example excessive hours, work overload or lack of control, but the overall balance of evidence is not in doubt: work is good for mental health. The benefits of employment greatly outweigh the risks, which are very small compared with the harmful effects of long-term worklessness.

Against this background, the following sections explore in more detail the costs to society that result from the adverse effects of mental ill health on work and employment. Also included is a brief review of the measures that can be taken by governments, employers and health service providers to reduce these costs. The discussion is in two parts, the first dealing with mental health problems among people who are currently in work and the second with mental ill health among those who are out of work.

# MENTAL HEALTH PROBLEMS AMONG PEOPLE IN WORK

## THE PREVALENCE OF MENTAL HEALTH PROBLEMS IN THE WORKFORCE

It is widely believed that people with poor mental health are unlikely to be found in paid employment. This is far from the case. Indeed, the evidence shows that the majority of working-age adults with a mental health condition have a job and are almost as likely to be working as anybody else [15]. The prevalence of mental health problems in the workforce is not much different from that in the population at large and, on average, employers should expect to find that at any one time nearly 1 in 6 of their workforce is affected by a mental health condition such as depression or anxiety, rising to over 1 in 5 if alcohol and drug dependence are also included [16]. As in the wider community, many of these problems are undiagnosed and untreated.

These high rates of prevalence are not well recognised by all employers. For example, in a recent survey of senior managers, nearly 30 per cent (excluding 'don't knows') thought that less than 1 in 20 of their workforce would ever suffer from a mental health problem during their working life, even though the actual rate at any one time is around 1 in 5 [17]. The same survey also found that 40 per cent of employers view workers with a mental health problem as a 'significant risk' and that 78 per cent of workplaces have no formal mental health policy.

The high prevalence of mental health problems in the workplace is reflected in a substantial financial burden on employers, although much of this could be avoided through effective action. The better management of mental health at work undoubtedly makes good business sense, but few organisations recognise this or give it sufficient priority. This is not only because many employers underestimate the prevalence of mental health problems in the workplace but also because many of the costs associated with these problems take hidden forms such as presenteeism (impaired performance while people are at work) rather than the more obvious and visible form of sickness absence.

According to a study published in 2007, the total cost to UK employers of mental health problems at work amounted to nearly £26 billion a year, equivalent to £1,035 for every employee in the workforce [18]. Drawing on this analysis, equivalent estimates for Scotland are set out below, distinguishing between three main components of cost: sickness absence, presenteeism and staff turnover.

## SICKNESS ABSENCE

Survey evidence suggests that rates of sickness absence have declined somewhat in recent years and employees in the UK now take an average of 6.5 days off work a year for health reasons [19]. It is estimated that mental health problems account for 40 per cent of the total, or 2.6 days a year, which at the aggregate level is equivalent to an annual loss of around 65 million working days.

In passing, it is important to note that only a small proportion of mental health-related sickness absence appears to be directly caused by work or working conditions. Evidence for this comes from an annual survey of self-reported work-related illness carried out by the Health and Safety Executive, which shows that in 2009/10 work-related mental health problems including stress accounted for 9.8 million working days lost (20). This is equivalent to less than 1 in 6 of all days lost for mental health reasons. Most mental ill health in the workforce therefore has other causes. This is not to underplay the importance of work-related mental

health problems or the need for effective management action such as the provision of mentally healthy working conditions. On the other hand, failure to distinguish between mental health problems in the workforce and mental health problems caused by work may lead to inappropriate policy or management responses and also runs the risk of blurring the crucial message that, overall, work is unquestionably good for mental health.

In estimating the cost of sickness absence, it is conventional to assume that absence entails a loss of output whose value in a competitive labour market equals the money wage, or – more accurately – total compensation per employee, i.e. the money wage plus on-costs such as national insurance and pension contributions. Using national accounts data (21), this currently implies an average cost of around £155 per day, but some adjustments are needed, for example to take into account the fact that rates of sickness absence tend to be higher among workers with below-average earnings. Including these adjustments, it is estimated that the cost of absence in the UK was around £130 a day in 2010, which in turn implies that the total cost of sickness absence attributable to mental health problems was £8.5 billion. This is equivalent to an annual cost of £340 for every employee in the UK workforce.

Taking into account the total number of employees in Scotland, the pay of these employees relative to the UK average and also the slightly lower prevalence of mental health problems in Scotland compared with the rest of the country, it is estimated that the total cost of mental health-related sickness absence in Scotland amounted to around **£690 million** in 2010.

This is significantly higher than the estimate of £359 million for 2004/05 given in our earlier report and reflects not only the effects of higher average earnings but also changes in the underlying assumptions regarding the proportion of total sickness absence attributable to mental health problems and the average daily cost of absence, based on the evidence of recent research [18].

## PRESENTEEISM

As already noted, presenteeism may be defined as the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity. Measurement is difficult, but there has been substantial recent progress – mainly in the US but also by international bodies such as the World Health Organisation – in the development of survey instruments that use self-reported information collected from samples of employees in order to assess the workplace costs of health problems [22]. Accumulating evidence from such surveys increasingly suggests that losses in on-the-job productivity are larger, perhaps several times larger, than the losses associated with sickness absence. Early work on the measurement of presenteeism in the UK broadly supports this conclusion [23].

Presenteeism is particularly important in the case of mental ill health. Among other reasons, this is because workers may be concerned about being labelled as mentally

ill by their employers and co-workers. Fearing possible stigma or discrimination, they turn up for work even if feeling unwell. It also appears that the productivity losses caused by mental health problems are more likely to take the form of presenteeism, rather than sickness absence, among white-collar workers than they are among blue-collar workers [24]. Looking ahead, this finding implies that presenteeism will become even more important than it is today, as the balance of work continues to shift in favour of non-manual employment. Finally, and particularly relevant in the present economic climate, there is evidence that presenteeism becomes more important relative to sickness absence when the labour market is weak and job insecurity is high, for example because employees seek to reduce their chances of being made redundant by maintaining a good attendance record even when unwell [25].

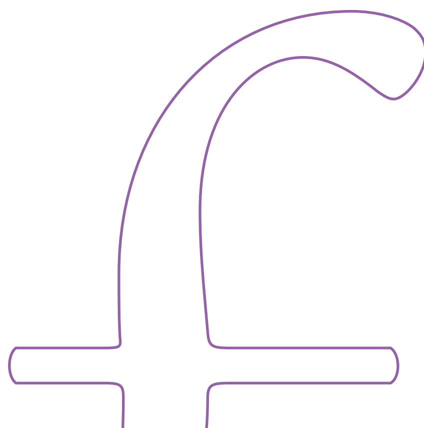
Research on the scale and cost of presenteeism is a relatively new subject and published work is largely US-based, although some studies have been undertaken in Canada, Australia and elsewhere. Drawing on the international evidence and adapting it to the UK context, it is conservatively estimated that in the UK presenteeism attributable to mental health problems accounts for 1.5 times as much working time lost as sickness absence [26]. This is almost certainly on the low side. For example, a recent survey in Unilever has found that for all health conditions combined the productivity losses associated with presenteeism are three times as large as those resulting from sickness absence, with even higher ratios for common mental health problems such as depression [27]. The same survey also found that 50 per cent of all working time lost from sickness absence and presenteeism combined was attributable to mental health conditions.

The average cost of presenteeism in the UK is put at £155 per working day lost, corresponding to the average gross daily compensation of employees. This is higher than the cost of sickness absence, mainly because the inverse association that is commonly observed between earnings and rates of sickness absence (i.e. lower-paid workers taking more time off than higher-paid workers) is not found in the case of presenteeism.

Taken together, these figures imply that the cost of presenteeism attributable to mental health problems amounted to around £15.3 billion in the UK in 2010, equivalent to a cost of £615 for every employee. A corresponding calculation for Scotland, taking into account the same factors as in the costing of sickness absence (relative size of workforce etc), indicates an aggregate annual cost of presenteeism in Scotland of around **£1,240 million.**

## STAFF TURNOVER

About 4 million jobs change hands each year in the UK, including over 350,000 in Scotland. The limited available evidence suggests that, while not a major cause of turnover, mental health problems including stress might account for up to five per cent of the total.



Turnover can have positive as well as negative effects, but some costs are always incurred when employees leave organisations and 70 per cent of employers report an adverse effect on business performance [28]. The average cost of a job change, including the costs of recruiting, selecting and training a replacement worker, is estimated at around £12,800. This is equivalent to about 40 per cent of average total pay, towards the bottom end of a range suggested by international evidence.

Based on these figures, staff turnover attributable to mental health problems has an estimated aggregate cost to employers of £2.6 billion a year in the UK. The cost in Scotland is estimated at **£220 million** a year.

## OVERALL COSTS

Bringing together the figures for sickness absence, presenteeism and staff turnover, quantifiable costs falling on employers because of mental health problems in the Scottish workforce in 2010 are as shown in the table below.

Overall costs are thus estimated at £970 a year for every employee in the Scottish workforce, or £2,150 million at the aggregate level. This is equivalent to around 3.5 per cent of the national pay bill. Presenteeism is the largest single element of cost, accounting for nearly three-fifths of the total.

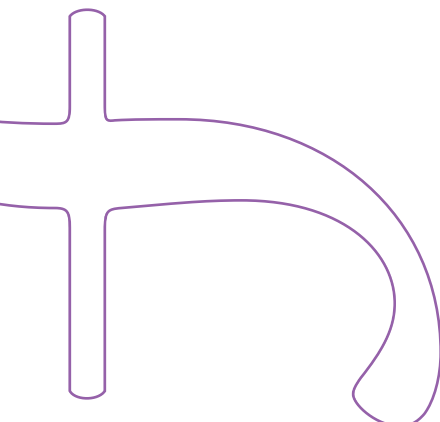
Some other costs can be identified but not easily measured in financial terms. For example, shortcomings in the management of mental health at work may give rise to risks of legal action under health and safety legislation, and may also damage a company's reputation among employees and customers.

## WORKPLACE INTERVENTIONS

The very large scale of costs associated with mental health problems in the workplace highlights the fact that mental health is – or should be – important to all employers as a business matter. One way of interpreting the figures given above is as a measure of the potential benefits to be derived from better management of mental health problems at

COSTS OF MENTAL HEALTH PROBLEMS IN THE WORKFORCE, SCOTLAND, 2010

| | COST PER AVERAGE EMPLOYEE (£) | TOTAL COST TO SCOTTISH EMPLOYERS (£ MILLION) | % OF TOTAL |
|---|---|---|---|
| Sickness absence | 310 | 690 | 32.1 |
| Presenteeism | 560 | 1,240 | 57.7 |
| Turnover | 100 | 220 | 10.2 |
| **Total** | **970** | **2,150** | **100.0** |



work, as a cost saved or averted is a benefit gained. Specific measures or programmes aimed at improving mental health in the workplace need to be justified in their own right, but the above evidence gives a clear indication of the potential benefits to organisations in terms of overall scale.

In making the case for workplace programmes, three main questions need to be addressed:

- What proportion of costs can realistically be saved?
- Does action to achieve these savings make good business sense?
- How can the savings be delivered?

Taking these in turn, some evidence on the scope for cost savings is available from the results of mental health programmes pursued by large organisations such as BT, Unilever, the Royal Mail Group and Rolls Royce. For example, BT has reported that its mental well-being strategy has led to a reduction of 30 per cent in mental health-related sickness absence and a return-to-work rate of 75 per cent for people absent for more than six months with mental health problems [29]. If all employers in Scotland could achieve the same reduction in sickness absence, with equivalent reductions in presenteeism and turnover, the overall saving would come to nearly £300 a year for every employee in the workforce, or around £650 million a year at the national level.

Dealing with the second question, published research provides increasingly strong evidence on the financial returns from mental health management programmes. For example, research on an Australian programme of early identification and treatment for employees with symptoms of depression indicates annual financial benefits in terms of higher productivity which are nearly five times the annual cost [30]. A similar programme in the US shows annual financial benefits of $1,800 per employee compared with costs of only $100–$400 a year [31]. Financial modelling based on the impact and effectiveness of a workplace health promotion and well-being programme undertaken in the UK offices of a large multinational company suggests that every £1 spent on the programme generated savings of nearly £10 in terms of reduced sickness absence and presenteeism [32].

Finally, on how these savings can be delivered, evidence suggests that the key ingredients are as follows:

- **Recognition** by employers that work is on the whole very good for mental health, as indeed it is for physical health, and also that people do not have to be entirely symptom free to remain in or return to work successfully
- **Prevention** of mental health problems, including the provision of mentally healthy working conditions and practices in line with the Health and Safety Executive's management standards on work-related stress and also access for all employees to generalised health promotion and well-being programmes in the workplace
- **Early identification** of emerging problems, as there is abundant evidence to show that, if undiagnosed and untreated, mental health problems of all kinds have worse long-term outcomes, including increased severity, persistence and functional disability. A noteworthy recent finding in this context is that health problems in their early stages may initially manifest themselves mainly in the form of increased presenteeism, which then acts as a strong predictor of future sickness absence [33]. Any unexplained change in an employee's productivity at work should

therefore be treated as a possible warning sign of early mental health difficulties

- **Awareness training** for line managers, to increase their knowledge and understanding of mental health issues and their ability to respond confidently and in timely fashion to employees in distress
- **Better access to help**, particularly access to evidence-based psychological therapies which wherever possible enable people to carry on working at the same time as receiving support
- **Effective rehabilitation** for those who need to take time off work, including regular contact with the employee during periods of absence

Common to most if not all of these ingredients is that they essentially involve no more than good management. Their implementation does not require the availability of costly or specialised resources such as a large in-house occupational health department, which may be beyond the means of many small and medium-sized organisations. Perhaps the most important first step is simply better understanding of mental health issues among senior managers.

To sum up, mental ill health affects every workplace in the country, but most employers underestimate the number of their staff who will have mental health problems and the financial implications. Those who take active steps to address the problem will reap the rewards for their efforts, as there is now an increasingly well-established evidence base on the effectiveness of interventions. Simple measures to improve the management of mental health in the workplace will result in the saving of costs on a substantial scale, the saving of jobs and sometimes even the saving of lives.

# MENTAL HEALTH PROBLEMS AMONG PEOPLE NOT IN WORK

## THE SCALE AND COST OF WORKLESSNESS AMONG PEOPLE WITH MENTAL HEALTH PROBLEMS

According to the latest available statistics, relating to 2010, the proportion of the population of working age in Scotland who are currently in employment stands at 70.2 per cent, or 2.4 million people [34]. The remaining 29.8 per cent (1.0 million people) are not in work and fall into two groups according to the reasons for worklessness:

- Unemployed, defined as not currently having a job but actively seeking employment
- Economically inactive, defined as not having a job and not actively seeking employment or being available for work

In 2010 unemployment accounted for 22 per cent of all worklessness and economic inactivity for 78 per cent. The main reasons for economic inactivity are ill health (31 per cent of the total in Scotland in 2010), enrolled as a student (22 per cent), looking after family/home (21 per cent) and early retirement (18 per cent). Among those who are inactive because of ill health, around 45 per cent have mental health problems which are given as the main reason for being unable to work, according to data relating to incapacity benefits [35].

Total numbers not in work in Scotland increased by 14 per cent between 2005 and 2010, equivalent in absolute terms to an extra 125,000 workless people. Most of this increase was caused by higher unemployment, which rose by no less than 60 per cent between 2005 and 2010, largely because of the recent recession. Previous research has shown that mental health problems are particularly likely to increase during a recession [36].

According to the estimates set out in "What's It Worth?", the cost to the Scottish economy in terms of lost output resulting from worklessness among people with mental health problems amounted to £915 million in 2004/05. Three main factors need to be taken into account in bringing this estimate forward to current values: first, an increase in the total numbers not in work, as just described; second, a rise in the proportion of people inactive for health reasons who cite mental health problems as the primary cause [35]; and third, an increase in average earnings, which raises the cost to the economy of lost output. Taking into account these factors, it is estimated that the costs of worklessness among people in Scotland with mental health problems have risen to around £1,440 million a year.

Evidence-based interventions aimed at reducing the scale and costs of worklessness among those with mental health problems may be considered under three main headings:

- Job retention
- Employment-related support for workless people with severe mental illness
- Support for those with less serious mental health problems

## JOB RETENTION

In recent years there has been increased recognition that much long-term unemployment can be avoided if the right steps are taken when employees' health problems are first identified at work. It makes sense to help people remain in work whenever possible, rather than wait for them to become completely detached from the workplace. The longer a person is off sick, the lower the chance of a successful return to work and the higher the risk of job loss, leading to long-term worklessness.

A pattern of lengthy spells of sickness absence followed by job loss is particularly common among people with mental health problems. Each year about 460,000 people in the UK have a spell of sickness absence of between 4 and 28 weeks in duration and a further 350,000 move on to long-term incapacity benefits after 28 weeks of sickness absence [37]. Among both groups, about half are people with mental health problems. There are a number of reasons why this pattern is so common in the case of mental ill health, including fear of disclosure among employees because of possible stigma and discrimination in the workplace, lack of support from managers, delayed and sometimes inappropriate clinical management by health professionals including too little emphasis on the benefits of a return to work, and an inability or unwillingness among employers to negotiate suitable adjustments for people with mental health problems such as flexible working.

The evidence base on what works in job retention remains incomplete in a number of respects, but sufficient is known to underpin a model of support in the workplace which involves organisational and individual measures with the following ingredients:

- **Prevention of mental health problems at work**, including at the organisational level the promotion of mentally healthy working conditions together with action to raise awareness and combat ignorance, prejudice and discrimination, and at the individual level such measures as resilience training, problem solving and mood management for those at risk

- **Early identification and intervention**, including the training of managers to recognise and engage with mental distress among their staff, early access to primary health care for people with emerging problems, including access to psychological therapy combined with employment advice, and good communications between the workplace and healthcare providers
- **Case management** for those on sick leave who are not recovering as expected, including active vocational rehabilitation, regular contact between employer and employee, and a return-to-work plan based on agreement from all parties on such matters as workload, suitable adjustments, disclosure and ongoing support

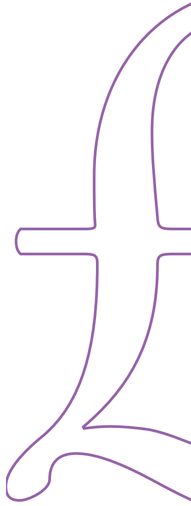
Successful implementation of these measures requires a fundamental change in the view that it is inappropriate for people to be at work unless they are 100% fit and that being at work usually impedes recovery from a health problem. As emphasised throughout this report, there is strong evidence that work is good for mental health and, as a corollary, that the return to work should itself be seen as an intervention which is effective on health as well as employment grounds. A lack of understanding about the positive links between work and mental health remains widespread, even among GPs and other health professionals. Much more emphasis should be given to helping people to stay in work with health problems and to a return to work as soon as possible after any spell of absence.

Finally, access to health treatment is vital, but – particularly for those not recovering as expected – treatment alone will not provide the support needed to get people back to work at the right time and reduce the risk of job loss. Employment support is also needed and there is clear evidence that work-focused healthcare and accommodating workplaces have a more significant impact on work outcomes than purely clinical care [38].

## EMPLOYMENT SUPPORT FOR WORKLESS PEOPLE WITH SEVERE MENTAL ILLNESS

Only about a fifth of people in Scotland with severe and enduring mental health problems are in work, the lowest employment rate of any of the main groups of disabled people [39]. This is not generally because of an unwillingness to work, as survey evidence indicates that 70–90 per cent of people with severe mental illness want to find employment [40]. Nor is the aspiration an unrealistic one, as severity of illness is a poor indicator of employability and the best predictor of success is a strong desire to work [41]. Other barriers seem to be more important, including negative attitudes among employers and low expectations among health professionals.

The low employment rate may also reflect shortcomings in traditional methods of vocational rehabilitation for people with severe mental health problems, particularly an emphasis on extended preparatory training before engagement with the labour market. This approach has had little success and many people find employment only in sheltered workshops. Much better outcomes can be achieved by the alternative approach of supported employment, particularly Individual Placement and Support (IPS), which turns the logic of the traditional model on its head and says that the top priority is to get people into competitive employment as



quickly as possible, with continuing training and support being provided on a continuing basis after job placement, not before. In short, place then train, rather than train then place.

The key principles of IPS are as follows:

- Competitive employment is the primary goal
- Everyone who wants it is eligible for employment support
- Job search is consistent with individual preferences
- Job search is rapid, beginning within one month
- Employment specialists and clinical teams work and are located together
- Support is time-unlimited and is individualised to both the employer and the employee
- Welfare benefits counselling supports the person through the transition from benefits to work

Early work on the development of IPS was largely undertaken in the US, but there is now an increasingly strong body of evidence to show that the model is readily transferable between countries, with broadly equivalent outcomes. A review published in 2008 brought together findings from 11 randomised controlled trials which compared compliant IPS programmes with traditional vocational services and found that on average the employment rate among service users was 61 per cent for IPS compared with 23 per cent for traditional services [42]. The review included findings from IPS trials in Canada and Australia as well as the US and also from a multi-site trial in Europe including London. In all these cases employment outcomes were in line with those observed in US studies, with the European trial showing employment rates of 55 per cent for IPS against 28 per cent for traditional services.

The evidence shows that people supported by IPS not only have higher employment rates but also work significantly more hours per month, have higher earnings and have better job tenure. There is no evidence to show that the higher rates of employment resulting from IPS have an adverse effect on clinical well-being or relapse. Indeed, in the European trial mentioned above, IPS was associated with reduced rates of psychiatric admission and less time spent in hospital [43]. Follow-up studies conducted after 8–12 years confirm that the greater effectiveness of IPS is sustained over the longer term [44].

These positive findings on effectiveness are generally supported by the evidence on cost-effectiveness. In particular, most studies show that IPS is less expensive to implement and run than other methods of vocational support and there is also increasing evidence of overall cost savings because of reduced mental health service use over the longer term. For example, a US study has provided information on employment and service use in a sample of 187 patients with severe mental health problems and co-occurring substance misuse [45]. Analysed retrospectively, the sample divided into two groups; a 'steady work' group and a 'minimum work' group, with the former working about 10 times as many hours a year on average as the latter. Measured over 10 years, spending on mental health services among the 'steady work' group was lower than among the 'minimum work' group by no less than $166,350 per head. Statistical analysis shows that this dramatic difference cannot be explained by differences in the severity of illness between the two groups

and is instead more plausibly explained as a consequence of people finding and keeping work. Stable employment promotes recovery for people with severe mental illness, leading to a better quality of life and much reduced use of mental health services.

Once again the evidence confirms that work is good for mental health. The fact that it may also lead to substantial savings in health service expenditure constitutes a compelling case for making supported employment services available to all those with severe mental illness who wish to use them.

## EMPLOYMENT SUPPORT FOR WORKLESS PEOPLE WITH LESS SEVERE MENTAL HEALTH PROBLEMS

The prevalence of severe and enduring mental illness is relatively low, at less than 1 per cent of the adult population, and the great majority of workless people with poor mental health suffer from the so-called common mental health problems such as depression and anxiety. Nearly all of these cases are dealt with by the NHS wholly within primary care and this group also makes up the bulk of those receiving health-related social security benefits. All told, there are around 1.3 million people in the UK who are in receipt of these benefits because of a mental health condition and it is estimated that total benefit expenditure on this group amounts to about £8 billion a year, equivalent to nearly £120 a week for each individual case [46]. Scotland's share of this spending is estimated at around £800 million a year.

Sizeable as these numbers are, they do not show the full extent of mental ill health in the workless population. This is for two reasons. First, there are around 0.5 million people in the UK who are receiving health-related benefits primarily because of a physical health condition but who also suffer from a co-existing mental health problem. And second, not at all workless people with a mental health condition are in receipt of health-related benefits. According to one estimate there may be as many as 1 million people in this group [47], and the numbers are expected to rise significantly in the future, as will be explained below.

As already discussed, there are strong links between worklessness and poor mental health, with the overall prevalence of mental health problems being more than twice as high among people out of work as among those in work [48]. Causation runs in both directions, in the sense that mental ill health may be a cause of unemployment and also a consequence. For example, 1 in 7 men develop clinical depression within 6 months of losing their job and the adverse impact increases, the longer the spell out of work. As seen, the longer the spell out of work, the lower the chances of ever getting back. More than two-thirds of all existing Incapacity Benefit claimants have been claiming for five years or more and after such lengthy periods of detachment from the labour market people are more likely to retire or die than to work again. And the adverse effects extend across the generations, as children living in workless households are at significantly elevated risk of experiencing serious emotional and behavioural problems, with major consequences for their life chances.

The pathway to long-term worklessness for people with mental health problems is not inevitable. No-one is intrinsically unemployable and most people could work

with the right support. Certainly there are barriers to be overcome, including stigma and discrimination among employers, low expectations, shortcomings in the design of the benefits system (particularly for people with fluctuating health conditions), and loss of confidence and loss of the work habit among those who have been out of work for long periods. Following the recession of the early 1980s, many people with mental health problems were written off as unemployable and their numbers on long-term incapacity benefits trebled within a decade. To avoid the risk of creating another lost generation, active steps must be taken to ensure that the right help is offered at the right time.

People with mental health problems who are out of work need coordinated support involving a range of services and agencies. Clearly this must include appropriate health care, but it is increasingly recognised that on its own this is not enough. Treating symptoms and improving functioning are not the same thing and regaining health does not necessarily result in a return to work [49]. Nor do people have to be free of symptoms in order to return to work. Positive work outcomes depend on employment-focused support as well as clinical care, and different practitioners have complementary roles to play, working together with common employment goals.

A key requirement in this respect is the development of better links between health and welfare-to-work services. Hitherto, there has been very limited connection between the two, with health service providers, particularly in primary care, focusing narrowly on clinical outcomes and giving little attention to employment issues and welfare-to-work services designing and implementing employment programmes which generally fail to take into account the particular requirements of people with poor mental health, such as the fluctuating nature of their condition. Better coordination thus needs to be accompanied by measures to strengthen the capacity of health services to meet employment needs and parallel measures to strengthen the capacity of welfare-to-work services to meet needs relating to mental health.

Some progress has been made in recent years. For example, in the NHS increasing use is now being made of employment specialists located in GP surgeries, working in support of clinical staff by offering patients a job brokerage service as well as vocational and psychological help. In the welfare-to-work area, important changes are in hand as part of a wider reform which will see existing employment support for all people out of work being consolidated into a new integrated Work Programme. The stated aim of this reform is to offer better support through more personalised delivery and also differential funding for service providers so as to provide additional support for people who have traditionally been hard to help, including those with mental health problems. It remains to be seen whether the new Work Programme will be more successful than previous mainstream employment programmes in helping people with mental health conditions into work. An independent review of specialist disability employment programmes is currently in progress and will report in the summer of 2011, although to date these programmes have been very little used by people with mental health problems.

Finally, changes are being made in the social security system which have profound implications for people with mental health conditions. These include the Coalition Government's proposal to replace all existing means-tested benefits for people of working age with a single Universal Credit, aimed at ensuring that work always pays. To the extent that this improves incentives for part-time as well as full-time working, this should be helpful for many people with mental health problems, but it will also be crucial that the new Credit is sufficiently flexible so that people who move in and out of work because of their health condition are not financially penalised, as can happen under the current system.

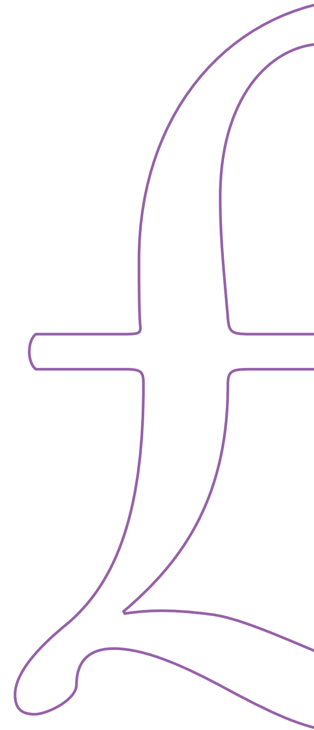
Of even greater importance is the reform of non-means-tested health-related benefits which began in October 2008, with the replacement of Incapacity Benefit by Employment and Support Allowance (ESA), initially just for new claimants but now being extended progressively to cover the whole caseload (except those near retirement age). The crucial feature of ESA is that eligibility is determined by a work capability assessment which may result in three different outcomes: first, claimants may be assessed as fit and ready for work, in which case they are not eligible for ESA and are transferred to Jobseeker's Allowance (and subject to the same rules governing job search etc as other recipients of JSA); second, claimants may be assessed as capable for work at some point with the right support, in which case they are eligible for ESA but must take part in work-related activities including the Work Programme, otherwise their benefits will be sanctioned; and third, claimants with more disabling conditions may be assessed as not able to work and will be entitled to a higher level of financial support which will not be conditional on any activity.

The main expected outcome of this change is that large numbers of people who would previously have been passive recipients of Incapacity Benefit will now be required to participate in work-related activities. Of all new claims for ESA made in 2009, 65 per cent were assessed as fit for work, 25 per cent were assigned to the work-related activities group and only 10 per cent were deemed not capable of work [50]. More generally, the Work Programme prospectus published by the Department for Work and Pensions in November 2010 estimates that between 500,000 and 790,000 ESA customers will access Work Programme support between 2011/12 and 2014/15, by which time all existing claimants of Incapacity Benefit will have been transferred to ESA and given the work capability assessment [51]. Very large numbers of the long-term sick and disabled will therefore be required to participate in mandatory mainstream employment programmes for the first time.

The precise impact of ESA will depend critically on the new work capability assessment. This has already been the subject of an independent review prepared for the government by Professor Malcolm Harrington [50], which has identified a number of deficiencies in the present arrangements. These include some relating specifically to mental health, for example lack of training and expertise in mental health issues among some assessors and shortcomings in the descriptors used to assess mental health difficulties. The government has accepted all the recommendations for improvement

made by Professor Harrington, but the practical implications of these changes have yet to be felt.

The programme of radical welfare reform outlined above clearly raises a number of concerns for people with mental health problems who are currently out of work. Many important issues remain to be resolved. At the same the reforms also offer opportunities. Employment is a realistic goal for most people with mental health conditions and a very desirable one, given the many benefits of work including better mental health. The challenge now is to ensure that these opportunities are taken. All of society will benefit, above all the many thousands of people with mental health problems whose participation in the world of work is much more circumscribed at present than it should be or need be.



## SAMH

SAMH is the Scottish Association for Mental Health, a charity working across Scotland. Every year, we provide over a million hours of support to people who need our help. Every week, we work with around 3,000 individuals in over 80 services. Every day, we campaign for better mental health for the people of Scotland.

To find out about making a donation, volunteering or training your staff in managing mental health at work, visit www.samh.org.uk or call 0800 917 34 66.

# NOTES


1. SAMH (Scottish Association for Mental Health) (2006) *What's it Worth?* Glasgow: Scottish Association for Mental Health
2. Singleton N, Bumpstead R, O'Brien M, Lee A and Meltzer H (2001) *Psychiatric Morbidity among Adults Living in Private Households*, 2000. London: HMSO
3. McManus S, Meltzer H, Brugha T, Bebbington P and Jenkins R (2009) *Adult Psychiatric Morbidity in England, 2007*. London: NHS Information Centre
4. As described in more detail in *What's It Worth?*, public expenditure on health and social care for people with mental health problems includes three main components: the cost of specialist or secondary mental health services provided by NHS Health Boards (inpatient services, outpatient and day care services, community psychiatric teams etc); relevant expenditure on family health services (GP consultations, drug prescriptions); and the cost of social care services for people with mental health problems paid for by local authorities. Information on spending in 2009/10 was obtained from the following sources: (i) secondary mental health services: Table R340 in ISD Scotland *NHS Resources*: Costs Book 2010, available at http://www.isdscotland.org/isd/4434.html. (ii) family health services: Table R390 in the same source, with the mental health shares of total spending on GP consultations and drug prescriptions assumed to be the same in 2009/10 as in 2004/05; and (iii) social care services: Annex F in The Scottish Government *Scottish Local Government Statistics 2008/09* (latest available year), available at http://www.scotland.gov.uk/Publications/2010/03/23110606/0
5. Total spending on health and social care in Scotland is given in Table 10.2 of HM Treasury *Public Expenditure Statistical Analyses 2010*, available at http://www.hm-treasury.gov.uk/pespub_pesa10.htm
6. Data on numbers employed and on average earnings in Scotland are given in the Labour Market section of Office for National Statistics *Regional Statistics – Online Tables 2010*, available at http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14161
7. Information on GDP in the UK as a whole is given in HM Treasury *Economic Data and Tools*, available at http://www.hm-treasury.gov.uk/data_gdp_fig.htm. It is assumed that Scotland's share of UK GDP is the same as its share of UK gross value added at current prices, as given in the Economy section of *Regional Statistics – Online Tables 2010*: see note 6 for full reference
8. Colman I, Ploubidis G, Wadsworth M, Jones P and Croudace T (2007) A longitudinal typology of symptoms of depression and anxiety over the life course. *Biological Psychiatry*, 62, 1265–1271
9. Green H, McGinnity A, Meltzer H, Ford T and Goodman R (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Crown Copyright. Basingstoke, Hampshire: Palgrave Macmillan
10. Collishaw S, Maughan B, Goodman R and Pickles A (2004) Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry*, 45 (8), 1350–1362
11. See for example: Colman I, Murray J, Abbott R, Maughan B, Kuh D, Croudace T and Jones P (2009) Outcomes of conduct problems in adolescence: 40-year follow-up of national cohort. *British Medical Journal*, 338, a2981; and Richards, M, and Abbott, R (2009) *Childhood Mental Health and Life Chances in Post-war Britain*, available at http://www.centreformentalhealth.org.uk/publications/life_chances.aspx?ID=596
12. Scott S, Knapp M, Henderson J and Maughan B (2001) Financial cost of social exclusion: follow-up of antisocial children into adulthood. *British Medical Journal*, 323, 1–5
13. Friedli L and Parsonage M (2007) *Mental Health Promotion: Building an Economic Case*. Belfast: Northern Ireland Association for Mental Health
14. Waddell G and Burton K (2006) *Is Work Good for Your Health and Wellbeing?* London: Stationery Office
15. The 2000 survey of adult psychiatric morbidity in England, Scotland and Wales found that, among all adults aged 16–74, 67 per cent were in work, including 49 per cent working full time and 18 per cent working part time. The corresponding figures among those with any kind of mental health problem were not very different: 63 per cent in work, including 47 per cent full time and 16 per cent part time. See Meltzer H, Singleton N, Lee A, Bebbington P, Brugha T and Jenkins R (2002) *The Social and Economic Circumstances of Adults with Mental Disorders*. London: HMSO

16. Figures based on the same source as in note 15

17. Shaw Trust (2010) *Mental Health: Still the Last Workplace Taboo?* Available at www.shaw-trust.org.uk

18. Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the Business Case*. Available at http://www.centreformentalhealth.org.uk/publications/MH_at_work.aspx?ID=575

19. CBI (2010) *On the Path to Recovery: Absence and Workplace Health Survey 2010,* London: CBI; and CIPD (2010) *Absence Management Survey* 2010, London: CIPD

20. Health and Safety Executive (2010) *Self-reported Work-related Illness and Workplace Injuries in 2009/10: Headline Results*. Available at http://www.hse.gov.uk/statistics/swi/index.htm#ill

21. See Table 1.2 in Office for National Statistics (2010) *United Kingdom National Accounts: the Blue Book: 2010 edition*. Basingstoke: Palgrave Macmillan

22. Kessler R, Ames M, Hymel P et al. (2004) Using the World Health Organisation Health and Work Performance Questionnaire to evaluate the indirect workplace costs of illness. *Journal of Occupational and Environmental Medicine*, 46(6) Supplement, S23–S37

23. See for example: Ashby K and Mahdon M (2010) *Why Do Employees Come to Work When Ill: an Investigation into Sickness Presence in the Workplace*. London: The Work Foundation

24. Hilton M (2007) *Getting Upstream of Psychological Disability in the Workforce*. Presentation at MRC conference on employment and mental health, 15–16 January 2007, Manchester

25. Schultz A and Edington D (2007) Employee health and presenteeism: a systematic review. *Journal of Occupational Rehabilitation*, 17(3), 547–579

26. For further details of this assessment, see Sainsbury Centre for Mental Health (2007) – full reference in note 18

27. Tscharnezki, O (2008) *Presenteeism Survey: Business Case and Missing Link*. Presentation at Unilever EfH Management Conference, 30–31 October 2008, London

28. CIPD (2007) *Recruitment, Retention and Turnover: Annual Survey Report 2007*. London: CIPD

29. Wilson A (2007) *The Commercial Case for Health and Wellbeing*. Presentation to the National Employment and Health Innovations Network, 20 July 2007, London. Available at http://www.centreformentalhealth.org.uk/employment/nehin_jul07.aspx

30. Hilton M (2005) *Assessing the financial return on investment of good management strategies and the WORC project*. WORC project paper, available at http://www.qcmhr.uq.ed.au/worc/Documents/Hilton_Paper(2005)pdf

31. Wang P, Simon G, Avorn J et al. (2007) Telephone screening, outreach and care management for depressed workers and impact on clinical and work productivity outcomes. *Journal of the American Medical Association*, 298, 12, 1401–1411

32. Mills P, Kessler R, Cooper J and Sullivan S (2007) Impact of a health promotion program on employee health risks and work productivity. *American Journal of Health Promotion*, 22, 45–53. The financial modelling based on this study is reported in Knapp, M, McDaid, D and Parsonage, M (editors) (2011) *Mental Health Promotion and Prevention*: the Economic Case. London: Department of Health

33. Bergstrom G, Bodin L, Hagberg J, Aronsson G and Josephson M (2009) Sickness presenteeism today, sickness absenteeism tomorrow? A prospective study on sickness presenteeism and future sickness absenteeism. *Journal of Occupational and Environmental Medicine*, 51(6), 629–638

34. See the Labour Market section of Office for National Statistics *Regional Statistics – Online Tables* (full reference given in note 6 above)

35. Brown J, Smith J, Webster D et al. (2010) *Scotland Incapacity Benefit Claimant Profile*. University of Glasgow: Scottish Observatory for Work and Health

36. Scottish Association for Mental Health (2009) *Crunch Time for Scotland's Mental Health*. Glasgow: SAMH

37. Black, Dame Carol (2008) *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*. London: TSO

38. Waddell G, Burton A and Kendall N (2008) *Vocational rehabilitation – what works, for whom, and when?* Report for the National Rehabilitation Task Group. London: TSO

39. Riddell S, Banks P and Tinklin T (2005) *Disability and employment in Scotland: a review of the evidence base*. Edinburgh: Scottish Executive

40. Secker J, Grove B and Seebohm P (2001) Challenging barriers to employment, training and education for mental health service users: the service user's perspective. *Journal of Mental Health*, 10(4), 395–404

41. Grove B and Membrey H (2005) Sheep and goats: new thinking about employability. In Grove, B, Secker, J and Seebohm, P (eds) *New thinking about mental health and employment*. Oxford: Radcliffe Press

42. Bond G, Drake R and Becker D (2008) An update on randomised controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal*, 31, 280–290

43. Burns T and Catty J (2008) IPS in Europe: the EQOLISE trial. *Psychiatric Rehabilitation Journal*, 31, 313–317

44. Salyers M, Becker D, Drake R et al. (2004) A ten-year follow-up of a supported employment program. *Psychiatric Services*, 55, 302–308

45. Bush P, Drake R, Xie H, McHugo G and Haslett W (2009) The long-term impact of employment on mental health service use and costs. *Psychiatric Services*, 60, 1024–1031

46. Estimate given in *Working our way to better mental health*, produced in 2009 by the cross-government Health, Work and Well-being Programme (London: TSO)

47. Perkins R, Farmer P and Litchfield (2009) *Realising ambitions: better employment support for people with a mental health condition*. London: TSO

48. Paul K and Moser K (2009) Unemployment impairs mental health: meta-analyses. *Journal of Vocational Behaviour*, 74(3), 264–282

49. Mintz J, Mintz L, Aruda M and Hwang S (1992) Treatments of depression and the functional capacity to work. *Archives of General Psychiatry*, 49, 761–768

50. Harrington M (2010) *An Independent Review of the Work Capability Assessment*. London: TSO

51. Department for Work and Pensions (2010) *The Work Programme Prospectus – November 2010*. Available at www.dwp.gov.uk/work-prog-prospectus-v2.pdf

© SAMH 2011

Scottish Association for Mental Health. SAMH is a company limited by guarantee, registered in Scotland No. 82340. Scottish charity no. SC008897. Registered office: Brunswick House, 51 Wilson Street, Glasgow, G1 1UZ