# EAST MIDLANDS
# MENTAL HEALTH AND EMPLOYMENT
# STRATEGY AND ACTION PLAN 2008-10

Version 2 January 2009

## Why do we need a strategy?

*The Rt Hon Stephen Timms, MP, Minister of State for Employment and Welfare Reform, concluded his speech to the National Welfare to Work Reform Conference on 19 June 2008 as follows:*

**"Work is good. It is good for people's health and well-being, for their self-esteem and for the well-being and future prospects of their children. Work promotes choice and independence and builds cohesion. It is the best route out of poverty. But we know that, for some, we need to provide more support to enable them to enjoy the advantages of work."**

## What are we aiming to achieve?

- *we want to increase opportunities and support for people with mental health problems who are workless, and possibly receiving Incapacity Benefit (Employment Support Allowance from October 2008), Jobseekers Allowance, or other income assistance, to re-enter, remain, and progress in work*
- *we want to reduce workplace absence and 'presenteeism' due to mental health problems – primarily helping those "off sick" due to stress, anxiety and depression to quickly return to, and stay in, work*
- *we want to promote positive images concerning mental health and employment and challenge discrimination directed at people with mental health problems*

## Why is it important?

- *more people than ever before are claiming Incapacity Benefit as a result of mental ill-health – 68,240 in the East Midlands (Jobcentre Plus Nov 2007)*
- *Incapacity Benefit claims on the basis of mental ill-health are increasing throughout the East Midlands - an average increase of 8.4% between 2000 and 2007 (ONS/JCP 2007)*
- *up to 4.7% of the working population of the East Midlands has been claiming Incapacity Benefit because of mental ill-health (www.neighbourhood.statistics.gov.uk 2008)*
- *in 2004/5 the East Midlands had the highest level of all the regions for days lost caused or made worse by work (one and a half million days)*
- *people with mental health problems have the lowest employment rate of all disabled groups – 27% in the East Midlands. The percentage of people with severe and enduring mental health problems is even lower*
- *mental health problems are the biggest cause of sickness absence from work – thirty times more days are lost to mental ill-health than to industrial disputes*
- *overall, meaningful work provides financial security and social support and those with severe types of illness recover more quickly when they remain in employment*
- *"we know that being in work is usually good for people with all types of mental health problems and so there is a clear need to support people with mental health conditions to overcome or manage their problems, helping them to find or remain in work." (former Secretary of State for Work and Pensions, Peter Hain, Nov 2007)*

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## Foreword

Increasingly, mental health is being recognised as an issue that has a significant impact on the social and economic well-being of society. A series of Government reports have particularly highlighted the need for action on mental health and worklessness, not least because employment benefits mental health.

Work provides financial security, social support and meaningful endeavour, and those with severe types of illness recover more quickly when they remain in employment. Mental health difficulties now constitute the largest single reason for sickness absence from work. People with mental health problems also have the lowest employment rate of any disabled group. The impact on our economy is huge. This was highlighted in the 2006 Report of the Regional Director of Public Health to the Assembly: *Improving the Health of the East Midlands: Keeping Health in Mind* which gave a fresh focus to mental health and recommended that it be a priority issue for the region.

In September 2006 the Cabinet Office document "Reaching Out: an Action Plan on Social Exclusion" stated that the Government would: "develop dedicated regional teams to provide further support for the implementation of good practice around the employment of those with severe mental health problems". This is clearly a priority, together with so-called "common" mental health problems, including depression and anxiety, which can be a major disabling factor in people's lives.

The East Midlands Regional Employment Team (RET) which was duly formed shared ideas and initiatives to improve the opportunities for people with mental health problems to find and retain appropriate employment. The team subsequently developed this strategy which sets out the process describing and underpinning its work.

I hope you feel able to support the strategy's principles and objectives and assist as appropriate in the implementation and monitoring required to achieve a successful outcome.

**Karen Foulds**
**Jobcentre Plus**
**Customer Services Director**
**East Midlands**

# 1. Introduction

In light of the 2006 Government proposal to develop Regional Employment Teams (RETs) a group of representatives from key organisations was drawn together as a RET to raise the profile of mental health and employment in the East Midlands and take forward this work in the context of current regional partnerships and strategies. The RET reports to the Employment Skills and Partnership Productivity Partnership (ESP) and links to a regional employment network made up of local county leads.

Partner organisations in the East Midlands RET have drawn up and agreed the objectives and priorities on which this strategy and action plan are based.

The strategy recognises that work is not an immediate option for all people with mental health conditions, and will explore and promote options that encourage inclusion and recovery, such as volunteering and community participation. Systems will be put in place to meet the requirements of those needing non-vocational support.

# 2. Context

A series of Government reports have highlighted the need for action on mental health and worklessness through a shared agenda. This has culminated in National Indicator 150 (NI 150) being included in the National Indicator Set (NIS). The NIS comprises 198 cross service indicators, on which upper tier local areas are required to report annually. NI 150 measures Adults in contact with secondary mental health services in employment.

To help identify and prioritise the action required a local report, Mental Health and Employment in the East Midlands, was commissioned by CSIP (attached as appendix 4). This document sets out a range of information about mental health and employment which will assist employers in the East Midlands to understand the issues and adopt best practice in developing a mentally healthy workplace. In particular the report presents data on mental health and employment from a variety of sources to illustrate the current situation in the East Midlands and nationally. The references and statistics therein have been used in conjunction with individual contributions from RET members to inform the strategy and action plan.

The strategy will strive to ensure that support is delivered holistically. People with mental health conditions will be helped to access or be referred to a range of services which meet their health and work needs across the employment spectrum. The vision is to maximise health, work and wellbeing outcomes by providing tailored packages of advice and support to meet the specific needs for clients to become work ready, obtain a job, and to sustain or progress in employment. An employment continuum for the RET is attached as appendix 5.

Activity in delivering this strategy will complement the work being undertaken under the umbrella of the East Midlands PSA 16 Sounding Board. PSA 16 is concerned with ensuring that 4 particular groups of socially excluded adults

have access to jobs and accommodation, and those with mental health problems are one of the groups identified as being at particular risk of long term social exclusion.  The East Midlands, with the support of Phil Hope, the Regional Minister, has a stated aim "To become an exemplar region in the delivery of PSA 16".

## 3.    Process

A process path was mapped out to:
* show regional partnership structures around mental health and employment
* identify linkages, key engagement points, main players including employers
* identify the most appropriate regional group in which to set the mental health and employment agenda, work with partners to get mental health and employment as a priority within these structures, map links to other interested groups
* gather evidence, set out a range of schemes, assess their benefit to mental health clients, assess their links and connectivity
* gather information, consult key employers for evidence of mental health and absenteeism and mechanisms for remaining in employment
* hold mini summit/priorities planning day with partner agencies
* draw up an implementation plan informed by evidence gathered as above
* agree strategic and spending priorities for allocated resource


## 4.    Process Map Showing Key Players

The key partner organisations which form the RET are listed below, and outlined in the process map showing the relationship of key players (attached as appendix 2).

* Care Services Improvement Partnership East Midlands (CSIP)/Strategic Health Authority (SHA)
* Jobcentre Plus (JCP)
* Government Office East Midlands (GOEM)
* East Midlands Development Agency (EMDA)
* Condition Management Programme (CMP)
* Learning and Skills Council (LSC)
* Framework Housing Association – representing Enable
* Rethink
* Advisory, Conciliation and Arbitration Service (ACAS)
* Business in the Community (BITC)
* Health & Safety Executive (HSE)
* National Institute of Adult Continuing Education
* Reed in Partnership
* Trades Union Congress (TUC)

Most of the partner organisations listed play an active part in the RET, though some (eg, HSE, TUC) are involved only electronically in a supporting role. Although service users are not directly represented in the RET their views are fed into the process through a wide variety of reports from key players in the East Midlands mental health and partnership structure and constantly taken into account.

## 5. Strategy Objectives

Following two in-depth meetings of the RET, in which ideas and initiatives were exchanged and developed, three key objectives were identified and agreed:

**5.1** - to increase opportunities and support for people with mental health problems who are workless, and possibly receiving Incapacity Benefit (Employment Support Allowance from October 08), Jobseekers Allowance, or other income assistance, to re-enter, remain, and progress in work

**5.2** - to reduce workplace absence and "presenteeism" due to mental health problems – primarily helping those "off sick" due to stress, anxiety and depression to quickly return to, and stay in, work

**5.3 -** to promote positive images concerning mental health and employment and challenge discrimination directed at people with mental health problems

## 6. Action Identified

By means of a mapping questionnaire the RET members provided information on the involvement of their organisations in respect of:

- helping individuals with a mental health problem to be ready to gain and retain employment
- working to reduce discrimination where it relates to people with a mental health problem finding and retaining employment
- working collaboratively with other organisations to take forward mental health and employment initiatives
- responding to policy directives or guidance documents to achieve good practice in respect of mental health and employment
- setting and achieving targets or performance measures
- joint planning initiatives such as City Strategy, Local Area Agreements, Local Employment Partnerships

After establishing this overview threats, opportunities and next steps were considered, and a range of actions and initiatives to take forward the work of the RET was considered and prioritised. The activities required to achieve the objectives outlined in the strategy have been developed in detail by the RET and are set out in the action plan (attached as appendix 1).

## 7. Accountability and Implementation

The RET is a multi-agency group reporting, and accountable, to the Employment Skills and Productivity Partnership (ESP) subgroup on Worklessness and Economic Exclusion. Participating RET members are committed to integrating this strategy into the work of their respective organisations and will draw up individual action plans for completing the activities assigned to their organisations under the strategy's action plan. Resources for activity workstreams should be provided by the organisation with lead responsibility or by negotiation in the event of joint responsibility.

## 8. Monitoring

Within central government the Cabinet Office has responsibility for PSA 16. A cross departmental board has been established to drive forward delivery, and this will report into the Life Chances (Social Exclusion) Cabinet sub-committee. At the regional level a link to PSA16 partners will be maintained through the Regional Sounding Board. A key indicator will be progress against NI 150. The RET will identify additional key indicators which cover all three strategy objectives, baselines will be established and arrangements for monitoring put in place.

The RET will seek to respond to key issues identified through the PSA 16 Delivery Plan at the national level, the PSA 16 Regional Sounding Board at the Regional level and other plans and policies emerging from other government departments and regional partners that will impact positively on the employment of people with mental health problems.

Within the region accountability is to the ESP via the Worklessness and Economic Inclusion group, and a process will be put in place to ensure that progress reports are made to those groups.

## 9. Contact Us

While this strategy has been developed by a relatively small RET the views and comments of all interested parties would be welcomed and taken into account as appropriate. If you would like to contact us please write to the RET Chair, Andy Scott: email: andy.scott@jobcentreplus.gsi.gov.uk
post: The External Relations Team, Floor 2, Newtown House, Maid Marian Way, Nottingham NG1 6GG

## 10. Appendices

**appendix 1 - action plan**
**appendix 2 - process map showing key players**
**appendix 3 - East Midlands mental health and employment partnership structure**
**appendix 4 - mental health and employment in the East Midlands (report)**
**appendix 5 - employment continuum for the RET**
**appendix 6 - glossary**

**Care Services Improvement Partnership East Midlands
Regional Mental Health and Employment Strategy
Action Plan 2008-10**

**Key objective i)   to increase opportunities and support for people with mental health problems who are  workless, and possibly receiving Incapacity Benefit (Employment Support Allowance from October 2008), Jobseekers Allowance, or other income assistance, to re-enter, remain and progress in work**

| Action required (Activity) | Outcome (Performance Indicator) | Lead Responsibility and partners | Relevant dates |
|---|---|---|---|
| 1. Promote, and facilitate participation in, Pathways to Work for non-mandatory customers through promotion of the programme in PCTs and other Health Care initiatives. | 1. Increase in number of voluntary participants in Pathways to Work going into work | **Jobcentre Plus (local level)** | Management information to be reviewed by end of March 2009 |
| 2.a) Actively support Improving Access to Psychological Therapies (IAPT)<br>2.b) Support PCTs/employment adviser pilot (Lincs) | 2.a) Increase in number of patients accessing IAPT scheme over 3 years 2008/2011<br>2.b) Establishment of an employment service within Lincs IAPT centres | **CSIP via IAPT Board**, PCTs<br><br>**CSIP via IAPT Board,** PCTs | Lincs and Nottm PCT pilots started, quarterly reviews via IAPT Board |
| 3. Promote, and facilitate participation in, Enhanced Housing Options Trailblazer schemes. Monitor progress. | 3. Increase in number of employment and training opportunities entered and retained. Good practice identified and disseminated. | **GOEM** | |

**Version 2** (8.01.09)

| Action required (Activity) | Outcome (Performance Indicator) | Lead Responsibility and partners | Relevant dates |
|---|---|---|---|
| 4. Strengthen partnerships with social firms and supported employment schemes. | 4. Increased number of companies signed up. | **Jobcentre Plus** | Report to be prepared by end of March 2009 |
| 5. Form links in local communities to promote JOBMAETS | 5. Number of clients accessing service which started in July 2008. | **Jobcentre Plus** | Report to be prepared January 2009 |
| 6. Encourage 'talent debate' scheme | 6. awareness of mental health issues raised | **BITC,** CSIP | *completed 13.10.08* |
| 7. Encourage those areas in receipt of Working Neighbourhood Fund (WNF) to take a pro-active approach to identifying those with mental health problems as priority clients | 7. Reduction in those receiving IB as a result of mental health problems in areas in receipt of WNF *(measurable through JCP data)* | **GOEM,** Jobcentre Plus | |
| 8. Encourage areas with City Strategies to take a pro-active approach to identifying those with mental health problems as priority clients | 8. Reduction in those receiving IB as a result of mental health problems in City Strategy areas | **GOEM,** Jobcentre Plus | |
| 9. Encourage employers to make use of Access to Work scheme | 9. Increase in number of employers using the scheme, and increase in participants in scheme | **Jobcentre Plus** | Report to be prepared January 2009 |

**Key objective ii)    to reduce workplace absence and "presenteeism" due to mental health problems – primarily helping those "off sick" due to stress, anxiety and depression to quickly return to, and stay, in work**

| Action required (Activity) | Outcome (Performance Indicator) | Lead Responsibility and partners | Relevant dates |
|---|---|---|---|
| 1.a) Explore early intervention options | 1.a) appropriate referrals, shorter waiting times for assessments | **CSIP,** Acas, PCTs, occupational health | begin Nov 08, bi-monthly reports to IAPT Board |
| 1.b) Identify and adopt good practice within early intervention initiatives | 1.b) timely information available for locality partners | **CSIP,**Acas, PCTs, occupational health | begin Nov 08, ongoing |
| 2. Explore and share 'Train to Gain' initiative | To be established. | **LSC** | Ongoing |
| 3. Build into next round of Local Employment Partnership awards recognition for those employers who have introduced a 'change of practice' initiative for taking on employees with mental health issues where practicable | 3. Raised profile for employers – increased number signing up for Mindful Employer and/or two ticks symbol | **Jobcentre Plus** | Prepare report for March 2009 |

**Key objective iii) to promote positive images concerning mental health and employment and challenge discrimination directed at people with mental health problems**
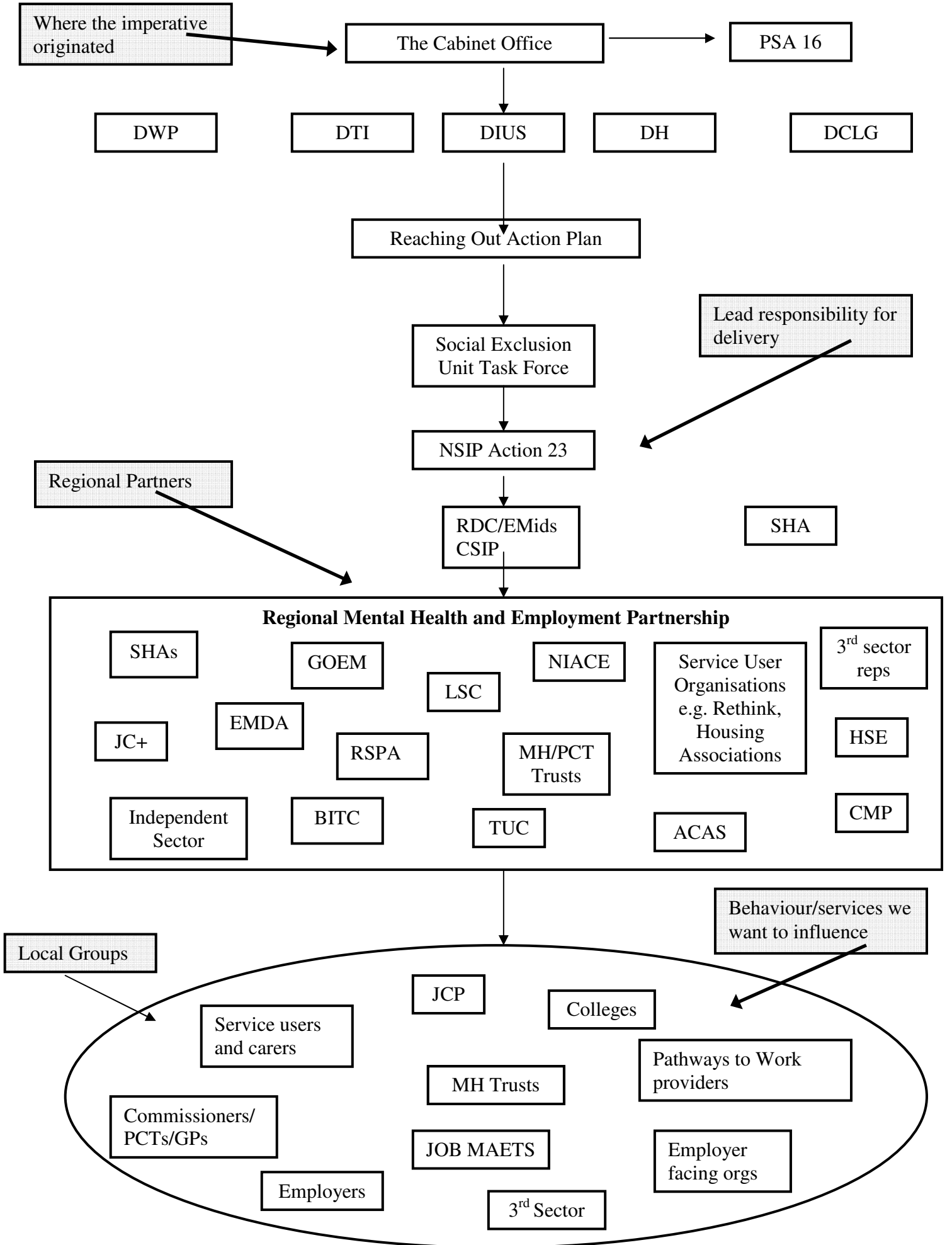
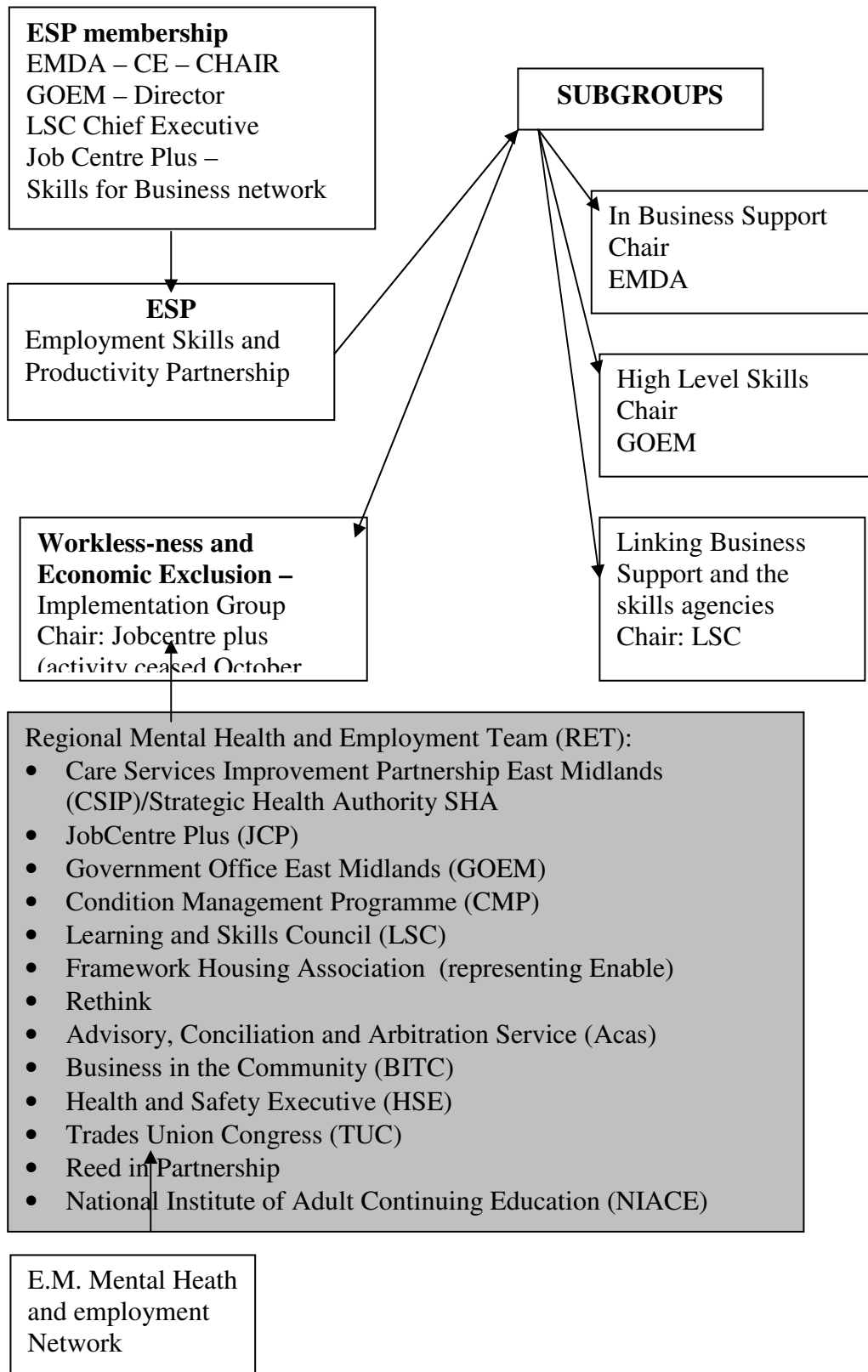| Action required (Activity) | Outcome (Performance Indicator) | Lead responsibility and partners | Relevant dates |
|---|---|---|---|
| 1. Promote the Mindful Employer, mental health kite marks, and two ticks disability symbol initiatives and monitor local sign-up via the websites | 1. Increase in number of supportive employers | **Jobcentre Plus,** all RET organisations | ongoing |
| 2. Encourage employers to review policies and recruiting procedures to overcome obstacles which may stand in the way of employing service users | To be established. | **Jobcentre Plus,** all RET organisations | |
| 3. Continue promoting awareness of mental health issues in the workplace, encouraging culture shift | To be established. | **Jobcentre Plus,** all RET organisations | |
| 4. Develop positive role model case studies that can be actively promoted through media links | 4. Check numbers of case studies available quarterly. | **emda**, JCP, all RET organisations | |

# Action required which applies to all key objectives

| Action required (Activity) | Outcome (Performance Indicator) | Lead Responsibility and partners | Relevant dates |
|---|---|---|---|
| 1. Develop a set of indicators / outcome framework which is capable of measuring the success of strategy | To be established. | **Jobcentre Plus,** all RET organisations | |
| 2. Develop a mechanism to share information and co-ordinate activity between partner agencies | To be established. | **Jobcentre Plus,** all RET organisations | |
| 3. Ensure there is active and positive representation of the user and carer perspective in the design and delivery of the strategy | 3. Service user forums in each county are consulted annually and at key points in the process | **CSIP** | ongoing |
| 4.a) Review RET membership to ensure adequate representation of key players<br>4.b)  agree terms of reference | 4.a) full involvement of appropriate partners<br><br>4.b) establishment of clear remit for RET | **CSIP,** all RET organisations<br><br> **CSIP,** all RET organisations | Ongoing<br><br>*completed 5.11.08* |
| 5.Identify successful and unsuccessful strategies within agencies and other areas, adopt and promote good practice | To be established. | **Jobcentre Plus,** all RET organisations | |

| Action required (Activity) | Outcome (Performance Indicator) | Lead Responsibility and partners | Relevant dates |
|---|---|---|---|
| 6. Formulate messages that are acceptable to small and medium businesses and promote 'business to business" | To be established. | **Acas, BITC,** all RET organisations | |
| 7.a) Review all relevant directives and guidance | 7.a) comprehensive reference document | **CSIP,** all RET organisations | 31.01.09 |
| 7.b) prepare briefing material | 7.b) resource for involved parties | **CSIP,** all RET organisations | 31.01.09 |
| 7.c) offer briefing material at local level to organisations that could benefit | 7.c) shared knowledge within East Midlands networks | **CSIP,** all RET organisations | 31.01.09 |
| 8. Recognise and support the part played by VCS organisations in the objectives of the strategy | 8. VCS representation at all meetings and events. Minutes of meetings | **All RET organisations** | |
| 9. Identify sustainable resources to enable organisations to pursue  the strategy's objectives | To be established. | **Jobcentre Plus,** all RET organisations | |

# Process Map Showing Key Players

Where the imperative originated

The Cabinet Office → PSA 16

DWP    DTI    DIUS    DH    DCLG

Reaching Out Action Plan

Social Exclusion Unit Task Force

Lead responsibility for delivery

NSIP Action 23

Regional Partners

RDC/EMids CSIP

SHA

**Regional Mental Health and Employment Partnership**

SHAs    GOEM    NIACE    Service User Organisations e.g. Rethink, Housing Associations    3rd sector reps

LSC

JC+    EMDA    RSPA    MH/PCT Trusts    HSE

Independent Sector    BITC    TUC    ACAS    CMP

Behaviour/services we want to influence

Local Groups

JCP    Colleges

Service users and carers

Pathways to Work providers

MH Trusts

Commissioners/ PCTs/GPs

JOB MAETS    Employer facing orgs

Employers    3rd Sector

# East Midlands Mental Health & Employment Partnership Structure

**ESP membership**
EMDA – CE – CHAIR
GOEM – Director
LSC Chief Executive
Job Centre Plus –
Skills for Business network

**SUBGROUPS**

In Business Support
Chair
EMDA

**ESP**
Employment Skills and
Productivity Partnership

High Level Skills
Chair
GOEM

**Workless-ness and Economic Exclusion –**
Implementation Group
Chair: Jobcentre plus
(activity ceased October

Linking Business
Support and the
skills agencies
Chair: LSC

Regional Mental Health and Employment Team (RET):
- Care Services Improvement Partnership East Midlands (CSIP)/Strategic Health Authority SHA
- JobCentre Plus (JCP)
- Government Office East Midlands (GOEM)
- Condition Management Programme (CMP)
- Learning and Skills Council (LSC)
- Framework Housing Association  (representing Enable)
- Rethink
- Advisory, Conciliation and Arbitration Service (Acas)
- Business in the Community (BITC)
- Health and Safety Executive (HSE)
- Trades Union Congress (TUC)
- Reed in Partnership
- National Institute of Adult Continuing Education (NIACE)

E.M. Mental Heath
and employment
Network

# Mental Health and Employment in the East Midlands

# INDEX

Appendices
       Appendix A – national statistics
       Appendix B – East Midlands statistics

## Introduction

It is well recognised that having employment can protect mental health by boosting confidence and self-esteem[1].

Even so, mental health conditions are now the single biggest cause of both absence from work and people claiming incapacity benefits. Around 40 per cent of people currently receiving incapacity benefits are doing so because of mental ill-health, ranging from common problems such as stress, anxiety and depression, to more serious conditions[2].

This document is intended to provide a range of information about mental health and employment, to assist employers in the East Midlands to understand the issues and to move forward with best practice in developing a mentally healthy workplace. It looks at a range of issues around stress and mental health in the workplace, including information on the legal framework and the business case for creating a mentally healthy workplace.

The document concludes with comprehensive appendices of statistics relating to the prevalence of mental ill health both in the East Midlands and nationally and its effect on the economy and the individual.

1. **East Midlands Public Health Observatory *Indications of Public Health in the English Regions 7: Mental Health East Midlands Regional Summary***
2. **The Centre for Economic Performance's Mental Health Policy Group, *A New Deal for Depression and Anxiety Disorders, 2006***

## National Statement

In November 2007 Peter Hain, the Secretary of State for Work and Pensions, announced his intention, in partnership with the Secretary of State for Health, to develop a National Strategy for Mental Health and Work, in order to ensure a coordinated response across government to the challenges faced by people of working age with mental health conditions and improve their employment chances.

The Strategy will include advice and support to employers, especially smaller businesses, to help them to manage and support people with mental health conditions to remain in or return to work.

It will explore ways to improve communications between GPs and employers to improve the likelihood of people working and make it easier for GPs to provide more helpful advice to patients and their employers about their fitness for work, especially for those with mental health conditions.

# The Scale of the Problem

<u>The National Picture</u>

- One in six adults at any one time has mental health problems[3].

- Mental health is the biggest cause of sickness absence from work[4].

- Estimated annual cost to the British economy of working days lost to depression, stress and anxiety is £4bn[5] and as much as £9bn in salary[6].

- Thirty times as many working days are lost due to mental ill health as from industrial disputes[7].

- An estimated 10 percent of the UK's gross national product (GNP) is lost each year due to job generated stress[8].

- Stress is the highest cause of absence among non-manual employees, with an estimated 12.8 million working days lost in Britain in 2003/04 due to stress and depression or anxiety ascribed to work related stress[9] and a total of 91 million days as a result of mental ill-health[10].

- Nearly three in every ten employees will have a mental health problem in any one year, the great majority of which will be anxiety and depressive disorders[11].

- Nationally, the percentage of days (full-day equivalent) off work due to self-reported stress and related illnesses shows a generally upward trend, with the highest figure (46%) being reported for 2006/7, thus accounting for nearly half of all days lost[12].

- People with mental health problems have the lowest rate of employment for any disabled group[13].

- The World Health Organisation estimates that depression will become the second most important cause of disability in the world[14].

- 52% of people with a psychiatric history have concealed this fact from their employer for fear of losing their job[15].

3. The Centre for Economic Performance's Mental Health Policy Group, *A New Deal for Depression and Anxiety Disorders, 2006*
4. CBI *Who Cares Wins: absence and labour turnover survey, 2005*
5. Layard, R. *Mental Health:Britain's Biggest Social Problem, 2006*
6. Shaw Trust *Mental Health, The Last Workplace Taboo, 2006*
7. The Centre for Economic Performance's Mental Health Policy Group, *A New Deal for Depression and Anxiety Disorders, 2006*
8. MIND *Stress and Mental Health in the Workplace, 2005*
9. ibid
10. The Mental Health Foundation *Mental Health in the Workplace, 2005*
11. MIND *Stress and Mental Health in the Workplace, 2005*
12. Health and Safety Executive *Self-Reported Work Related Illness in 2004/5: Results from the Labour Force Survey, 2005*
13. Social Exclusion Unit *Mental Health and Social Inclusion Report, 2004*
14. SHIFT *Line Managers Guide, 2007*
15. www.mindfulemployer.net

## The East Midlands Picture

According to the Regional Director of Public Health's 2006 Report to the East Midlands Regional Assembly, *Keeping Health in Mind*[16], it is difficult to gauge accurately the true picture of mental health and wellbeing due to a lack of consistent data at local and regional level. However, available statistics indicate:

- More people than ever before are claiming Incapacity Benefit as a result of mental ill-health – over 68,240 in the East Midlands[17].

- The impact of working days lost to mental ill-health in the East Midlands alone is likely to be £260m per annum[18].

- According to the East Midlands Public Health Observatory[19], the links to the indices of deprivation and the prevalence of mental ill health suggest that the East Midlands should be lower than other English regions in terms of prevalence of mental ill health. However:
  - The East Midlands shows the highest regional rate of average days lost per worker due to self-reported stress, depression and anxiety caused or made worse by work; a marked increase from the situation in 2004 where the East Midlands was ranked 10th by this measure[20].
  - The East Midlands has the fifth highest rate of self-reported stress, depression or anxiety caused or made worse by work in Great Britain[21].
  - The percentage of people with mental ill-health in employment in the East Midlands is marginally lower than in the rest of England[22].

- Incapacity Benefit claims on the basis of mental ill-health are increasing throughout the East Midlands[23]– an average increase of 8.4% between 2000 and 2007[24].

- Up to 4.5% of the working population of the East Midlands can be claiming Incapacity Benefit because of mental ill-health[25].

- The largest pay-out for stress in the workplace (£185,000) was awarded against an East Midlands Employer[26].

16. East Midlands Regional Assembly *Keeping Health in Mind, 2006*
17. Figures from JobCentre Plus November 2007
18. Emphasis: the East Midlands Public Health Network *Improving Health in the East Midlands:Keeping Health in Mind, 2007*
19. East Midlands Public Health Observatory *Indications of Public Health in the English Regions 7: Mental Health East Midlands Regional Summary*
20. Health and Safety Executive *Self Reported Work Related Illness in 2004/5: Results from the Labour Force Survey, 2005*
21. *ibid*
22. Cabinet Office Social Inclusion Task Force *Socially Excluded Adults PSA: Indicator Data for the East Midlands, 2007*
23. ONS 2007/JobCentre Plus
24. *ibid*
25. www.neighbourhood.statistics.gov.uk 2008
26. www.thompsonslaw.co.uk

## The Legal Framework

The key pieces of legislation around mental health in the workplace are:
• The Health and Safety at Work Act 1974
• The Disability Discrimination Act 1995 and 2005
• The Human Rights Act 1998
• The Management of Health and Safety at Work Regulations (1999)

It is important to recognise issues of stress in the workplace, which may or may not lead to mental health problems or sickness absence (these are dealt with under Health and Safety legislation) and the employment rights of people who have (or have had) mental health problems, which are covered by the Disability Discrimination Act.

Health and Safety at Work Act 1974

Companies have a duty of care under the Health and Safety at Work Act 1974 to ensure people are not made ill by their jobs. The Health and Safety Executive has made clear this covers stress-related illness. Employers also have a responsibility under the Management of Health and Safety at Work Regulations 1992 to assess risk to staff health and take reasonable steps to prevent harm. Again, the HSE has stipulated this covers stress.

Most people find work stressful at times. Many people cope with stressful jobs on a daily basis. But when excessive demands, impossible deadlines or long hours make work intolerable and cause health to suffer too it can be tempting to think the law might hold the answer.

Increasingly, people are taking employers to court to claim compensation for damage to their health caused by stress.

Case studies[27]:

There have been several high profile actions including:

• A social worker with a county council who suffered two nervous breakdowns due to stress at work. He was awarded £175,000 in an out-of-court settlement, in the first successful claim for damages on stress grounds.

• A draughtswoman who suffered a breakdown after she was moved to a front-line post in housing, without proper training. She was awarded £67,000 in court. This was the first case in which an employer admitted liability for causing personal injury due to stress.

• A teacher who won £47,000 damages in an out-of-court settlement against a local education authority in 1999.

27. Case studies courtesy of Thompsons Solicitors -  www.thompsonslaw.co.uk

Disability Discrimination Act 1995

Under the Disability Discrimination Act 1995 (DDA), it is unlawful for an employer to treat a disabled employee, or potential employee, less favourably than others by:

- discriminating against a disabled person in employment
- failing to provide any reasonable adjustments for a disabled employee or applicant who is at a serious disadvantage in relation to others

Changes to the DDA introduced in December 2005 mean that mental illness no longer has to be a clinically well-recognised condition to be covered by the Act. Applicants will have to prove only that the disability has a substantial and long-term effect on their ability to carry out normal day-to-day activities.

19% of all cases heard under the DDA so far have been mental health related[28].

Case Studies[29]:
- a teacher with hypomania requested a reduction in working hours, a classroom assistant and an electronic organiser. The reduction in working hours was agreed but not the organiser or the classroom assistant. This was held to be a failure to make a reasonable adjustment.
- an employee was not allowed to have a graduated return to work following a period of psychiatric inpatient care. This was held to be a failure to make a reasonable adjustment.

Stigma

"Negative, stigmatising attitudes are a serious obstacle to the development and successful implementation of a mental health policy and hence the improved mental health of employees. Consequently the most important step in the process is to bring about a positive change in attitude and assumptions amongst employees and management towards mental health"[30].

It is also important to remember that harassment in the workplace is in contravention of the Health and Safety at Work Act 1974 and the Human Rights Act 1998. In addition, disability related harassment is unlawful under the Disability Discrimination Act 1995.

28. Incomes Data Services *Monitoring the DDA, Disability Rights Commission, 2005*
29. Case studies courtesy of Chatterton's Solicitors Ltd
30. Chartered Institute of Personnel and Development (CIPD) factsheet *Mental Health at Work*

## The Business Case

**"Staff have to be 'happy, healthy and here' (i.e. at work) in order to deliver efficiency gains and first rate services. That is the best way to position our organisations to better deliver core functions"** Lord Hunt of Kings Heath, Ministerial Task Force on Health, Safety and Productivity[31].

Work-related stress is the root cause of a significant degree of mental ill health. Stress can manifest itself in absenteeism, reduced productivity, and increased staff turnover. Excessive stress can lead to fatigue, impaired judgement and decision-making, and the onset of both mental and physical health problems[32].

According to the Shaw Trust[33], the question Chief Executives should be asking themselves about mental health and work-related stress is 'what impact is this having on my business?'

The answer is that it is costing them money in terms of recruitment and training costs, the cost of sickness absence, loss of productivity, and the loss of their competitive advantage if others are managing this issue better than they are. Dr Paul Litchfield, Chief Medical Officer from British Telecom[34] says that businesses which don't take mental health seriously will not be successful in the 21st century.

Presenteeism, or reduced productivity when employees attend work but function at less than full capacity because of ill health, accounts for 1.5 times as much working time lost as absenteeism and costs more to employers because it is more common among higher-paid staff. Simple steps to improve the management of mental health in the workplace, including prevention and early identification of problems, should enable employers to save 30% or more of these costs – at least £8 billion a year. Taking Action to promote wellbeing among staff, to give better help to those experiencing distress and to support those who need time off to come back to work makes business sense. The cost of neglecting mental distress at work is simply too high to be ignored any longer[35].

Some of the figures relating to mental ill health and stress in the workplace have been laid out in the earlier section "The Scale of the Problem". In addition, previous sections have laid out the legal issues and potential financial implications of failing to meet them. It is important, however, to recognise that people with mental ill-health have much to offer an employer. SHIFT[36] offers the following CVs as examples of achievements of people with mental health problems:

- I have been a Prime Minister, a world champion heavyweight boxer, a Nobel Prize winner and a national newspaper editor. Mental illness has not been a barrier to my success.

- I have represented my country at cricket and football. I am a keen artist and my paintings have been sold at auction for tens of millions of US dollars.

- I am an actor and screenwriter and my talent has been recognised with Academy Awards, Golden Globes, Emmy Awards and BAFTAs.

31. Health and Safety Executive *Improving Efficiency and Productivity by Managing Attendance and Work Related Stress 2006*
32. CIPD factsheet *Mental Health at Work*
33. Shaw Trust *Mental Health, the Last Workplace Taboo, 2006*
34. SHIFT *Line Managers Guide, 2007*
35. The Sainsbury Centre for Mental Health: Policy Paper 8, Mental Health at Work: Developing the Business Case
36. SHIFT *Curriculum vitae, 2007*

## Creating a Mentally Healthy Workplace

In a CBI survey of over 800 companies, 98 per cent of respondents said mental health should be a company concern, with 81 per cent of those saying that the mental health of employees should be a company priority. However, fewer than one in ten of the companies surveyed had an official policy on mental health[36].

Employers who wish to create a healthy work environment must recognise the need to establish policies and procedures in the area of mental health. The Health and Safety Executive[37] recommends that a mental health policy should be an integral part of any organisation's health and safety at work policy and its Stress at Work guide offers workshops and advice.

Due to fear of discrimination potential employees may choose not to disclose a mental health problem in their application or at the interview stage[38]. It is important to:

- make it known, at the recruitment stage, that the employer is willing to make reasonable adjustments for disabled applicants and that this policy includes people with mental health problems
- ensure all employees understand the concept of adjustment within the organisation's equal opportunities policy

Look at reasonable adjustments to the workplace. Can a member of staff with mental health problems have a graduated return to work, a part-time or job-share agreement or flexible working?

The Shaw Trust[39] suggests that these solutions will be developed under four main themes:

1. Awareness – of the scale and prevalence of mental ill-health and its implications for business
2. Health and well-being – assistance in preventing the development of mental ill-health and approaches to health promotion in the workplace
3. Early warning – systems that allow potential mental health problems to be identified and managed before they become too severe
4. Workplace support – a range of services for employers and employees, from training and guidance to specialist occupational health support

SHIFT[40] offers the following advice to employers

1. Make sure the demands placed on staff are fair and realistic
2. Allow staff a say in how they do their work
3. Provide staff with the information and support they need
4. Protect staff from conflict and unreasonable behaviour
5. Ensure that staff understand their roles and your expectations
6. Communicate with staff during times of change, and listen to their concerns

The TUC recognises that hundreds of thousands of people at work face ignorance, prejudice and stigma because of mental health problems. Even more – who are both able and willing to work – cannot get a job if they have or have had a mental health problem because of discrimination by employers. The TUC has published guidance to help trade union representatives and officials resolve mental health issues in the workplace, and in the process persuade managers and employers to adopt a less prejudiced attitude to mental health in general[41].

36. MIND *Stress and Mental Health in the Workplace, Executive Summary,2005*

37. www.hse.gov.uk

38. CIPD factsheet  *Mental Health at Work*

39. Shaw Trust *Mental Health, the Last Workplace Taboo, 2006*

40. SHIFT *Line Managers Guide, 2007*

41.  TUC *Representing and supporting members with mental health problems at work* Guidance for trade union representatives

## Some examples of good practice

• Lincolnshire Partnership NHS Trust's Primary Mental Health Care Service took part in a national pilot collaborative in which graduate mental health workers and General Practitioners developed ways in which to support and advise people with common mental health problems back into the workplace.

• Seven organisations in the East Midlands have signed up to the "Mindful Employer" charter mark to demonstrate their commitment to 'showing a positive and enabling attitude to employees and job applicants with mental health issues'[41]. This includes putting positive statements in recruitment literature.

• Leicestershire Department of Planning and Transportation has devised and delivered a short course on stress management to its staff[42].

• Leicestershire County Council together with the Health and Safety Executive has engaged a network of employees in the "Less stressed Leicestershire" initiative[43].

• Abbey Building Society has developed the 'Great Place to Work' initiative, including respite rooms where staff can leave their office environment and refresh themselves if they have been dealing with a difficult customer[44].

## Mental health and self-employment

Little research has been carried out into the benefits of self-employment on mental health. An Australian study in 2004[45] examined the associations between work stressors and mental health with both employed and self-employed people, and found no benefit to the mental health of those people who were self-employed.

However, Social Firms UK[46] are keen to promote social enterprise as one of the solutions to mental ill-health and believe that social enterprises are already providing both recovery and employment for people with mental health problems.

When considering self employment, however, it is also important to be aware that the East Midlands has a large farming population amongst its self-employed and that Defra[47] has recognised the high levels of suicide and self-harm amongst the farming community. Indeed, farmers are recognised as being amongst the highest risk occupational groups for psychiatric disorder, especially depressive disorder, as well as occupational, relationship, financial problems and physical illness[48].

41. www.mindfulemployer.net
42. MIND *Stress and Mental Health in the workplace Report, 2005*
43.
44.ibid
45. Parslow, R; Jorm, A.; Christensen, H; Rodgers, B; Strazdins, L; D'Souza, R; *Work and Strees Vol 18, 2004*
46. www.socialfirms.co.uk
47. Defra, *Stress and Suicide in the Farming Community, 2004*
48. ibid

# Where to get support

**Useful web-sites:**

**National:**

National Statistics Online: http://www.statistics.gov.uk/

Health & Safety Executive: http://www.hse.gov.uk/

SHIFT: http://www.shift.org.uk/  http://shift.org.uk/~employers.html

Mindful Employer: http://www.mindfulemployer.net/

MIND: http://www.mind.org.uk/

Mental Health Foundation: http://www.mentalhealth.org.uk/

**East Midlands:**

East Midlands Public Health Observatory:
http://www.empho.org.uk/THEMES/mentalhealth/mh9.aspx

Intelligence East Midlands: http://www.eastmidlandsobservatory.org.uk/

Lincolnshire Research Observatory: http://www.research-lincs.org.uk/default.asp

Northamptonshire Observatory: http://www.northamptonshireobservatory.org.uk/

Leicestershire Observatory: http://lsora-content.leics.gov.uk/lsora/

Nottingham Observatory: http://www.theobservatory.org.uk/

Derbyshire County Council: http://www.derbyshire.gov.uk/

# Appendix A – National Statistics

Appendix A presents data on mental health and employment from a variety of sources to illustrate the current national picture.

References have not been included in the body of the document in order to aid clarity of presentation. They are available in a separate section at the end.

It should be noted that the information presented herein has been gathered from a diverse range of organisations and sources, some of whom collate their data on a UK-wide basis, and some on an English and regional basis. It has not always been possible to present data consistently for this reason.

## **The National Picture:**

- In 2006, it was noted by Centre for Economic Performance's Mental Health Policy Group that one in six adults at any one time has mental health problems[1, 5]:

**Figure 1**

| Percentage of people currently suffering from mental illness (people aged 16-75) | |
| --- | --- |
| Schizophrenia | ½ |
| Depression | 2½ |
| Anxiety disorders | |
| Generalised anxiety | 4½ |
| Social phobia, agoraphobia, etc | 2 |
| Obsessive compulsive disorder | 1 |
| Panic disorder | 1 |
| Mixed depression and anxiety | 5 |
| Total | 16½ |

- The CBI noted in 2005 that mental health is the biggest cause of sickness absence from work[2].

- The Layard report of 2006 estimated annual cost to the British economy of working days lost to depression, stress and anxiety is £4bn[3].

- Mind reports that an estimated 10 percent of the UK's gross national product (GNP) is lost each year due to job generated stress.[4]

- Stress is the highest cause of absence among non-manual employees, with an estimated 12.8 million working days lost in Britain in 2003/04 due to stress, and depression or anxiety ascribed to work related stress.[4]

- Nearly three in every ten employees will have a mental health problem in any one year, the great majority of which will be anxiety and depressive disorders.[4]

- The Confederation of British Industry (CBI) estimates that 30 times as many working days are lost due to mental ill health as from industrial disputes.[4]

- In a CBI survey of over 800 companies, 98 per cent of respondents said mental health should be a company concern, with 81 per cent of those saying that the mental health of employees should be a company priority. However, fewer than one in ten of the companies surveyed had an official policy on mental health.[4]

- The Centre for Economic Performance's Mental Health Policy Group found in 2004 that 38% of Incapacity Benefit claims nationally are due to mental ill health[5]:

**Figure 2**



Incapacity Benefits Recipients by medical condition, 2004

Nervous System 10%
Musculo-Skeletal 20%
Circulatory and Respiratory System 9%
Injury, poisoning 6%
Others 17%
Mental Disorder 38%
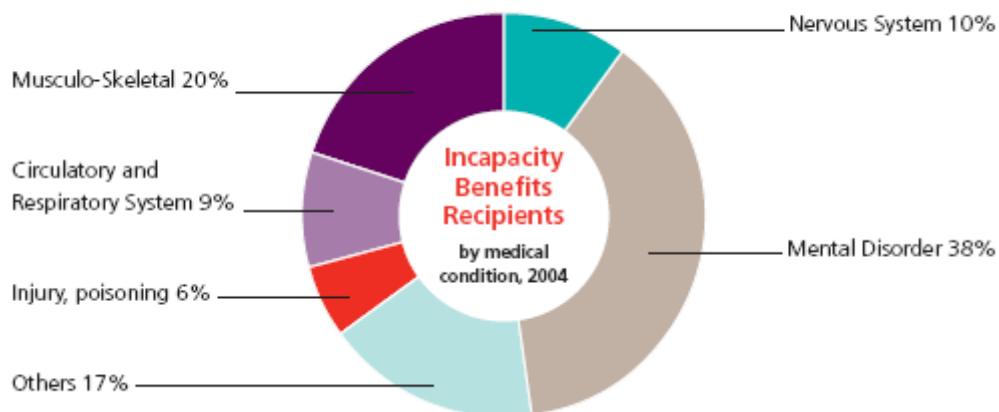
The data to the end of this section on the national picture is sourced from the Health & Safety Executive reports (2003/4 & 2004/5), and from the headline (i.e. summary national) data released for the 2006/7 survey in November of 2007.

- The 2007 data does **not** include an in-depth analysis of the latest survey. (The report due in April/May 2008 has not yet been released, however, the existing data has been used to compare with earlier years wherever relevant.)

- The HSE found that there has been an upward trend of self-reported illness caused by stress and related disorders from 1990 to 2001/2, with a slight decline thereafter to 2004/5 for those in employment in the last 12 months. Levels at the latest data point are running at approximately double the1990 rate (see chart below)[6]:

**Figure 3** Comparison of estimated prevalence rates of self-reported work-related illness, for people working in the last 12 months in England and Wales, 1990 to 2004/05
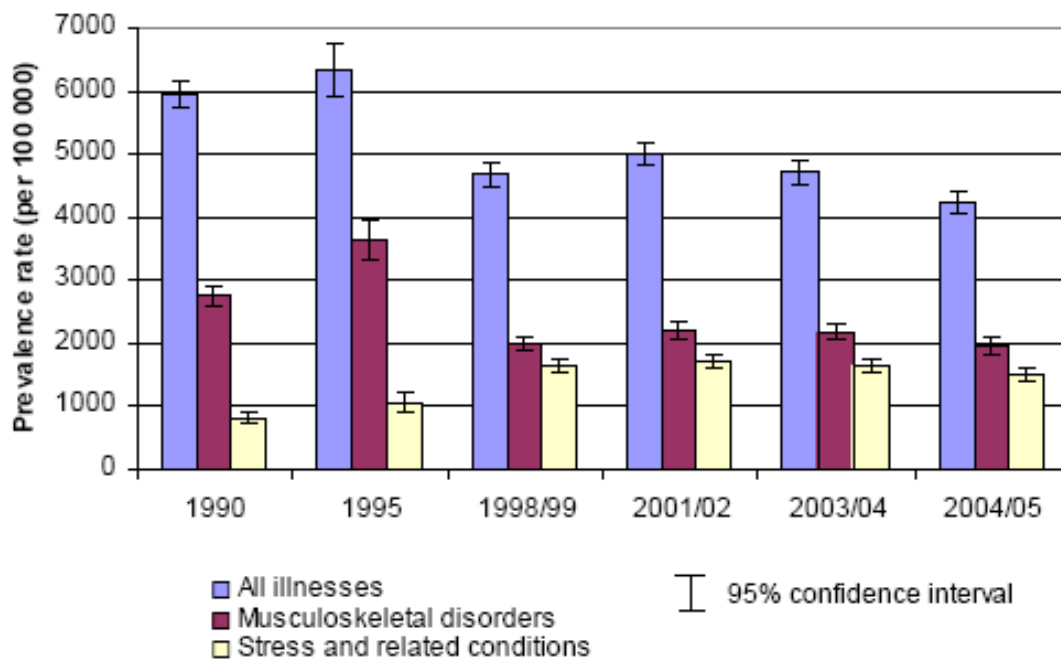


- The data for those that have ever been employed (that is, those that have worked at some point but not necessarily in the last 12 months) indicates a relatively stable prevalence of self-reported stress and related disorders. However, it can be noted that the 2007 figure (1230 per 100,000) is the highest on record[7]:

**Figure 4** Estimated prevalence and rates of self-reported illness caused or made worse by work, by type of illness, for people ever employed.
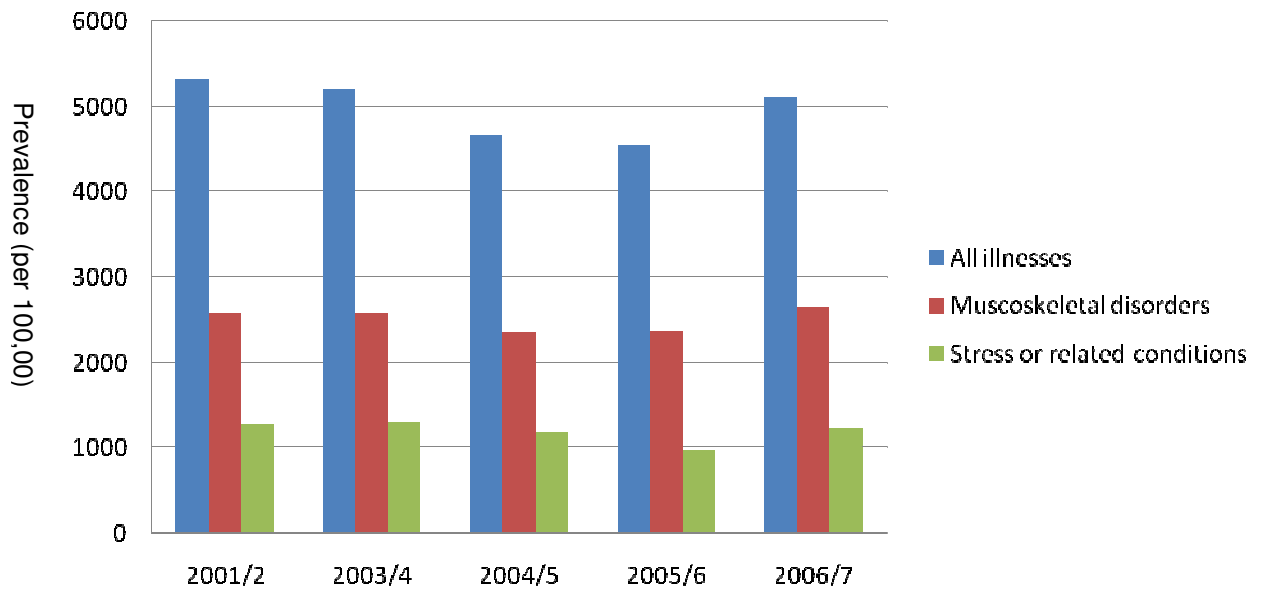


- Nationally, the % of days (full-day equivalent) off work due to self-reported stress and related illnesses shows a generally upward trend, with the highest figure (46%) being reported for 2006/7, thus accounting for nearly half of all days lost[7]:

**Figure 5** Percentage of days (full-day equivalent) off work due to self-reported work-related stress or related illness.
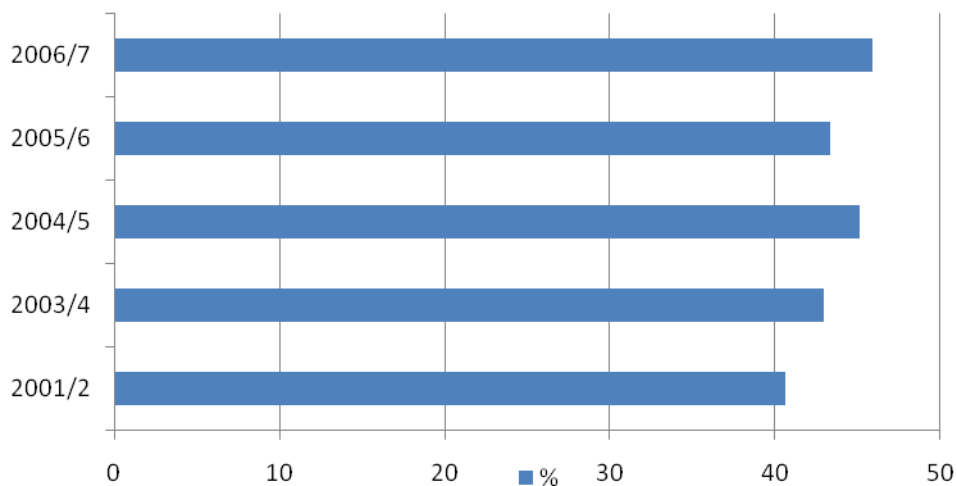
- The HSE (2005) further found that stress, depression and anxiety is most prevalent amongst socio-economic classifications 1 & 2 (Higher Managerial and Professional and Lower Managerial and Professional groups)[6]

  The rate per hundred (left-hand side of the graph) can be read as a percentage occurrence within that socio-economic group, and the estimated prevalence in thousands (right-hand side of the graph) shows the actual number of people within that socio-economic group. All graphs that follow in this format follow a similar method of presentation of that data:

**Figure 6**

Estimated 2003/04 prevalence and rates (%) of self-reported stress, depression or anxiety caused or made worse by the current job, by socio-economic classification
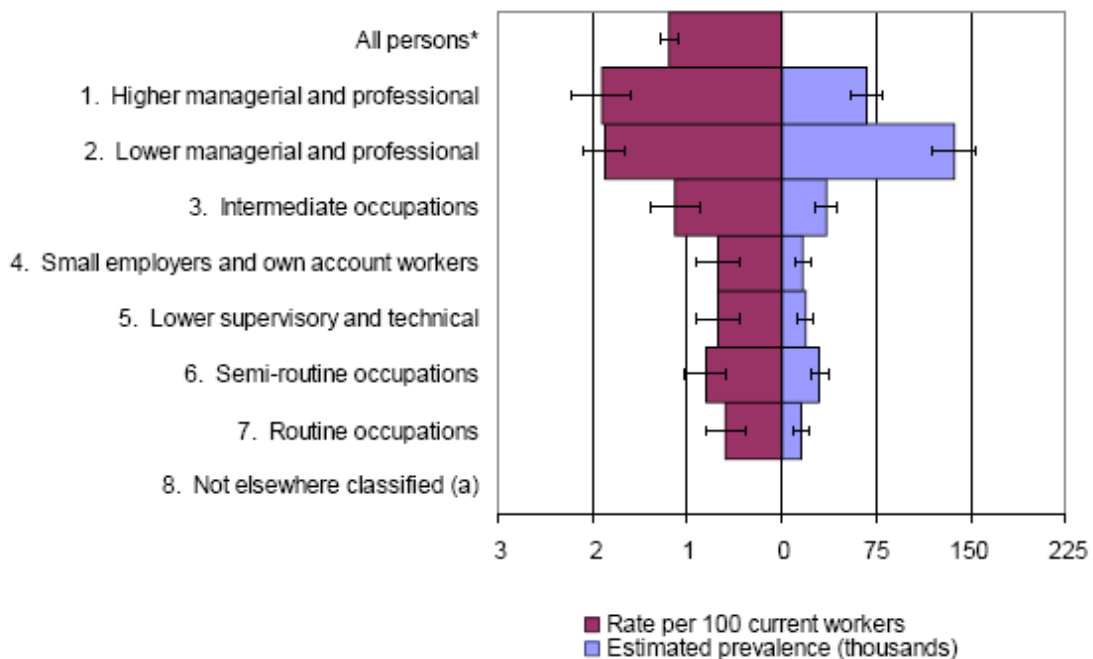
- Stress, depression and anxiety is most prevalent amongst industry sectors traditionally associated with public services, although it runs at roughly half this rate in all sectorss[6]:

**Figure 7** Estimated 2004/05 prevalence and rates (%) of self-reported stress, depression or anxiety caused or made worse by current or most recent job, by industry section, for people who worked in the last 12 months



■ Estimated prevalence (thousands)

■ Rate per 100 employed in the last 12 months

**Key**
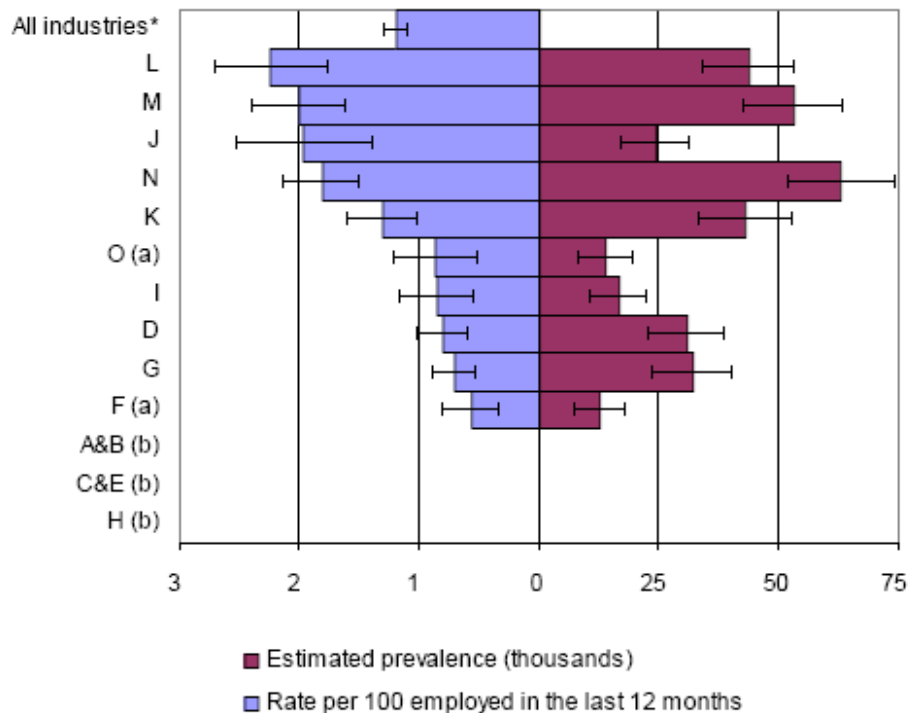
| | |
|---|---|
| L | Public administration and defence; compulsory social security |
| M | Education |
| J | Financial intermediation |
| N | Health & Social work |
| K | Real estate, renting and business activities |
| O(a) | Other community, social and personal service activities |
| I | Transport, storage and communication |
| D | Manufacturing |
| G | Wholesale and retail trade, repair of motor vehicles, motorcycles and personal and household goods |
| F(a) | Construction |
| A&B(b) | Agriculture, hunting, forestry and fishing |
| C&E(b) | Extractive and utility supply industries |
| H(b) | Hotels and restaurants |

- When the data is analysed by occupational major group, the highest self-reporting incidence is seen in professional occupations, associate professional and technical occupations and managers and senior officials[6]:

**Figure 8** Estimated 2004/05 prevalence and rates (%) of self-reported stress, depression or anxiety caused or made worse by current or most recent job, by occupational major group, for people working in the last 12 months



■ Rate per 100 employed in the last 12 months
□ Estimated prevalence (thousands)
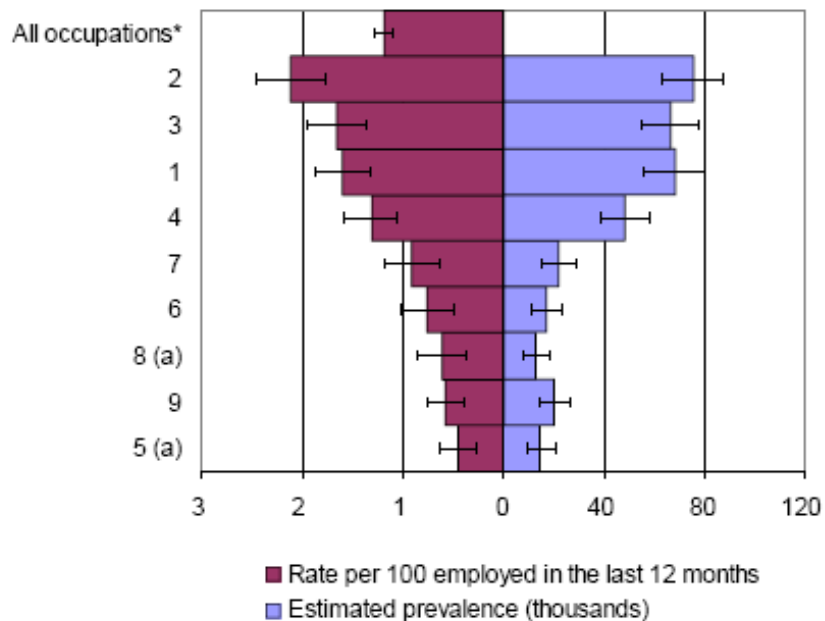
**Key:**

| | |
|---|---|
| 2 | Professional occupations |
| 3 | Associate professionals and technical occupations |
| 1 | Managers and senior officials |
| 4 | Administrative and secretarial occupations |
| 7 | Sales and customer service occupations |
| 6 | Personal service occupations |
| 8(a) | Process, plant and machine operatives |
| 9 | Elementary occupations |
| 5(a) | Skilled trades occupations |

- The highest number of average days lost per worker occurs nationally in the industry sections of Public administration and defence and Health and social work[8]:

**Figure 9**  Estimated days (full-day equivalent) off work and associated average days lost per worker in 2004/05 due to self-reported stress, depression or anxiety caused or made worse by current or most recent job, by industry section
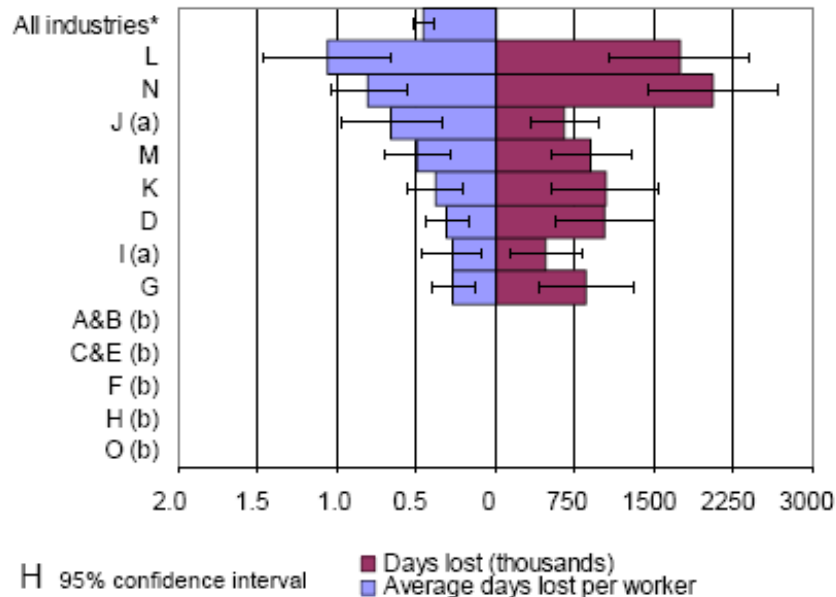


Key:
L    Public administration and defence; compulsory social security

N    Health and social work
J    Financial intermediation
M    Education
K    Real estate, renting and business activities
D    Manufacturing

I    Transport, storage and communication

G    Wholesale and retail trade; repair of motor vehicles, motorcycles and personal and household goods
A&B    Agriculture, hunting, forestry and fishing
C&E    Extractive and utility supply industries
F    Construction
H    Hotels and restaurants
O    Other community, social and personal service activities

**Note:** this particular analysis not available in the latest (2005) HSE report.

- The highest number of average days lost per worker occurs nationally in the occupational major groups of associative professional and technical occupations and administrative and secretarial occupations. Managers and senior officials is a close third[6]:

**Figure 10** Estimated days (full-day equivalent) off work and associated average days lost per worker in 2004/05 due to self-reported stress, depression or anxiety caused or made worse by current or most recent job, by occupational major group
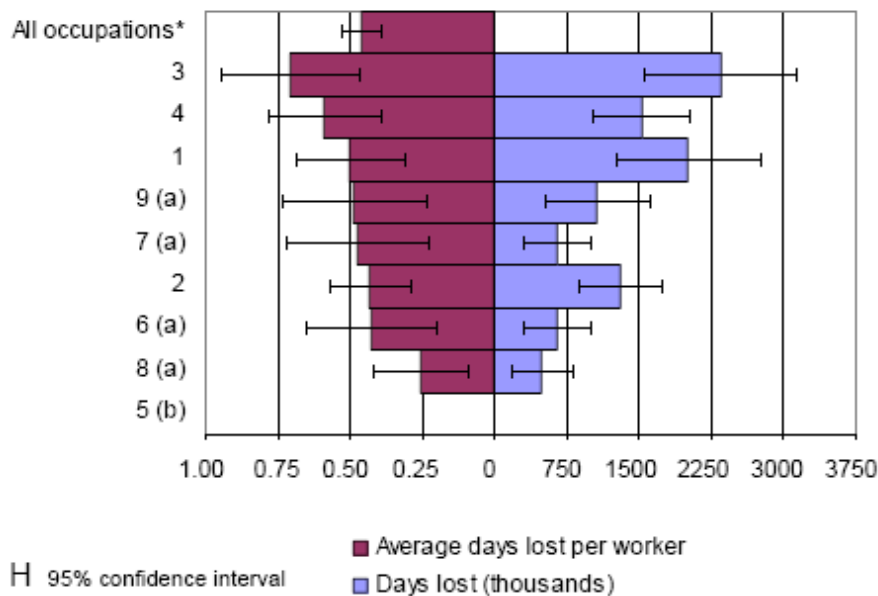


Key:
| | | | |
|---|---|---|---|
| 3 | Associate professional and technical occupations | 2 | Professional occupations |
| 4 | Administrative and secretarial occupations | 6 | Personal service occupations |
| 1 | Managers and senior officials | 8 | Process, plant and machine operatives |
| 9 | Elementary occupations | 5 | Skilled trades occupations |
| 7 | Sales and customer service occupations | | |

**<u>References – Appendix A</u>**

[1]Department of Health, *More Information on Mental Health*, Choosing Health Resource Pack, Spring 2004.

[2]CBI, *Who cares wins: absence and labour turnover survey*, 2005.

[3]Layard, R. Mental Health: Britain's biggest social problem, Paper prepared for a Prime Minister's Strategy Unit seminar held on 6th December 2006.

[4]Mind, *Stress and Mental Health in the Workplace*, May 2005.

[5] The Centre for Economic Performance's Mental Health Policy Group, *A New Deal for Depression and Anxiety Disorders,* 2006.

[6]Health and Safety Executive, *Self-reported Work Related Illness in 2004/5: Results from the Labour Force Survey*, 2005.

[7]Health and Safety Executive, *Self-reported work-related illness and workplace injuries in 2006/07*: Headline results from the Labour Force Survey, 2007.

[8]Figures from the Department of Work and Pensions, May 2005.

# Appendix B – East Midlands Statistics

Appendix B presents data on mental health and employment from a variety of sources to illustrate the current picture in the East Midlands.

References have not been included in the body of the document in order to aid clarity of presentation. They are available in a separate section at the end.

It should be noted that the information presented herein has been gathered from a diverse range of organisations and sources, some of whom collate their data on a UK-wide basis, and some on an English and regional basis. It has not always been possible to present data consistently for this reason, although data sourced specifically for the East Midlands has a consistent format by local authority area.

**The East Midlands:**

- The Department for Work and Pensions (2005) reported that more people than ever before are claiming Incapacity Benefit as a result of mental ill-health – over 61,500 in the East Midlands[1]. Since this figure was published, the total has risen to 68,240 in 2007[7].

- East Midlands Public Health Network (2007) noted in a report on regional health that the impact of working days lost to mental ill-health in the East Midlands alone is likely to be £260m per annum[2].
- The HSE (2005) found that the East Midlands shows the fifth highest regional rate of self-reported stress, depression or anxiety caused or made worse by work[3]

**Figure 1** Estimated 2004/05 prevalence and rates (%) of self-reported stress, depression or anxiety caused or made worse by work, by country and government office region, for people ever employed
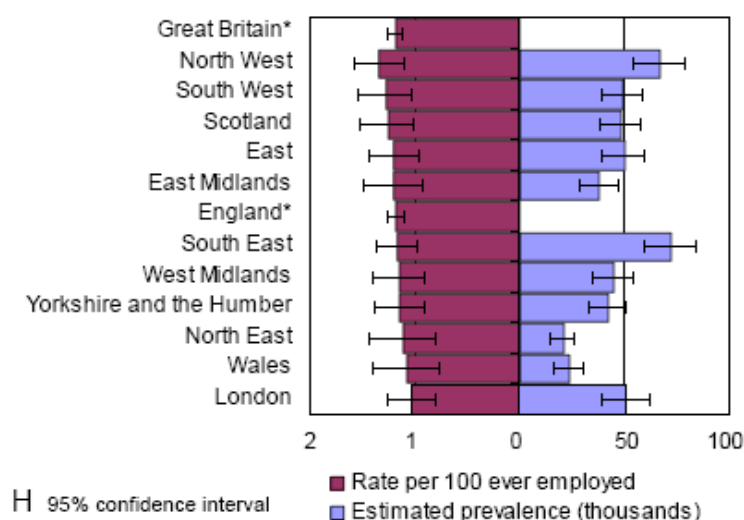
- By contrast to the above, the East Midlands showed the highest regional rate of average days lost per worker due to self-reported stress, depression and anxiety caused or made worse by work in 2005. This shows a marked increase from 2004 where the East Midlands was ranked 10th by this measure[3,4]:

**Figure 2**



Estimated days (full-day equivalent) off work and associated average days lost per worker in 2003/04 due to self-reported stress, depression or anxiety caused or made worse by work, by country and government office region within England

**Figure 3** Estimated days (full-day equivalent) off work and associated average days lost per worker in 2004/05 due to self-reported stress, depression or anxiety caused or made worse by work, by country and government office region within England
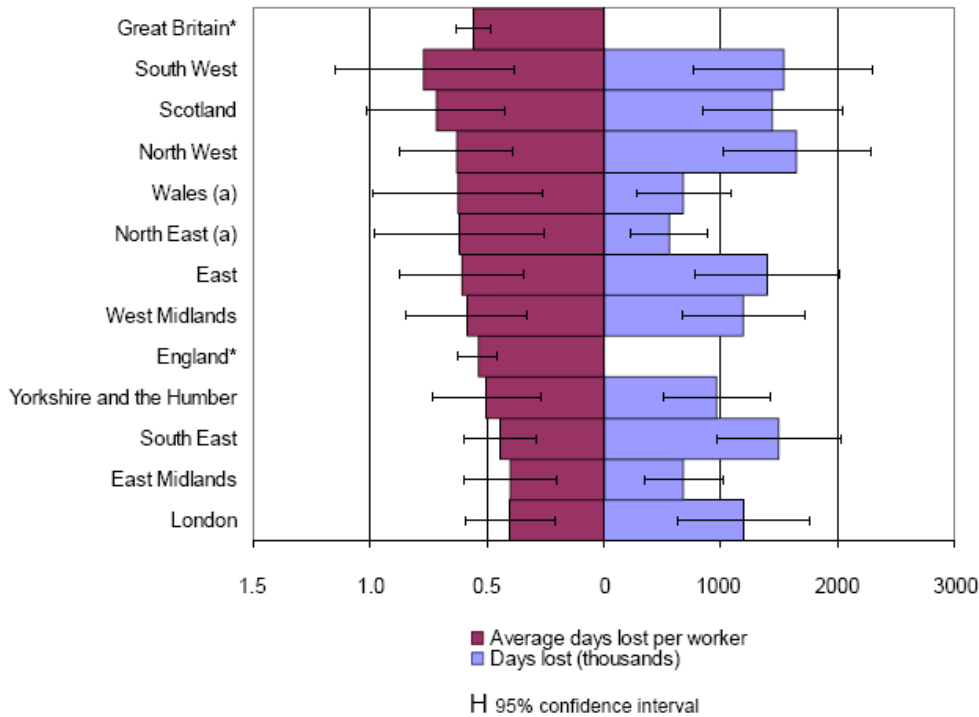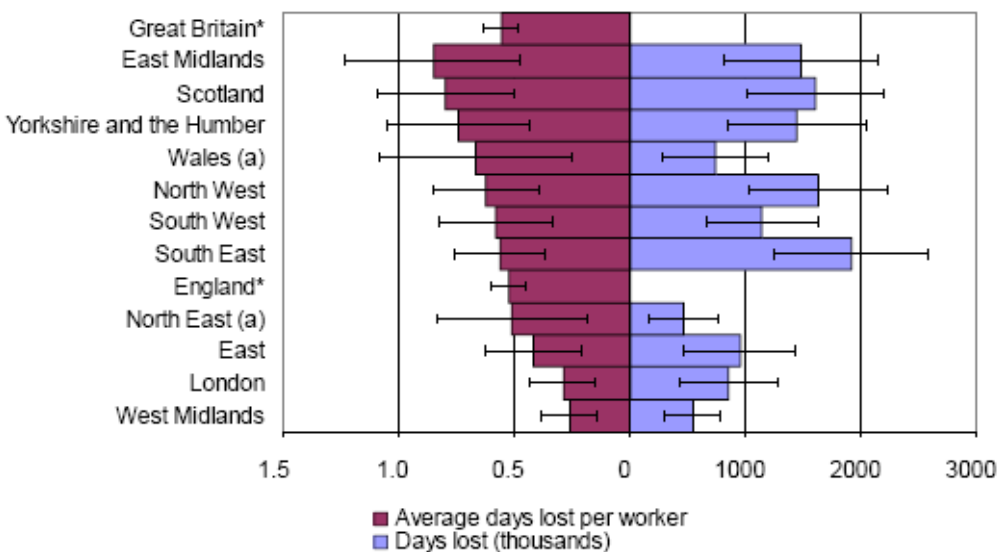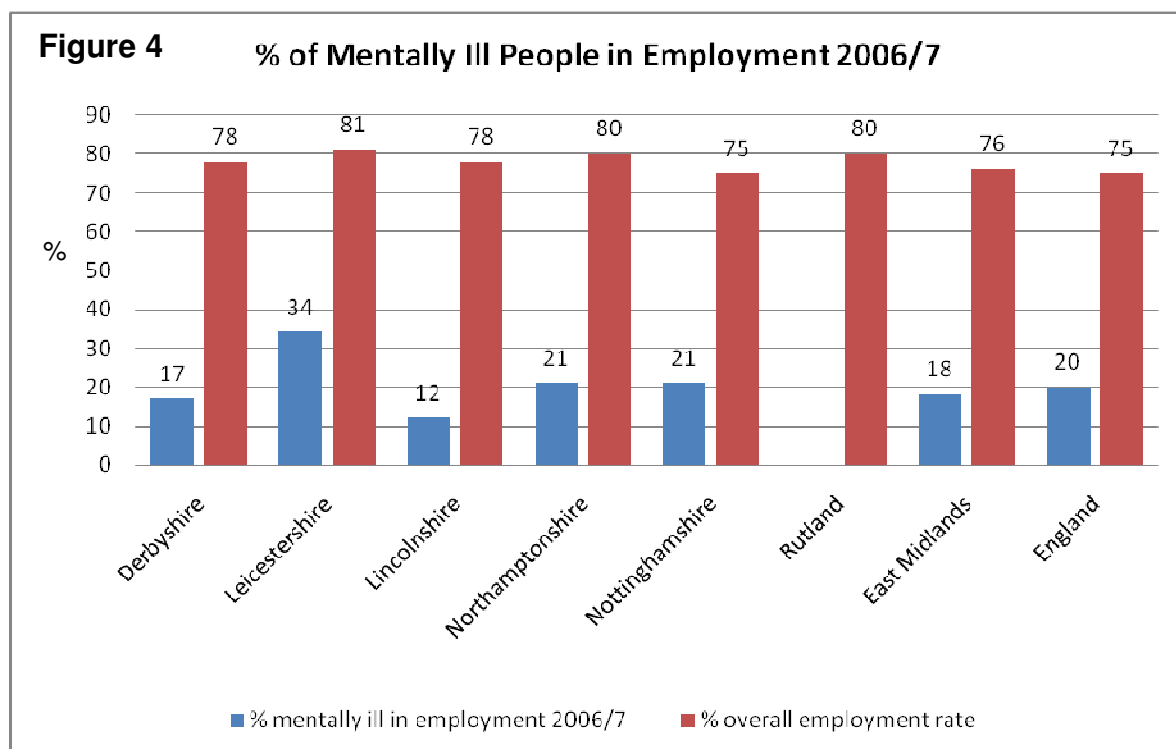
- East Midlands Public Health Observatory reports in a summary that employment can protect mental health by boosting confidence and self-esteem. People with mental health problems can be particularly sensitive to the negative effects of unemployment. The East Midlands has relatively high rates of employment in the working age population (76.1% compared to 75.1% for England) and the percentage of people with a mental health problem in employment is significantly higher than that for England as a whole.[5]

- The Social Exclusion Task Force (2007) reports that the percentage of people categorised as mentally ill and in employment for each county within the East Midlands is shown below, with overall employment rates and regional and national data included for comparison. It shows that employment rates for mentally ill people are typically around a quarter of the overall employment rate in the region, but can be as low as one sixth (Lincolnshire). Compared to national rates, the overall employment rate is marginally higher, but for mentally ill people it is marginally lower[6]:

**Figure 4**



% of Mentally Ill People in Employment 2006/7

Categories: Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire, Rutland, East Midlands, England

% mentally ill in employment 2006/7: 17, 34, 12, 21, 21, (none shown), 18, 20
% overall employment rate: 78, 81, 78, 80, 75, 80, 76, 75

Legend: ■ % mentally ill in employment 2006/7   ■ % overall employment rate

- The following table, sourced from Emphasis: the East Midlands Public Health Network *Improving Health in the East Midlands: Keeping Health in Mind,* 2007, shows a clear trend for Incapacity Benefit claims made on the basis of mental ill health to be increasing across the East Midlands in all areas, with the average percentage of claims due to mental ill health in the East Midlands in 2007 being 37.6%[2, 7]:

**Figure 5**

| % of IB claims made due to mental ill health 1995 - 2007 | | |
|---|---|---|
| | **1995** | **2007** |
| **Derby** | 26.9 | 39.8 |
| **Derbyshire** | 20.3 | 35.6 |
| **Leiester** | 26.8 | 42.0 |
| **Leicestershire** | 23.5 | 40.2 |
| **Lincolnshire** | 22.8 | 35.4 |
| **Northamptonshire** | 26.1 | 39.0 |
| **Nottingham City** | 28.7 | 46.3 |
| **Nottinghamshire** | 21.6 | 38.3 |
| **Rutland** | 33.3 | 34.6 |

**Figure 6**

## East Midlands Incapacity Benefit (IB) & Severe Disablement Allowance (DA) Data – 2007[7]

| County | Local Authority | Working-age Population | IB & SDA all claimants | Mental disorders=medical reason for claimimg | % of IB/SDA claims due to mental disorders | % of working age population with IB/SDA claims due to mental disorders |
|---|---|---|---|---|---|---|
| **Derbyshire** | districts | | | | | |
| | Amber Valley | 72800 | 5065 | 1705 | 34% | 2.3% |
| | Bolsover | 44700 | 5115 | 1585 | 31% | 3.5% |
| | Chesterfield | 61100 | 6240 | 2380 | 38% | 3.9% |
| | Derbyshire Dales | 41100 | 1830 | 605 | 33% | 1.5% |
| | Erewash | 68000 | 4385 | 1505 | 34% | 2.2% |
| | High Peak | 56400 | 3425 | 1300 | 38% | 2.3% |
| | North East Derbyshire | 58700 | 4455 | 1430 | 32% | 2.4% |
| | South Derbyshire | 55200 | 3300 | 1050 | 32% | 1.9% |
| | Derby City | 145100 | 11395 | 4535 | 40% | 3.1% |
| **Derbyshire** | | **603100** | **45210** | **16095** | **36%** | **2.7%** |
| | | | | | | |
| **Leicestershire** | | | | | | |
| | Blaby | 56600 | 2225 | 780 | 35% | 1.4% |
| | Charnwood | 103300 | 4320 | 1820 | 42% | 1.8% |
| | Harborough | 48700 | 1615 | 655 | 41% | 1.3% |
| | Hinckley & Bosworth | 64000 | 2835 | 1110 | 39% | 1.7% |
| | North West Leicestershire | 54700 | 3170 | 1095 | 35% | 2.0% |
| | Melton | 29900 | 1000 | 340 | 34% | 1.1% |
| | Oady & Wigston | 33600 | 1415 | 580 | 41% | 1.7% |
| | Leicester city | 184500 | 15825 | 6640 | 42% | 3.6% |
| **Leicestershire** | | **575300** | **32405** | **13020** | **40%** | **2.3%** |

# Appendix 4

| County | Local Authority | Working-age Population | IB & SDA all claimants | Mental disorders=medical reason forclaiming | % of IB/SDA claims due to mental disorders | % of working population with IB/SDA claims due to mental disorders |
|---|---|---|---|---|---|---|
| **Lincolnshire** | | | | | | |
| | Boston | 34000 | 2845 | 1585 | 56% | 4.7% |
| | East Lindsey | 77800 | 7915 | 2325 | 29% | 3.0% |
| | Lincoln | 56400 | 4555 | 2025 | 44% | 3.6% |
| | North Kesteven | 60200 | 3010 | 895 | 30% | 1.5% |
| | South Holland | 46400 | 2955 | 815 | 28% | 1.8% |
| | South Kesteven | 77600 | 3730 | 1215 | 33% | 1.6% |
| | West Lindsey | 50400 | 3345 | 1170 | 35% | 2.3% |
| **Lincolnshire** | | **402800** | **28355** | **10030** | **35%** | **2.5%** |
| | | | | | | |
| **Northamptonshire** | | | | | | |
| | Corby | 33700 | 2820 | 1040 | 37% | 3.1% |
| | Daventry | 48100 | 1785 | 685 | 38% | 1.4% |
| | East Northamptonshire | 50500 | 2200 | 730 | 33% | 1.4% |
| | Kettering | 53600 | 2975 | 1135 | 38% | 2.1% |
| | Northampton | 127100 | 7615 | 3320 | 44% | 2.6% |
| | South Northamptonshire | 54400 | 1545 | 505 | 33% | 0.9% |
| | Wellingborough | 46300 | 2665 | 1010 | 38% | 2.2% |
| **Northamptonshire** | | **413700** | **21605** | **8425** | **39%** | **2.0%** |

| County | Local Authority | Working-age Population | IB & SDA Claimants | Mental disorders=medical reason for claiming | % of IB/SDA claims due to mental disorders | % of work population with IB/SDA claims due to mental disorders |
|---|---|---|---|---|---|---|
| **Nottinghamshire** | | | | | | |
| | Ashfield | 71200 | 6590 | 2195 | 33.3% | 3.1% |
| | Bassetlaw | 68100 | 6320 | 2380 | 37.7% | 3.5% |
| | Broxtowe | 69900 | 4090 | 1420 | 34.7% | 2.0% |
| | Gedling | 68800 | 4245 | 1530 | 36.0% | 2.2% |
| | Mansfield | 61200 | 7055 | 2290 | 32.5% | 3.7% |
| | Newark & Sherwood | 66600 | 4985 | 1590 | 31.9% | 2.4% |
| | Rushscliffe | 66200 | 2600 | 910 | 35.0% | 1.4% |
| | Nottingham City | 192500 | 17550 | 8130 | 46.3% | 4.2% |
| **Nottinghamshire** | | **664500** | **53435** | **20445** | **38.3%** | **3.1%** |
| **Rutland** | | **22400** | **650** | **225** | **34.6%** | **1.0%** |
| **EAST MIDLANDS** | | **2681800** | **181660** | **68240** | **37.6%** | **2.5%** |

- A year-on-year picture, obtained from the ONS for the East Midlands (2007), is given in the table below. It shows a clear trend of increase in IB/SDA claims due to mental or behavioural disorders across all local authority districts. The average increase across the East Midlands as a whole is 8.4% between 2000 and 2007.[8]
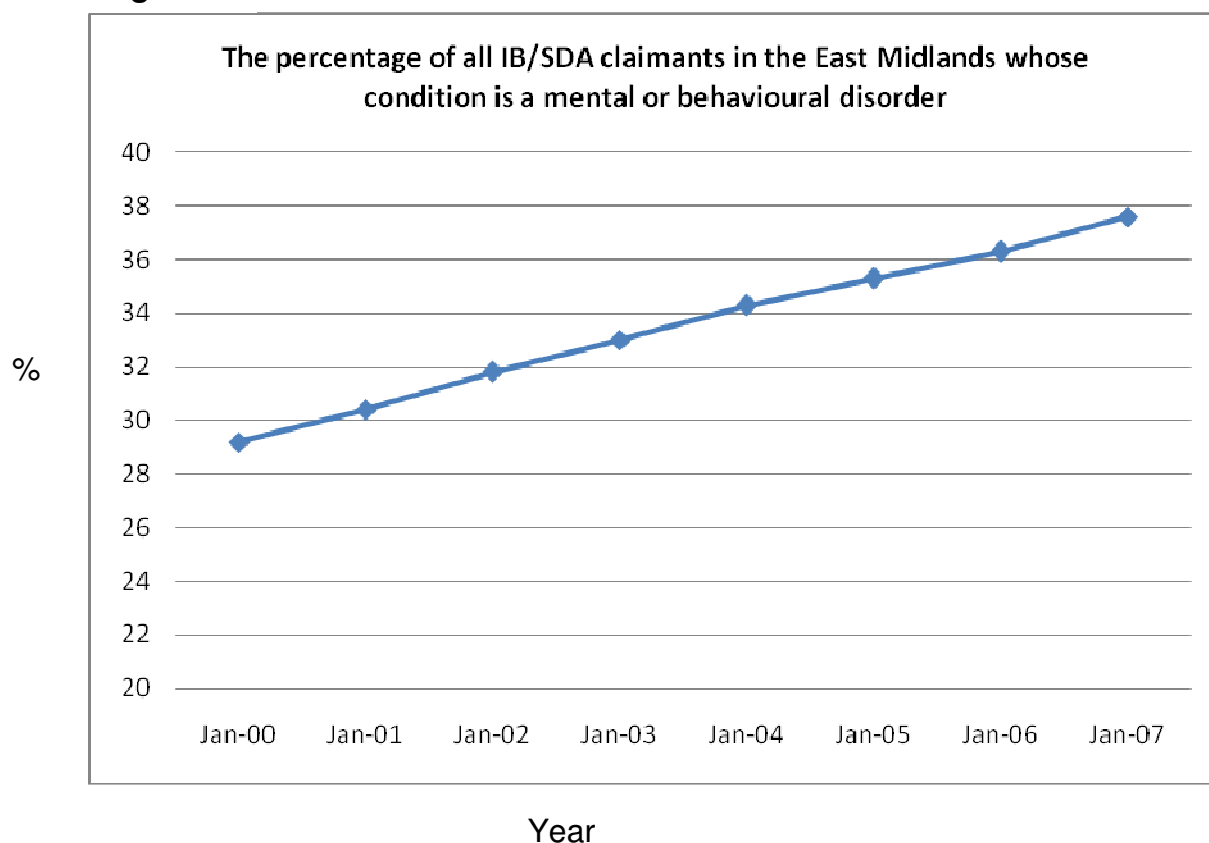
**Figure 7**

Percentage of Incapacity Benefit (IB) & Severe Disablement Allowance (SDA) Claims Due To  Mental Ill-Health 2000 - 2007

| County | Local Authority | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|
| **Derbyshire** | | | | | | | | | |
| | Amber Valley | 27.2% | 28.4% | 29.7% | 30.4% | 32.3% | 32.8% | 33.1% | **33.7%** |
| | Bolsover | 23.5% | 24.6% | 26.5% | 27.3% | 29.3% | 29.8% | 30.9% | **31.0%** |
| | Chesterfield | 31.3% | 32.2% | 33.7% | 34.7% | 35.7% | 36.5% | 37.1% | **38.1%** |
| | Derbyshire Dales | 27.7% | 28.8% | 30.3% | 30.7% | 31.5% | 31.3% | 31.6% | **33.1%** |
| | Erewash | 27.1% | 28.8% | 29.9% | 31.4% | 32.2% | 33.6% | 34.1% | **34.3%** |
| | High Peak | 29.1% | 29.8% | 32.3% | 34.4% | 36.4% | 37.1% | 37.8% | **38.0%** |
| | North East Derbyshire | 25.1% | 26.3% | 27.1% | 28.6% | 29.7% | 30.3% | 30.9% | **32.1%** |
| | South Derbyshire | 22.3% | 24.7% | 26.6% | 27.7% | 28.7% | 30.6% | 31.2% | **31.8%** |
| | Derby City | 31.8% | 32.8% | 34.5% | 35.5% | 37.3% | 37.7% | 38.8% | **39.8%** |
| **Leicestershire** | | | | | | | | | |
| | Blaby | 29.1% | 29.8% | 30.9% | 30.9% | 33.5% | 34.4% | 33.5% | **35.1%** |
| | Charnwood | 32.2% | 32.4% | 34.2% | 35.9% | 37.9% | 39.3% | 40.1% | **42.1%** |
| | Harborough | 32.0% | 34.4% | 34.4% | 36.0% | 37.7% | 37.3% | 36.7% | **40.6%** |
| | Hinckley & Bosworth | 28.0% | 30.4% | 31.8% | 33.0% | 35.5% | 37.1% | 37.5% | **39.2%** |
| | North West Leicestershire | 27.3% | 28.4% | 30.2% | 30.1% | 31.7% | 32.5% | 33.5% | **34.5%** |
| | Melton | 28.4% | 30.2% | 29.4% | 30.1% | 31.1% | 32.3% | 33.3% | **34.0%** |
| | Oady & Wigston | 29.1% | 30.8% | 31.7% | 35.0% | 37.4% | 38.6% | 39.6% | **41.0%** |
| | Leicester City | 34.7% | 35.9% | 37.1% | 38.6% | 39.7% | 40.4% | 41.2% | **42.0%** |
| **Lincolnshire** | | | | | | | | | |
| | Boston | 23.7% | 24.6% | 27.1% | 28.5% | 29.0% | 30.0% | 29.9% | **55.7%** |
| | East Lindsey | 23.5% | 24.6% | 25.7% | 26.4% | 27.0% | 27.8% | 28.9% | **29.4%** |
| | Lincoln | 36.2% | 37.7% | 37.8% | 38.7% | 39.8% | 42.1% | 42.7% | **44.5%** |
| | North Kesteven | 26.4% | 26.4% | 27.6% | 28.3% | 28.3% | 28.9% | 29.2% | **29.7%** |
| | South Holland | 21.4% | 22.9% | 23.7% | 24.0% | 24.5% | 26.1% | 26.6% | **27.6%** |
| | South Kesteven | 29.4% | 30.1% | 30.4% | 30.7% | 30.8% | 31.1% | 32.2% | **32.6%** |
| | West Lindsey | 28.9% | 30.0% | 30.5% | 31.3% | 33.0% | 34.3% | 34.9% | **35.0%** |
| **Northamptonshire** | | | | | | | | | |
| | Corby | 25.9% | 27.7% | 29.0% | 30.8% | 33.0% | 33.0% | 35.4% | **36.9%** |
| | Daventry | 28.0% | 30.1% | 30.9% | 33.0% | 35.2% | 35.4% | 37.6% | **38.4%** |
| | East Northamptonshire | 25.3% | 26.2% | 27.0% | 29.5% | 30.8% | 31.9% | 32.6% | **33.2%** |
| | Kettering | 29.6% | 31.2% | 31.3% | 33.4% | 34.1% | 34.9% | 36.1% | **38.2%** |
| | Northampton | 34.8% | 36.2% | 38.0% | 39.5% | 40.5% | 41.0% | 42.5% | **43.6%** |
| | South Northamptonshire | 26.6% | 27.0% | 28.6% | 29.1% | 30.7% | 30.1% | 31.8% | **32.7%** |
| | Wellingborough | 29.1% | 29.4% | 31.2% | 33.8% | 34.9% | 35.3% | 37.2% | **37.9%** |

**Nottinghamshire**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ashfield | 25.6% | 26.9% | 27.9% | 29.3% | 30.3% | 31.5% | 32.8% | **33.3%** |
| Bassetlaw | 29.2% | 30.4% | 31.1% | 32.9% | 34.6% | 35.5% | 36.6% | **37.7%** |
| Broxtowe | 27.7% | 28.9% | 30.6% | 31.4% | 33.3% | 33.3% | 34.1% | **34.7%** |
| Gedling | 27.3% | 28.1% | 29.6% | 31.3% | 33.5% | 34.3% | 35.7% | **36.0%** |
| Mansfield | 23.3% | 24.4% | 25.7% | 27.3% | 28.1% | 29.7% | 31.5% | **32.5%** |
| Newark & Sherwood | 24.9% | 26.8% | 27.6% | 28.6% | 28.8% | 30.7% | 31.3% | **31.9%** |
| Rushscliffe | 26.4% | 28.1% | 30.5% | 31.1% | 32.0% | 33.1% | 34.9% | **35.0%** |
| Nottingham City | 35.9% | 37.3% | 39.5% | 40.8% | 42.4% | 43.4% | 45.0% | **46.3%** |

**Rutland**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rutland | 30.5% | 32.8% | 34.4% | 35.5% | 33.3% | 34.8% | 33.8% | **34.6%** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **East Midlands** | **29.2%** | **30.4%** | **31.8%** | **33.0%** | **34.3%** | **35.3%** | **36.3%** | **37.6%** |
| **England** | **31.9%** | **33.4%** | **34.9%** | **36.4%** | **37.8%** | **39.0%** | **40.0%** | **41.1%** |

- The following chart illustrates the above data for the East Midlands as a whole, and clearly shows the upward trend noted above:

**Figure 8**



The percentage of all IB/SDA claimants in the East Midlands whose condition is a mental or behavioural disorder

- The following table illustrates the percentage of IB/SDA claims due to mental ill health, the percentage of working population with IB/SDA claims due to mental ill health, and the index of depivation for local authorities in the East Midlands for 2007 [7, 9]:

**Figure 9**

| County | Local Authority | Percentage of Incapacity Benefit (IB) & Severe Disablement Allowance Claims Due To Mental Ill-Health 2007 | % of work population with IB/SDA claims due to mental health disorders 2007 | Index of Deprivation 2007 |
|---|---|---|---|---|
| **Derbyshire** | | | | |
| | Amber Valley | 33.7% | 2.30% | 18.1 |
| | Bolsover | 31.0% | 3.50% | 28.9 |
| | Chesterfield | 38.1% | 3.90% | 25.8 |
| | Derbyshire Dales | 33.1% | 1.50% | 12.5 |
| | Erewash | 34.3% | 2.20% | 18.0 |
| | High Peak | 38.0% | 2.30% | 15.3 |
| | North East Derbyshire | 32.1% | 2.40% | 17.4 |
| | South Derbyshire | 31.8% | 1.90% | 13.9 |
| | Derby City | 39.8% | 3.10% | 26.6 |
| **Leicestershire** | | | | |
| | Blaby | 35.1% | 1.40% | 8.4 |
| | Charnwood | 42.1% | 1.80% | 12.0 |
| | Harborough | 40.6% | 1.30% | 7.1 |
| | Hinckley & Bosworth | 39.2% | 1.70% | 10.9 |
| | North West Leicestershire | 34.5% | 2.00% | 14.7 |
| | Melton | 34.0% | 1.10% | 10.4 |
| | Oady & Wigston | 41.0% | 1.70% | 10.5 |
| | Leicester City | 42.0% | 3.60% | 34.7 |
| **Lincolnshire** | | | | |
| | Boston | 55.7% | 4.70% | 22.3 |
| | East Lindsey | 29.4% | 3.00% | 24.6 |
| | Lincoln | 44.5% | 3.60% | 26.6 |
| | North Kesteven | 29.7% | 1.50% | 10.3 |
| | South Holland | 27.6% | 1.80% | 16.2 |
| | South Kesteven | 32.6% | 1.60% | 11.5 |
| | West Lindsey | 35.0% | 2.30% | 16.8 |
| **Northamptonshire** | | | | |
| | Corby | 36.9% | 3.10% | 26.2 |
| | Daventry | 38.4% | 1.40% | 10.6 |
| | East Northamptonshire | 33.2% | 1.40% | 11.8 |
| | Kettering | 38.2% | 2.10% | 15.1 |
| | Northampton | 43.6% | 2.60% | 21.2 |
| | South Northamptonshire | 32.7% | 0.90% | 6.5 |
| | Wellingborough | 37.9% | 2.20% | 17.8 |

| **Nottinghamshire** | | | |
|---|---|---|---|
| Ashfield | 33.3% | 3.10% | 25.3 |
| Bassetlaw | 37.7% | 3.50% | 24.1 |
| Broxtowe | 34.7% | 2.00% | 14.4 |
| Gedling | 36.0% | 2.20% | 15.4 |
| Mansfield | 32.5% | 3.70% | 31.8 |
| Newark & Sherwood | 31.9% | 2.40% | 18.0 |
| Rushscliffe | 35.0% | 1.40% | 8.1 |
| Nottingham City | 46.3% | 4.20% | 37.5 |
| **Rutland** | | | |
| Rutland | 34.6% | 1.00% | 7.5 |

- The indices of deprivation include claimant statistics, as well as many other factors. It is necessary therefore to be wary of seeking correlations between claimant data and the indices. However, as the graph below (source, ONS) illustrates, there is a striking correlation between the percentage of working population claiming IB/SDA in a council authority and the indices of deprivation in that same authority.

**Figure 10**



Graph to show % of working population claiming IB/SDA against Index of Deprivation

$R^2 = 0.841$
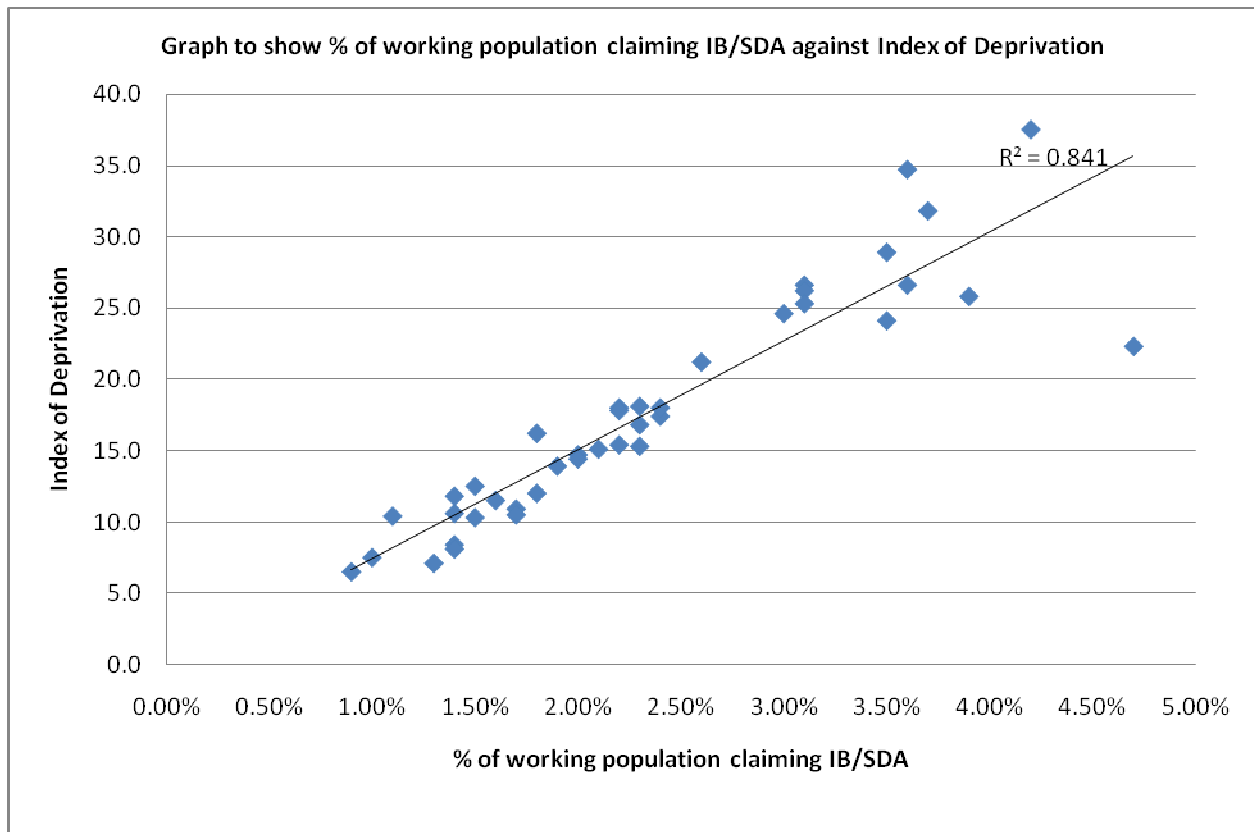
- Expressing the data for IB/SDA claims for mental ill health as a percentage of working population yields the picture given below. This indicates that up to 4.7% of the entire working-age population can be claiming IB/SDA on grounds of mental ill-health in some areas of the East Midlands (also see table above, pages 15 -17).

  IB/SDA claims due to mental and behavioural disorders as a percentage of working age population, updated for 2007 from a 2005 presentation[2, 7]:

**Figure 11**



IB/SDA Claims due to mental and behavioural disorders as a % of working age population.

- >= 3.31%   **4.7%** ;%
- >=2.43% to <3.31%
- >=1.85% to <2.43%
- >=1.55% to <1.85%
- >=0.7%   to <1.55%
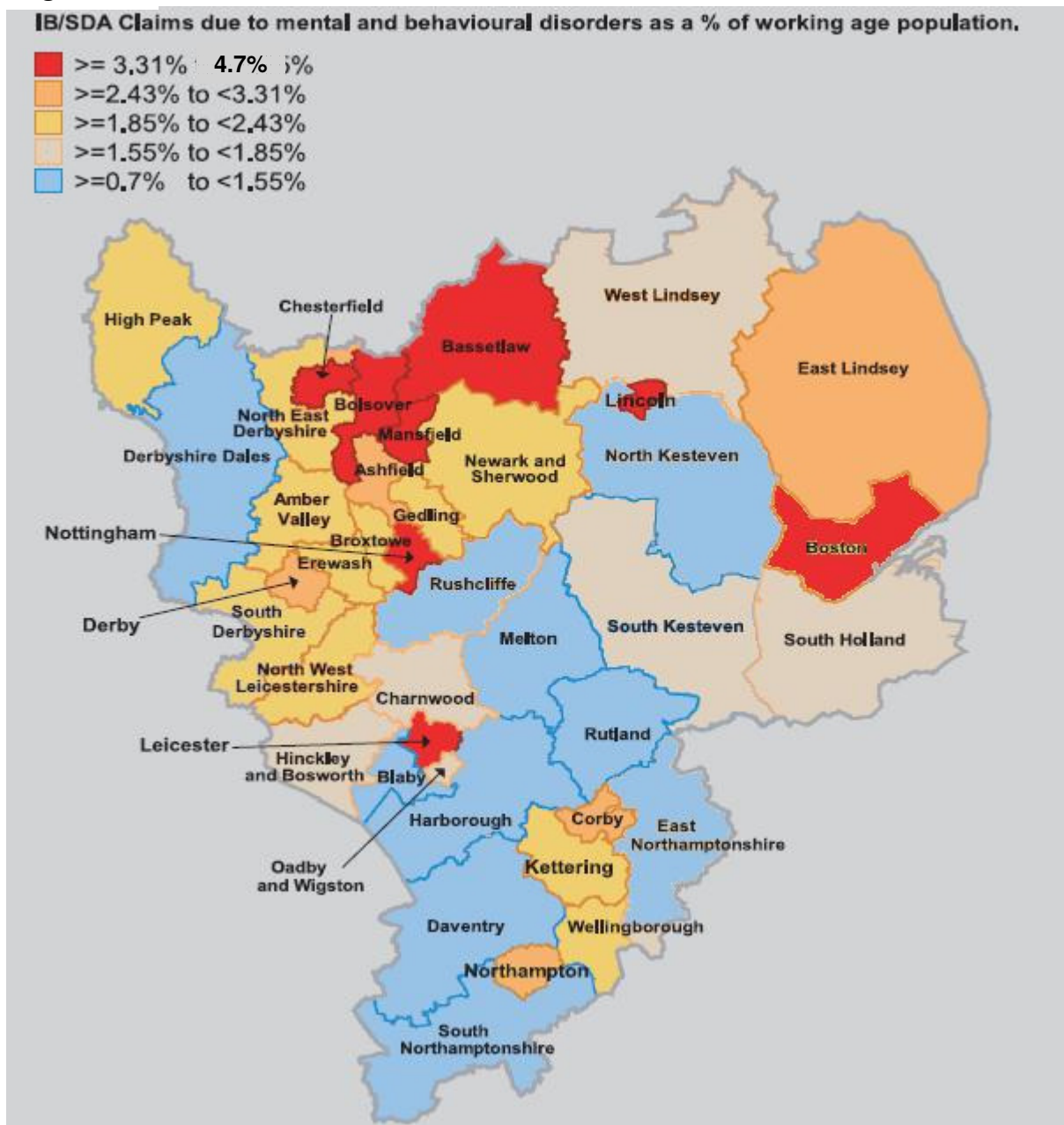
## **References – Appendix B**

[1]Figures from the Department of Work and Pensions, May 2005.

[2]Emphasis: East Midlands Public Health Network, *Improving Health in the East Midlands: Keeping Health in Mind*, 2006.

[3]Health and Safety Executive, *Self-reported Work Related Illness in 2004/5: Results from the Labour Force Survey*, 2005.

[4]Health and Safety Executive *Self-reported Work Related Illness in 2003/4: Results from the Labour Force Survey*, 2004.

[5] East Midlands Public Health Observatory, *Indications of Public Health in the English Regions 7: Mental Health East Midlands Regional Summary*, 2006.

[6] Cabinet Office Social Exclusion Task Force, *Socially excluded adults PSA: Indicator data for the East Midlands*, 2007.
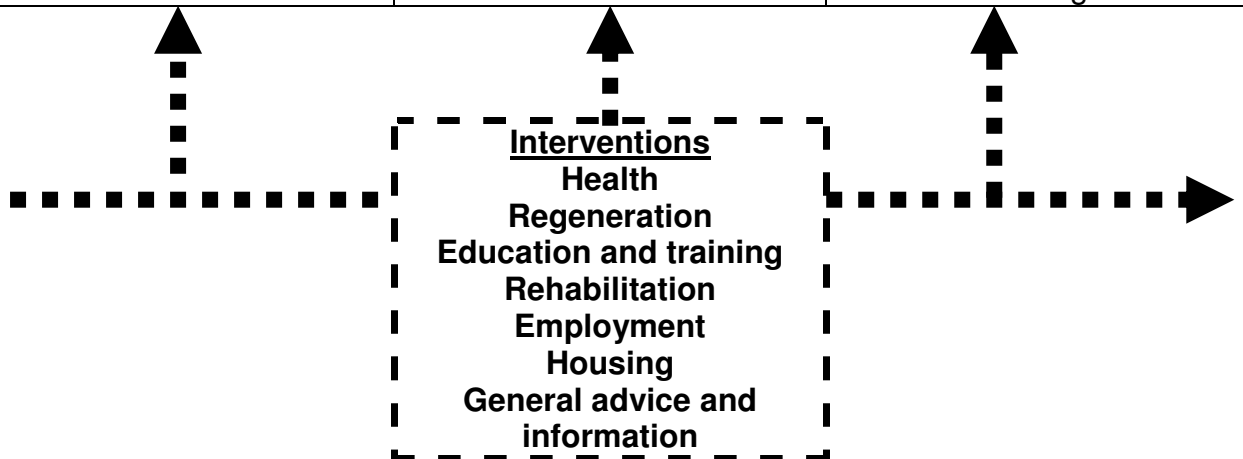
[7]Office of National Statistics, data search at: www.neighbourhood.statistics.gov.uk, 2008.

[8] Information received courtesy of ONS - East Midlands Regional Presence  2007.

[9] Social Disadvantage Research Centre, http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/ , 2007.

**Employment continuum for Regional Employment Team**     **Appendix 5**



**Relationship to Labour Market**

| Out of work long term | Close to labour market | In Work |
|---|---|---|
| **Aim** | **Aim** | **Aim** |
| • To reach out and engage the long term unemployed<br>• Prepare them for the labour market<br>• Improve confidence and motivation<br>• Promote cultural change<br>• Neighbourhood renewal | • Enable people to access work opportunities<br>• Manage the welfare to work gateway/transition to work<br>• Encourage employers to recruit people | • Become productive and contribute to profitability<br>• Promote sustainable employment<br>• Encourage progression (development and promotion)<br>• Prevent a drift back to benefits |
| **Key tasks** | **Key tasks** | **Key tasks** |
| • Outreach and marketing<br>• Address practical obstacles to work<br>• Upskilling<br>• Build capacity<br>• Manage condition | • Job broking<br>• Benefit security<br>• Work incentives<br>• Transitional help<br>• Employer engagement<br>• Work tasters | • Job retention<br>• Sickness management<br>• Occupational health<br>• In work support<br>• Reduce stigma<br>• Cultural change<br>• Career management |

**Interventions**
**Health**
**Regeneration**
**Education and training**
**Rehabilitation**
**Employment**
**Housing**
**General advice and information**

**GLOSSARY** **Appendix 6**

ACAS   Advisory Conciliation and Arbitration Service
BITC   Business in the Community
CAMSH   Child and Adolescent Mental Health Services
CMP   Condition Management Programme
CPA   Care Programme Approach
CSIP   Care Services Improvement Partnership
DCLG   Department of Communities and Local Government
DH   Department of Health
DIUS   Department for Innovation, Universities and Skills
DTI   Department of Trade and Industry
DWP   Department of Work and Pensions
EMDA   East Midlands Development Agency
ESA   Employment and Support Allowance
ESP   Employment Skills and Productivity Partnership
GOEM   Government Office East Midlands
GP   General Practitioner
HSE   Health and Safety Executive
IAPT   Improving Access to Psychotherapy Services
IB   Incapacity Benefit
JOBMAETS   Job Multi Agency Employment Teams
JCP   JobCentre Plus
LAA   Local area Agreement
LDPB   Learning Disability Partnership Board
LEP   Local Employment Partnerships
LSC   Learning and Skills Council
LSP   Local Strategic Partnership
MAPPA   Multi Agency Public Protection Arrangements
NIACE   National Institute of Adult Continuing Education
NSIP   National Social Inclusion Programme
PCT   Primary Care Trust
PtW   Pathways to Work
PSA   Public Service Agreement
RDC   Regional Development Centre
RES   Regional Employment Strategy
RET   Regional Employment Team
RSPA   Regional Skills for Productivity Alliance
SEEM   Social Enterprise East Midlands
SHA   Strategic Health Authority
TUC   Trades Union Congress