UNUM

Mental Health Foundation

Added Value:

Mental health as a workplace asset

2016

Contents

Foreword

Jenny Edwards, CBE, Chief Executive, Mental Health Foundation

There is a growing awareness of the importance of good mental health and wellbeing in the workplace. Line managers report a growing need for help and support. At a strategic level, and of concern to HR professionals and senior managers, there is a need for organisations not only to address the challenge of staff absence and presenteeism, but also to maximise the opportunities to recruit, tap into and retain talent. Wise leaders are conscious that their organisations are strongest and most resilient when they have a diverse workforce, fully engaged with their work.

This is an issue of fundamental importance to society as a whole. For this report, Oxford Economics estimates that people living with mental health problems contributed £226 billion gross value to UK GDP in 2015 – 12.1% of the country's economic output. This is nine times more than the cost of mental health problems to economic output – an estimated £25 billion in foregone gross value added that the UK economy missed out on because people with mental health problems could not join the labour force, were less productive at work, took sick days or required informal carers to leave employment for them.

Mental health is a universal asset – for individuals, organisations and society as a whole. We all have mental health. Like our physical health, there are challenges in life that can harm our mental health, along with protective factors that allow us to manage the times when our resilience is challenged.

As the UK's charity for mental health, the Mental Health Foundation focuses on prevention. We believe that the best way to prevent the profound impact mental problems can have is to seek to understand the factors that contribute to them, and to identify and apply effective solutions.

Through engaging with businesses and workplaces, we can take steps to minimise the chances of mental health problems developing for people in general (primary prevention); for people who, for various reasons, face higher risks (selective prevention); and for people where problems are already present or starting to emerge (indicated prevention).

This report, for the first time, brings together an analysis of the positive contribution people with lived experience of mental health problems make to the economy; an authoritative survey of both line managers and people with lived experience of mental health problems; and qualitative research that delves into more detail on some of the key issues raised.

Disclosure is a key issue in workplace mental health. We need people to feel safe and comfortable in disclosing distress, but we must recognise that this is not currently the case in all workplaces.

Of the respondents to our survey, only half who had been diagnosed with a mental health problem in the last five years had chosen to disclose it to an employer in that period; of those, just over half had a mainly positive experience of doing so. A small majority of those who disclosed did so because they wanted to. Others felt that they had to disclose in order to get something they needed, or were unable to hide their mental health problem because of an episode at work.

A common cause of people not disclosing was fear or experience of discrimination or harassment, showing that we still have some distance to travel in addressing stigma. The fact that 41% of those choosing not to disclose cited shame as a reason shows that we need to take on self-stigma too, and to give individuals a reason to be proud of living with and through distress – as we do with those living with and through physical health challenges, such as cancer.

Reported experiences of support at work vary, some relating excellent practice, and others describing very challenging experiences. Though those in our research who disclosed living with a mental health problem reported receiving the best support (compared with those who didn't disclose), they also reported the most discrimination, and were most likely to feel that their career or job security would be jeopardised by their mental health problem.

When considering what might help, both respondents to the survey and participants in the qualitative research highlighted the fact that valuing, protecting and improving mental health required a consistent commitment from top to bottom across the whole organisation – rather than just a piecemeal approach.

It was no surprise to discover that relationships with line managers were key, but that line managers could only build good relationships at work if given the necessary time, training and support. Mental health policies were seen as important – better still, the integration of mental health across HR practice – but only if implementation was monitored, and continuous improvement undertaken.

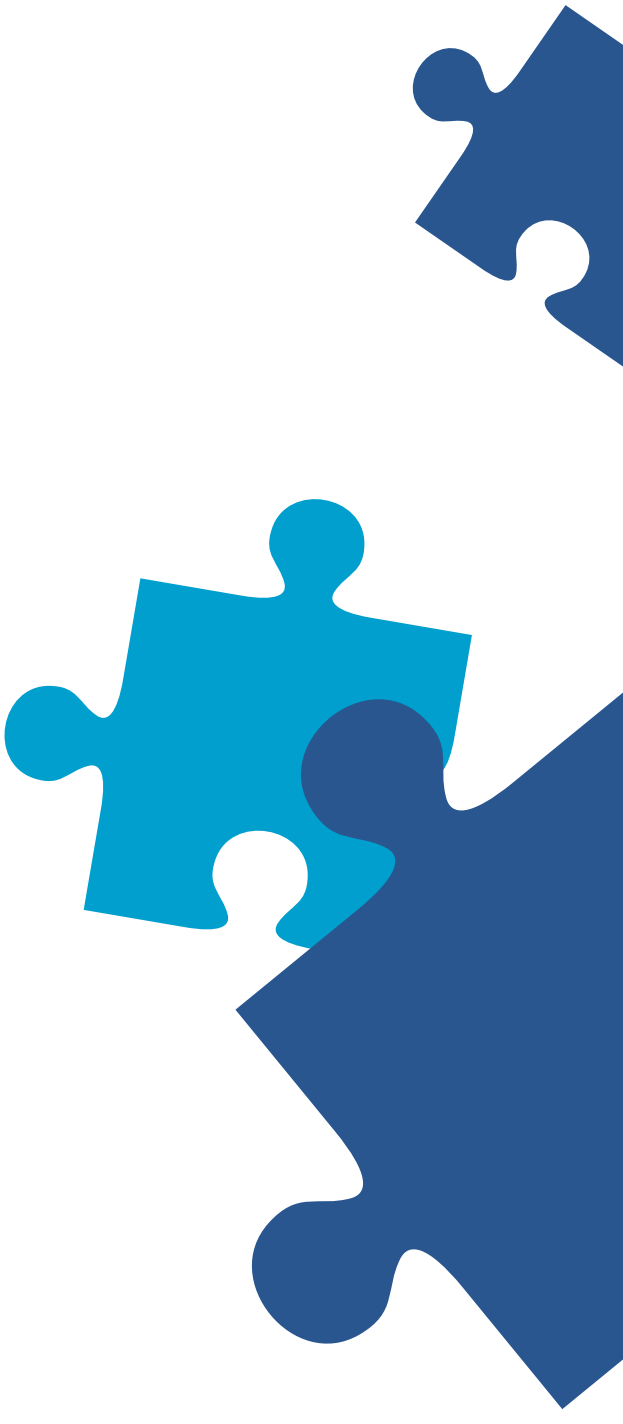
Line managers and people with lived experience identified the same three success factors for achieving a sustained positive impact on mental health at work: culture, leadership and policy.

We need to create a culture in which mental health is valued: where disclosure is encouraged, support is present, and everyone feels that their work and the benefits they receive contribute to their wellbeing.

Workplaces need leadership that demonstrates commitment to mental health as an asset of the organisation, and one that is critical to achieving business results or strategic outcomes. This needs to cascade from board champions and senior leadership to middle management and then first line supervisors. At each level, leaders need to feel that investing in mental health is a valuable use of their time. At every touch point – whether analysing absence figures in the boardroom or in appraisal and performance management in frontline supervision – leaders need to understand how to engage with mental health.

This research points out that business is right to be concerned about mental health at work – with discrimination, fear and shame in play, it is very hard for the massive potential of mental health as an asset to be realised, and it is time this changed. Workplaces need systems and policies that support mental health. And consistency is critical. It can be achieved with well-implemented policies shaped both by leadership and by those with lived experience. Support is only effective if people know it is available, can utilise it without fear, and find it helpful.

We hope that this report becomes an important resource for all interested and engaged in improving workplace wellbeing. By working with Unum and Oxford Economics on this research, we have been able to reach new audiences on a large scale, and to explore areas that demand much greater attention and understanding. The scale and significance of mental health in the UK's workplaces must be recognised. Everyone takes their mental health state to work and is affected by the circumstances they find there. We see enormous untapped potential for most workplaces to contribute positively to mental health. Getting this right could also produce substantial benefits for businesses, getting the most out of workforce talent and improving the lives of millions of working people.



Liz Walker, HR Director, Unum UK

Due to advances in technology, work is no longer restricted to the workplace. Smartphones allow employees to be contactable 24/7, and Unum's 'Future Workplace' report identified that 73% of British workers feel they are expected to be available for work at all times. As the office is now in the palm of our hands, it is harder and harder to escape work completely. This can turn stress into distress, impacting both performance and wellbeing.

Employee wellbeing is rising up the agenda of employers in the UK, and a fundamental aspect of this is safeguarding the mental health of staff. Organisations are responsible for ensuring practices are put in place to support those who live with mental health problems, as well as those who may do so in the future. By embedding a culture that is led by senior management, organisations can encourage a healthier work–life balance that is beneficial for both employee and employer.

Society depends on a healthy workforce, and protecting mental health is central to employees' wellbeing. As a result of increased mental health awareness, organisations have now been encouraged to adopt a more rounded approach to health and wellbeing that also addresses the psychological risks affecting the health of staff. Line management plays a critical role in this, by educating staff on mental health, by communicating the support that is available, and by providing that support to those who may need it.

At Unum, we realise that training is crucial, not only for a healthy workplace but also to the success of a business. We have undertaken a number of initiatives for staff, including mental-health first-aid training and an online training module on stress awareness. We believe it is essential that employers provide HR and line managers with the necessary tools and time to help identify, manage and prevent poor mental health in the workplace. Our partnership with the Mental Health Foundation is vital proof of this, showing that we are committed to creating a culture in which mental health is taken seriously

Introduction

The Mental Health Foundation, Oxford Economics and Unum undertook this research to help businesses to value, improve and protect mental health in the workplace.

We want to shift the narrative on workplace mental health from discussion of the financial burden of mental health problems to one of the value of mental health as an asset: of individuals, of companies and of the economy. For any business to fulfil its potential, it is necessary to understand the factors that affect its value, both positively and negatively. By doing this, it is possible to implement strategies for growth, to recognise and mitigate risk, and to ensure that legal and ethical standards are maintained throughout. Here we demonstrate the case for businesses to approach mental health in exactly this way, developing a strategic approach that connects best practice with company mission and values.

We start from a baseline acknowledgement that most people in employment recognise that their work is an important factor in maintaining their mental health. Financially, socially and for our identity, our work is often a key part of our self-worth. Our research supports this across the board. Critically, we found that people with mental health problems regard their work as especially important to their mental health.

For business to address mental health, it is important that mental health continues to be given greater priority, moving from being solely a HR matter to being included in the overall metrics of company performance, and to framing the objectives of senior management. For people with mental health problems to recover and to then thrive at work, it is important that they feel able to disclose, and that they feel supported. It is not enough to just ask people to be open and honest; a workplace must support safe disclosure.

A period of distress can be defined as a time when a person is not coping. Distress may arise from a mental health problem, but it may also be a result of stress, life events or a combination of factors.

In this research, we have taken a specific interest in the experience of distress in the workplace. With one in six adults experiencing a common mental health problem in the last week (APMS, 2014), we seek to widen the perspective on mental health at work from a discussion of mental illness to the recognition that most of us experience distress that affects our work.

Supporting people with early signs of distress – and enabling those with existing mental health problems to recover and avoid relapse – is a prevention model that mitigates impact both for individuals and for businesses.

Our aims with this work were threefold:

- to understand the experiences of people working while experiencing distress
- to explore the ways that managers and organisations respond to distress expressed by staff
- to recommend whole-workplace strategies that support those who experience mental health problems and maximise the overall mental health of the workplace

The research combines three approaches:

- **Qualitative research undertaken by the Mental Health Foundation.** This includes 25 in-depth qualitative interviews with people with mental health problems; with line managers; and with HR directors, collecting detailed accounts of personal experience that help to frame the quantitative work.
- **A cost analysis by Oxford Economics.** This uses publicly available data to demonstrate the value added to the economy by employing people with mental health problems. Additionally, Labour Force Survey (LFS) data is used to analyse the composition of the labour force with regard to mental health problems.
- **A workplace mental health and wellbeing survey commissioned from YouGov PLC by Unum and Mental Health Foundation**. This combines a sample of around 1,000 people who have self-defined as having mental health problems with a further sample of around 1,000 people with line-management responsibilities.

The report summarises the findings from this data and suggests recommendations for action.

Sample and methodology

This study used two data collection strategies to gather both detailed personal data and large-scale survey data, using qualitative interviews and focus groups for the former and a bespoke survey conducted by YouGov for the latter. The methodologies for both are summarised below.

Qualitative research

For the qualitative study, a mixture of semi-structured interviews and focus groups were conducted in order to explore experiences of mental health in the workplace. A range of participants with varying experiences and perspectives were recruited.

The groups included in the study were:

1. **individuals with personal experience of living with a mental health problem**, particularly those in work (with the aim of exploring the barriers to employment, staying in work and getting back to work, as well as coping strategies, what helps and the support structures currently available)
2. **line managers** who manage people with mental health problems
3. **HR managers or HR leads** (with the aim of discovering the barriers they face, as well as what best practice looks like)

A non-probability, snowball-sampling technique was used to recruit participants, with a call for participants outlining the inclusion and exclusion criteria on the Mental Health Foundation website. Participants were invited to contact the research team, who then screened for suitability. As participants were recruited from across the UK, they were given the choice of a telephone interview or a focus group that would take place in London. By using telephone interviews as a data collection method, a wider range of participants was recruited.

A total of 25 participants took part in the study, coming from a variety of employment backgrounds and sectors, and with a range of experiences. Fourteen participants had experience of having a mental health problem (accounting for 56% of the sample). HR leads accounted for 24% (n=6) and line managers for 20% (n=5). Most participants interviewed were female (80%, or n=20).

Interviews and focus groups were transcribed and analysed, and the results then presented. The preliminary findings from the qualitative study informed the development of the questions used for the quantitative survey.

Quantitative research

YouGov PLC conducted a survey of working adults with lived experience of mental health problems and working adults with line-management responsibilities. Fieldwork was undertaken between 12 and 24 August 2016. The survey was carried out online.

The target sample size was 1,000 working adults with lived experience of mental health problems and 1,000 adults with line-management responsibilities.

The total sample size achieved was 2,019 adults, and it comprised 1,375 adults with lived experience of mental health problems and 1,099 line managers. A total of 1,265 of the 1,375 had been diagnosed by a health professional within the last five years as having a mental health problem.

A total of 455 respondents had both lived experience of mental health problems and line management responsibilities, thus providing unique insight.

Of the sample, there were 628 managers who had no experience of mental health problems. They provide a useful comparison as a population with no recent mental health problems (although care should be taken in regarding this population as representative of the general population).

Overall, the sample was gender balanced and achieved a reasonable diversity in terms of age of respondent. The sample was strongly biased towards respondents in ABC1 social groups (77%, vs 23% in C2DE). The sample was strongly biased towards employees in the private sector (73%); this may increase the relevance of the findings for business audiences, but care must be taken in generalising these findings to the population as a whole.

Findings

The findings of the study are presented in five sections:

1. **the economic importance of safeguarding mental health in the workplace:** the business case for change, including a cost analysis by Oxford Economics
2. **the benefits of work to mental health,** exploring the extent to which people feel that their working life is important in protecting and maintaining their mental health, drawing on both the qualitative interviews and the survey results
3. **people's experiences of mental health at work**, focusing primarily on survey data to present findings of respondents' experiences of distress at work, of absence patterns, and of supporting others
4. **barriers to disclosure**, focusing on disclosure of distress and on stigma and discrimination
5. **supporting mental health at work,** exploring the support people with mental health problems have received in the workplace, looking at what people feel their employers did well, and what they feel their company could do to improve the mental health of the workforce

1. The economic case for change

A detailed economic analysis was conducted for this study by Oxford Economics, and is presented in its entirety as a standalone document and appended to this report. The economic analysis presents a breakdown of the composition of the workforce who reported having experience of a mental health problem in the Labour Force Survey, and undertakes an economic analysis of the value added to the economy by this workforce, contrasting this with the costs. The key findings are presented in summary here:

People with mental health problems deliver significantly more benefits than costs for the UK economy

People with mental health problems – working in a wide range of industries, from construction to entertainment – made an estimated £226-billion gross value added contribution to UK GDP in 2015 (12.1% the country's economic output). This is greater than the contribution to GDP made by all industries located in the East and West Midlands combined. Nearly three quarters of the total was created in the private sector.

That contribution is nine times more than the cost of mental health problems to economic output.

Nevertheless, businesses should pay attention to the costs to business and individuals arising from mental health problems. An estimated £25 billion in foregone gross value added to the UK economy is missed out on because of the cost of mental health problems to individuals and to business. This includes the cost of absence and staff turnover, lost productivity, carers leaving the workforce, and people with mental health problems not being employed.

An estimated £19 billion (or 76%) of this total foregone gross value added is estimated to affect the private sector.

The majority of those with common mental health problems are employed, and they work across all industrial sectors

In 2015, an estimated 8.6 million people aged 16 or older in the UK were affected by a common mental health problem such as stress, depression or anxiety, and nearly 4.9 million of these were in work (15.3% of the total employed population in 2015).

A further 590,000 people aged 16 or older had a serious mental health problem such as bipolar disorder or schizophrenia, and an estimated 130,000 of these were in work (1.1% of the total employed population in 2015).

In total, people with mental health problems made up an estimated 15.9% of total employment in 2015. Of these, 75% worked in the private sector.

Among the working-age population (16–64 years), 64% of people with a common mental health problem and 26% of people with a serious mental health problem were employed.

People with mental health problems work in every industrial sector of the economy, although they are relatively more prevalent in the healthcare and education sectors and relatively less prevalent in agriculture, forestry, fishing and real estate.

Reducing the costs of mental health problems could bring substantial benefits in the future

By 2030, the foregone gross value added due to the challenges arising from staff mental health problems is predicted to rise to £32.7 billion.

Some businesses have shown that it is possible to reduce the costs associated with staff mental health problems. If just 10% of the costs were mitigated, the UK economy could be £3.3 billion larger than it otherwise would be in 2030 (0.1% of forecasted GDP that year).

2. The benefits of work to mental health

Work is a key factor in supporting and protecting mental health. It is even more important for people who have lived experience of mental health problems. Many people with mental health problems want to be at work, and they value the part it plays in their lives.

A strong majority of respondents across the survey sample (n=2,019) said that their job and their being at work was important to protecting and maintaining their mental health:

- 47% of all respondents said employment was very important to their mental health;
- 39% said it was fairly important;
- 12% either said it was not very important (8%) or not important at all (4%).

People who had been diagnosed with a mental health problem within the last five years (n=1,265) were significantly (p=<0.05) more likely than those who had not (n=628) to regard their job as very important to their mental health (49% vs 43%). Line managers who also had lived experience of mental health problems (n=455) were significantly (p=>0.05) more likely to regard their work as very important to protecting and maintaining their mental health than those without lived experience (52% vs 43%).

The qualitative research undertaken echoed these themes. Participants reported that work had a positive influence on their recovery, wellbeing, self-esteem, social connectedness, and identity. The majority said that they enjoyed their work and that it was empowering for them because they are good at what they do.

Participants with mental health problems also felt that returning to work following absence or periods of being unwell was necessary and beneficial for their own wellbeing.

> “In a way, work keeps me well.”

> “I found being off work very frustrating. I felt that I had lost my identity for about two months into my period off... Returning to work was a big part of my recovery.”

> “Work is my identity. If I hadn’t got work, I don’t know what I am!”

Even where participants identified that the stress they experienced at work was related to the impact of their mental health problem, they noted that work was still a necessary element of their lives, providing a routine, as well as their source of income.

> “For me, it’s a case of I need to pay the rent so I need to be in work.”

Consequently, it was clear that sickness absence or leaving work altogether was considered a last resort for most individuals. For many, the considerable benefits that work brought to their lives meant that absence was not even an option to consider.

Most HR directors and line managers agreed that keeping people healthy and in work also had benefits for the individual in their process of recovery.

> “Work is stressful, but coming to work, having a structure, having the support of colleagues, or having that human social contact... you know, can be very beneficial for people.”

The research findings complement guidelines by the National Institute for Health and Care Excellence (NICE) on workplace health, which highlight the important role that good work can play in promoting mental wellbeing, due to the role of employment in identity formation, building self-esteem and providing opportunities for social interaction.

Work was key to promoting and preserving mental health and wellbeing for respondents across the sample, and was regarded as even more so by those who have experienced mental health problems and are working. This is a key finding for making the case for 'proportionally universal' strategies for workplace mental health – strategies that include everyone within a company community but that focus on those at greater risk of distress, or who have already experienced mental health problems.

We know that people who are in work and who have experience of mental health problems play a vital part in the economy. For those consulted for this research, absence was a last resort, and maintaining a good work life was important.

3. Experiences of mental health at work

The Mental Health Foundation defines distress at its most basic level as 'having trouble coping, for whatever reason'. Most of us therefore experience distress at some level from time to time. The responses highlight the wide range of distress that an employee can experience while at work, whether or not this is obvious or known to colleagues or managers.

Respondents to the survey were asked about their personal experiences of mental health and wellbeing at work, and to identify which statements from a list of options applied to them. The questions were split into three themes relating to the experience of distress; to supporting other people; and to absence from work.

Figures 1 and 2 present respondents' self-reported experience of distress.

Across the whole sample (n=2,019) the majority of respondents signified that they had at some time experienced distress, with 73% selecting 'I have been through times where I felt stressed, overwhelmed or had trouble coping, for whatever reason.' Among those who had been diagnosed with a mental health problem in the last five years, this rose to 88%. Nearly four in ten line managers who had no history of mental health problems (39%) indicated that they had experienced distress.

Figure 1: Proportion of respondents who selected the statement 'I have been through times when I felt stressed, overwhelmed or had trouble coping, for whatever reason'

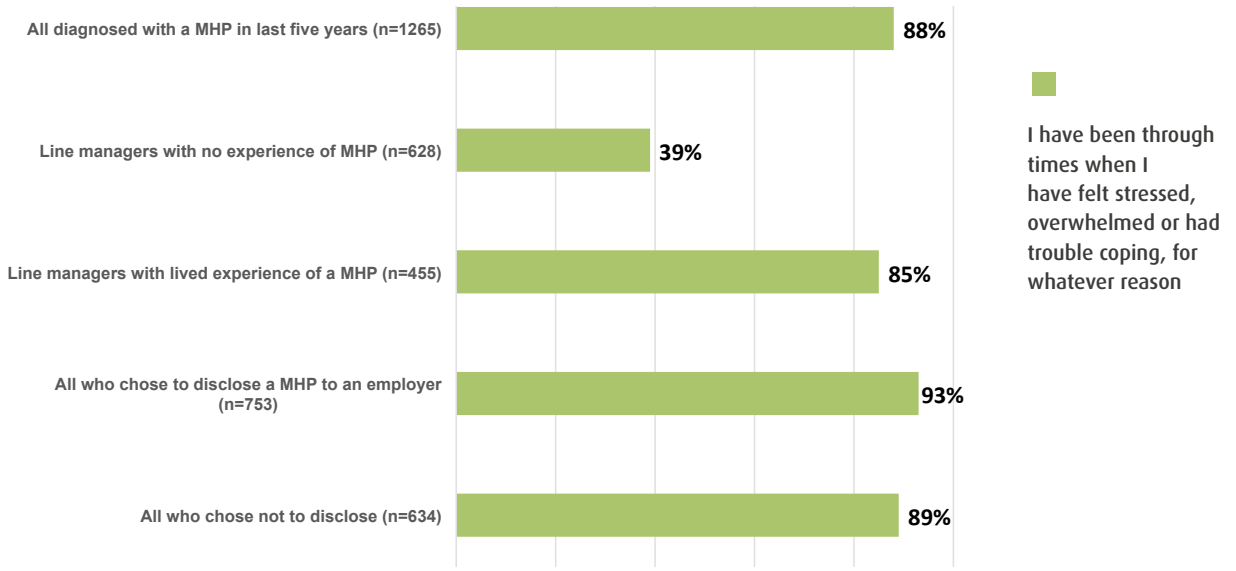
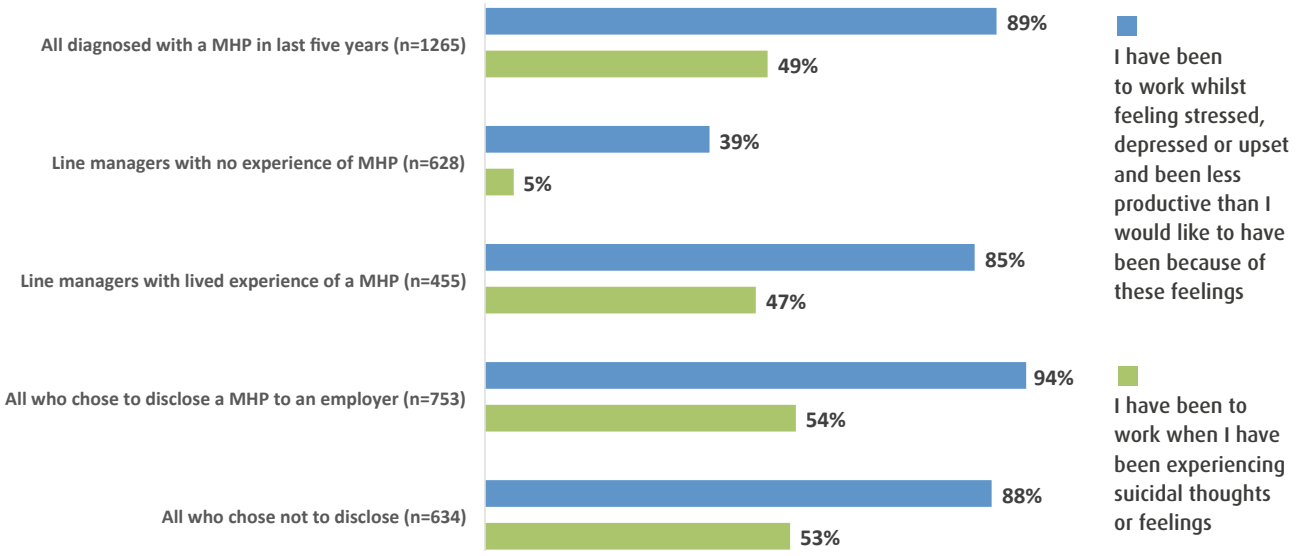


Figure 2: Proportions of survey respondents who selected statements relating to personal experience of distress in the workplace



Overall, 89% of respondents who had been diagnosed with a mental health problem in the last five years selected the statement 'I have been to work whilst feeling stressed, depressed or upset and been less productive than I would have liked because of these feelings.'

39% of line managers with no experience of mental health problems also reported that the statement applied to them.

It is clear from the data that distress is an issue that affects a major proportion of the workforce, whether or not they have experienced a mental health problem.

With 39% of respondents who have no experience of mental health problems indicating that distress has left them less productive than they would like, there is a potential association with Presenteeism if distress is leaving them less productive that they would have liked. We know that the costs to employers of presenteeism can be substantially higher than that of absenteeism, and this alone demonstrates the need to address mental health and wellbeing as a whole-company priority.

Suicidal thoughts and feelings at work

Respondents were also asked whether they had been to work when experiencing suicidal feelings or thoughts. This question was intended to provide a clear indicator of the number of people going to work while severely distressed – whether because of a mental health problem or not.

Nearly half of respondents who had been diagnosed with a mental health problem in the last five years (49%) reported going to work while experiencing suicidal thoughts or feelings. Five per cent of respondents who had not experienced a mental health problem had nevertheless gone to work while experiencing suicidal thoughts or feelings.

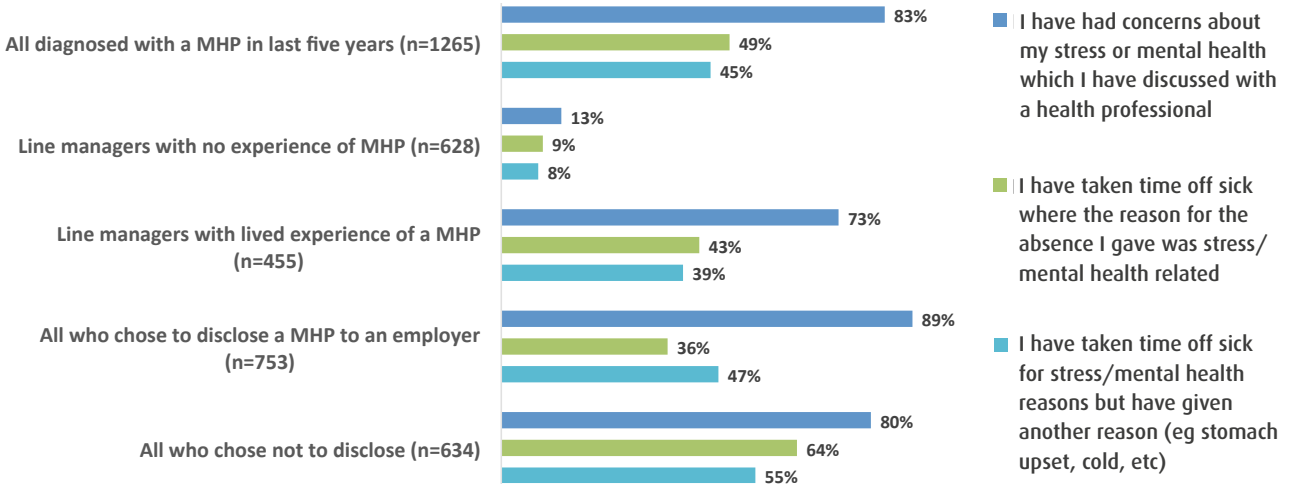
Sickness absence

We wanted to find out more about employees: in particular, whether they discussed concerns about their mental health with a health professional, and how this connected with the reasons they gave their employers for sickness absence. Do employees disclose the true nature of time off for mental-health-related matters, or do they give other reasons?

The data is summarised in figure 3.

The Adult Psychiatric Morbidity Survey of 2014 indicates that a fifth of adults (20.6%) have had thoughts of suicide at some point, indicating that thoughts of suicide are relatively frequent in the population. We cannot conclude from our data that half of people with experience of mental health problems are actively suicidal, but this data does indicate that suicidal thoughts or feelings are a concern in workplaces today – and not just for those who have a recent history of mental health problems.

Figure 3: Proportions of survey respondents who selecting statements relating to help seeking and disclosed and undisclosed sickness absence related to mental health



Forty-nine per cent of people who had been diagnosed with a mental health problem in the last five years had taken mental-health-related sickness absence, while 45% of those people reported having taken time off but giving another reason. Among line managers with lived experience of mental health problems, 43% had taken a disclosed mental-health-related absence and 39% had taken mental-health-related absence but given other reasons.

Sixty-four per cent of those who had disclosed a mental health problem to an employer had taken a disclosed mental-health-related absence, compared with 36% of those who had chosen not to disclose a mental health problem. Sixty-four per cent of those who had chosen not to disclose a mental health problem had taken mental-health-related absence but given another reason, compared to 34% of those who had disclosed their mental health problem. This clearly demonstrates an increased willingness of people who have disclosed to take the time off when they need, and that people who had chosen to disclose were far more likely than those who had not to be open about reasons for absence ; this issue is therefore critical for creating a positive culture and for gathering accurate data about absence.

Only around half of those people who had experienced a mental health problem in the last five years had taken time off from work and given mental health reasons for this. This may indicate that while mental health is a component of many absences, the experience of mental ill health doesn't always lead to absence – indeed, from the qualitative research, we know that people value staying in work for as long as they can.

Across most sample groups, a sizeable proportion of respondents had taken absence for mental health reasons but had given another reason – essentially lying. In many companies, this would be regarded as a disciplinary matter, but many people still feel the need to lie about some or all of their absences. Responding to this matter needs to be a priority in addressing discrimination and disclosure. Disclosure and comfort with disclosing is key to ensuring that companies can accurately assess the scale of the problem.

As one put it: "We are not in the position yet where you can phone in to work sick with a mental health issue."

4. Barriers to disclosure

Recognising distress and disclosing it to others is one of the most complex challenges in addressing mental health at work. Disclosure of a mental health problem is, for many people, considered as different to disclosure of other health concerns. What can we learn about why people either do or do not disclose?

We know that early disclosure of distress can enable people to find their way to calmer times without the need for health service involvement, and before distress becomes a mental health problem. However, for many, the workplace is an inherently competitive environment, where personal performance is under scrutiny and where we invest a lot into trying to be at our best.

For people with mental health problems, the fear of discrimination – which evidence suggests is well founded – can deter them from disclosure until the point of absolute necessity, by which time problems both in terms of health and in terms of work relationships may be too entrenched to achieve good outcomes.

Disclosure seems to be changing, however. Among those diagnosed with a mental health problem in the last five years nearly three out of every five surveyed (58%) had disclosed their problem to an employer in this time, and over half (54%) of those choosing to disclose had a net positive experience. However, it should be noted that a large percentage of these disclosures were not out of choice but perceived necessity.

Despite this, stigma and discrimination is still a major factor in the workplace; fear of discrimination or harassment, as well as previous negative experiences, are major inhibitory factors in deciding whether to disclose. This fear is justified: discrimination is relatively common, and so this understandably leads to a fear of disclosing, underpinning the feelings of shame and self-stigma that can inhibit people with lived experience of mental health problems from reaching their full potential.

There appears to be a 'disclosure premium': that those who have disclosed seem to have a better understanding of what support is available, and a better appreciation of it. Equally, managers and HR directors point out that disclosure is still the filter through which support has to pass, so companies need to look at ways of improving the disclosure experience and the 'payback' that it provides in terms of support. We have sought through this research to form a more detailed picture of the reasons why people disclose, or choose not to.

Choosing to disclose

We asked all survey respondents who indicated that they had lived experience of a mental health problem whether they had disclosed this to an employer.

Nearly three in five respondents (58%) who had been diagnosed with a mental health problem in the past five years had chosen to disclose it to an employer in this time. This was lower for line managers with lived experience (n=455), among whom 47% had disclosed. This is worthy of further research, but it may relate to age, experience or perceptions of employer expectations among managers, or the perception of having too much to lose to risk a negative experience.

Just under half of respondents (45%) who had been diagnosed with a mental health problem had chosen not to disclose this to an employer in the past five years. Among responding line managers who also had lived experience of mental health problems, 43% had chosen not to disclose.

Disclosure is not a binary decision, with people choosing to disclose to some employers but not others. Of those people who had chosen not to disclose to an employer, 35% had in fact disclosed at another time in the past five years, perhaps because they have changed employer or moved within an organisation. Of those who had chosen to disclose to an employer, 27% had chosen not to disclose at another point.

In the qualitative research, a lack of knowledge about what happens when one does disclose was often discussed by individuals:

> "I haven't talked [to work] ... I have always worried that if it goes in any kind of personnel record or any kind of written thing where someone might access my medical report so it would mean that I would have difficulties with getting another job or promotion or anything like [that], so I don't tend to talk about it."

HR leads and directors recognised that the challenge lies in enabling staff to feel safe disclosing, citing a perceived belief among staff that disclosure would jeopardise their job. One HR manager managing several teams providing employability services for people with mental health problems said:

> "The majority do not like to disclose that they have a mental health condition. We try and advise people to discuss it, we spend time doing disclosure statements with the employees because we think it's better for their wellbeing, their health, if the employer is aware ... but the majority of people decide not to do that, whether it is past experience or what they have heard ... to be honest, the majority of people don't choose that option."

Disclosure is a decision made according to circumstance, with around a third of people having chosen both to disclose and to not disclose at different times within the past five years, to different employers.

This implies that disclosure is a decision carefully made according to perception of the risk of doing so when moving between employers or between teams or business units in a company. Mental health problems fluctuate; for many people, even a severe episode can be a one-off. Privacy must be considered when encouraging disclosure. People rightly want to be identified by their skills rather than their history, if it is not relevant. Conversely, some people will require adjustments throughout their career, but these needs may change.

British Telecom (BT) has more than a decade of experience of company-wide mental health and wellbeing programmes. They use a 'BT Passport' system so that employees with long-term conditions, mental health problems or caring responsibilities can note and communicate needs to managers. The passport can then be used to communicate efficiently with other areas of the business when the need arises.

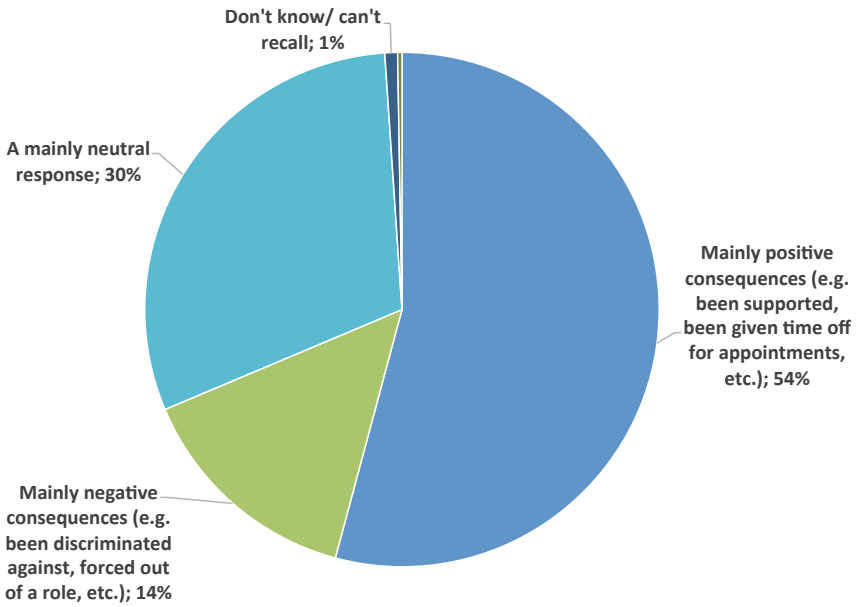
Experiences of disclosure at work

Employees face a dilemma about disclosing a mental health problem at work, and about who they should disclose to. If employees do disclose, what are their experiences? What can we learn from who they chose to disclose to?

Respondents who said that they had chosen to disclose their mental health problems to an employer in the last five years 753 respondents were asked to describe whether the experience had been mainly positive, mainly negative or mainly neutral. As figure 4 shows (below), the majority of respondents had a positive experience of disclosure, with 84% overall having a mainly positive (54%) or neutral (30%) experience.

Nevertheless, 14% of respondents had experienced a mainly negative response.

Figure 4: Reported experiences of disclosure in respondents who had declared a mental health problem to an employer in the past five years (753 respondents)

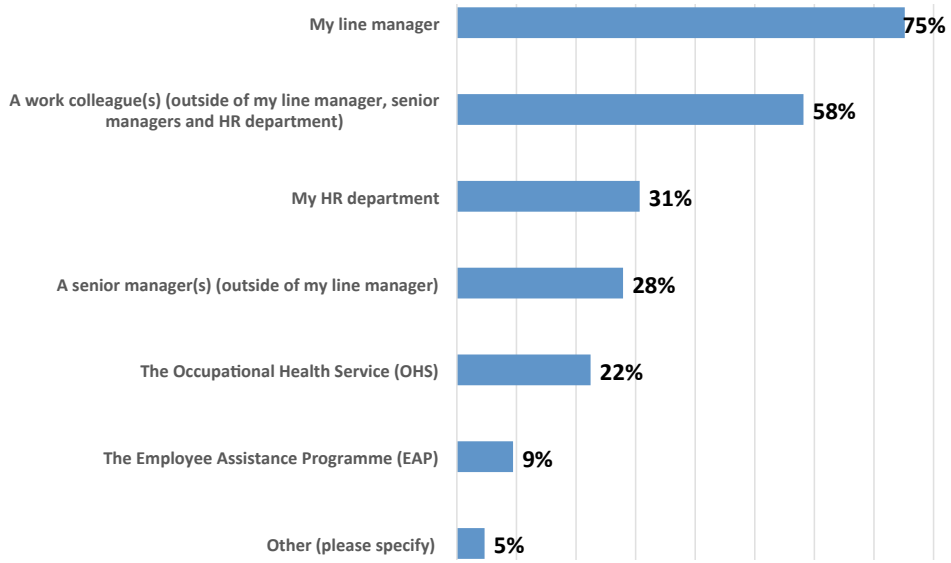


Line managers who also had lived experience of mental health problems, and who had disclosed (215 respondents), were more likely to report a mainly positive experience (61%) and less likely to report a mainly negative experience (11%) than people with lived experience of mental health problems as a whole (51% mainly positive and 16% mainly negative).

Respondents were also asked to identify the people or agencies at work that they had disclosed to. Figure 5 (below) shows the main people those choosing to disclose to an employer had made that disclosure to. The most popular recipients of disclosure – for those who have disclosed in the past five years – were line managers, and by a considerable margin (75% disclosing to a line manager). This was followed by disclosure to colleagues outside the line-management chain (58%), then HR (31%) and senior managers (28%).

Just 9% of respondents who had disclosed had done so to an employee assistance programme (EAP). Among those who had chosen not to disclose in the past five years, this was halved, with only 4% of those choosing not to disclose at work having spoken to an EAP.

Figure 5: People or agencies to whom respondents that have disclosed in the past five years have ever disclosed a mental health problem (753 respondents)



Line managers are the most likely people to receive a disclosure of a mental health problem. This is probably both because they are the first line of official connection between employee and employer and because the opportunity arises in the course of line-management interactions. Line managers also have the authority to grant discretionary leave, and are most likely to see impacts of distress on a day-to-day basis. With 58% of those disclosing discussing their mental health with a work colleague outside the chain of management, the need to ensure all staff are comfortable and capable of discussing distress is clear. There is a strong argument for ensuring that promoting and protecting mental health at work is seen as a universal responsibility, and not just a welfare or performance issue within individual management relationships.

Disclosures to HR and occupational health services are perhaps lower than may be expected. It is not possible to know if this is because these services are not available to respondents, although this is a factor, particularly in SMEs. Equally, it may indicate that while some mental health problems at work require HR support and occupational-health advice, most periods of distress do not, and can be addressed and supported through line manager relationships. Enabling managers to provide this support confidently enables HR and occupational health support to be directed to the management of complex cases, as well as making the early and effective addressing of distress feel like a more normal and everyday process.

Reasons for disclosing

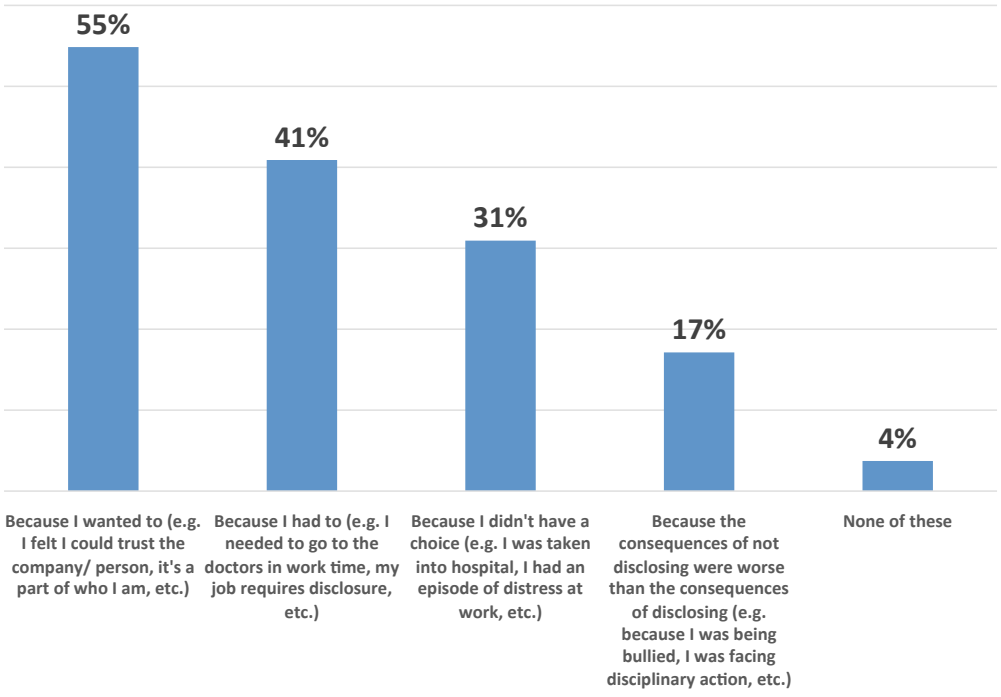
What motivates an employee to disclose a mental health problem? Do employees feel that they are able to do so of their own accord, or is it a reaction to external necessity?

The survey also asked people who had disclosed a mental health problem to their employer in the last five years (n=754) to share their reasons for making that disclosure. This data is summarised in figure 6, below.

place and manner of disclosure may be taken out of their hands, and where they may not have the time or insight to plan what to say.

Seventeen per cent of respondents who had disclosed selected the reason 'because the consequences of not disclosing were worse than the consequences of disclosing (e.g. because I was being bullied, I was facing disciplinary action, etc.)'. This indicates that for some people disclosure is a last-ditch option – something that had to be done.

Figure 6: Reported reasons for disclosing mental health problems to an employer in the last five years (multiple selections possible) (754 respondents)



For many people, choosing to disclose was something they wanted to do, 55% of those who had disclosed selecting the option 'because I wanted to'. This is an ideal situation, the decision and the terms of disclosure being in the hands of the individual.

Forty-one per cent of respondents had disclosed because they had to – for instance, because they needed time off or an adjustment to be made. Around a third of respondents (31%) reported that they had disclosed because they didn't have a choice – for example, they were taken into hospital or had an episode of distress at work. These results highlight that many people do not disclose until they reach crisis, where the time,

The majority of those participating in the qualitative research, however, reported that they didn't tell anyone in work until they needed to take time off as a result of their mental health problem. Only a small number of participants had openly disclosed their experience when applying for jobs, or at an early stage of becoming unwell.

> "They weren't aware until they got the medical report."

For almost all the qualitative participants with personal experience of having a mental health problem, disclosure was described as reactive, with almost all participants noting that they didn't disclose until they reached a crisis point in their

mental health experience, for example hospitalisation.

While it was recognised that disclosure at these reactive crisis points is too late, the challenges of disclosing continued to pose considerable problems for individuals – preventing them from acting on this awareness.

While a majority of those who had chosen to disclose gave personal choice as a reason for doing so, it appears that a wider range of disclosure reasons arises from circumstances where disclosure is reactive.

It is clear that disclosure is not a decision taken lightly, and as such it is something best considered carefully and rationally – and not at a time of crisis. Employers should adopt an approach where disclosure is encouraged and supported, which is most likely to be in an environment where people feel engaged and able to be authentic.

Reasons for choosing not to disclose

What reasons do employees have for choosing not to disclose a mental health problem to their employer? Do employees believe it is even necessary?

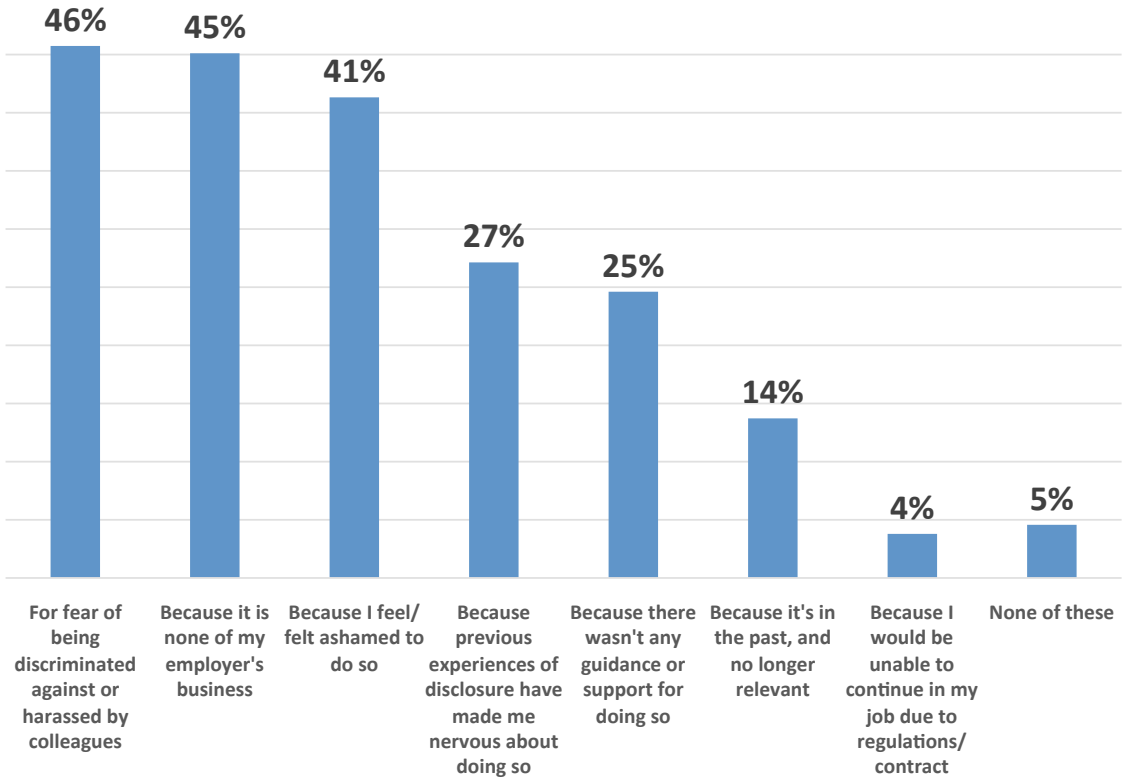
The survey also asked people who had chosen not to disclose a mental health problem to their employer in the last five years (n=634) to share their reasons for making that disclosure. This data is summarised in figure 7 below.

Several of the reasons frequently selected by respondents for choosing not to disclose a mental health problem were connected with stigma, discrimination and self-stigma. The most commonly reported reason for not disclosing – among respondents who had chosen not to do so in the past five years – was the fear of being discriminated against or harassed by colleagues, with 46% of respondents selecting this reason. Forty-one per cent of respondents reported not disclosing 'because I feel or felt ashamed to do so', and 27% reported not disclosing 'because previous experiences of disclosure have made me nervous about doing so'.

The second most frequently selected response was 'because it is none of my employer's business', with 45% of those respondents who did not disclose choosing this reason. Twenty-five per cent of respondents had pointed to not disclosing because there wasn't any support or guidance for doing so – a point raised in the qualitative research. Fourteen per cent of respondents said that they had not disclosed their mental health problem 'because it is in the past and no longer relevant'.

Some 4% of respondents reported not disclosing 'because I would be unable to continue in my job due to regulations or contract'. It is not possible to determine the proportion of these respondents whose professional regulations compel disclosure (e.g. in medical or veterinary practice, or in safety-critical roles) or whose contracts of employment stipulate that mental ill health may be grounds for dismissal (e.g. the financial services sector).

Figure 7: Reasons given for not disclosing a mental health problem in the last five years (multiple selections possible) (634 respondents)



It may be considered a strength that 45% of people choosing not to disclose felt that their mental health was none of their employer's business, and that 14% felt that it was in the past and no longer relevant. Certainly, people have a right to their privacy when there is no legal obligation to disclose. That said, it may be possible that by making the benefits of disclosure more clear – and by celebrating the value that people with lived experience of mental health problems bring – more people may feel that their mental health is in fact their employer's business. For many people, an experience of mental ill health is a one-off episode. Equally, even people with ongoing mental health conditions often regard them as resolved and under control. As such, it is to be expected that some people regard them as in the past.

Within the qualitative research, lack of disclosure was highly linked to the issue of stigma and lack of understanding about mental health, as well as to lack of knowledge regarding how to disclose at work. This was difficult for individuals as it meant that their mental health was a hidden burden that they could not share, or for which they could not access appropriate support.

> "It has felt like a millstone around my neck in many ways because obviously in itself it [depression] is tiring, and trying to keep things together and make certain I can hold it together has actually taken a lot out of me."

In contrast, a number of participants felt that they had learnt from experiences in previous roles in which they did not disclose, thus changing their position on disclosure. They felt that moving forward for their own wellbeing meant disclosure of their mental health problems to new employers. As a result, those participants felt that their anxieties surrounding disclosure reduced and that more appropriate support was made available to them. This was found to be empowering but was only pursued because the work environment felt safe enough for them to do so. This safety was necessary for people to disclose, and was seen as central to the work environment.

> "I don't think people will be more open about it until they know that someone will understand."

Respondents selected a range of reasons for having chosen not to disclose to an employer. Anticipated discrimination and self-stigma were very strongly represented. Nearly half of respondents feared that they would face discrimination or harassment at work, with 27% saying that a previous experience of disclosure made them wary of doing so. This presents a compelling case for addressing stigma and discrimination strongly, and ensuring that this is seen to be done. There is an opportunity for companies that do well in this area to make their standpoint and policies clear to applicants who may have previous bad experiences. With 25% of people saying that they had chosen not to disclose because there wasn't any guidance or support for doing so, it should be relatively simple to provide this guidance – and so hopefully to increase the number of people who feel able to disclose and receive support.

The proportion of respondents citing shame as a reason for not disclosing is of concern. This indicates both a high level of self-stigma (internalisation of stereotypes about mental ill health) and a concerning level of distress – it is unlikely that going to work ashamed and unable to be open is conducive to being at one's best. Simply put, people should not routinely go to work ashamed of themselves. There is much to be learnt from the LGBT-rights movement in terms of building a sense of pride and strength through solidarity among peers who share an invisible, but highly stigmatised, protected characteristic.

Stigma and discrimination

Efforts to address stigma and discrimination on grounds of mental health have been in place in the UK for over a decade. While progress has certainly been made, especially in increasing the awareness of mental ill health and distress, there is still some distance to go to achieve sustained behaviour change.

Our findings present an up-to-date picture of the experience of work-based discrimination on grounds of mental ill health. However, it is important to state that the qualitative findings also highlight the role that wider societal attitudes play in determining workplace discrimination – and self-stigma in particular, where social attitudes and beliefs about mental health are internalised.

Participants in the qualitative research noted that the stigma that exists in the workplace is a symptom of the wider social stigma faced by people who experience mental health problems. It was seen as impossible to change the culture of stigma observed by some in the workplace without tackling the negative culture around mental health more widely.

> "The fact [is] that this is not a workplace issue so much as it is a societal-level issue."

One senior HR director working for a large global corporation reflected that, for their organisation, the biggest obstacle to addressing mental health problems in the workplace was the stigma around talking about how people are feeling in this context.

> "I think there is still quite a big stigma around either they [members of staff] are feeling stressed, anxious or depressed but they don't really want to talk about that with their manager and equally the managers I think are still reluctant to or quite nervous about, oh somebody has mentioned the stress word and where that potentially could end up from the employee-relations side of things."

Stigma and discrimination at work

Participants in both the qualitative research and the quantitative survey frequently reported that they had experienced mental health stigma or discrimination in the workplace. What can we learn from these experiences?

Experiences of discrimination highlighted by the qualitative interviews and focus groups varied. For some, the discrimination was from colleagues, while for others it arose from structural factors or management – for example, where people had faced disciplinary procedures for absence due to their mental health condition. Many of those who had not disclosed their mental health condition reported that their decision not to disclose arose from a fear of stigmatisation in the workplace. Anticipated discrimination was a factor, with fears such as 'Will I lose my job because of this?' being a concern for many people.

For others, discrimination was more obvious, and a number of participants reported having had their competency and capabilities questioned when they disclosed their mental health condition, or when returning to work following sick leave. This was seen as particularly harmful for those in recovery from mental health problems as it made them internalise such stigma.

> “I went back and I have a back-to-work interview and my manager, she was awful about it, and was just, kind of like, ‘Do you think that you can even do this job?’”

> “It harms recovery a great deal because they don’t believe you.”

Within the quantitative survey, with its greater level of anonymity, we were able to explore experiences of stigma, discrimination and disclosure in more detail. Respondents were asked to report whether they had experienced a number of situations or experiences relating to stigma, discrimination or harassment at work. These are summarised in figure 8 below.

Figure 8: Self-reported experiences of stigma and discrimination at work in the past five years

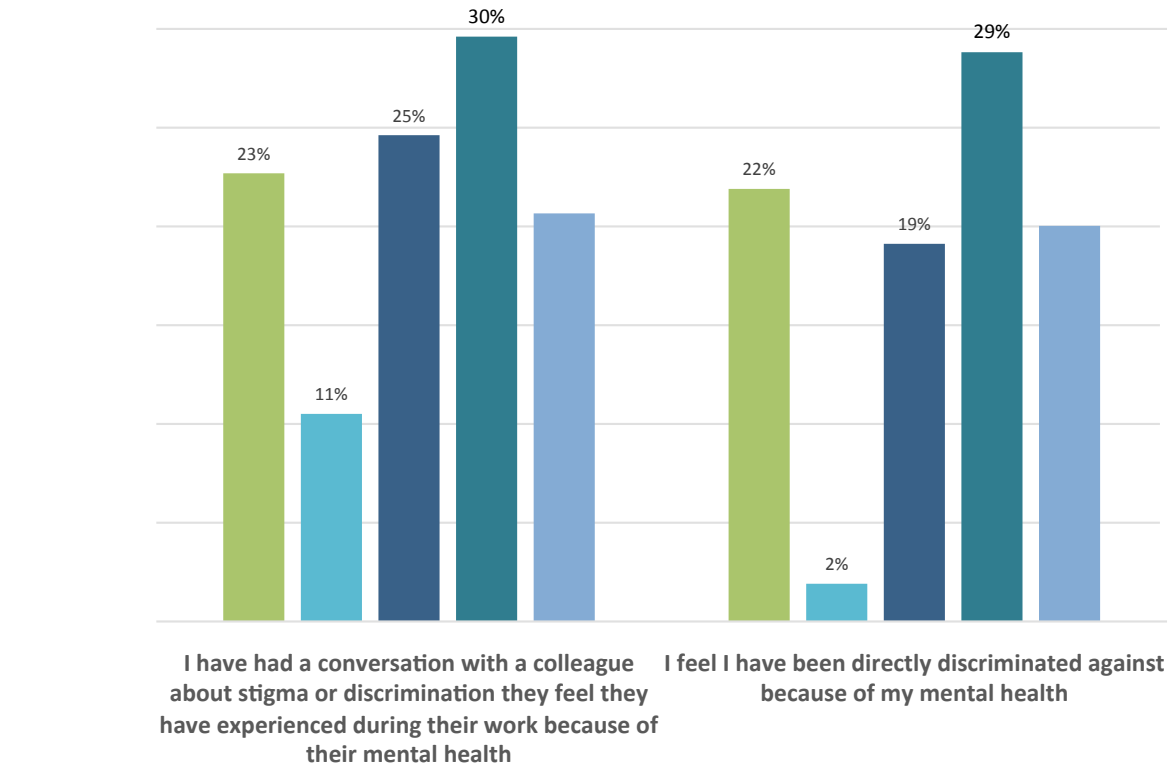
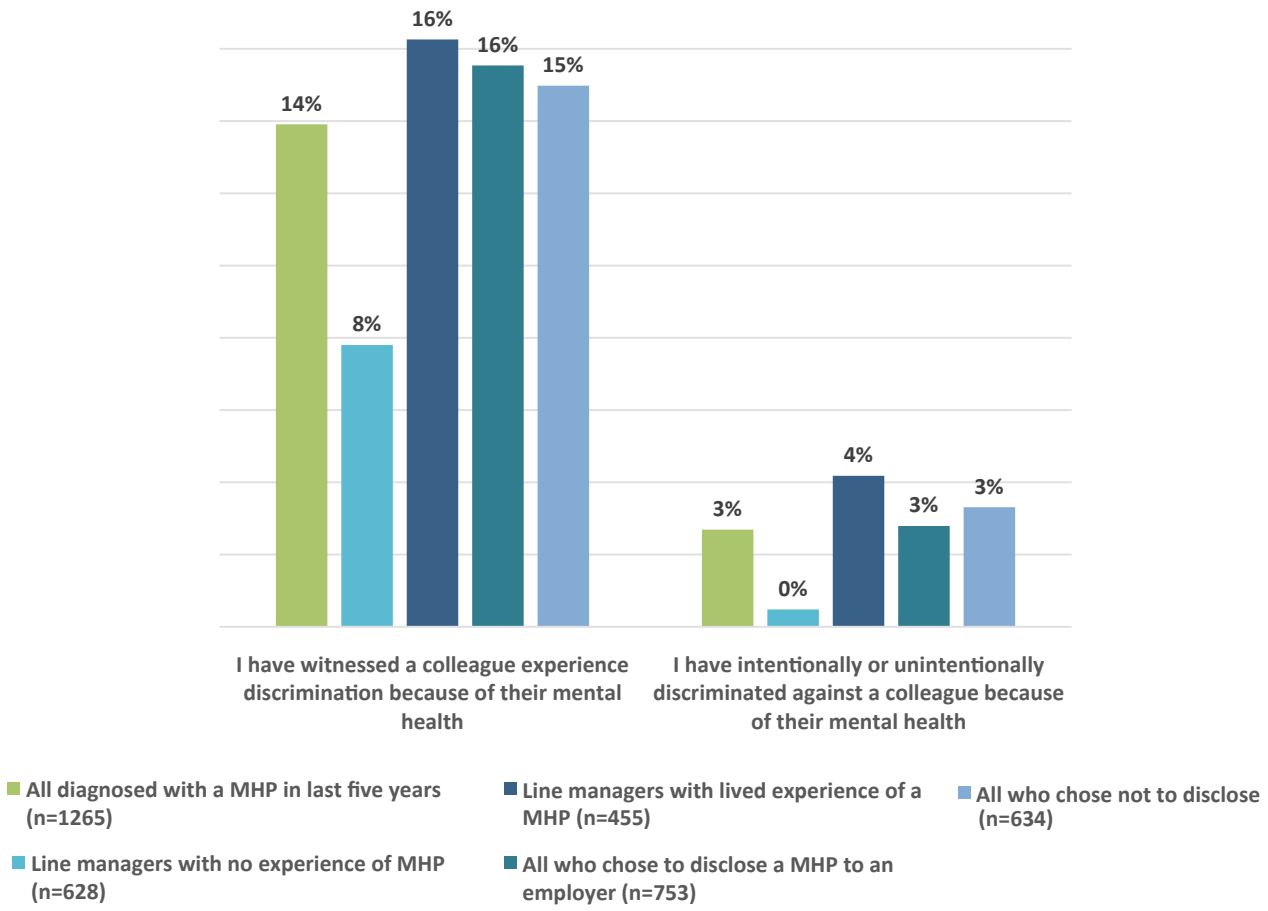


Figure 8: Self-reported experiences of stigma and discrimination at work in the past five years



Twenty-three per cent of respondents who had been diagnosed with a mental health problem in the last five years reported having had a conversation with a colleague about stigma or discrimination which that person was experiencing, with line managers who also had lived experience of a having a mental health problem even more likely (25%) to have such conversations. The group most likely to have had conversations with colleagues about stigma and discrimination faced by that colleague were those who had disclosed a mental health problem in the last five years (753 respondents), of whom 30% reported having such conversations. Line managers with no lived experience of having a mental health problem were least likely to have had such conversations, with only 11% reporting that they had done so. This implies strongly that people with a personal lived experience are more likely to be approached by colleagues who feel they have experienced discrimination.

Twenty-two per cent of respondents with lived experience of having a mental health problem selected the statement 'I feel that I have been directly discriminated against because of my mental health' – nearly a quarter of people who had been diagnosed with a mental health problem in the past five years. For those who had disclosed a mental health problem at work, this rose to 29%, indicating that fears of discrimination were, to some extent, legitimate. Line managers with lived experience of having a mental health problem were slightly less likely than people with lived experience as a whole to report direct discrimination, with 19% of these respondents selecting this statement.

Some 14% of respondents who had been diagnosed with a mental health problem reported witnessing a colleague experiencing discrimination because of their mental health. This rose to 16% both for managers who also had a lived experience of having a mental health problem and for all those who had disclosed a mental health problem at work. Managers with no lived experience were half as likely to have witnessed discrimination (8%). This may suggest that relevant experience increases vigilance and awareness of the behaviour that constitutes discrimination in the workplace.

Just 2% of the sample admitted to having intentionally or unintentionally discriminated against a colleague because of their mental health. This was doubled to 4% for line managers with lived experience. This could relate to a greater awareness of the potential impact of their actions as managers on those who experience mental health problems.

Across the sample (n=2,019), 17% of respondents indicated that their current workplace 'treats stigma or discrimination on mental health grounds as severely as discrimination on grounds of race, gender or sexual orientation'. This figure (around a fifth) was consistent across different groups of respondents. This highlights an under appreciation of the legal requirement to regard discrimination on grounds of mental health the same as discrimination in relation to other protected characteristics defined in the Equality Act.

Self-stigma in relation to work

Self-stigma refers to the internalisation of commonly held negative beliefs about people with mental health problems. As shown in figures 8 (above) and 9 (below), there are a range of views about the competence and potential of people with mental health problems at work. And with 41% of respondents choosing not to disclose a mental health problem to an employer because they feel ashamed to do so, it is clear that self-stigma is a valid concern.

A number of those people interviewed related coming to believe the stigmatising thoughts others might have about them because of their mental health condition, with some reporting that they questioned their own capabilities and competence within their job role because of the negative attitudes that others had when they disclosed their mental health condition.

Stigma and discrimination are alive and well in workplaces; while mental health awareness has improved in recent years, the attitudes and behaviours towards people with mental health problems are not changing as fast. This is unsurprising – addressing discrimination can take a generation – but this research shows that there is a clear need to actively address stigma and discrimination.

The Equality Act (2010) covers many people with mental health problems. This is because, whether or not individuals recognise it, and whether or not they disclose at work, most mental health problems meet the Act's definition of disability. This means that direct or indirect discrimination because of mental-health-related disability – perceived or actual – is illegal. The Act also applies to people who have met the definition of disability in the past, whether or not their disability currently has a substantial and adverse effect on their day-to-day life. This is very important for people who have previously experienced mental health problems, and for their ability to seek early support in relapse. The Act also covers discrimination towards carers of people who are or have been disabled – meaning that carers treated less favourably because of a relative's disability, for example, are as entitled to legal redress as if they were disabled themselves.

In this study, we see that nearly 30% of those people who have chosen to disclose to an employer in the last five years feel that they have been directly discriminated against on grounds of mental health in that period. This is a hugely significant finding, because direct discrimination (where an employer is aware of the disability) presents a significant risk of legal action for the employer.

The fact that respondents reported feeling that their company treated discrimination less severely than discrimination relating to other, more recognised protected characteristics – such as race or sexual orientation – indicates that parity for mental-health-related disability is still some way off, and that measures to encourage the reporting of discrimination may be helpful.

In terms of effectiveness, the strongest evidence for anti-stigma programmes is for social contact, where the direct, lived experience of a peer is used to challenge attitudes and behaviours. We can see from our findings that staff with mental health problems – especially managers and those who have disclosed – are the most likely to have conversations in which other colleagues discuss stigma and discrimination that they feel they have faced. It is a further argument for peer support, and for the celebration of diversity in mental health as a business asset.

> “That’s part of the stigma that I have internalised … If you are not around then you are skiving … I feel very vulnerable coming out as having mental health conditions, particularly in this sector [research], in case people might not think I am actually very capable of what I do … I am still scared; I am still full of doubt about my own capacity.”

For one participant, self-stigma relating to telling people she was absent due to mental health problems led her to pretend she was still at work for a period of time when she was off sick.

Comparing line managers’ beliefs with reported experience

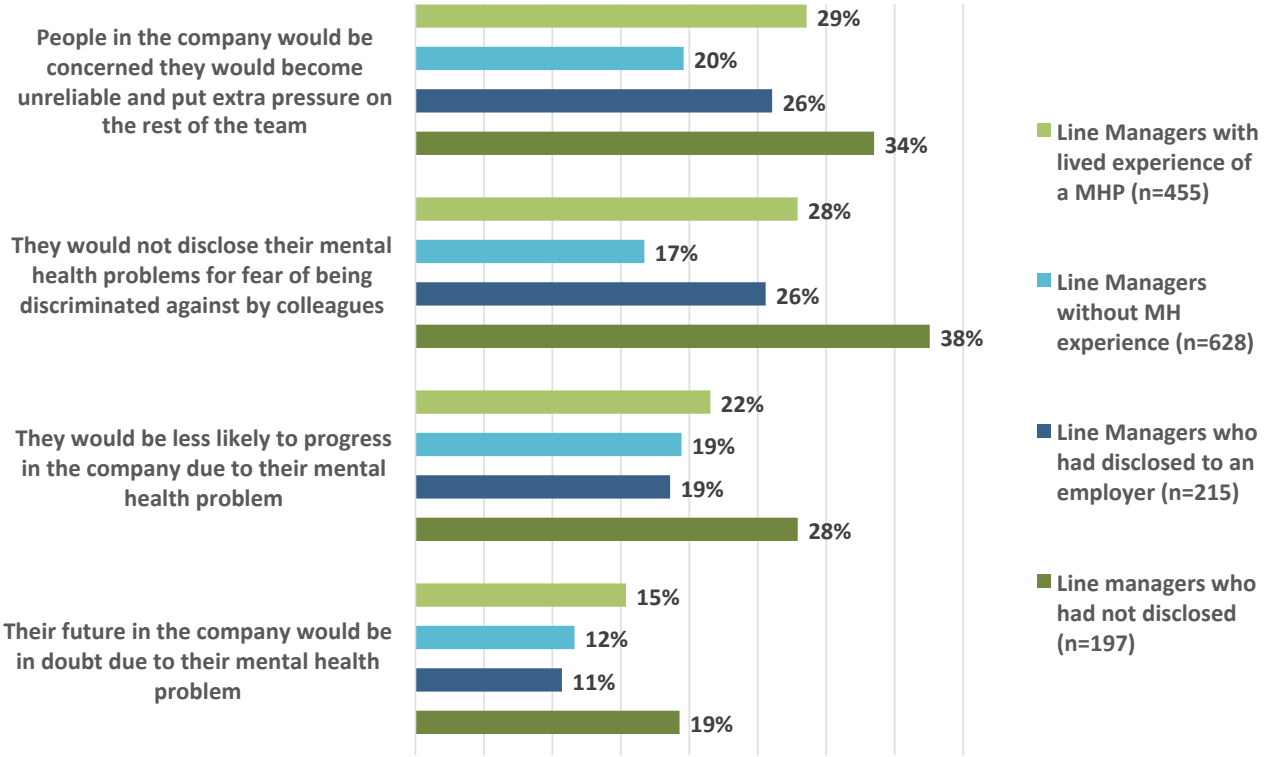
Do line managers have realistic expectations about whether people in their company would experience discrimination if they disclosed a mental health problem?

Figure 9 (below) summarises data relating to the statements associated with negative or discriminatory experiences, for a range of line manager populations.

Overall, nearly one in four line managers (23%) reported that people in the company would be concerned about a person’s reliability and the impact of their mental health problem on the rest of the team. A smaller proportion of line managers without lived experience of having a mental health problem (20%) believed this to be the case. Line managers with lived experience were more likely (29%; almost three in ten) to believe that people in the company would be concerned that a person with mental health problems would be unreliable and put pressure on the team. Of line managers with experience who had not disclosed a mental health problem, 34% believed this statement.

Remembering that 46% of those respondents that chose not to disclose a mental health problem at work cited fear of discrimination or harassment as a reason, 22% of the responding line managers believed that people would not disclose for this reason. This was as low as 20% among line managers who had not experienced mental health problems, indicating a substantial underestimation in this group. Of line managers with lived experience, 28% selected this statement. Line managers with experience who had not disclosed had the highest positive response of all (38%).

Figure 9: Line manager perceptions of what might happen to a person disclosing a mental health problem in their current workplace



Approximately one in five line managers surveyed (20%) agreed that a person disclosing a mental health problem in their organisation would be less likely to progress because of this. This figure was similar for managers who had lived experience, those who had not, and those who had disclosed. Of managers with lived experience who had not disclosed, 28% indicated that a person disclosing a mental health problem would be unlikely to progress.

Thirteen per cent of line managers surveyed indicated that a colleague's disclosure of a mental health problem would place that person's future with the company in doubt. Fewer line managers who had disclosed a mental health problem indicated this (11%), while markedly more respondents who had chosen not to disclose indicated that disclosure would jeopardise a person's future (19%).

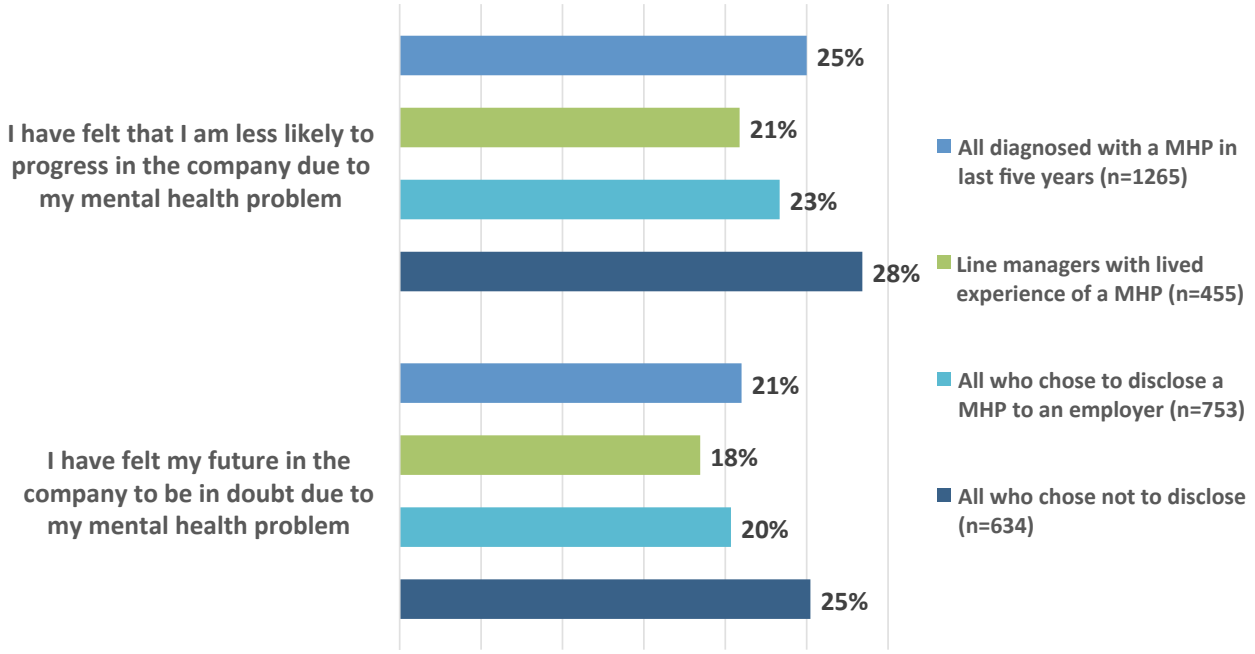
People reported experiencing exactly these consequences

Respondents with lived experience (n=1,265) were asked to consider whether a range of statements applied to their actual experiences of mental health problems while working at their current workplace. Figure 10 (below) summarises the data.

Of the respondents who had been diagnosed with a mental health problem in the last five years, 23% felt that they were less likely to progress in the company due to their mental health problem. Around one in five (20%) felt that their future in the company was in doubt because of their mental health problem.

Line managers with lived experience were slightly less likely to believe that their future progress would be jeopardised – potentially because they may already have progressed or be in positions that are felt to be more secure.

Figure 10: Self-reported experiences of mental health problems while working with current employer



When line managers were asked whether people in their company would experience discrimination, their impressions broadly matched the experiences of discrimination people reported having. This validates the fear underpinning many respondents' decisions not to disclose a mental health problem at work, and the fears expressed by participants in the qualitative interviews.

Across the board, people who had disclosed mental health problems at work in the last five years were more likely to feel that their career progression or future in the company was likely to be jeopardised by their mental health problem. It is not possible to determine whether this is because of their realistic or unrealistic beliefs about the impact of their mental health problems or because of their perceptions of the company.

However, it was identified that respondents who had chosen to disclose were more likely than people with lived experience in general to report support from line managers, HR and colleagues, and to have had reasonable adjustments made. We know that 30% of people who had disclosed reported experiencing direct discrimination; it is possible that some of those experiences related to seeking career development, or to facing the prospect of losing their job because of their mental health problem.

We know that experiences of stigma and discrimination have a major effect, through self-stigma, on an individual's future attitudes to disclosure and help-seeking, and on their beliefs about their own abilities and potential. We see this anticipated discrimination in the reasons outlined for not disclosing, and through the qualitative interviews. These factors underline how important it is to ensure that disclosing is a positive experience for staff experiencing distress or mental health problems for the first time. Equally, there are indications that development programmes could build confidence and career aspiration among people who have lived experience of having a mental health problem – in the same way that mentoring and development programmes have increased the visibility of women, LGBT people and people from BAME communities in senior roles.

5. Supporting people at work

In this section, we present findings that relate to support offered in workplaces, as related by both participants in the qualitative research and respondents to the quantitative study.

In the qualitative research, most participants with personal experiences noted that there was a lack of support in workplaces for mental health. They felt it was the structures and culture at work that were most responsible for this feeling.

Overall, participants pointed to a lack of knowledge and understanding about mental health within the workplace. Participants felt that this highlighted the need for prevention, with companies appreciating the ways in which distress could be better managed at an early stage.

Many people felt that mental health did not receive the same respect and understanding as physical health, and that this meant there was a struggle for sickness absence for mental health problems to be recognised or accepted as a genuine reason for absence.

> "Taking just a day off is unheard of. I think a lot of people do end up getting themselves signed off by the doctor. If you have to go to the point where you are so stressed out, so ill, that you have to be signed off for two, four, six weeks at a time with anxiety, it has already gone too far... and that is quite frightening actually for me, because no one does it unless it is going to be long term, no one is able to say, 'I have a mental health problem and I can't come to work today.'

Line managers and HR leads described it as a challenge for both the organisation and their own practise when individuals do not disclose their mental health condition to their employers. One line manager, however, reported that even if they were aware of someone's condition they may still not know how best to support them, and that seeking an individual's input on these matters was crucial to keeping people well in work.

> It is not a well-worn path some of this stuff. You know, if somebody comes to you and starts on day one and they are in a wheelchair, I think it is pretty obvious and clear what kind of challenges [there] are going to be. But mental health, even saying [that] this is the diagnosis, doesn't necessarily guide you or give you the tools as to what you need to do.

Another line manager described the importance of understanding the fluctuating nature of mental health problems and the various ways a mental health problem may affect the same person at different times, suggesting that open, frank discussions with the employee helped them to support their work during difficult periods:

> I have one member of staff who has confided in me that she suffers from anxiety, so she finds public speaking very difficult – and even, for a period, interviews very difficult – and it is quite a core part of her role and so... we discussed all the things we could do and she chose what she felt would be best for her and is now able to do these things again.

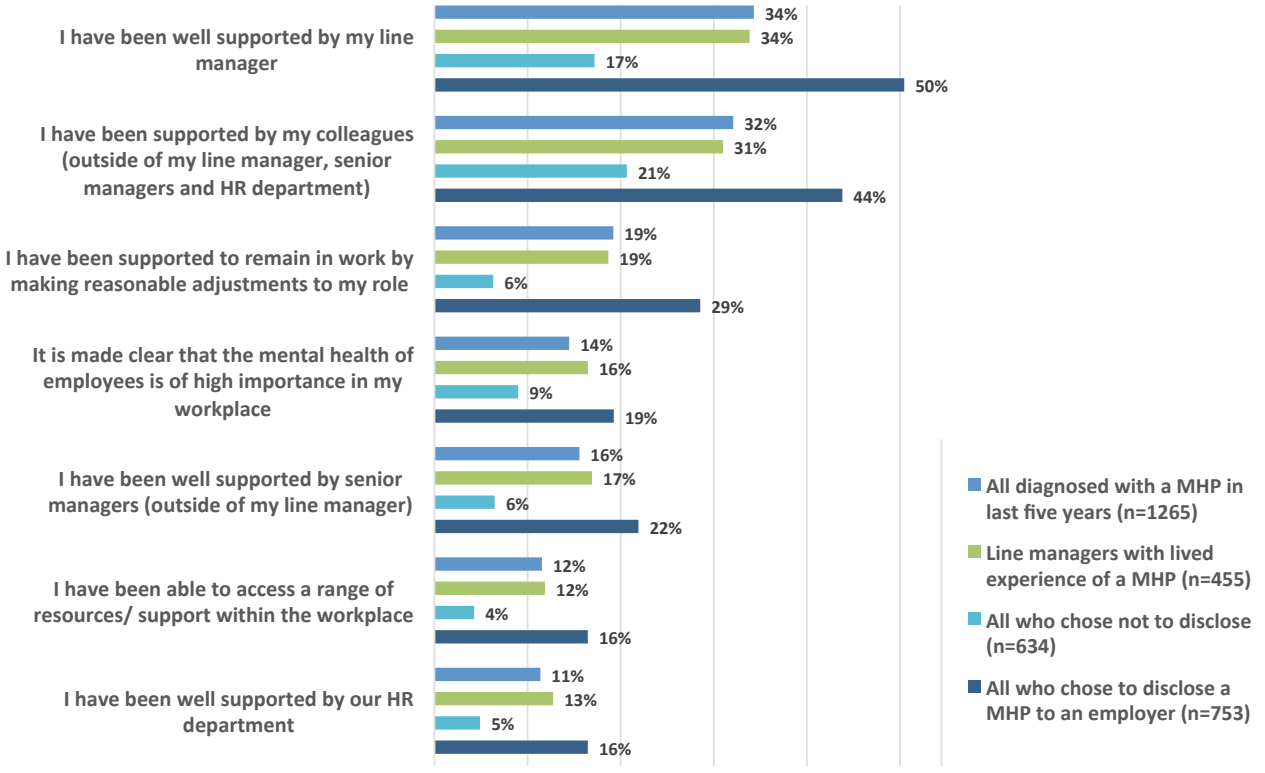
Support received by people with lived experience

For those who do disclose a mental health problem, from where do they receive support, and do they feel reasonable adjustments are made to enable them to remain in work?

Respondents who had been diagnosed with a mental health problem in the last five years (n=1265) were asked to select statements that applied to them in relation to the type of support they had received in their current workplace. This data is summarised in figure 11, below.

Of respondents who had been diagnosed with a mental health problem in the last five years, 34% indicated 'I have been well supported by my line manager'. The proportion of respondents who indicated that they had been well supported by a line manager was far greater (50%) among respondents who had chosen to disclose a mental health problem in the last five years (compared with just 17% of those who had chosen not to disclose).

Figure 11: Experience of support in relation to mental health in current workplace



Support from colleagues is key to workplace wellbeing across the board: of the respondents who had been diagnosed with a mental health problem in the past five years, a similar proportion felt that they were supported by colleagues as felt that they were supported by line managers (32% vs 34%). Again, those who had disclosed felt substantially more supported by colleagues (44%) than those who had chosen not to disclose (21%).

Around one in five people who had been diagnosed with a mental health problem in the last five years indicated having been supported to remain in work by reasonable adjustments to their role. Most reasonable adjustments are made following disclosure, and it therefore follows that 29% of those disclosing had received adjustments compared to only 9% of those not disclosing.

There is a clear 'disclosure premium' to note here, in keeping with the argument that support is easier to provide when a need is made clear. However, with levels of support for those who had disclosed never above 50%, it is clear that there is still a job to be done across workplaces to enable and incentivise disclosure through more clearly defined benefits.

These results indicate that employers still have work to do in defining and implementing measures to support people who experience distress.

People who had chosen to disclose to an employer experienced the most support, and those who had chosen not to, the least. Clearly, from a company perspective, it is more straightforward to provide support to those whose needs are clear. Even so, when only half of respondents who had disclosed indicated that they had been well supported by a line manager, and only 29% had received reasonable adjustments, it is understandable that people choose not to disclose.

We know from the disclosure questions above that some respondents felt that their mental health wasn't their employer's business, or that they were unsure of how to disclose in practice. By making the support available more widely known, and making disclosure straightforward, employers should see an increase in disclosures and therefore be better able to make adjustments and offer support.

Line manager readiness to support

With line managers being the most likely people to receive a disclosure of a mental health problem, do managers actually recognise that staff mental health is a key aspect of their work? Do they feel that they know how to have a conversation with a team member who has said they've been having trouble coping? Do they themselves feel supported to support their staff?

Line managers responding to the survey were asked to select the statements that applied to them from a list relating to their confidence and readiness to address mental health in their current workplace. This data is summarised in figure 12, below.

The majority of line managers (65%) indicated that they would know how to have a conversation with a team member who told them they were having trouble coping. Responding line managers with lived experience of mental health problems were much more likely to report that they knew how to have these conversations (72%), compared to only 60% of those without lived experience. Line managers who had disclosed a mental health problem to an employer were most likely to know how to have conversations about not coping (81%).

This pattern was repeated in agreement with statements related to confidence in addressing distress, and in recognising the responsibility a manager has in recognising distress, where line managers with lived experience, especially those who had chosen to disclose to an employer, were most likely to report ability or willingness to support others.

Line managers who had personal experience of mental health problems were more likely than those who had not to express confidence in recognising that a team member was having problems coping (67% vs 51%). Line managers who had chosen to disclose a mental health problem to an employer were most confident of all in recognising distress in a colleague (79%).

Providing ongoing support for people with mental health problems is often cited as a challenge for managers; it is also an area frequently not covered by training courses, which tend to focus on recognising and responding to acute distress.

Managers with lived experience were much more likely to feel confident in providing day-to-day line management to a person with a mental health problem than those who had no personal experience, 66% of those managers with lived experience indicating that they felt confident in providing everyday line management compared to 47% of line managers with no personal experience. This is often reflected in descriptions of poor experiences in the workplace, where basic HR processes appear to be compromised through embarrassment, ignorance or stigma. Three quarters (75%) of managers who had chosen to disclose a mental health problem to an employer expressed confidence in providing day-to-day line management to a person with mental health problems. This indicates that this population of managers may be in a prime position to advise and support management peers in providing ongoing compassionate support.

Fewer than half of managers without lived experience believed that it was their responsibility to spot signs of recurring mental health problems (45%). This contrasts with 56% of line managers with lived experience, and with 63% of those who had disclosed a mental health problem at work in the last five years. This may indicate a feeling of peer connection between line managers with lived experience and colleagues having similar experiences.

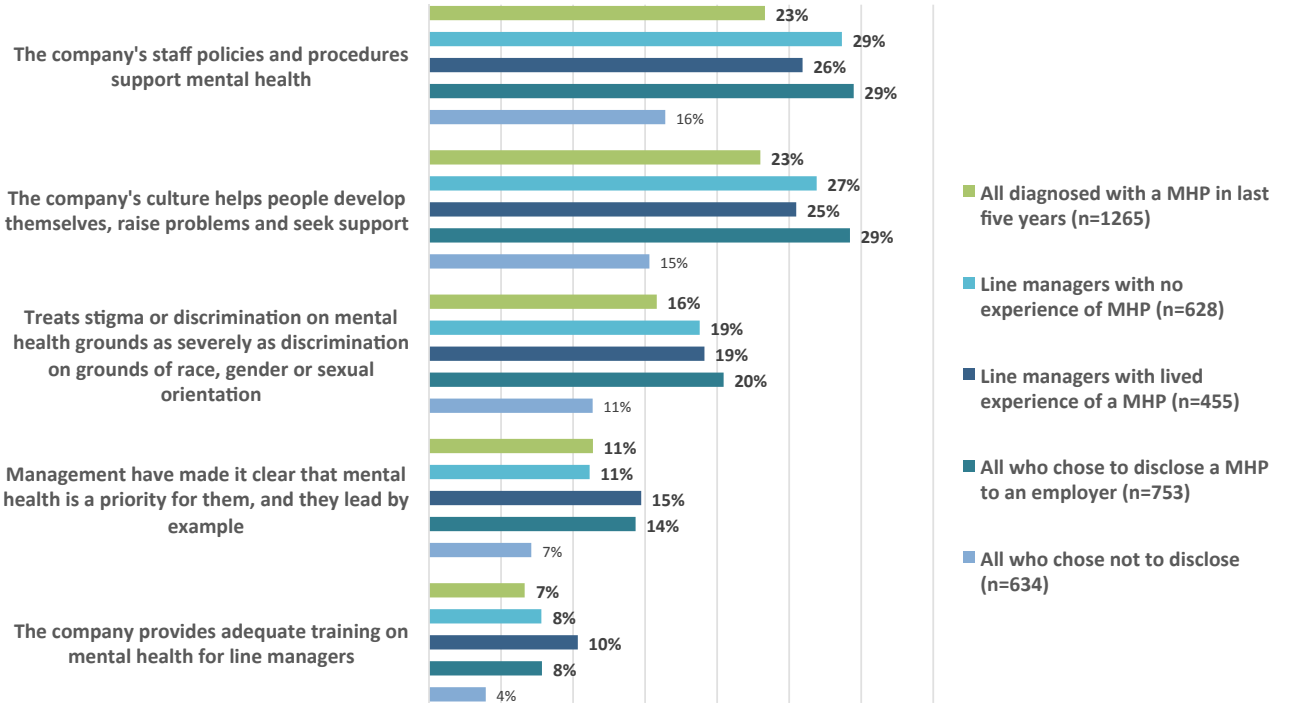
In considering support available and understanding legal obligations and training, the response pattern differed.

Only 39% of line managers – with or without lived experience – knew what support was available to them in the company if they needed help supporting a person with mental health problems. This rose to 52% among line managers who had disclosed, probably reflecting the fact that they may have used that support themselves, and therefore become aware of it.

Only 10% of line managers felt that they had received sufficient training to deal with mental health problems at work, indicating a training need. Training is clearly part of any mental health strategy in the workplace, but when we asked respondents to identify three top priorities for action, specific training was selected by only 18% of line managers with lived experience and 22% of those with no lived experience. As can be seen in the recommendations below, however, wider holistic actions like implementation of policy and improving culture were prioritised more frequently, and it is clear that there is a training and organisational development component to achieving these objectives.

Awareness of the legal obligations of companies was low among line managers, with 35% of responding line managers aware, rising to 39% for those with lived experience.

Figure 12: Line manager readiness to support



It was highest among those who had disclosed (49%), again reflecting the fact that their disclosure journey may well have included research on their rights in the workplace.

Most line managers recognised that staff mental health is a key aspect of their work, with only 3% believing that mental health has nothing to do with them.

In the qualitative research, only a small minority of participants understood their rights in relation to legal obligations and the types of support that should be available. This minority reported that having that knowledge in hand was a benefit when they felt at their most vulnerable.

Among HR leads and line managers interviewed for the qualitative research, there were concerns about the impact on business of supporting people with mental health problems in the workplace while at the same time pursuing business objectives and regulatory requirements. HR directors reported challenges in trying to ensure they act fairly to all employees.

> “If I am making reasonable adjustments for one individual, do these adjustments impinge upon other people? Or, if somebody else comes to me on a different day with a different problem, do I treat that with the same kind of judgement and fairness?”

Some line managers, particularly from smaller organisations where resources may be more limited, discussed the challenge of deciding when the business had reached the limit of ‘reasonable’ support – there being a point where organisations cannot continue to offer further support without affecting the business as a whole.

> “With the resources of a small charity, as we are, where is the line whereby you say, look, I am really sorry, we can’t do any more for you? And that is a difficult call to make. There is no right or wrongs about that.”

One HR manager related their feeling that all options should be discussed as part of assessing support for an individual – including supporting a person to recognise that base requirements of the role they are in, or are absent from, might be contributing to that individual’s poor mental health.

> “And sometimes we do actually need to speak to people about retention. They don’t realise there is other employment than what they are doing. So if they trained to be a social worker, they feel they have got to be a social worker, rather than considering [other options]. We focus on transferable skills.”

This was felt as true by a few participants who, after reflecting that they had become unwell at work, and recognising that work stress was a trigger for them, had changed jobs or role, or were looking for work in another sector. For some, changing work and removing themselves from the negative workplace was a strategy for keeping well.

In the qualitative research, there was a range of opinions on the extent to which organisations – and line managers in particular – should be responsible for recognising distress or the relapse of mental health problems.

Recognition of distress was seen primarily as the individual’s responsibility, with no one mentioning that that it was their workplace’s responsibility to recognise that their mental health was at risk, or that they appeared to be under stress.

The additional stress and pressure that was experienced as a result of work was often not recognised until the topic was approached or absence occurred. One interviewee asked colleagues to tell her boss that she looked stressed, as it had gone unrecognised for so long.

For line managers, HR leads and directors, the greater responsibility of recognising and disclosing lay with the employee in the majority of cases. However, a number of line managers also acknowledged that this can be extremely difficult to do in practice, and that not all individuals will have developed the self-awareness around their condition to know what strategies and approaches in the workplace would help them manage themselves better, particularly if someone is experiencing an episode for the first time.

> “You can have people who have lived with mental ill health for a long time, and have got strategies... and can therefore help you as a manager to manage them, or you can have people who have maybe experienced [an] acute stress episode for the first time, and they don’t have the tools.”

Culture and environment

Participants in the qualitative research saw the culture and environment of the workplace as crucial to supporting mental health and wellbeing, frequently reporting that the culture and environment did not always, in practice, reflect the intentions of policies or initiatives that might be in place.

The overall picture in the quantitative research suggests that those likely to be in the know – especially line managers, line managers with lived experience, and staff who have disclosed mental health problems – are more likely to report or recognise the presence of supportive factors in the workplace. Respondents who had chosen not to disclose to an employer were the least likely to report thinking that their employer does well in key areas of good practice (figure 13) .

Those who had a positive experience with work discussed the helpful aspects of their environment being their strong and collaborative team, flexible working environment, and passion for the work. In contrast, many people talked about the challenges of a workplace culture in which productivity and outputs were prioritised over wellbeing and mental health.

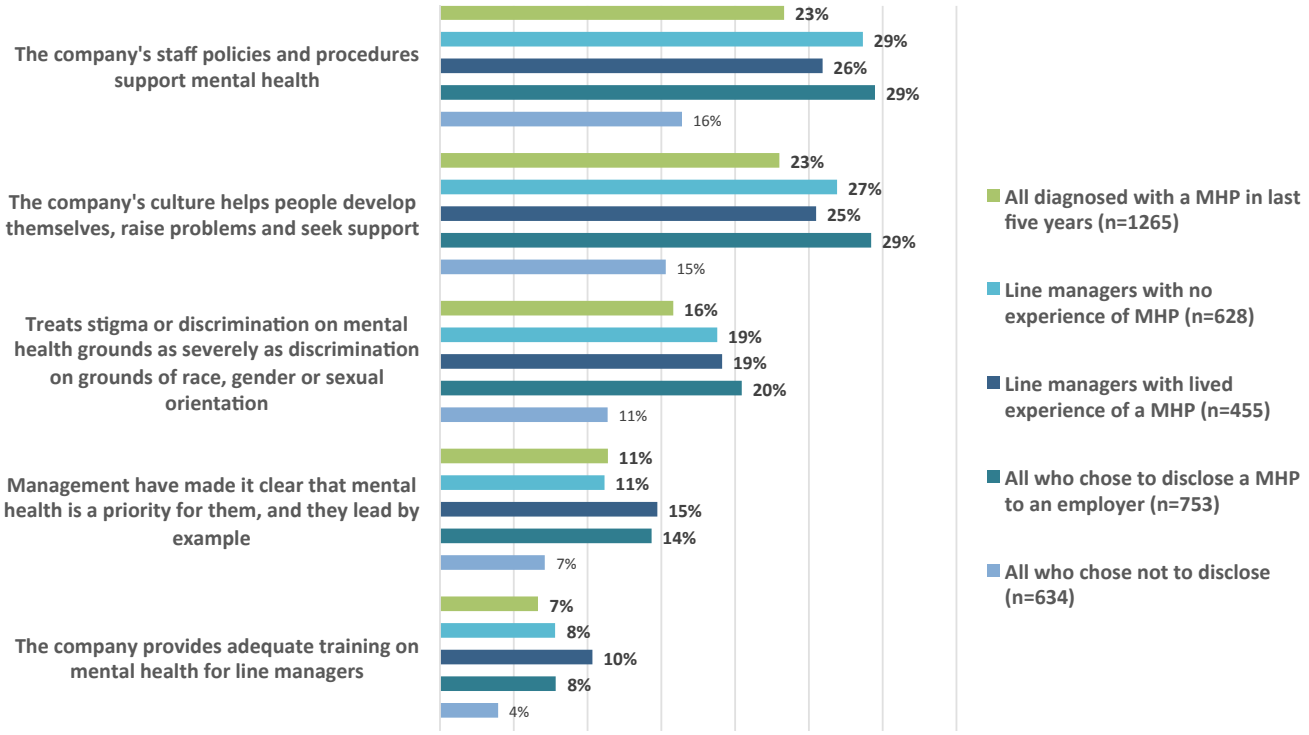
> “It’s the working environment that I find hard sometimes, not the actual work itself.”

> “[We are] so obsessed with efficiency that we forgot about people and needs... We have forgotten the basics. We have forgotten the basic principles of being human...”

Participants felt that to keep people at work it was necessary to create a safe and open environment where mistakes were allowed to happen as a way of learning, and where people felt they were treated like people, rather than part of a machine. This is in keeping with the factors that create engaged and productive workforces in general.

Respondents to the survey were asked to identify whether their workplace did well on a range of cultural and environmental issues in relation to which they can support people with mental health problems. These responses are summarised in figure 13, below.

Figure 13: Environment and culture selections for ‘What do you think your company does well to support mental health and wellbeing?’



Only 25% of respondents believed that their company policies and procedures supported employee mental health. This rose to 27% among line managers and 29% among those who have disclosed a mental health problem at work.

A similar proportion believed that the company culture helps people to develop themselves, raise problems and seek support. Unsurprisingly, only 15% of those who had chosen not to disclose believed this to be the case, compared with 29%, or nearly double the proportion, of those who had disclosed. This highlights a significant disparity between how employees think they will be supported if they disclose a mental health problem at work and the perceptions of those who have disclosed.

Policies need to be applied across organisations

In the qualitative research, few participants with lived experience reported being aware of their workplace policy regarding mental health. Many were able to list a range of policies that could be related to mental health, such as absence policies, but none were able to discuss their workplace policy specifically in relation to wellbeing or mental health.

> "I don't think we have a mental health procedural policy; we have an absence management policy and we have a discrimination and equality and dignity-at-work policy, but we have nothing specifically related to mental health."

A number of people reflected that the policies and procedures can often add to the stresses in the workplace.

> "I have got a back-to-work interview next week and I am not looking forward to it at all because there is no support and no understanding and I will probably feel more stressed when I have had it."

Line managers' knowledge of mental health and stress policies varied across the qualitative sample groups. For some managers, particularly from smaller organisations, there was no apparent policy in place that covered stress management.

A few managers spoke of mental health being woven through all of their organisation's policies, in addition to having a policy on stress and stress management. Other managers described not really having a policy in place that specifically addressed mental health.

> "We don't have any formal training or any formal policies on it. It's not really seen as being a priority."

> "In general, we have got mental health woven through the policies of the organisation... We have a policy on stress and stress management but I think it is more important to [have mental health in all policies at work] because what you can end up doing with mental health is kind of I suppose annexing it or boxing it into a right-we-have-ticked-the-mental-health box."

One issue that was highlighted when discussing policies was that, while they may exist – with copies printed and available – it doesn't mean they will change day-to-day practice positively.

> "You can have all of these fancy anti-bullying, health, sickness, we-care policies, but in practice it never worked."

Few people believed that policies have an impact in practice. One reason given for this was that these policies are only ever read or used at crisis point. Processes and policies were seen as more of a bureaucratic need than things to support individuals in practice. Some participants felt that the policies and procedures they had seen or used were overly complex or time consuming, indicating that a more streamlined approach might be better used in practice.

> "I tend to look at policies when I need them."

> "I found dealing with all the paperwork... it is quite bureaucratic."

> "In an ideal world, you don't have to go through the rigorous HR procedures."

Where organisations had policies in place, line managers were aware that they existed but did not know the specifics. They shared that nuances and processes were learnt when a situation presented itself. Most often, managers discussed their preference for using their own skills and knowledge in preference to seeking HR support.

Policies must be holistic, and widely implemented

A key theme in the qualitative research was the need for mental health policies to promote and protect mental health in every area of the business, and not to focus purely on what to do in the event of a crisis.

> “You have broken glass all over the floor, people are walking all over it, and you are putting on sticking plasters. The thing you need to do is take away the broken glass!”

HR professionals interviewed reported a common feeling that they were not brought into situations early enough, and that sometimes managers were not able to recognise when individuals were exhibiting signs early enough in the timeline of events to be able to address it proactively.

> “I think perhaps too often people don’t come to HR early enough, and that can be an issue where, you know, managers even in the field or not, you know, are perhaps struggling with something, but haven’t quite really uncovered the fact that it could be an issue around mental health.”

Participants expressed clearly the opinion that comprehensive approaches to mental health at work should include recognition of challenges and hazards to mental health, with sustainable, integrated strategies such training, a positive working environment, positive relationships and flexibility suggested as necessary elements of approaches to mental health at work. Concern was raised by several participants about potentially damaging ‘tokenistic nods’ towards wellbeing and mental health in the workplace.

Management culture

The need for senior managers to set a good example of work-life balance was highlighted by a number of participants in the qualitative research.

> “I still work until 8pm... but I am trying to get better at kind of stopping myself getting to the crashing point. I am sure I will still get to that point at some point, but I am trying to let myself have that odd day sick if I need to. It’s a new thing for me.”

A number of participants highlighted that the demands of work often outweigh the time available to achieve outcomes. As the work culture is often driven by these outcomes, and by the need to achieve, it was felt by many people that the human cost was often forgotten, and often with detrimental effects on the individual’s mental wellbeing.

> “Everyone is so obsessed with efficiency that it sort of, it is just a vicious cycle of efficiency and stress and illness, and then clambering to get the efficiency back after you have been ill, and then working twice as hard and making yourself twice as ill, and it could go on forever really.”

This was borne out in the survey, where only 11% of people who had lived experience, and a similar proportion of managers without lived experience, indicated that management had made it clear that mental health was a priority, and had led by example.

It is clear that there is a need to support companies in taking the time to integrate mental health and wellbeing at every level of their business. This clearly includes a need to develop the skills of managers in this regard, including senior managers.

Things that could help: flexible working

Respondents to the survey were asked to select from a list of options of strategies and interventions that ‘in general they felt workplaces could do to support people with mental health problems to stay in the workplace’.

The most commonly selected response in terms of culture was the ability to use flexible working to informally support mental health: 67% of respondents overall, rising to 81% of those who had disclosed and 74% of those who had chosen not to disclose. Coupled with the second and third most popular responses – creating a workplace culture where open discussion of mental health is possible (60%) and taking a zero-tolerance approach to stigma and discrimination (57%) – flexible working is the strategy most likely to support the self-care strategies that qualitative interview participants regarded as critical.

In the qualitative research, some participants reported that they had made the personal decision to reduce their work

to part-time hours or to become self-employed in order to manage their mental health and stay healthy. Others recognised that their work environment was detrimental to their mental wellbeing and as a result had changed jobs, or were in the process of changing. Flexibility in working time was also mentioned as a requirement for those still receiving treatment or therapy.

For most of the participants this flexibility was necessary to ensure that they were able to manage their workload, but also to manage their mental health. As each person experiences mental health problems differently, flexibility meant that individuals could manage these aspects of their lives more easily and continue to work effectively.

> "I mean, I couldn't do a job without flexi-time because sleep is such an issue for me."

A phased return was commonly used to support people returning to work following a period of absence. While this was considered a positive strategy for many participants, there was concern that following the phased return there were no other changes or strategies in place to support them when the workload returned to the same (often overwhelming) level as before they became unwell.

> "How can I have not even full-time hours and more than a full-time workload?"

This may indicate that, even when a strategy is put in place to support a person recovering from a mental health problem, there can be a tacit expectation that people will resume behaviours, such as routine excessive workloads, that are damaging to mental health.

Being able to practise a level of flexibility with individuals with mental health problems was also highlighted by HR leads and line managers as an approach that works well, not only to keep people in work but in demonstrating that individuals are valued.

> "The manager allowing enough flexibility to say if you need to take time off, take it off, and kind of putting parameters in place to say, well, if you do need to take the day off just call me, at whatever time, and let me know."

> "I think a lot of HR departments do a gradual return to work, but it's more to it than that. It's getting to know the person, getting to know the job, and marrying up how it could work."

For many of those who had personal experience of a mental health problem, self-care was the primary strategy for keeping well. This was a personalised approach, with each person employing different strategies to improve and support their own mental wellbeing.

> "Just making sure there is time in the week to do stuff for yourself."

> "I tried to look after myself the best way I could in terms of just rest and eating well and doing all things like the medical appointments and medication."

It was noted, however, that with the pressures of the workplace this was difficult, and that spending time on yourself rather than working could feel lazy. While it was difficult, it was noted that, when weighted against the option of getting unwell again, it was something that was necessary.

> "It is really tough to prioritise [self-care] ... but this is what I need to do, and so I do, otherwise I am going to go again and I don't want to do that."

Relationships at work

Relationships are crucial to mental health. The negative impact of isolation and loneliness is thought to be on a par with the impact of smoking or obesity on physical health. And the relationships we make and maintain in the workplace are crucial, with those in full-time work in the UK spending more time with colleagues than with family or friends. The report highlighted that employees were about as likely to have daily contact with work colleagues (62%) as with their own children (64%), and that over four in ten (44%) had daily contact with their bosses compared with only 26% having daily contact with their mothers and 16% with their friends.

A key theme of the qualitative research interviews was the need to get the basics right in order to promote and protect mental health at work. Treating people humanely and with compassion was seen as important across sectors. Participants

recognised that this responsibility often started with line management, but that creating a work environment that promotes healthy, respectful relationships is a broader task for organisations.

> “It is not just the manager, obviously. It is the organisation and the culture of the organisation, so while [he's] my manager, it wasn't his policy; he didn't put it in. The directors of the company agreed to that policy so, you know, it started from the top and trickled all the way down, which is a good thing. So I mean, you might have the world's most understanding line manager but, you know, if the company itself doesn't support your needs, then you might find yourself sort of similarly in a difficult position than if you just had a non-understanding line manager. It involved everyone.”

One senior HR consultant reflected that effective management of mental health at work goes beyond training managers to effectively manage people and spot the signs of a mental health problem, and also beyond providing stress and resilience training to your employees.

> “It is all about the basics if you have the right policies and practices in place. And I am talking the real basics, from a good job description to being paid and rewarded well to having a good benefit system around that, i.e. you are allowed to take time off; you are allowed to take time off in lieu; your access to training is the same for everybody else... It is some of these basics in place that could probably prevent a lot of it.”

Having someone to talk to was highlighted as very important, including while in work, while absent and when returning to work. As one participant highlighted, it can be difficult if you feel you are dealing with a machine rather than with people; open communication was therefore considered a basic need. Without it, individuals experiencing mental health conditions were likely to feel more isolated, alienated and alone throughout the difficult and confusing process of navigating policies and procedures.

> “There should be open talk with a line manager... You should be able to, if you are feeling really low, talk to them.”

> “There were times I was feeling, I get shaken up, and my advisor would always be on the end of the telephone, and I can't tell you the difference that made to just kind of have someone to talk to.”

Managers are also integral to supporting HR processes that can be daunting and confusing. A lack of support from managers left many people feeling isolated and floundering with regard to what to do next, or how to handle the situation.

A positive relationship with a line manager can be key to disclosure and retention

Almost all the qualitative interview participants mentioned their line manager as the key person to supporting their mental health in the workplace. They could make the work environment either a positive or a negative experience.

> “I went back and they managed it quite well. I was able to have conversations with my manager. If I'd had a different manager, it could have been very, very different for me.”

Having a good relationship with line managers was seen as one of the most important aspects to consider when discussing mental health in the workplace. Key traits for managers that were explored by individuals who had experience with mental health problems included empathy, understanding and reassurance, which could help reduce the isolation and fear associated with having a mental health problem. For some people, it was having a good manager that made the difference for them, and helped keep them well.

> “What could have been a really nasty and difficult conversation was actually handled so well that I came away feeling really positive – that she had thought about it and that she had tried to view what was best for me... she hadn't kind of ignored the fact, and she hadn't blamed it.”

Without a good relationship with line management, individuals reported feeling unsupported and isolated. This was often related to choosing not to disclose, because of a perception of not being heard or valued:

> "I mean, if I couldn't talk to friends I certainly wasn't going to be able to talk to my employer pre-crisis."

> "I don't think it is fair to ask people with mental health issues to open up if they are not going to be heard."

A key factor of positive experiences in which participants felt that managers were able to support the mental health needs of their staff was how well those staff felt the managers understood mental health and possibilities for managing it. Many people with personal experience noted that it wasn't that their managers did not want to help, but that they didn't know what to do.

A need for training in mental health was outlined by the majority of participants, as being heard, understood and a sense of consideration of how mental health problems can impact on someone's work life (for example, the impact of medication) was seen as central.

> "My overwhelming experience is that people that matter, sort of the managers and HR managers, don't really understand the whole sort of impact that mental health can have on you."

Those who did disclose and had positive experiences in their workplace often attributed this to the good relationship they had with their line manager. In contrast, negative experiences were often attributed to a manager with poor understanding and a workplace's lack of support for mental health.

Line managers themselves also recognised the important role they played in supporting people with mental health problems in the workplace. However, they reflected that having a good manager with the right skillset, who is understanding and good at managing people, comes down to luck.

> "It's very difficult to find people who are actually good at managing people. It's my struggle, not just in my industry, but sort of wider management generally. I hear terrible stories from colleagues and friends about other managers that they have worked with who just aren't very good with people, who are not sympathetic at all and really struggle to see people's circumstances from another point of view."

Similarly, HR leads identified the critical role of an individual's relationship with their line manager as paramount to keeping people in work.

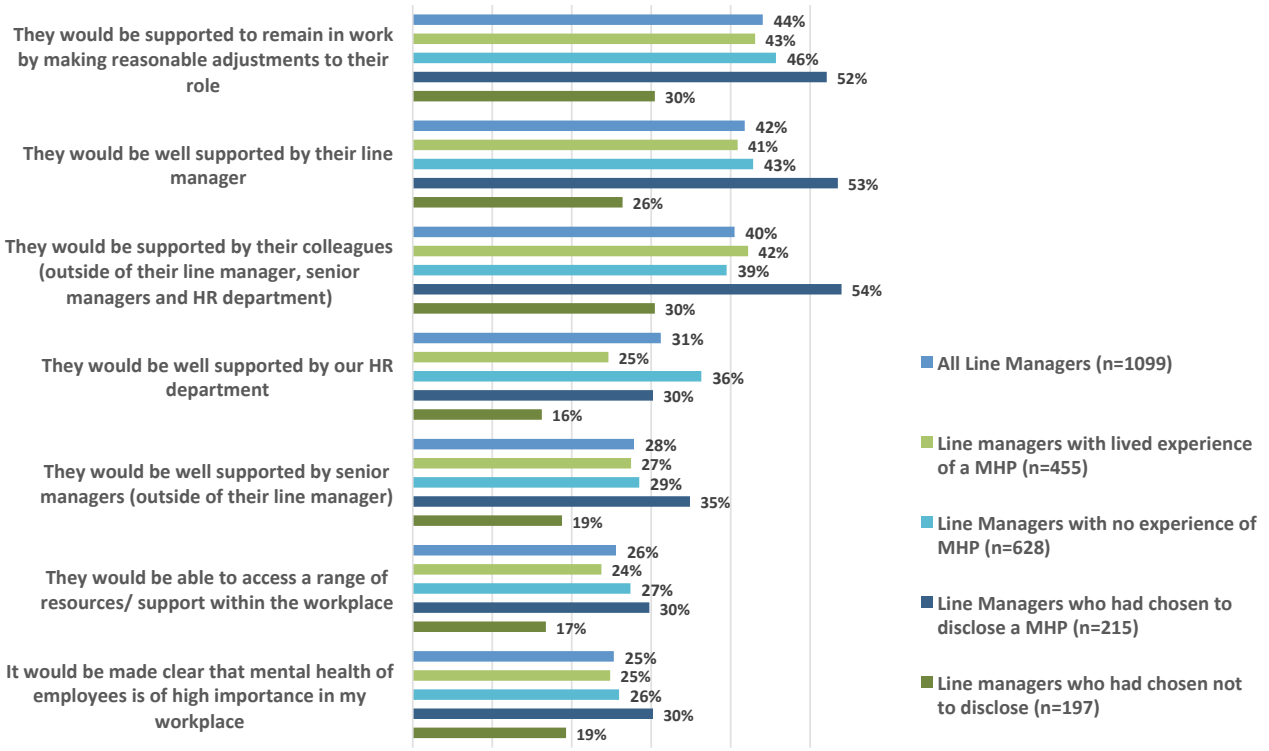
> "Critically, it's going to be their relationship with their line manager, if they feel they can talk to the line manager and the line manager isn't going to discriminate against them, either positively or negatively, because I think sometimes if you disclose you might feel you are getting the sympathy card, so I guess it's neutrality to a certain extent. I think it's the most important because ultimately that is where the day-to-day relationship exists."

Line manager perceptions of support in their company

Line managers were more optimistic that their company would provide positive support to staff with mental health problems than seems to be justified when compared with reports from other respondents who had experience of mental health problems. However, managers who had chosen not to disclose a mental health problem had the least positive impression of what support a person developing a mental health problem might receive in their company.

Line managers were asked to consider statements relating to what they think would happen if someone in their current workplace was to experience a mental health problem. This data is summarised in figure 14, below. This should be contrasted with figure 11, above, which shows what people with lived experience reported happening to them. In general, respondent manager perceptions of what would happen in a hypothetical situation were more optimistic than appear warranted by the reported experiences of respondents with lived experience.

Figure 14: Line manager perceived experiences of positive support at work



Line managers were the strongest believers that people developing mental health problems would be supported to remain in work through reasonable adjustments being made. Forty-four per cent of responding managers said they felt this would be the case in their company, and 52% of managers who had disclosed a mental health problem at work. However, only 19% of managers who had been diagnosed with a mental health problem had benefited from reasonable adjustments, and only 29% of the respondents in general who had disclosed.

Line managers were more likely to believe that people with mental health problems would be well supported by their line managers (42%) than was the case in reality, only 34% of people with mental health problems reporting being well supported by a manager.

In terms of support from HR departments, 36% of line managers without personal mental health experience believed a person with mental health problems would be 'well supported by our HR department'. This is markedly higher than the proportion of line managers with lived experience who reported such support (25%). Looking back at figure 10, we see that the actual proportion of people with lived experience saying they had received good support from their HR department was lower still (11%).

Things that could help: good line manager relationships

In relation to the list from which respondents were asked to select things that, 'in general, they felt workplaces could do to support people with mental health problems to stay in the workplace', line manager relationships were seen as critical.

Of respondents who had been diagnosed with a mental health problem in the last five years, 75% indicated that good line management relationships were important. This rose still further (82%) in respondents who had disclosed a mental health problem at work. Of line managers with lived experience, 73% selected this statement, compared to just 60% of managers who had no lived experience. This substantial difference may indicate that line managers who don't have personal experience underestimate how important line management is to people with lived experience. The decision to invest in developing high-quality line management

relationships is likely to impact positively across a business, where time to sensitively address personal concerns and actively support development is likely to improve mental wellbeing across the board.

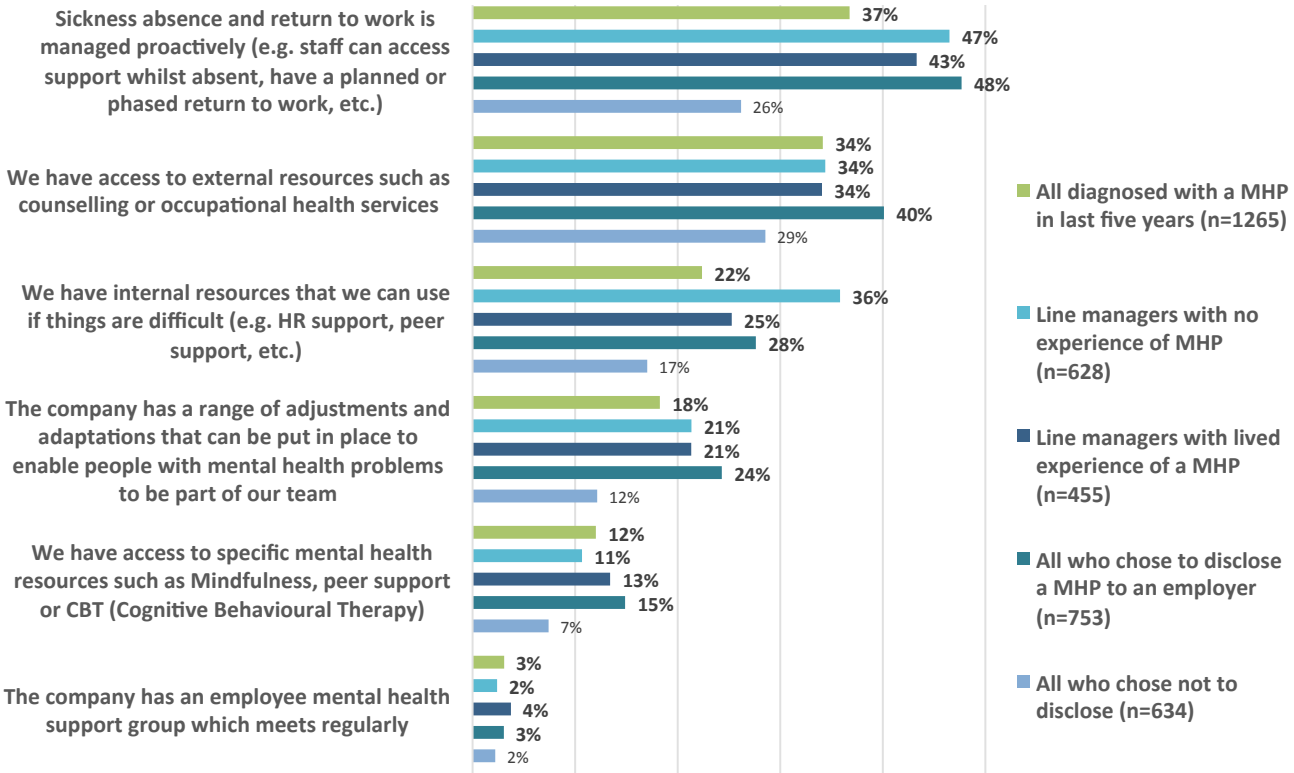
Of respondents who had been diagnosed with a mental health problem in the last five years, 65% felt that it was important for line managers to have sufficient training in dealing with mental health. Again, this rose to 71% among those who had disclosed a mental health problem at work, and fell to below half for those managers with no lived experience (49%). This implies that line managers who haven't had personal experience are less aware of a training need, or perhaps less able to prioritise it among other pressures.

Systems and structures

The final key area for action by employers was in implementing systems and structures that support mental health at work. Systems and structures must go hand in hand with improving culture and environment, as improved culture without systems and structures may be vulnerable to changing when individuals move within organisations, or when managers change. Equally, implementing systems and structures without supporting people to use them risks them being unknown or unused in practice.

All respondents (n=2,019) were asked to identify whether their workplace did well on a range of systems and assets that can support people with mental health problems. The responses are summarised in figure 15, below.

Figure 15: Things the workplace does well (systems and structures)



The most frequently selected response was that the workplace managed sickness absence proactively, but even then, only 37% of respondents who had been diagnosed with a mental health problem in the past five years believed this to be the case. Line managers were slightly more likely to believe this to be the case (43% of those with lived experience and 47% of those without lived experience), and respondents who had disclosed a mental health problem at work were the most likely (48%). In each group of respondents, then, less than half believed that sickness absence and return to work was proactively managed.

Just over a third of respondents either with lived experience or without (both 34%) reported having access to external resources such as counselling, occupational health services, or similar. This rose to 40% among those who had disclosed, again indicating that this group was more likely to have needed to discover these assets. This indicates a need to publicise the available resources more effectively.

Line managers who had no lived experience were substantially more likely than managers with lived experience, or indeed people with lived experience in general, to state that there were internal resources such as HR or peer support that they could use if things were difficult (36% vs 25% vs 22%). This may indicate that line managers without lived experience believed that the things that were in place were more helpful than those people with lived experience believed them to be.

Only 21% of managers indicated that the company had a range of reasonable adjustments that could be made to 'enable a person with mental health problems to be part of our team'.

Even among those who had disclosed a mental health problem, less than a quarter (24%) reported that their organisation had a range of adjustments it could make. This implies that for many people disclosure had not automatically led to a discussion about adjustments that could assist them.

Of respondents who had disclosed a mental health problem in the past five years, 15% reported that their company had provided access to specific mental health support resources, such as cognitive behavioural therapy (CBT) or peer support – this despite there being a range of evidence-based tools that workplaces can use.

Overall, the data suggests that employers lack systems to recognise and address mental health at work, especially in relation to absence management and making adjustments.

The business case on absence management is clear, and the ability to make adjustments are a legal necessity. We might expect to see fewer respondents reporting newer, evidence-based mental health tools like mindfulness at work, or peer support resources. However, it is important to ensure that staff are aware of even the basic provisions, such as absence management strategies, adjustments, EAPs and more specific resources, where provided.

Things That Could Help: Systems and Structures

In terms of systems and structures, and in relation to the list from which respondents were asked to select things that, 'in general, they felt workplaces could do to support people with mental health problems to stay in the workplace', the most commonly selected response was providing training to help line managers and employees better manage challenges they face at work.

Of respondents who had been diagnosed with a mental health problem in the last five years, 55% selected this statement, rising to 60% of those who had disclosed and nearly 56% of those who had chosen not to disclose.

In the qualitative research, pathways and procedures for taking sick leave due to mental health reasons were seen to be confusing and badly defined across the board. The bureaucracy was off-putting for individuals with lived experience, and, during a time of stress or poor wellbeing, often tiring.

Line managers talked of sometimes feeling stretched between trying to support the individuals they manage and meeting the business demands set by senior management.

> If you were to visualise it, I'd shape it like an egg-timer – you know, with the wide section at the top? I have got the staff... At the bottom, you have got all the board of trustees, the people that actually make all the decisions about how this place runs, and then in the middle you have got the manager, and I am kind of the person squeezed in the middle because I have no decision-making powers whatsoever.

Recommendations

Value mental health and wellbeing as core business assets

Organisation's should develop a strategy for maximising mental health and wellbeing as a business asset. The aim of this should be to enable every member of staff in the business to recognise, value, improve and protect their mental health, whether or not they have experienced a mental health problem.

It is important to align wellbeing strategies for staff in general with strategies to support and develop staff who might be at greater risk of mental health problems, as well as with strategies to support and provide adjustments to those already living with mental health problems. Such strategies include:

Designate champions both at board level and within senior management to oversee the development and implementation of a mental health strategy at the heart of the business

Champions at senior levels can drive forward and protect the interests of mental health and wellbeing at times when there is pressure from other priorities. Senior leadership champions who have personal experience of mental health problems can be a valuable asset, using their experience to drive action and engage staff. However, it is critical that a senior-level champion has the reach and authority to ensure such action. Champions should lead by example, encouraging staff at all levels to recognise, value, improve and protect their mental wellbeing at work.

Set targets and KPIs for improving mental health and wellbeing that integrate with main company performance metrics and with HR performance metrics

We all work better if we have clear goals toward which we are working, and mental health in the workplace is no different. Identify the key drivers and key indicators for mental health, and what level the company should achieve. Ensure that they are an integral part of your company's performance targets.

Many companies already use surveys, benchmarking tools and award programmes to gather insights on engagement, health and attitudes at work. Companies can identify mental health indicators in existing data-sets, as well as undertaking specific mental health benchmarking or research.

Commit to assessing the mental health impact of all HR strategies and ensure that processes and systems are optimised to promote and protect the mental health and wellbeing of staff and to reduce barriers to seeking help

All policies and procedures should be reviewed to assess mental health impact. If you have a mental health policy, or if you choose to develop one, involve staff at all levels and make sure the policy is implemented on the ground, and that best practice is shared and celebrated.

It is important to ensure that initiatives are balanced, to ensure that initiatives to encourage disclosure run parallel with meaningful activities to improve wellbeing across the company, and vise versa. It is also critical to ensure that initiatives to support mental health and wellbeing seek to recognise and address psychological hazards at work – both individual and corporate – the presence of which may reduce staff engagement in wellbeing activities that they may regard as superficial.

Companies with EAPs or vocational rehabilitation and absence management products should examine the extent to which these products cover mental health problems and support prevention-focused mental health strategies. This could include inviting feedback from staff who have used such programmes.

Recognise and celebrate the impact of existing employee benefits and corporate social responsibility activities (CSR) on the mental health and wellbeing of staff

Many companies already provide opportunities for staff to improve both their own and others' wellbeing and through flexible benefits and CSR. A first step is to audit the mental

health impact of the things already on offer.

Subsidised gym memberships, salary sacrifice schemes, flexible pay and pension packages, and annual-leave buy-back schemes are all good examples of initiatives that have a positive mental health impact. These assets should be made to complement the mental health strategy and demonstrate that the company recognises the importance of maintaining and protecting mental health.

There is also a direct mental health benefit from doing something good for others. Provide company resources or time for volunteering; matched funding for personal fundraising; and support for staff-initiated projects, as all of these activities can improve staff morale and engagement. Where these programmes connect to mental health initiatives in local communities, there is a benefit for both company and community.

Support the development of compassionate and effective line management relationships

Recognise and support the critical role that line managers play in creating mentally healthy teams, responding to distress and supporting recovery in the longer term

Line managers are the first 'official' connection between staff and the organisation. As such, they are responsible for both setting a tone and culture – shaping the expectations staff have of their employer – and recognising and responding to distress.

Supporting mental health and wellbeing should be a core skill of line managers and leaders in business. Competence in this area should be part of the selection, education and professional development of managers at all levels. Competencies to be implemented could include managers:

- organising time to support their team's mental health and wellbeing
- being available and approachable to staff wishing to discuss personal concerns, including mental health issues
- actively dealing with employees' mental health problems when they arise
- showing compassion when engaging with these problems
- using relevant life experiences to support staff and colleagues
- sharing positive experiences with peers and learning how to support staff with mental health problems
- firmly addressing stigma, discrimination or gossip about mental health problems, whether or not directed at particular individuals

Training is clearly necessary for achieving these competencies; however, implementing them in practice requires a company's commitment to integrating them into the culture at every level.

Provide opportunities for managers to attend relevant training that addresses mental health problems

A training needs analysis and a skills audit are crucial to developing a mental health strategy for an organisation.

A core training offer for managers should include support in responding to distress (addressing concerns that managers have about having difficult conversations), but it should also place mental health in the context of the business as a whole. Areas that should be covered include:

- **foundations of mental health at work:** developing understanding of how mental health fits into business priorities and how to plan and deliver business objectives without compromising mental health
- **building resilience:** developing personal self-management skills and learning how to coach and support staff during periods of challenge, either personally or within the organisation
- **signposting to support:** enabling managers to direct staff to the resources the company has available, as well as to information about NHS services and community groups and assets
- **line management and mental health:** enabling managers to feel confident in delivering everyday line management and adjustments for someone who is under stress or has disclosed a mental health problem

Provide support for staff who are line-managing people with mental health problems, including access to HR and, where necessary, occupational health services

Ensure that managers have rapid access to HR support when they feel out of their comfort zone. Use this HR support to increase managers' confidence in their own skills, so that HR time can be devoted to cases that are more complex.

Involve managers and close colleagues (with the consent of those involved) in the development of adjustments and return-to-work programmes. Consider self-management programmes as measures both to promote and protect recovery and to minimise the impact of recurrent mental health problems; put plans in place to recognise triggers or warning signs and then connect these to actions for the individual, their colleagues and the organisation.

Recognise that line managers who have personal lived experience are a unique asset for a company

Throughout this research, a new population of key stakeholders for workplace mental health has emerged. Line managers who have lived experience of having a mental health problem are more likely to recognise and support mental health as a business asset than line managers who do not have lived experience. Directly engage line managers who have disclosed personal experience of mental health problems when formulating your mental health strategy. They may be able to champion the cause directly, they may have key insights, and they may also be able to act as mentors and role models.

Address discrimination and support disclosure

Ensure that discrimination on grounds of mental health status is seen to be as unacceptable as discrimination in relation to protected characteristics such as race, gender or sexual orientation

It is time we stopped regarding stigma in mental health as anything other than illegal discrimination and harassment. Employers have a crucial role to play, starting with a high-level commitment to ending discrimination towards those with mental health problems, and then following through on this in practice. Both managers at all levels and staff on the ground need to know that the company regards ending such discrimination as critical, and that attitudes and behaviours must shift, just as they have in recent decades regarding discrimination that relates to gender, race and sexual orientation.

Build a disclosure premium by undertaking specific activities to create an organisational culture that values authenticity and openness

In an ideal world, disclosure of distress and a positive response that brings about support and a positive outcome would be something normal that could be relied upon. To get to this point, concerted efforts are needed to make disclosure easier and to address any negative consequences that follow.

Encouragement and support should be given to people to share their experiences and to have conversations about how they are feeling about work, and about wider work concerns. Mental health champions, peer support and other explicit measures are great; however, people at all levels talking about wider issues, such as bereavement, or stress around deadlines, all help to create an environment where conversations can take place.

Ensure that staff know how to disclose and are aware that the company regards the decision to come forward as courageous and valued. Consider creating a disclosure policy or template, or perhaps a publication or intranet page that specifically discusses disclosure, including examples of people talking about their experiences and the benefits of disclosing. This must address the challenges that people report as reasons for non-disclosure, such as shame, fear of discrimination, and lack of guidance.

If your company or organisation regards non-disclosure of a medical condition as grounds for disciplinary action, consider a disclosure amnesty to allow people who may not have disclosed to come forward, knowing they will not be penalised. However, where there is a regulatory or legal reason for disclosure being mandatory, an amnesty is not possible, as non-disclosure is either criminal or professionally negligent.

Encourage staff to report discrimination either that they face personally or that they witness

Just as with other types of discrimination, companies cannot place the onus to disclose solely on the individual

experiencing discrimination. Members of staff need to know what discrimination in mental health looks like, and how to come forward. This work can take place alongside promotion of codes of practice and wider bullying and harassment policies, both of which are critical to protecting and promoting good mental health.

Value the diversity and transferable skills that lived experience of mental health problems brings

Include mental health in diversity and inclusion strategies, and recognise that mental health is a relevant factor in wider diversity and inclusion programmes

As mental health becomes de-stigmatised and being open about lived experience becomes safer, companies can benefit from the diversity and resilience that people with lived experience and subsequent recovery can bring. Including mental health in diversity programmes enables people to engage, knowing that they can safely choose to be open about their mental health from day one. These strategies also allow companies to connect to employability services who seek to support disabled people, including those with mental health problems returning to work or entering the labour market for the first time.

Wider diversity and inclusion strategies also create opportunities for people who are at greater risk of poor mental health to benefit from career opportunities and improved professional development. Strategies to increase confidence, develop potential or increase access from underrepresented populations will probably already seek to improve mental health and resilience. Recognise and celebrate this.

Consider diversity and inclusion strands to recruit apprentices who have been in care, graduate trainees who come from non-traditional backgrounds, and professionally qualified people who have lived experience of mental ill health.

Recognise that staff who have disclosed a mental health problem have taken a risk in doing so. Acknowledge and value the trust they have placed in you

Actively seek the involvement of staff who have disclosed in initiatives to address mental health at work. These staff will need to be confident that the appropriate consent will be sought, and that their involvement will be positive and in their control.

If you are a large employer, consider setting up a reference group or panel, learning from diversity groups in other areas, such as LGBT staff networks and disabled staff networks. Recognise that staff with mental health problems don't always self-identify as disabled, and so not all disability-related initiatives include staff who might otherwise benefit from them.

Invite staff groups or panels to help shape strategies for the business; wherever possible, equip them with a budget line, a set of outcomes to achieve, and high-level sponsorship.

Nurture and develop peer support in the workplace, both formally and informally

Look at opportunities to fund and facilitate peer support at work for people with similar experiences of living with mental health problems. This can include hosting or directing people to support groups, or creating a confidential forum so that staff with lived experience can provide informal support.

The research shows that people with lived experience are more attuned to distress in others and more likely to have conversations about stigma or discrimination. Some of this population might be prepared to become points of contact for colleagues or managers, and there are well-developed training programmes for peer mentors adopting this role.

Peer support can also include manager peer support, with formal staff-development opportunities; these can include mentoring for staff and peer-to-peer learning for managers, such as action-learning sets for sharing experiences of managing mental health at work.

Conclusions

At every stage in this research, we sought to examine areas of interest and concern for people who are at work today and living with distress. For the final question in the survey, we asked respondents to prioritise three actions they would like to see their current employer take to improve mental health and wellbeing. The three top priorities identified were consistent across population groups in the survey, and echo the findings of the qualitative survey. They contain the same principles that underpin diversity and inclusion strategies across the business world. They were:

- a workplace culture that supports mental health and enables people to seek help when they need it
- a clear commitment from senior leadership to support mental health and wellbeing in the company
- clear mental health policies within the company that are implemented at all levels

These three actions describe the essence of a mentally healthy workplace. Beneath them lie a myriad of variables, some of which have been explored in this research and the recommendations that have arisen from it. In addition to these actions, there are three key areas of interest from our findings in which further research and insight would be useful.

1. Disclosure premium. We need to appreciate that when people feel most able to disclose distress they are easier to support. Equally, we must recognise that calling for 'honesty' is not the way forward. By addressing discrimination and investing in the talent of people with lived experience, while simplifying and celebrating disclosure, businesses can create a disclosure premium in which they benefit from talent and staff feel engaged and supported to achieve at their best.

2. Below-the-line distress. We need to recognise that many people whose work and personal lives are affected by distress do not have a diagnosable mental health condition, and even those who do may not share this with work. To reap the benefits of promoting and protecting mental health at work, employers need to be proactive and anticipatory, seeking and addressing psychological hazards at work and enabling staff to seek help both within formal structures and informally or anonymously through community or EAP provision.

3. Balance and authenticity of approach. Employers need to recognise that creating a mentally healthy culture requires more than a brief focus on mental illness at work. Measures to support people with mental health problems must be balanced with initiatives both to address challenges that affect all staff and to support those at greater risk. There is a very real possibility that superficial activity may prove unsustainable or may alienate either staff with lived experience or the wider staff population. This research shows that staff with lived experience, particularly line managers with lived experience, have a unique perspective to offer, and should be encouraged to do so.

Mental health will continue to grow as an issue of concern to HR professionals and to business, and benefits from a range of stakeholder interest. We hope to see further efforts to coordinate both action and research in this area, involving the widest range of stakeholders and sectors as is possible.

Appendix: The economic importance of safeguarding mental health in the workplace

by Oxford Economics

Mental health problems in the workplace are often seen as a cost: something employers must bear and employees must be mindful of. The analysis in this chapter, by Oxford Economics, seeks to change that view. People with mental health problems contribute hugely to the UK economy, making a major difference to UK GDP. By quantifying the scale of the gross value added contribution to UK GDP that people with mental health problems create by working, and by considering the cost of lost working days or lower productivity (again, measured as foregone gross value added), this work seeks to correct misconceptions about the costs of mental ill health. It goes on to explore the difference that exemplar employers are making by mitigating these costs through working with employees to address difficulties in the workplace. And it quantifies what it could mean for UK GDP if even a tenth of the costs of mental health problems could be mitigated by 2030.

A very substantial number of people in the UK live and work with a mental health problem. So-called 'common' mental health problems like stress, anxiety and depression (see glossary for detailed definitions) affect about 16.2% of the population aged 16 and over (about 8.6 million people) and 17.6% of the working-age population (ages 16–64). People who say that their main health problem is a 'serious' one, such as bipolar disorder or schizophrenia, constitute a further 1.1% of the population (590,000 people).

Inevitably, with so many people affected in some way, people with mental health problems already constitute a significant proportion of the labour force. These workers already make an important contribution to the country's GDP in all industries – from construction to entertainment – and in all regions of the economy. People with mental health problems could potentially contribute even more to the UK economy if the broad range of challenges that they face could be addressed.

Mental health problems prevent some people from joining the labour force, or can cause people to leave the formal labour force or reduce their hours to care for someone else with a mental health problem, meaning that the economic contribution they could have made is foregone. Where people with mental health problems do work, their illness can lead to absence or to lower productivity while at work, both of which result in foregone gross value added. This chapter seeks to explore the scale of this impact, and to quantify how much larger UK GDP could be if effective ways to overcome the challenges could be found and widely implemented.

Main data sources used in this chapter

This chapter makes extensive use of five main data sources, discussed in turn below. Chapter endnotes provide more detail about how each source is used in specific calculations and estimations.

Adult Psychiatric Morbidity Survey (APMS): This is a household survey commissioned by the Health and Social Care Information Centre and funded by the Department of Health. It assesses mental health and wellbeing in the population. The APMS is considered authoritative because of the broad range of treated and untreated conditions it asks survey participants about, and because one phase of the survey, involving about 8% of the total sample, is conducted by clinically trained research interviewers. This chapter uses data from the 2007 variant of the survey; data from the latest survey, conducted in 2014, is due to be published in September 2016. APMS data is used to estimate the number of people in the UK who have common mental health problems such as stress, anxiety and depression; this could not be reliably estimated from Labour Force Survey data, which is otherwise the preferred source

of data because of its extensive detail around demographics and labour force status.

Labour Force Survey (LFS): The LFS is conducted by the Office for National Statistics and is the largest household survey in the UK. It asks 100,000 people each quarter about their working status and life circumstances, including general and mental health problems. This chapter analyses the quarterly labour force survey conducted from January to March 2015 and published in 2016, chosen because of the availability of health questions (not all questions are asked in every quarter). LFS data offers a level of detail that other sources do not – such as the demographics, labour force status, industry of employment, and qualifications of people with mental health problems – and is therefore critical to the modelling inputs and descriptions in this chapter.

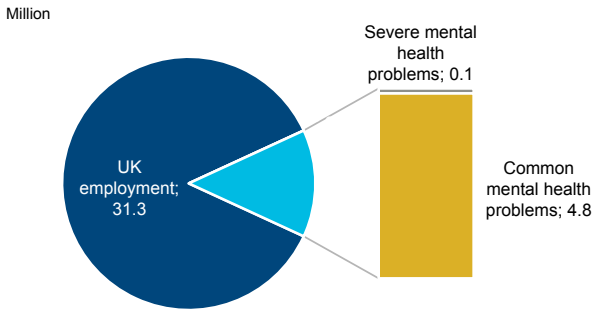
Office for National Statistics (ONS): The ONS is the official statistical agency of the UK. It is the source for a wide range of data used in this chapter for comparisons and estimates, including overall UK employment and GDP; employment and gross value added by industry; population estimates; and population forecasts.

Survey of Carers in Households: This survey was commissioned by the Department of Health and was conducted over 11 months in 2009/10 by the Health and Social Care Information Centre. It is a face-to-face survey of people who care for others conducted among a representative sample of homes in England. Data from this survey provides important modelling inputs, such as carers' labour force status, and whether they are caring for someone with a mental health problem.

Economic contribution of people with mental health problems

Mental health problems are common in the workplace, just as they are common in the population at large. At any one time in 2015, an estimated 4.9 million people were in work with a mental health problem (figure 1.1). That is nearly 16% of the 31.3 million people who were employed in the UK that year, or one in every 6.3 people in the workplace.

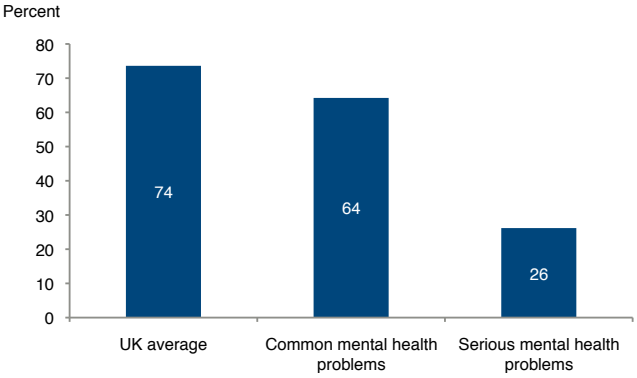
Figure 1.1: Number of people in work with mental health problems, 2015



Source: NHS (2007), OECD (2013), ONS Labour Force Survey (2016)

Indeed, people with common mental health problems are employed more often than they are not. And while people who have serious mental health problems have lower than average employment rates, these rates are far from zero. Some 64% of people with common mental health problems and 26% of people with serious mental health problems are employed (figure 1.2). That is compared with the 74% employment rate for the entire 16–64-year-old population.

Figure 1.2: Employment rates of people aged 16–64, 2015



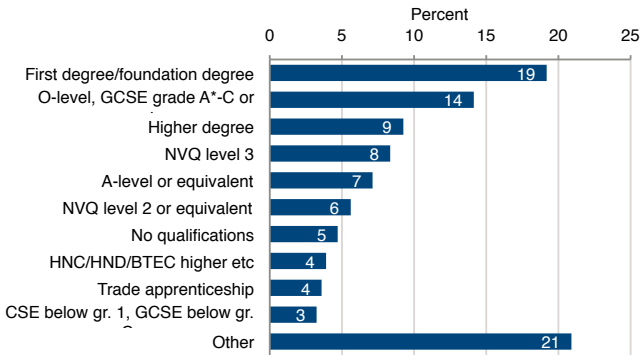
Source: OECD (2013), ONS (2016), ONS Labour Force Survey (2016)

Most of those in the labour force with a mental health problem are experiencing stress, anxiety or depression. These are so-called common mental health problems and account for 97% of those working with a mental health problem. As many as 17.6% of the working-age population in the UK (those aged between 16 and 64) have a common mental health problem at a given time.

A wide range of skills are brought to the labour force by people who have mental health problems (figure 1.3). According to Labour Force Survey data, of the 5 million people who were employed and had a mental health problem in

2015, 19% had a first degree or a foundation degree, 14% had O-level/GCSE grade A*–C or equivalent qualifications, 9% had a higher degree, 8% had a national vocational qualification (NVQ) level 3, and 7% had A-level or equivalent qualifications. Just 5% had no qualifications.

Figure 1.3: Highest level of education for employed people with a mental health problem, 2015

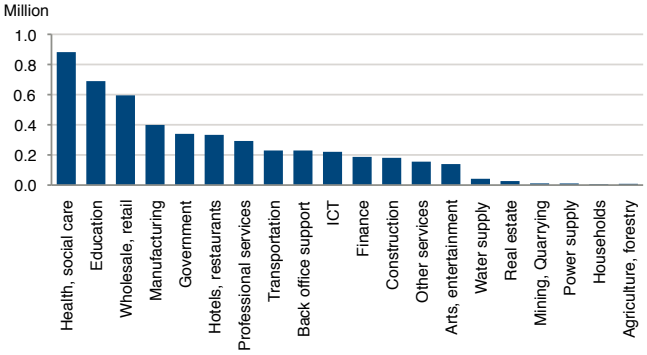


Source: ONS Labour Force Survey (2016)

People with mental health problems also work in all industrial sectors of the economy, from health and social care to agriculture and forestry (figure 1.4). In 2015, an estimated 880,000 people with mental health problems were employed in the health and social care sector (18% of all people employed with mental health problems), 690,000 were employed in the education sector (14%), 600,000 in wholesale and retail (12%), nearly 400,000 in manufacturing (8%), and 340,000 in government (7%). Combined, these five sectors accounted for 58% of all employment of people with mental health problems, slightly more than the share of employment in those industries overall, at 48%.

Several of these sectors, including health and social care, education and government, have high concentrations of public sector workers. This is consistent with other studies that have found that the public sector has a high prevalence of people employed with mental health problems. It is not clear why, although there are several possibilities. Perhaps these sectors are especially stressful and contribute to mental health problems; they may attract people who are prone to mental health problems, either because of a perception that they offer more support or appealing terms and conditions, or because people with mental health problems are drawn to helping others; or it could be a combination of these effects.

Figure 1.4: Employment by industry for people with mental health problems, 2015

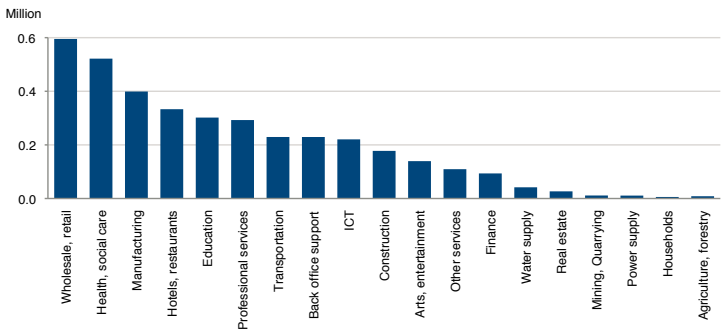


Source: ONS APMS, ONS Labour Force Survey (2016), Oxford Economics

Even so, the vast majority of people with mental health problems work in the private sector (figure 1.5). An estimated 3.7 million people were employed in the private sector and had a mental health problem in 2015, or 75% of all employment among people with mental health problems.

Excluding public sector employees then, people with mental health problems are most commonly employed in wholesale and retail (600,000 or 16% of all private sector employment of people with mental health problems), health and social care (520,000 or 14%), manufacturing (400,000 or 11%), hotels and restaurants (330,000 or 9%) and education (300,000 or 8%). Combined, these sectors accounted for 2.2 million people who were employed with mental health problems, which is 57% of the total. For comparison, these sectors make up 49% of all private sector employment.

Figure 1.5: Private sector employment by industry for people with mental health problems, 2015



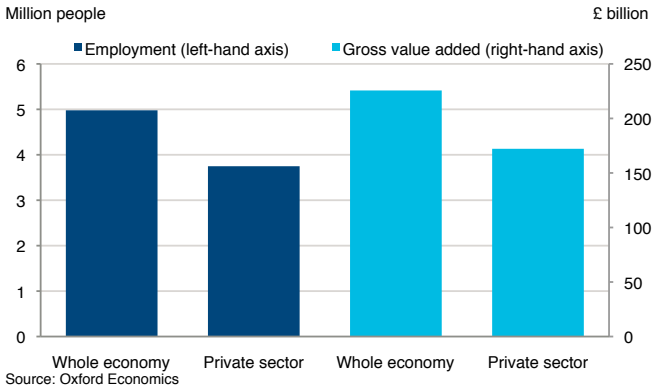
Source: ONS APMS, ONS Labour Force Survey (2016), Oxford Economics

There are some sectors where people with mental health problems are notably under-represented. These include agriculture, forestry and fishing (where 2.3% of the private sector labour force is estimated to have a mental health problem), real estate (5.4%), back-office support sectors (8.5%) and construction (8.9%). For each of these industries, prevalence is lower than an estimated 14.4% prevalence rate in the private sector overall.

All of these people working with mental health problems made a substantial contribution to the UK economy in 2015. Taking into account the industries in which they work and the rates of full-time and part-time work among those with mental health problems, we estimate that the 5 million people in work with mental health problems made a £226 billion gross value added contribution to UK GDP in 2015, or 12.1% of the total (figure 1.6).

While it is difficult to measure accurately, we estimate that the vast majority of this contribution came from the private sector. By accounting for the distribution of public and private sector employment in each of the 20 industries we analysed, we estimate that people with mental health problems who were working in the private sector generated a £172 billion gross value added contribution to UK GDP in 2015. That is 76% of all gross value added created by those with mental health problems, and 9.2% UK GDP that year.

Figure 1.6: Employment and gross value added contribution of people with mental health problems, 2015



Source: Oxford Economics

Foregone contributions to UK GDP

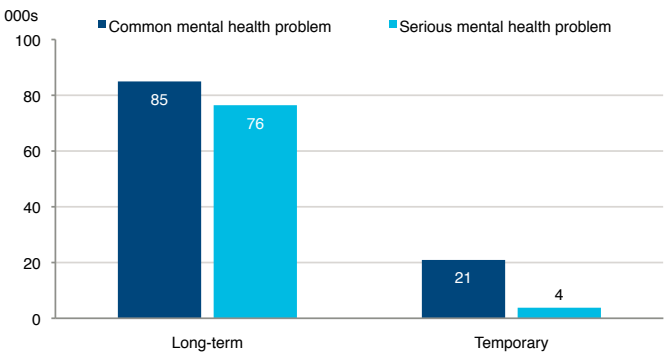
As the previous section conclusively demonstrates, people with mental health problems contribute substantially to the UK economy. But mental health problems also have costs for people and for businesses. For example, mental health problems may prevent people from joining the labour force, may cause people to be absent or less productive at work, or may force them to leave the labour force. This section attempts to estimate the degree to which UK GDP is smaller because of mental health problems, along with their effects on people and businesses. We also acknowledge that many of these losses are difficult to measure, however, and they should therefore be considered only indicative of the scale of the problem.

In total, we estimate that the UK GDP could have been £25 billion higher in 2015 if not for the cost arising from the consequences of mental health problems to both individuals and businesses. This is 1.3% of GDP in that year, or equivalent to the gross value added produced by all people working in Birmingham in 2013. Each element of these losses is discussed in turn below.

Mental health problems can prevent people from joining the labour force

The largest of the costs of mental health problems is that the UK economy is smaller than it otherwise would be because some people with mental health problems are unable to work. Labour Force Survey data collected by the Office for National Statistics indicates that 186,100 people wanted to work in 2015 but could not join the labour force because of their mental health problem (figure 1.7). About 161,400 of these people said their mental health problem was a long-term one and the reason they were not searching for a job, while 24,700 said their problem was temporary.

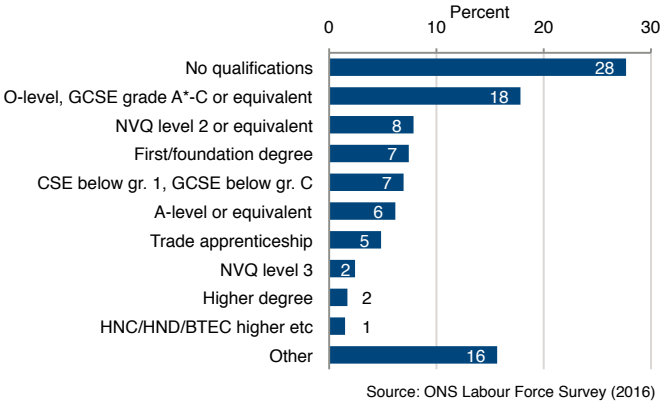
Figure 1.7: People not in the labour force due to a mental health problem, 2015



Source: ONS Labour Force Survey (2016)

Many of those who cannot join the labour force because of their mental health problem are nonetheless well-qualified, suggesting a relatively high productivity loss. Over 72% of those who say they would like to work but aren't searching for a job because of their health problem had some sort of qualification (figure 1.8). For example, 18% had O-level or GCSE grade A*–C or equivalent qualifications and 7% had a degree.

Figure 1.8: Highest qualification for people who want a job but are not looking because of their mental health problem, 2015



Source: ONS Labour Force Survey (2016)

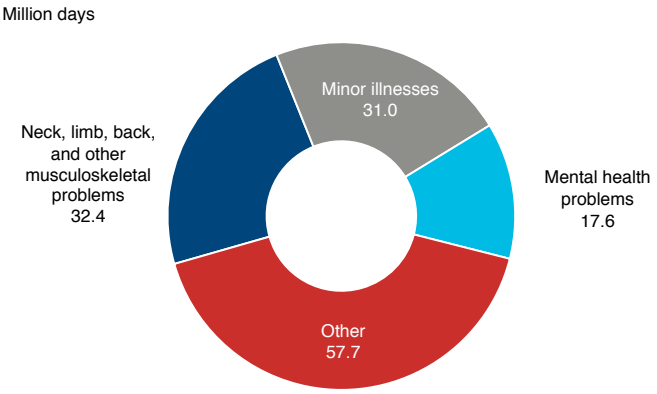
It is possible to estimate the scale of the GDP contribution foregone because people with mental health problems are not in the labour force by looking at the productivity of workers with mental health problems. Given the industrial sectors they choose to work in, the average worker with a mental health problem is estimated to make a £45,325 gross value added contribution to UK GDP economy in 2015. Multiplying this figure by the 181,600 people who could not join the labour force because of their mental health problems suggest some £8.4 billion was lost in foregone gross value added. About £7.3 billion of this amount (87% of the total) is from long-term illness, while £1.1 billion (13% of the total) arises from temporary illness. The private sector's share of this lost gross value added is likely around £6.4 billion, or 76% of the total. For context, that is about 0.5% of all private sector gross value added created in the UK in 2015.

Mental health problems can cause sickness absence

Where people are able to continue to work, people with mental health problems, just as those with physical health problems, may take days off work due to their illness. These are counted as sickness absences by the Office for National Statistics, and reduce UK GDP.

According to the ONS Labour Force Survey, in 2015, people took 138.7 million working days off because they were ill or in pain (figure 1.9). That is about 4.4 days per person employed. Neck, limb, back and other musculoskeletal problems combined were the most common main cause cited for sickness absences, adding up to 32.4 million working days lost, or 23% of the total. Common and serious mental health problems were the third most important cause, leading to 17.6 million sickness absence days in 2015, or 12.7% of the total.

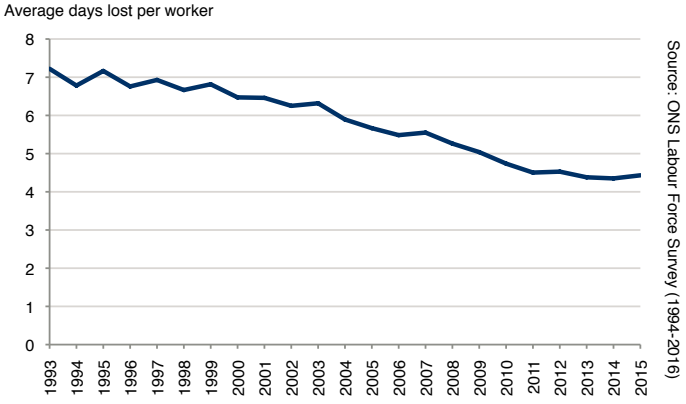
Figure 1.9: Number of working days lost due to sickness absence, 2015



Source: ONS Labour Force Survey (2016), Oxford Economics

The average number of sickness absences per worker has been declining for two decades (figure 1.10). The latest ONS data shows that the number of days absent from work due to sickness per person employed in the UK in 2015 was 4.4, which is 60% of the number of days taken per person employed in 1993, at 7.2. And while it is beyond the scope of this study to determine the causes, the observed data is striking, and suggests that some combination of the following has been occurring: people have grown healthier, are more often attending work while ill, or are taking fewer illegitimate sickness absences.

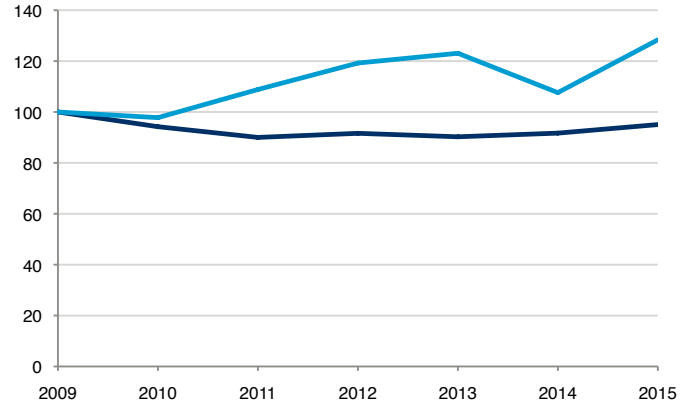
Figure 1.10: Number of sickness absence days taken for all reasons, 1993–2015



Source: ONS Labour Force Survey (1994-2016)

Less historical data is available about sickness absences due to mental health problems. In 2015, slightly more than three sick days per person employed with mental health problems were taken because of those mental health problems, up slightly from previous years (figure 1.11). It is not clear from this relatively short time-series that this is part of a genuine, long-term trend or if it is merely a short-term fluctuation.

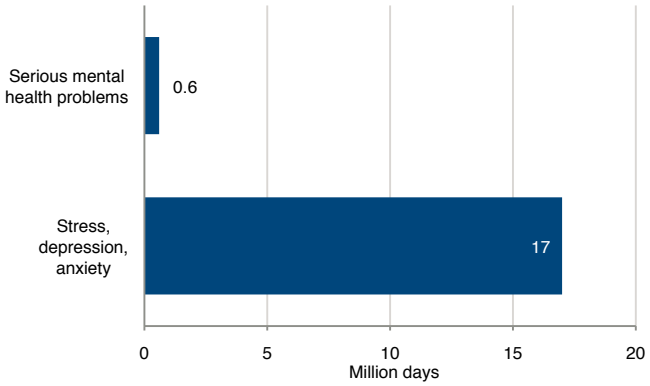
Figure 1.11: Number of sickness absence days taken per person employed in the UK by reason, 2009–2015



Source: ONS Labour Force Survey (2010-2016)

Most absences taken because of mental health problems – 17 million, or 97% of all sickness days taken due to mental health problems – were a result of common mental health problems like stress, depression and anxiety (figure 1.12). The remaining 600,000 days, or 3%, were due to serious mental health problems like bipolar disorder and schizophrenia.

Figure 1.12: Number of sickness absence days taken due to mental health problems, 2015



Source: ONS Labour Force Survey (2016)

Based on the same productivity estimate used in the section discussing workers who cannot join the labour force because of mental illness (£45,325 per employee per year for those who have mental health problems), we estimate that these sickness absences resulted in a foregone gross value added contribution to UK GDP of about £4.3 billion in 2015.

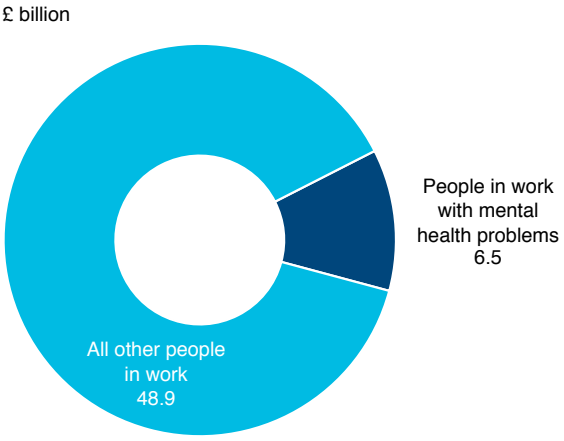
Mental health problems can reduce productivity

In addition to sickness absences, those who are in work and experiencing a mental health problem may experience reduced productivity, often called 'presenteeism'. Considering there are an estimated 5 million people in the UK who are in work with a mental health problem, the foregone productivity from presenteeism could be significant.

It is difficult to accurately measure the foregone economic contribution from reduced productivity, as few, if any, estimates exist for how much less productive staff are when they turn up for work when unwell. Therefore, this report, following Sainsbury Centre for Mental Health (2007), adopts findings from an international academic literature review to produce a conservative estimate. The literature suggests that presenteeism could cause between 1.9 and 6.8 times as many working days lost as absenteeism. Because the estimates vary widely, it is sensible to err on the side of caution. Therefore, taking the same conservative approach as the Sainsbury Centre (2007) report, we assume that presenteeism results in 1.5 times as many working days lost as absenteeism, which is slightly lower than the lowest estimate found in the literature review.

Using that rule of thumb, the foregone gross value added contribution to UK GDP due to the productivity costs that mental health problems impose is estimated to have been around £6.5 billion in 2015 (figure 1.13). To put that in context, it is nearly 12% of the estimated cost of presenteeism to the UK economy across all types of employees, at £55.3 billion (3% of UK GDP in 2015).

Figure 1.13: Cost of presenteeism for the UK economy of those with mental health problems and of all other people in work



Source: ONS Labour Force Survey (2016), Sainsbury Centre (2007)

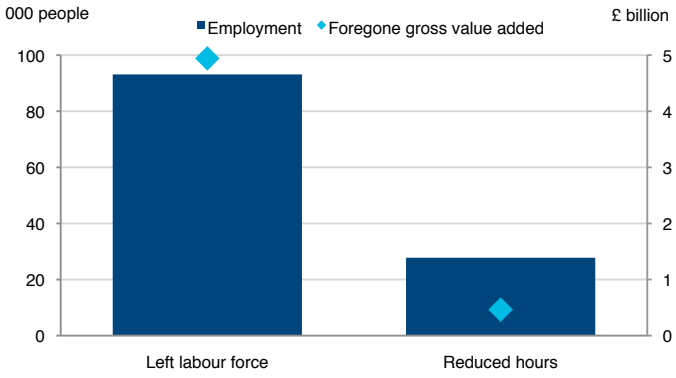
Wider, knock-on effects of mental health problems

Mental health problems may also have a range of wider, knock-on effects for the UK economy. Not all are easily quantifiable. One example is the number of people who leave the labour force or reduce their hours to care for those with mental health problems. Informally caring for others is immensely valuable to society, but because it is not a market-based activity this social contribution is difficult to measure and is not counted as part of GDP.

However, it seems intuitive that if mental health problems were less prevalent then more people could participate in the formal labour force rather than caring for relatives or friends, and this would contribute to measured GDP in the UK. The foregone gross value added contribution to UK GDP from carers leaving the labour force is one indicator, albeit imperfect, of the scale of the costs of mental health problems in the UK. In 2015, an estimated 93,100 people were out of the labour force because they were caring for someone with a mental health problem (figure 1.14). A further 27,800 people were working reduced hours in order to care for someone with a mental health problem.

Assuming the people who needed to leave the labour force to care for relatives or friends with mental health problems are as productive as the average UK worker, and assuming that those who reduced their hours to provide such care became part-time workers (in the absence of better data), UK GDP may have been £5.4 billion smaller in 2015 than if those carers could have continued with their original jobs or hours. The vast majority of this amount (£4.9 billion, or over 91%) was due to people leaving the labour force entirely to care for someone with a mental health problem.

Figure 1.14: Number of people who left the labour force or reduced their hours in order to care for someone with a mental health problem, and foregone gross value added, 2015

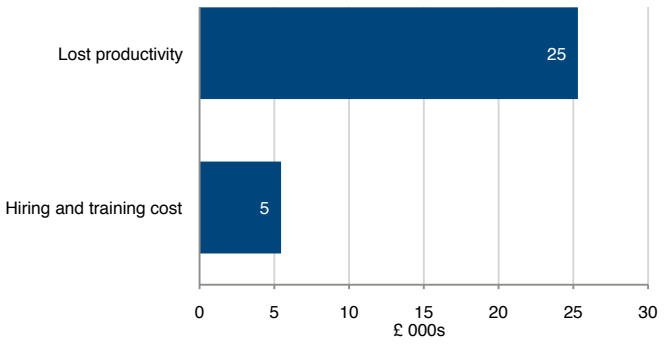


Source: NHS Survey of Informal Carers in Households (2009/10), ONS (2016)

Those with mental health problems and carers leaving the labour force can result in lost productivity and training costs for employers. Employers may need to hire temporary replacements, then find and train permanent replacements. This can be costly. Oxford Economics has previously estimated that the cost to businesses and the economy from lost gross value added of the time that new employees take to reach optimal productivity is £25,200 per worker who leaves. Businesses then bear a cost of about £5,500 per employee to find and train a new employee (figure 1.15).

Based on Labour Force Survey data, we estimate that about 16,000 people whose main health problem is a mental health problem left their jobs for health reasons in 2015. And assuming that carers are equally likely to leave the labour force at any age, an estimated 1,900 may have left in 2015 alone. If so, this would mean a foregone gross value added contribution of about £460 million that year as replacement workers take time to reach optimal productivity.

Figure 1.15: Lost productivity and hiring and training cost when an employee leaves his or her job, 2015



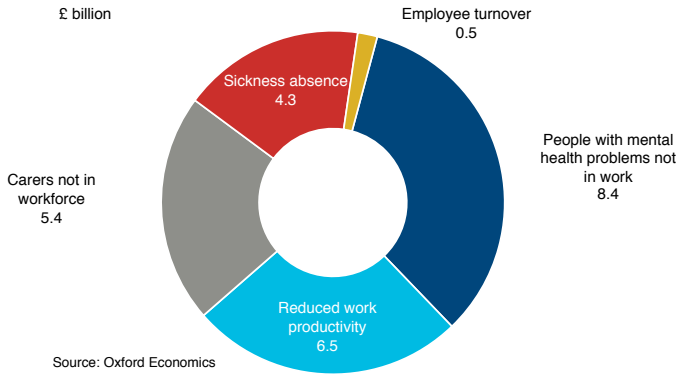
Source: Oxford Economics (2014) findings updated for 2015

Total foregone contribution to UK GDP due to mental health problems in the UK, 2015

Evidence presented in this chapter shows that mental health problems impose substantial costs on people and businesses. Including people who can't join the labour force, carers leaving the labour force or reducing hours, sickness absence, and employee turnover, we estimate that mental health problems are responsible for about £25 billion in foregone gross value added (figure 1.16). For comparison, that is equivalent to 1.3% of UK GDP in the UK in 2015.

About 34% of this total amount is accounted for by economic activity foregone because people with mental health problems do not join the labour force, 26% by reduced worker productivity (presenteeism), 22% by people who left the labour force to care for relatives or friends with mental health problems, 17% by sickness absence caused by mental health problems, and 2% by employee turnover.

Figure 1.16: Total costs to individuals and business arising from mental health problems, 2015



Source: Oxford Economics

The private sector's share of the total foregone gross value added is likely to have been around £19 billion, an estimate that takes into account the industrial sectors in which people with mental health problems work in.

There have been a handful of other studies that have assessed the costs of mental health problems in the UK. These are discussed in the box below. Because of methodological and measurement differences, none are directly comparable to the estimates presented in this chapter.

Findings from similarly-themed studies

The Sainsbury Centre for Mental Health (2003) report examined three types of costs: quality of life costs, costs to businesses and the economy (termed 'output' costs) and healthcare costs. The study found that mental health problems imposed quality of life costs worth £41.8 billion on individuals in 2002/3 (this and other pound values in this box have not been adjusted for inflation); at the same time, businesses, the economy and the unpaid sector experienced costs or foregone output worth £23.1 billion; and the NHS, local authorities and informal carers bore costs of £12.5 billion due to mental health problems. The cost to businesses and the economy are variously measured as lost productivity, foregone employee compensation, or other, unspecified costs. Elsewhere in this study, all foregone contributions to the UK economy are measured as gross value added. Because of these measurement differences, the Sainsbury Centre for Mental Health estimates cannot be compared directly to the estimates presented elsewhere in this report.

Sainsbury Centre for Mental Health (2007) assessed the costs businesses experienced due to mental health problems and did not assess healthcare or quality of life costs, as in the 2003 report. The 2007 report found that reduced productivity due to mental health problems may impose a £15.1 billion annual cost on businesses; sickness absences a further £8.4 billion; and staff turnover another £2.4 billion. These estimates are not directly comparable to those presented elsewhere in this report because costs to businesses are not synonymous with foregone gross value added. In addition, there is a large methodological difference between Sainsbury Centre for Mental Health (2007) estimates and Oxford Economics estimates of the number of sick days that can be attributed to mental health problems. Labour Force Survey data suggests that 12.7% of all sickness

absences in 2015 were due to mental illness, or about 17.6 million working days. In contrast, Sainsbury Centre for Mental Health (2007) estimated that 40% of all sickness days taken in 2007 were due to mental health problems, which was estimated at the time to amount to 70 million working days. We could not find evidence to support such a high figure in the literature at the time or since then.

The Centre for Mental Health (2010) was an update to the Sainsbury Centre for Mental Health (2003) report. The former used changes in employee compensation, GDP and expenditure on adult mental health services by the NHS and local authorities to extrapolate earlier findings. The updated report found that quality of life costs had grown to £53.6 billion (up 28% from 2002/3), costs to businesses and the economy rose to £30.3 billion (up 31%), and health and social care costs rose to £21.3 billion (up 70%). For the same reasons as discussed for Sainsbury Centre for Mental Health (2003), Centre for Mental Health (2010) estimates are not directly comparable to the foregone gross value added estimates presented elsewhere in this report.

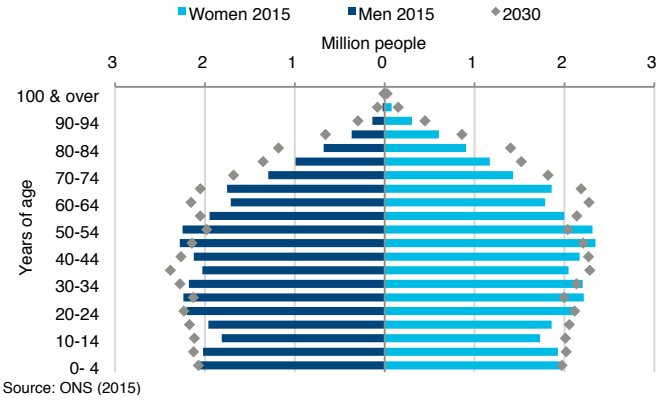
How mental health problems will affect the UK economy in 2030

In the context of the opportunity foregone to boost UK GDP by enabling more people with mental health problems to remain in the labour force or by reducing the impact of absenteeism or presenteeism, it is instructive to consider how UK GDP might change if these patterns could be altered, even if only a little. This section of the report forecasts the number of people who will have a mental health problem in the UK in 2030, and how they will affect the economy. We will then consider the potential benefits if 10% of the costs of mental health problems were eliminated.

We expect the number of people with mental health problems to grow in proportion to the population, with little to no contribution from increasing prevalence. That is because, at present, there appears to be no evidence that the prevalence of mental health problems is increasing. The King's Fund, an English health charity, found in 2008 that 'there is no evidence that we are becoming more anxious or depressed or that many more of us are suffering from serious conditions such as schizophrenia and severe personality disorders'. We are not aware of any evidence to the contrary, including findings in the 2000 and 2007 versions of the Adult Psychological Morbidity Survey.

The Office for National Statistics (2015) expects the UK population to get bigger and older between now and 2030 (figure 1.17). Based on these population projections, the number of people with mental health problems is expected to grow from 9.2 million to 9.9 million, an increase of 7.7%. This increase is slightly less than the population growth rate (which is forecast to be 9.6% between now and 2030) because older people have a lower prevalence of mental health problems than younger people (perhaps because they are less affected by workplace and child-rearing stresses) and the older population is expected to grow faster than the younger population.

Figure 1.17: Current and forecasted demographic profile of the UK, 2015–2030



Holding the prevalence of mental health problems and employment by age constant at 2015 rates and allowing population by age to grow according to Office for National Statistics projections, the number of people who are in work and have a mental health problem is expected to increase from 5 million in 2015 to 5.2 million in 2030, an increase of 3.6%. Based on this, and an estimate of how UK workers' productivity is likely to increase over the next 15 years, we forecast that people with mental health problems will make a £294 billion gross value added contribution to UK GDP in 2030. That is up from £226 billion in 2015, a 30% increase due mostly to expected productivity growth.

Mental health problems could by that time result in UK GDP being £33 billion lower than it otherwise would be by 2030, by preventing people from joining the labour force, requiring

they take sick days off work, reducing productivity while at work, and causing employee turnover (for both those with mental health problems and carers). These costs, like the benefits above, are expected to be 30% higher than the equivalents in 2015, due mostly to expected productivity growth in the next 15 years.

The potential benefits of a reduction in the costs of mental health problems

Some businesses have successfully reduced the costs of mental health problems among their workers, particularly by improving productivity and work satisfaction (see the case study on mitigating the cost of mental health problems below). If more businesses did so, the UK economy could benefit substantially. For example, if just 10% of the forecasted, foregone gross value added contribution to UK GDP were mitigated by 2030, it would result in an increase in UK GDP of £3.3 billion (0.1% of forecasted UK GDP in 2030).

Case study: mitigating the cost of mental health problems

Can any of the costs that mental health problems impose on people and businesses be mitigated?

The Organization for Economic Cooperation and Development (OECD) recently discussed some examples of good practices by UK companies that may have mitigated some of the costs of mental health problems.

For example, BT, the telecommunications company, has programmes to promote wellbeing and mental health as well as to identify distress and intervene early using an online stress assessment; it even provides a CBT service for 'mild-to-moderate' mental health problems. The OECD report notes that BT's programmes have, according to BT, reduced sickness absences attributable to poor mental health by 30% and helped 75% of people who had been absent for more than six months return to work.

The OECD also mentioned EDF, the energy company, which has said it was losing about £1.4 billion per year from reduced productivity among employees with mental health problems. The company responded by offering psychological support to employees and training for managers to help them recognise and manage the effects of mental health problems. The company has estimated that its initiatives saved nearly £230,000 from productivity improvements, while increasing job satisfaction from 36% to 58%.

Conclusion

This chapter assessed the economic contribution that people in work with a mental health problem made in 2015, as well as the foregone gross value added caused by mental health problems.

The results are important because they clearly show that the 5 million people who had a mental health problem in 2015 contributed about nine times more to UK GDP than their mental health problems cost the economy. In 2015, people with mental health problems contributed an estimated £226 billion gross value added contribution to UK GDP, while the economy was likely smaller by about £25 billion because of the challenges mental health problems pose.

A forecast based on the prevalence of mental health problems and population growth by age suggests that people with mental health problems will make important gross value added contributions to the economy for years to come, growing to an estimated £294 billion by 2030.

Furthermore, some companies have shown that the costs of mental health problems can be mitigated, illustrated in two case studies. Economy-wide, eliminating just 10% of foregone gross value added due to mental health problems could increase UK GDP by £3.3 billion, or 0.1% of forecasted total GDP in 2030.

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[i]GDP is the most commonly used statistic to measure the health of the UK economy and whether the economy is entering or exiting a recession. It is all revenue earnt by UK companies and industries minus the value of the goods and services used while generating that revenue (with minor adjustments for taxes and subsidies).

[ii]Gross value added is most simply understood at the firm level as the difference between turnover and bought-in costs used up in the creation of that turnover. Summed across all businesses and industries in the UK, gross value added is equal to GDP (after minor adjustments for taxes and subsidies).

[iii](NHS Information Centre for Health and Social Care, 2007)

[iv](Office for National Statistics. Social Survey Division, 2016)

[v]The structure of the Labour Force Survey questionnaire is such that the most accurate results are available for respondents' 'main' health problem rather than all listed health problems; unfortunately, results for peoples' main health problem are not suitable for estimating the prevalence of common mental health disorders, as the latter can coexist with more pressing health problems.

[vi]Definitions of mental health problems, including common vs serious mental health problems, were adopted from the ONS Labour Force Survey and the Adult Psychiatric Morbidity Survey.

[vii](Office for National Statistics, 2016)

[viii](OECD, 2014) and (Office for National Statistics. Social Survey Division, 2016).

[ix](Labour Force Survey (via ONS), 2016)

[x](NHS Information Centre for Health and Social Care, 2007).

[xi](Health and Safety Executive, 2015)

[xii]Full-time and part-time rates of employment were derived from (Office for National Statistics. Social Survey Division, 2016). About 64% of employed people with common mental health problems and 56% of people with serious mental health problems work full-time, while the remainder work part-time. In the UK on average, 73% of employed people work full-time.

[xiii]Private sector employment by industry was estimated by subtracting public sector employment by industry from total employment by industry (Office for National Statistics, 2016). Gross value added in the private sector was estimated by multiplying employment in the private sector by gross value added per employee in each industry in the UK overall. This assumes that private sector and public sector employees are equally productive, which may not be the case.

[xiv](ONS, 2016). Birmingham is defined as the NUTS3 region coded 'UKG31'. NUTS is the nomenclature of territorial units for statistics used widely in official statistics.

[xv]Estimates are based on the number of people in the Labour Force Survey who said that they wanted to work but were not looking for a job because of a short-term or long-term illness and they stated elsewhere that their main health problem was a mental health condition.

[xvi]This assumption may not hold if those who cannot join the labour force because of their mental health condition are more seriously ill than those who are in the labour force. In addition, this may be an overestimate to the extent that this group of people is more likely to have no qualifications than the group who is employed (28% compared to 5%). However, the estimates presented may underestimate the true figures because it includes only those whose main health problem is a mental health condition and does not count those who may have a mental health problem that is secondary to another health problem. We used

the Labour Force Survey variable coded 'HEALTH' that asks about the main health problem because the Labour Force Survey's usage notes advise: 'For more accurate results always use the variable HEALTH as it gives the respondent's main/most significant health problem and not a general problem.'

[xvii]This assumes that people who are not in the labour force due to a mental health condition would otherwise be employed in the public and private sector, by industry, and in full-time vs part-time capacities in the same proportions as those who have mental health problems and are employed.

[xviii](Department for Business, Innovation and Skills, 2015) and (Office for National Statistics, 2016)

[xix](Office for National Statistics, 2016). A working day is defined as 7.5 hours.

[xx]The Labour Force Survey asks 'What was the main condition that caused you to take this sickness absence?'

[xxi](Office for National Statistics, 2016)

[xxii](Office for National Statistics, 2014), which analyses sickness absences in the UK using Labour Force Survey data, gives schizophrenia and bipolar disorder as examples of serious mental health problems.

[xxiii](The Sainsbury Centre for Mental Health, 2007)

[xxiv](Tilse & Sanderson, 2005) was a study of 10 call centres in Australia. It found that presenteeism may have cost 1.9 times the cost of absenteeism. (Collins, 2005) looked at presenteeism and absenteeism in the US firm Dow Chemical Company. (Ozminkowski, 2004) studied productivity at a large telecommunications firm in the US. (Stewart, 2003) analysed the American Productivity Audit, a national survey of the US workforce, to determine the absenteeism and presenteeism costs of painful conditions. (Ronald, 2006) looked at absenteeism and presenteeism in the US using The National Comorbidity Survey Replication data. (Goetzel, 2004) studied absenteeism and presenteeism in the US using productivity surveys and the Medstat MarketScan Health and Productivity Management database. And (Dewa & Lin, 2000) studied absenteeism and presenteeism in Canada using the Ontario Health Survey's 1990/91 Mental Health Supplement dataset.

[xxv]Presenteeism costs are based on sickness days taken due to back pain; neck and upper limb problems; other musculoskeletal problems; stress, depression, anxiety; serious mental health problems; minor illnesses; respiratory conditions; gastrointestinal problems; headaches and migraines; genito-urinary problems; heart, blood pressure, circulation problems; eye, ear, nose & mouth/dental problems; diabetes; and 'other', including those who prefer not to say (Office for National Statistics, 2016). The analysis multiplies the number of sickness absence days by a factor of 1.5 times and average UK productivity.

[xxvi](Department of Health, 2011)

[xxvii]This implicitly assumes that those who leave the workforce to care for others have the same propensity to work full-time or part-time as the rest of the workforce, and the same employment distribution across UK industries as the rest of the workforce. There is no reason to believe that this under- or over-estimates the result.

[xxviii](Oxford Economics, 2014). The report looked at the financial costs of employee turnover in the IT/tech, accounting, legal, media/advertising and retail sectors.

[xxix]Oxford Economics' 2014 estimates were updated for 2015 using the ratio of gross value added per employee between the two years (applied to the productivity loss) and the ratio of the GDP deflator between the two years (applied to the hiring and training cost).

[xxx]People may be more likely to leave the workforce to become carers when older than when younger, so this assumption may not hold perfectly. The carers survey does not indicate when the carers left the workforce (Department of Health, 2011).

[xxxi](Sainsbury Centre for Mental Health, 2003)

[xxxii](The Sainsbury Centre for Mental Health, 2007)

[xxxiii](Office for National Statistics, 2016)

[xxxiv]A commonly cited Health and Safety Executive report on work-related stress, anxiety and depression statistics in Great Britain (2015) stated that 'In 2014/15 stress accounted for 35% of all work related ill-health cases and 43% of all working days lost due to ill health' (Health and Safety Executive, 2015). However, the calculation is based on a subset of illnesses – those that were caused by or made worse by work – and this cannot be applied to all sickness days.

[xxxv](Centre for Mental Health, 2010)

[xxxvi](King's Fund, 2008)

[xxxvii](NHS Information Centre for Health and Social Care, 2007)

[xxxviii]Productivity is defined as GDP per person employed, which Oxford Economics forecasts will rise by about 26% between 2015 and 2030.

[xxxix](OECD, 2014)