Directorate-General for Health & Consumers

MENTAL HEALTH IN WORKPLACE SETTINGS

CONSENSUS PAPER

Mental Health

MENTAL HEALTH

IN WORKPLACE SETTINGS

CONSENSUS PAPER

CONSENSUS PAPER:

Mental Health in Workplace Settings

This paper has been written by:

David McDaid

Has had the additional technical input of:

Karl Kuhn; Paul Litchfield; Linda Seymour; Richard Wynne

Was based on input by a consensus group that met in Luxembourg (29th February 2008, see participant list at: http://www.ec-mental-health-process.net), and has been commented by:

Accor; Robert Anderson; Maria Helen Andre; Gregor Breucker; Jean-Francois Cholat; Stefan Clauwaert; Cary Cooper; Sarah Copsey; Tom Cox; Jorge Manuel Costa David; Trude Eliassen; Bea Berruga Garcia; Bob Grove; Richard Hopkins; Jorma Jarvisalo; Eva Jané-Llopis; Sine Mutanu Jungersted; Maria Kopp; Stavroula Leka; Lennart Levi; Allyson McCollam; Tobias Müllensiefen; Sue Newberry; Chris O'Sullivan; Jurgen Scheftlein; Christian Puppinck; Becca Randell; Nathalie Renaudin; Maria J San Pío Tendero; Jurgen Scheftlein; Solvay; Anne Vandenhende; Jacques van der Vliet; Jukka Vuori; Kristian Wahlbeck; Wellbeing in the Work Place CSR Laboratory; Richard Wynne; Maurizio Zollo;

This report has been prepared under a tender contract with the European Commission (contract SI2.493939 Lot 4: Mental Health), lead by the Department of Health Government of Catalonia in collaboration with National Research and Development Centre for Welfare and Health - Stakes, the London School of Economics and the Scottish Development Centre.

More information and the electronic version of the paper are available at:
http://www.ec-mental-health-process.net
A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server (http://europa.eu.int).

This document should be quoted:

McDaid (Ed). (2008). Mental Health in Workplace Settings. Consensus paper. Luxembourg: European Communities.

ISBN-

Printed by the services of the European Commission (OIL), Luxembourg

MENTAL HEALTH IN WORKPLACE SETTINGS
Consensus paper

Employment is a fundamental component of quality of life and wellbeing, the main source of income for most people, commonly a major influence on our social networks, and a defining feature of social status. Given the high prevalence of mental health problems in the general population - at any one time between one in five and one in six workers may be affected by mental health problems - the workplace needs to be able to provide a healthy environment that is supportive to all workers.

There is a strong business case for tackling poor mental health at work: absenteeism, reduced productivity while at work and premature withdrawal from the labour force because of mental health problems can have a significant impact on European productivity and competitiveness.

The case for action from a governmental perspective is strong: early retirement and exclusion from the labour force due to work-related stress and mental health problems, particularly depression, now account for an ever greater share of long term social welfare benefits, and indeed may even challenge their long term sustainability.

The case for action from the employee perspective is strong: research demonstrates that work increases self-esteem and quality of life. Providing a healthy and inclusive working environment can prevent mental health problems and make it possible to enter and remain at work when experiencing such problems.

Prevention of social exclusion and promotion of social inclusion: promoting labour market participation for people with mental health problems is one way of achieving this objective. At the same time it contributes to the EU goals of sustained economic growth, more and better jobs and greater social cohesion.

1. POLICY CONTEXT

One of the four priority areas of the 2005 relaunch of the Lisbon Strategy on Growth and Jobs has been to 'invest in people and modernise labour markets'. More specifically, the objectives of the strategy include improving the skills, employability and adaptability of the workforce, as well as promoting the functioning of labour markets in the EU, including the greater participation of population groups that currently face difficulties and may be excluded from the labour market. Promoting and maintaining good mental health and wellbeing in the workplace is of key relevance to the achievement of these objectives across the European Union.

This importance of mental health and wellbeing is also recognised in the *Community Strategy on Health and Safety at Work* for 2007-2012. This refers to the contribution of good health in

guaranteeing that quality and productivity at work can play in promoting economic growth and employment. It highlights the common and increasing consequences of work-related stress and poor mental health as reasons for work absenteeism and occupational disability. Taking account of projections from the WHO that psychological problems will be the principle source of incapacity by 2020, it advocates a change towards a more preventive culture, including making the promotion of mental health at the workplace a priority.

The Commission White Paper "*Together for Health: A strategic approach for the EU 2008-2013*" in emphasising the substantial economic costs of mental disorders, noted that the majority of these are due to lost productivity in the workplace. Community actions in the field of mental health and measures to promote the health of the workforce were announced in this document.

In addition to the legally binding Framework Directive 89/391/EEC on occupational safety and health which states that "*employers have a duty to ensure the safety and health of workers in every aspect related to the work*", there are also two policy instruments at Community level that are the results of European social dialogue and specifically focus on mental health at work. The EU-level social partners concluded these two Framework Agreements in 2004 and 2007 to address the prevention of "work-related stress"[1] and "harassment and violence at work"[2] respectively. Together with their member organisations they committed themselves to implement these agreements at national level, with a view to identifying, preventing and managing problems of work-related stress, harassment and violence in workplaces across Europe.

In the context of the social protection and social inclusion process, the 2007 Commission Communication on "Modernising social protection for greater social justice and economic cohesion: taking forward the active inclusion of people furthest from the labour market" proposes a holistic strategy that can be termed active inclusion. The aim is to break down barriers to the labour market, while ensuring adequate levels of social protection for those furthest from the labour market, including people with mental health problems. The Active inclusion strategy is complementary to the Flexicurity strategy which states a new perspective on working life which implies that new forms of flexibility and security are needed for individuals of all ages and companies, as well as for Member States and the EU, in order to achieve the Lisbon objectives of more and better jobs.

2. RISK FACTORS AND TRENDS

2.1. What do we know about prevalence and risks of poor mental health in the workplace?

Poor mental health affects all of us. One in four European citizens can expect to experience a mental health problem during their lifetimes. In any one year up to 10% of the European

population experience some type of depressive disorder[3], while psychotic disorders are much less common impacting on 2.6% of the population [4].

Employment is beneficial to physical and mental health[5] [6]. Maintaining good mental health in the workplace can also help boost business productivity and at the same time help the EU achieve its Lisbon agenda goals for economic growth and global competitiveness. It can also contribute to general population health goals through health promotion activities. The workplace can provide a healthy culture and environment that is psychologically supportive to the workforce. It also helps promote the social inclusion of people with mental health problems, providing an income allowing them to more fully participate in society.

The challenge however is not only to address that minority of mental health directly caused by work, but also those caused by non work-related problems that may become visible and sometimes exacerbated within the working environment. Vulnerability to psychosocial stress, burn out and mental health problems is becoming more challenging as the nature of work in Europe continues to change. More individuals now work in the service sectors (where there is a need for high levels of potentially stressful consumer interaction) or high technology sectors (where it may be difficult to keep up with the pace of change).

New working practices may be in place, intended to help adapt economies to the challenges of competing in a global marketplace. This may increase job insecurity, for instance where there is a possibility of outsourcing tasks to locations outside Europe. The impact of these structural and technological changes may be compounded by evolution of a workforce that reflects demographic changes in society which accommodates more women, older workers, new migrants and those who shift between employment sectors when skill requirements change.

In a recent report[7], the European Agency for Safety and Health at Work, highlighted some emerging psychosocial risk factors behind poor mental health in the workplace including: reduced job security and more fixed term employment contracts; work intensification – a higher workload often without additional reward; high emotional demands at work, including bullying and violence; and a poor work-life balance. Data on the quality of the working experience, collected as part of the Fourth European Survey on Working Conditions[8], suggest that many of these risk factors are widespread across the EU, affecting both men and women (See Figure 1).

In particular, more than two thirds of workers do not think their jobs will enhance their career prospects, nearly two thirds must work at high speed or to very tight deadlines, while more than 40% only receive low levels of assistance from line managers or are engaged in monotonous tasks. Other risk factors include a lack of control over work and lack of participation in decision making; poor social support at work and unclear management structures. While many of these issues are common across the EU, there are some differences between the old and the new Member States: 25% of workers in the latter are

fearful of losing their jobs within six months compared with just 11% in the former; moreover more individuals are engaged in shift and monotonous working in the new Member States.

Figure 1: Working Conditions in the EU-25 by gender

	Percent		
	Total	Men	Women
Work organisation and content of work			
Working at very high speed[1]	60	63	56
Working to tight deadlines[1]	62	68	54
Short repetitive tasks < 10 min	39	37	41
Monotonous tasks	43	42	44
No job control			
No control over task order	36	37	36
No control over work methods	33	33	33
No control over speed of work	31	31	31
Low social support			
Low assistance from colleagues[2]	33	33	33
Low assistance from supervisors[2]	44	46	42
Working time			
Long working days[3]	16	22	9
Work shifts	17	17	17
Harassment and discrimination			
Bullying, harassment	5	4	6
Job insecurity, satisfaction with earnings and possibilities for career advancement			
Might lose my job in the next six months[4]	13	13	13
Not well paid for the work[5]	56	53	59
Job don't offer good prospects of career advancement[5]	68	66	71

The risk of common mental health problems in workers with high job strain or poor effort-reward balance may be as much as 80% higher than that for the working population as a whole. The combination of a high level of job strain and high job insecurity may increase the risk of depression by fourteen times compared to those who have control over active, secure jobs. Long working hours are associated with depression in women while sickness absence is positively associated with monotonous work, not learning new skills and low control over work and non-participation at work.

2.2. What impact does work-related stress and poor mental health have on absenteeism?

While caution should be exercised in the interpretation of data because of differences in the structure of social welfare systems, across Europe the levels of absenteeism, unemployment and long term disability claims due to work-related stress and mental health problems have

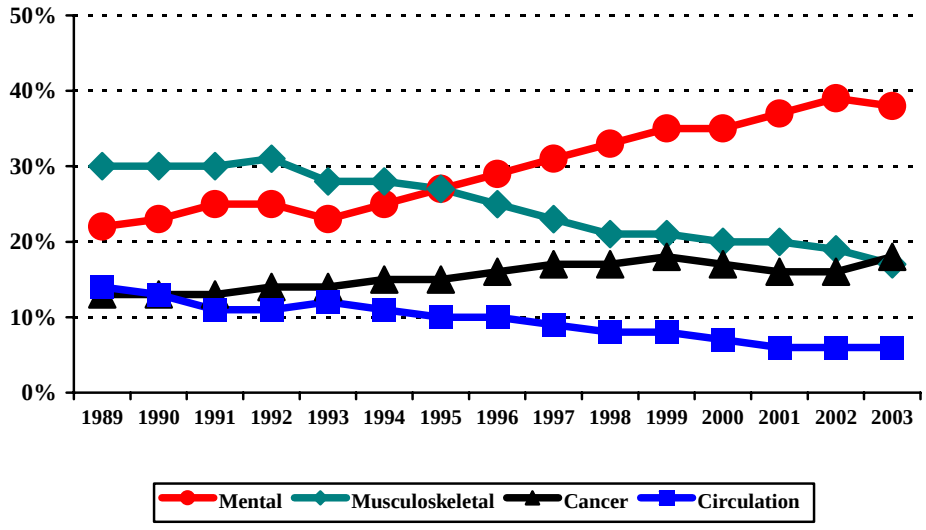
been increasing; in many countries they have now overtaken musculoskeletal problems as the leading cause of days of absence from work and withdrawal from the labour market.

For example, 40% (€3.9 billion) of all long term disability benefit payments in England, Scotland and Wales in 2007 were due to mental and behavioural disorders[9]. Moreover, the total number of individuals claiming disability benefit for mental health problems in those countries is now greater than the total number of claimants for unemployment benefit. Upward trends in disability benefit claims can be seen elsewhere: for instance in the Netherlands between 1970 and 2003, there was a steady increase in the risk of workers being registered as disabled because of a psychological disorder; by 2003 this accounted for 35% of all registrations[10]. In Austria, while days of absenteeism for all causes decreased by 13% between 1993 and 2002, days of absenteeism due to mental health problems increased by 56%. Common to the situation reported in other European countries, this duration of absenteeism increased more for women (72%) than men (37%)[11].

2.3. What are the links with premature retirement?

Workers increasingly cite work-related stress and mental health problems as reasons for seeking early retirement. Premature retirement from work due to work-related stress and mental health problems is on the increase, as for instance indicated in Germany (Figure 2).[12] By 1996 poor mental health was the leading reason for early retirement, while by 2003 the average retirement age for people due to mental health problems was just 48.

Figure 2: Reason for early retirement in Germany



Source: German Federal Health Monitoring 2007

Data elsewhere, e.g. from Finland and Sweden, also indicate that retirement due to mental health problems occurs at an earlier age than for other health problems, leading to long-term

reliance on disability benefits, exclusion from the workforce and the loss of positive advantages that employment brings. By 2005 35% of all early retirements in Sweden were linked to mental health problems[13]. In Finland, the Ministry of Social Affairs has now launched a programme, MASTO, which specifically aims to improve mental health and reduce retirement due to depressive disorders.

2.4. What are the costs to business?

Poor mental health has many consequences for business. Firstly, there can be substantial immediate productivity losses due to sickness absenteeism and early retirement. In addition, employers then have to incur recruitment costs necessary to obtain replacement workers. Where there has been a loss of highly skilled employees, companies may have to invest in additional time consuming training courses for replacement employees.

The impacts on business go beyond absenteeism and retirement. There can also be a reduction in the productivity whilst at work of individuals with unsupported mental health needs. This is known as *presenteeism.* While difficult to measure, some studies suggest that its impact may mean that productivity losses experienced by business may be between 50% to 500% greater than estimates of cost based on absenteeism alone.[14] [15]

People with poor mental health also have a much higher risk of developing physical health problems including cardiovascular disease compared to the general population, increasing work-related absenteeism.[16] The converse is also true: absenteeism from work because of poor physical health can also increase the risk of poor mental health. The impacts of poor mental health in a workplace also go beyond individual workers: for those working in teams, ill health and sickness absence may lead to an increased workload and work-related stress in other team members.

If a business is perceived to have high levels of absenteeism it can also potentially have an adverse impact on its reputation. This might be perceived, rightly or wrongly, by both the general public and potential future recruits as a signal of the low priority that a company places on having a healthy workforce. Potentially it might lose customers and procurement contracts. Within the workforce there might be a detrimental impact on morale and staff loyalty. The image of a business might also be adversely affected if it is not seen to have a diverse workforce, including people living with enduring mental health problems.

2.5. What is the overall economic impact to the European economy?

The total productivity related costs of mental health disorders in the EU-25 (plus Norway, Iceland and Switzerland) have been estimated to be €136.3 billion (2007 prices)[17]. The majority of these productivity losses, €99.3 billion per annum, were linked to depression and anxiety related disorders. This is substantial: the productivity losses associated with another major health problem in Europe, cardiovascular disease, are much lower at €36.1 billion in the EU-25 [18]. This estimate is nonetheless conservative: it does not take into account the long

term impacts on career progression of periods of absenteeism, reduced educational opportunities and the social exclusion that people with mental health problems can experience. Moreover, the cost estimates for poor mental health though enormous, do not reflect all of the costs incurred by business: presenteeism, which is dependent on the nature of the job and industry, may increase business costs by between 50% and 500%.

2.6. What do we know about the participation of people with enduring mental health problems in work?

Data on the employment rates of people with enduring mental health problems remains limited in many European countries. The majority of countries with data report employment rates of between 20% and 30%; in the case of people with severe mental health problems like schizophrenia (the majority of whom are capable of and wish to work) employment rates can be much lower, circa 10%[19]. This may in part reflect stigma and discrimination that these individuals encounter in the labour market, or firms lack of ability to adjust the workplace or working environment to their needs, as employment rates are much lower than for people with severe physical disabilities[20].

3. A FRAMEWORK FOR ACTION

While more evidence on the effectiveness of different approaches is still required, a range of measures have been shown, to differing degrees, to be effective in promoting mental wellbeing, preventing and managing mental health problems and helping reintegrate people back into work [21 22]. There is also some growing evidence suggesting that the business case for investment in such measures can be strong with costs avoided far outweighing the cost of workplace programmes[23 24]. Critical to the success of any action is the need to consider any one action in isolation but to combine interventions at both the organisational level with those targeted at improving the mental well-being of specific individuals. Effective dialogue and partnership between employers, employees and their representatives can play a vital role in this process. Mechanisms to safeguard confidentiality for people with mental health problems in the place can also help encourage individuals to make use of support in the workplace when required.

Governments may also have a vital role to play in facilitating action. Given that the benefits of a healthy workforce accrue to the government as well as to individual companies, providing support to those small and medium sized enterprises, who otherwise might find it difficult to deliver or fund some health promotion activities may be merited. At both a European and national level monitoring and enforcement of existing directives and legislation to promote workplace mental health and tackle also discrimination in the workplace is also critical.

3.1. Promotion of mental well-being at work

The workplace provides an important setting in which population level health promoting activities and support can be delivered to individuals who inevitably are leading increasingly busy lives in the 24/7 economy. The objective of good physical and mental wellbeing might be embedded within an enterprise's corporate social responsibility policy; being seen to actively promote health might in turn help enterprises recruit and retain staff in the global marketplace. Employers and employees, working in partnership, therefore have a critical role to play in helping to facilitate a healthy organisation and working environment. They can help foster a value based culture which promotes a positive and stimulating approach to management and enables employees to maximise their potential to the full. This in itself can help strengthen employee morale and thus promote health.

Many general workplace health promotion programmes help promote both physical and mental wellbeing, e.g. through improved working conditions, exercise schemes (e.g. biking to work, exercise classes) or relaxation programmes. Other programmes aim to provide general health and lifestyle related advice and maybe linked to a general wellness screening programme (See Box 1).

Box 1. Implementation of a work-based health promotion programme[25]

In a controlled evaluation a multi-component health promotion programme for office based employees of Unilever PLC in the UK provided participants with a personalised health and well-being report and highlighted the personal health areas in need of improvement and gave practical suggestions as to how to achieve the recommended changes. They also received personalised health, well-being, and lifestyle web portal that included articles, assessments, and interactive online behaviour-change programmes. Participants also received tailored emails every two weeks on personal wellness topics relevant to them, as well as packs of information and seminars on key health topics. Participants were found to have significantly reduced health risks including work-related stress and depression, reduced absenteeism and improved workplace performance. The cost of the intervention to the company was €120 per employee; these costs were more than outweighed by a reduction in absenteeism and improvements in workplace productivity.

The way in which the workplace is organised can help promote wellbeing. This maybe through practical measures intended to minimise discomfort from excessive noise, poor air quality including exposure to chemicals, uncomfortable working temperature, poor lighting to ergonomic measures. It might also be through the introduction of measures to help maintain the work-life balance, whether this is through the provision of child-care facilities, changing patterns of shift working or ensuring that workers use up their annual holiday entitlements.

3.2. Prevention of work-related stress and mental health problems in the workplace

Preventive actions can be divided between primary measures, predominantly at the organisational level intended to reduce the risks of undue stress and mental health problems occurring in the first place and secondary measures intended to prevent further adverse impacts in individuals who already have these problems. Actions need to be developed and implemented in partnership between senior and middle management and employees; drawing

on employees' on-the-job experience is a vital resource in identifying problems and solutions. In the longer term promoting the discussion of occupational health issues within the curriculum of business and management orientated degrees might also help facilitate action.

The first step in developing preventive measures is to identify sources of stress within the workplace. These may vary considerable depending on the nature of the employment sector and the type of employee – e.g. managerial versus manual etc. Tools are available to help organisations identify such risk factors e.g. the stress assessment checklist produced by the ILO[26] or *Open Minds: Head First - A Guide to Mental Wellbeing at BT* produced by BT Group plc. Surveys might be undertaken to establish the baseline for risk in different workplace settings. This risk analysis might then be compared with available services and supports available, thus identifying potential gaps in what is needed.

Some preventive measures focus on adapting the workplace organisational structure and environment to minimise the risk of undue levels of stress. For instance, they might include flexible working arrangements, including measures to promote work-life balance; job and or task redesign; better dialogue and collaboration between managers and employees or enhanced use of teamwork. Making the workplace more supportive and transparent, i.e. allowing greater participation in decision making by employees can help improve job satisfaction, reduce the likelihood of work-related stress developing and mitigate the impact of non work-related stress. Workers can be given more control over the nature of their work. Ensuring that there are appropriate levels of reward for efforts within the workplace and the possibility of job/career progression can also be preventive.

Multi component awareness and stress management programmes that generally combine interventions to help individuals deal with work-related stress and organisational measures to deal with risk factors for undue levels of stress can be effective preventative measures and benefit business productivity (See Box 2).

Box 2. The business case for risk assessment and stress management programmes

One Belgian pharmaceutical company instigated a multi-component awareness and stress management programme in 1994 at a time of economic uncertainly which had fuelled a sense of job insecurity in its workforce. During the period of the evaluation absenteeism decreased by approximately 19%. If all of this reduction in absenteeism was linked to the stress management programme then the cost avoided by the company were more than 2.25 times greater than the costs of implementing the scheme[27].

In the UK the insurer, Royal and Sun Alliance, introduced a risk assessment and stress management programme in 2000. Evaluation indicated improved work satisfaction levels for staff and managers as well as reductions in anxiety, depression and long-term sickness absence. The programme also had significant financial benefits because of the decrease in productivity losses due to sickness absence generating a 3:1 return on investment[28].

There is a strong role in these programmes to be played be managerial staff such as line managers and workers' representatives, whose skills and awareness of work-related stress and mental health issues can be improved. This can help develop an environment within the

workplace where people feel comfortable talking about mental health issues. Line managers and other key workers might also be trained to monitor staff so as to spot and manage with greater confidence the early signs of distress. Well established, but short, simple and inexpensive education and training programmes for managers and other workers are available. In addition, programmes might also involve the use of specialist trainers or facilitators whose aim is to improve enhance the resilience and coping skills of individuals in dealing with stressful situations. Other training courses might include time management, dealing with harassment in the workplace and enhancing assertiveness.

3.3. Early detection of undue stress and mental health problems in the workplace

While the primary prevention of stress is the ideal, the early detection and support for people with stress and/or mental health problems, regardless of cause, has also been shown to be effective (See Box 3)

Box 3 – The APRAND Programme[29]

In France, Electricite de France and Gaz de France implemented the APRAND programme (Action de Prévention des Rechutes des troubles Anxieux et Dépressifs). The aim was the early identification of anxiety and depressive disorders by screening individuals on sick leave presenting to company occupational health physicians. Individuals meeting screening criteria were placed on a health promotion programme involving the provision of information on their condition and a recommendation to consult with their general practitioner, occupational physician or psychiatrist. Overall this group had a significantly higher rate of remission and recovery compared with individuals in a control group.

Counselling can also be effective for employees identified as having job-related stress and mental health problems. The most effective approaches may focus on problem identification and problem solving. Counselling can, of course, also help individuals in learning how to cope with some of the non work related causes of stress and depression that nonetheless impact on work, such as problems in personal relationships or a death in the family.

Another intervention that might form part of a holistic approach to approach to supporting people is the provision of structured cognitive behavioural therapy (CBT) over a short number of sessions (perhaps no more than eight) either on a face to face, telephone or computer basis delivered by specialists in the fields of stress and depression. One recent US study, reported that individuals who were identified through a workplace screening programme and then subsequently received CBT and medical support had significantly better mental health outcomes, higher rates of job retention and more hours worked (an additional two weeks) at twelve months compared to those individuals receiving usual care alone[30]. The business case again was strong: there was a positive return on investment to the company because of the avoidance of hiring and training new staff.

3.4. Support for return to and reintegration into work

For individuals who have been on long term sick leave, interventions to promote a more rapid return to work, include regular contact with company occupational physicians from early into any period of absence. Referring individuals to such services after two or three months rather than six months has been shown in some cases to substantially cut duration of absence. Reintegration to work may be done gradually, perhaps initially on a part time or flexi time basis and with job redesign or modification (See Box 4). Return to work plans should include issues such as disclosure in order to deal with potential stigmatisation and discrimination.

Box 4 – BTs approach to reintegration into work[31]

As part of a long term structured approach to mental wellbeing BT Group plc ensures that line managers regularly keep in touch with individuals on sick leave. A rehabilitation plan aims to help people back to work, initially on a reduced-hour basis. It looks at aspects of jobs that are particularly pressured and rearranges responsibilities. Jobs may be adjusted to reduce workload and there may be time off to attend therapeutic sessions. Shift patterns may be changed, allowing a later or earlier start to avoid rush-hour travel. The company also provides a quiet place to go to if individuals feel anxious or stressed. In the first five years of the scheme, mental health related sickness absence and premature retirement decreased by 30% and 80% respectively. Almost 80% of people off work for more than six months with mental ill health get back to their own jobs, compared with 20% nationally.

How can we integrate people with severe and/or enduring mental health problems into the workplace?

The existence of active return– to- work policies across Europe is increasing, combining a range of regulatory measures and economic incentives for individuals and employers. When needed, these measures can be used as a support to firms who want to recruit people with mental health problems. Improved understanding of mental health issues is critical in companies and among co-workers if efforts to integrate people with mental health problems into the workforce are to be successful.

Of course, many individuals with more enduring and often severe mental health problems are excluded from work altogether. Yet many are able to work and pursue careers, if properly supported; diagnosis is often a poor predictor of employability. Moreover work can increase self-esteem and quality of life. Return to work can be a key element of the recovery process.

Measures taken to help people with severe mental illness return to work can be very different from those taken in relation to people who maintain a link to their former workplace or with the wider labour market. Interventions which seek to match individuals with suitable opportunities on the open employment market and then provide on the job support appear to be most successful. Although developed in the US, this approach *(Individual Placement and Support – IPS)* has recently been shown to be effective across a number of European countries compared to well-designed vocational services which provide opportunities for rehabilitation through work in sheltered settings (Box 5). It can also be cost effective: one small scale study

in London estimated a net gain of €3,090 per person participating due to a reduction in benefits paid and increased taxes collected. Higher rates of employment also have other benefits, such as reduced need for health care services (because of improved health), increased levels of social inclusion and improvements in quality of life[32].

Box 5 – Evaluation of a European IPS scheme[33]

Individuals with severe mental health problems in six European countries were randomly allocated to IPS or conventional vocational rehabilitation services. Over the 18 month study period the average number of days working in competitive employment in the IPS group was 130 compared with 31in the vocational service group. 55% of people in the IPS group worked at least one day in competitive employment compared with 28% in the vocational service group. Time spent in hospital in the IPS group was half that in the vocational service group.

Social welfare and disability benefits intended to act as a safety net for the vulnerable may in fact operate as perverse incentives for individuals to leave employment or remain economically inactive[34] . In some cases it may not be financially worthwhile for an individual to seek employment, whilst in other situations there is a need for more flexibility in the benefit system. Reform of disability benefits, as in England, where individuals can now regain their benefits rapidly if employment does not work out can help encourage individuals to become more active jobseekers. This is one element of the 'Pathways to Work' approach being implemented by the government. This scheme includes interviews with employment specialists to provide advice and support as part of a process of helping return individuals to employment. It now also includes voluntary cognitive/educational health programmes to help people manage their condition (Condition Management Programmes) which have reported good results for people with mental health problems[35]. Any package of measures also needs to include consideration on how best to enforcement anti-discrimination legislation, promote flexible working arrangements, provide support for employers and to help counter stigma by facilitating mental health awareness training for both employers and employers.

3.5 How can we best improve the knowledge base?

Significant gaps remain in our knowledge of what works in the workplace, and there is much scope at an EU level for research and exchange of information, including potential future work under the European Commission's Seventh Framework Programme. In particular, further robust information is needed on the effectiveness of organisational interventions and their impact on business productivity. To date, most evaluations have focused on actions targeted at individuals. Other issues include looking at overcoming new innovative ways for promoting workplace mental health and better understanding the impact of emerging psychosocial risks in the workplace as well as how the impact of external causes of poor health in the workplace may be countered.

As yet, information on the impact of reduced productivity while remaining at work (presenteeism) across Europe remains extremely limited; quantifying this impact and improving our understanding of how it is manifested and can be alleviated across different sectors is required.

It would also be helpful to improve our understanding of the extent to which people with mental health problems participate in the workplace and the impact of differences in social welfare benefits on the level of absenteeism and premature retirement seen in different countries. What approaches to making benefit systems more flexible have been successful in promoting return to work without impacting negatively on those who cannot work?

Mapping the availability of services and professionals to help promote mental wellbeing in the workplace can help in determining whether sufficient services are available to meet needs. This is of particular interest in the case of small and medium size enterprises that may not have the resource to provide in-house health promotion programmes. Developing benchmarking for services and approaches across Europe might also be helpful.

Potentially there is a wealth of information on effective practice in the corporate sector that might better be disseminated. These for instance might include umbrella group initiatives such as the Wellbeing in the Workplace laboratory being developed by CSR Europe. It would also include specific company and sector based activities. This might also help strengthen the business case for investment in workplace mental health promoting interventions. It is also important to look at whether interventions that have been successfully implemented in specific settings in Europe might be adapted for use elsewhere.

REFERENCES

[1] Available at: http://ec.europa.eu/employment_social/news/2004/oct/stress_agreement_en.pdf
[2] Available at: http://ec.europa.eu/employment_social/social_dialogue/docs/harassement_agreement_en.pdf
[3] Alonso J, Angermeyer MC, Bernert S et al. Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychtr Scand Suppl* 2004; 420 (21-7).
[4] Wittchen H-U, Jacobi F. Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies. *European Neuropsychopharmacology* 2005;15 (357-376)
[5] Waddell G, Burton A K. Is work good for your health and wellbeing? Norwich: The Stationery Office, 2006.
[6] Black C. Working for a healthier tomorrow. London: The Stationery Office, 2008.
[7] European Risk Observatory. Expert forecast on emerging psychosocial risks related to occupational safety and health. Bilbao: European Agency for Safety and Health at Work, 2007.
[8] Parent-Thirion A, Fernández Macías E, Hurley J, Vermeylen G. Fourth European Working Conditions Survey. Dublin: European Foundation for the Improvement of Living and Working Conditions, 2007.
[9] UK Department of Work and Pensions, 2007.
[10] Statistics Netherlands. (2004). Available from: www.cbs.nl
[11] Zechmeister I. Financing Mental Health Systems – Austria, London: Mental Health Economics European Network, 2004.
[12] German Federal Health Monitoring (2007). http://www.gbe-bund.de/gbe10/pkg_isgbe5.prc_isgbe?p_uid=gast&p_aid=&p_sprache=E.
[13] Swedish Social Insurance Agency, 2007. http://statistik.forsakringskassan.se.
[14] Sainsbury Centre for Mental Health. Mental health at work: developing the business case. London, Sainsbury Centre for Mental Health, 2007.
[15] Sanderson K, Andrews G. Common mental disorders in the workforce: recent findings from descriptive and social epidemiology. *Canadian Journal of Psychiatry* 2006; 51(2):63–75.
[16] Boedeker W, Klindworth H. *Hearts and Minds at Work in Europe*. Essen: BBK Bundesverband, 2007
[17] Andlin-Sobocki P, Jonsson B, Wittchen H U, Olesen J. Cost of disorders of the brain in Europe. *Eur J Neurol* 2005; 12 (Suppl 1): 1-27
[18] Leal J, Luengo-Fernández R, Gray A, Petersen S, Rayner M. Economic burden of cardiovascular diseases in the enlarged European Union, European Heart Journal 2006; 27(13):1610–19
[19] Kilian R, Becker T. Macro-economic indicators and labour force participation of people with schizophrenia. *Journal of Mental Health*. 2007; 16(2): 211-222
[20] Sainsbury Centre for Mental Health. Mental Health and Employment. Briefing 33. London, Sainsbury Centre for Mental Health, 2007.
[21] Seymour L. Workplace interventions for people with common mental health problems: evidence review and recommendations. London: British Occupational Health Research Foundation, 2005.
[22] Michie S, Williams S. Reducing work related psychological ill health and sickness absence: a systematic literature review. *Occup. Environ. Med* 2003; 60:3-9
[23] De Greef M, Van den Broek K. Healthy Employees in Healthy Organisations. Making the Case for Workplace Health Promotion. European Network for Workplace Health Promotion, 2004.
[24] Price Waterhouse Coopers. Building the case for wellness. London: PWC, 2008.
[25] Mills PR, Kessler RC, Cooper J, Sullivan S. Impact of a health promotion programme on employee health risks and work productivity. American Journal of Health Promotion 2007; 22(1):45–53
[26] See http://www.ilo.org/public/english/protection/safework/stress/prevpgm.htm
[27] Poelmans S, Compernolle T, De Neve H, Buelens M, Rombouts J. Belgium: a pharmaceutical company, In: Preventing Stress, Improving Productivity: European Case Studies in the Workplace (ed. Kompier M and Cooper CL), London: Routledge, pp.121–48, 1999.
[28] Tehrani N (2004) Recovery, Rehabilitation and Retention: Maintaining a Productive Workforce, London: Chartered Institute of Personnel and Development.
[29] Godard C, Chevalier A, Lecrubier L, Lahon G. APRAND programme: an intervention to prevent relapses of anxiety and depressive disorders. First results of a medical health promotion intervention in a population of employees. *European Psychiatry* 2006; 21(7):451–59.

[30] Wang PS, Simon GE, Avorn J, Azocar F, Ludman EJ, McCulloch J, Petukhova MZ, Kessler RC. Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomised controlled trial. *JAMA* 2007; 298(12):1401–11.
[31] For more information see: http://www.btplc.com/Societyandenvironment/SocialandEnvironmentReport/section.aspx?sectionid=b3551f94-9ef4-410f-83c6-31262aedeb5c
[32] Perkins R, Hardisty J, Harding E et al (2002) User Employment Programme Progress Report. London: South West London and St George's Mental Health NHS Trust.
[33] Burns T, Catty J, Becker T, Drake RE, Fioritti A, Knapp M, Lauber C, Rössler W, Tomov T, van Busschbach J, White S, Wiersma D, EQOLISE Group. The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. *Lancet* 2007; 370:1146–52.
[34] Jarvisalo J, Andersson B, Boedeker W, Houtman I. Mental disorders as a major challenge in the prevention of work disability: experiences in Finland, Germany, the Netherlands and Sweden, Helsinki: The Social Insurance Institution, 2005.
[35] Barnes H, Hudson M. Pathways to Work: Qualitative research on the Condition Management Programme. Research Report 346. London: Department of Work and Pensions, 2006.