Federal Ministry of Labour and Social Affairs

Federal Ministry of Health

Background document for the EU Thematic Conference:

"Promotion of Mental Health and Well-being in Workplaces"

3rd – 4th March 2011, Berlin

Thematic Conference under the European Pact for Mental Health and Well-being

organised by the European Commission and the German Federal Ministry of Health in cooperation with the German Federal Ministry of Labour and Social Affairs

with the support of the Hungarian Presidency of the European Union

eu trio.hu

Mental Health

supported by the BKK Federal Association

BKK

Background document for the EU Thematic Conference:

"Promotion of Mental Health and Well-being in Workplaces"

3rd – 4th March 2011, Berlin

Background document for
The Thematic Conference on Mental Health in the Workplace under the European Pact for Mental Health and Well-being

" Promotion of Mental Health and Well-being in Workplaces "

Berlin, 3-4 March 2011

Scientific coordinator: David McDaid

European Commission, DG Health and Consumers
London School of Economics and Political Science

This paper has been written by: David McDaid

With technical input from: Annette Bauer

Has had the additional technical coordination of: Fleur Braddick and Andrea Gabilondo of the Techncial Secretariat at the Department of Health, Generalitat de Catalunya (Gencat).

And has received comments and contributions from: Steve Bell (NHS Health Scotland), Gregor Breucker (BKK Federal Association, Germany), Anneliese Degen (DEAKON), Susan Flocken (ETUCE), Pol Gerits, Hana Horka (DG SANCO), Geoff Huggins, Johannes Klein Heisling (Bptk), Lee Knifton, Gert Lang (FRK), Lennart Levi, Malgorzata Milczarek (EU-OSHA), Ivana Nekulova (FX Meiller), Christoph Oberlinner (BASF), Zinta Podneice (EU-OSHA), Robert Roe (EFPA), Jürgen Scheftlein (DG SANCO), Elke Schroer, Shruti Singh (OECD), Tomas Stracke, Rebekah Smith (BusinessEurope), Jacques van der Vliet (CPME), Mary Van Dievel (MHE), Marianna Virtanen, Heinrich Wollny (DG EMPL).

This document has been prepared under a tender contract with the European Commission (Contract No SANCO/C4/2009/01 – Lot 3: Mental Health), led by the Department of Health of the Government of Catalonia (Gencat).

This document should be quoted:
McDaid, D. (2011). Background document for the Thematic Conference on Promotion of Mental Health and Well-being in Workplaces. Luxembourg: European Communities. © European Communities, 2011

Promoting mental health and well-being at work: making it happen

Prologue: The Berlin conference on the promotion of mental health and well-being

The European Pact for Mental Health and Well-being, launched in June 2008 by a high-level conference hosted by the European Commission provides an EU-framework enabling exchange and cooperation between stakeholders in different sectors including health, employment and education on the challenges and opportunities in promoting better mental health.

As part of the Pact, a conference on the promotion of mental health and well-being at work is taking place in Berlin on 3-4 March 2011. The conference is the last of a series of five events organised around different themes in the Pact. It is being organised by the European Commission together with the German Federal Ministry of Health and the Federal Ministry of Labour and Social Affairs. It will create an opportunity to raise awareness about the relevance of mental health and well-being for workplaces, as well as exchange and improve cooperation on the challenges and opportunities in workplace mental health and well-being.

Theme and focus of conference

The Berlin conference will, in particular, focus on the public health case for action, seeing the workplace as both a determinant (both positive and negative) of the level of mental health in the working population, and equally a setting for preventive and health-promoting interventions. How can a more holistic approach to mental well-being be strengthened? What more can health policy and social welfare *and many other sectors* do to help support initiatives in the workplace to strengthen the ability of individuals to *reduce and/or* cope with the stress and strains of life and potentially avoid leaving the workplace? What role might health policy and funders of health care systems together with social welfare/security play in collaborating with workplace stakeholders to implement measures to promote and protect mental health, as well as foster well-being and increase mental capital at all workplaces - private and public, small, medium or large.

The conference will also provide an opportunity to look at the current state of the art in the implementation of effective workplace mental health promotion action and also highlight policies and initiatives that are being developed. The contribution of national and regional policy and practice initiatives in different parts of Europe will be highlighted, including efforts to promote partnership working arrangements across government sectors, the business community and social partners.

The conference will explore how health and social policy, health care and social welfare systems can help to disseminate evidence on approaches that have been shown to work well in different settings. Examples of corporate leadership initiatives, strategies and programmes to promote mental health, to prevent mental ill health-related strain and disorders, as well as programmes to retain or reintegrate people with mental health problems into work will also feature. It will consider how good practice in specific *work* settings may be transferable or adaptable to different sectors and contexts across Europe.. It will also look at how all stakeholders can work together to disseminate the business case for action.

Outcomes of the conference are likely to include recommendations for action. It will also contribute to the wider dissemination of good mental health and well-being promotion practices through a variety of channels including a website and online-database European Compass for Action on Mental Health and Well-being.

CONTENTS

Background paper: a primer on mental health and well-being in the workplace

Key Messages

Employment in a good working environment is beneficial to health.

Better mental health at work is essential for the implementation of the European Union's "Europe 2020" agenda with its objective of smart, sustainable and inclusive growth.

For people who have experienced poor mental health, maintaining or returning to employment can be a vital element in the recovery process, helping self esteem, confidence and social inclusion.

Better mental health and well-being at the workplace can have positive economic impacts for business, as well as health and social security systems.

The workplace is an important setting for the identification of non-work related poor mental health.

A poor working environment increases the risk of stress and poor mental health. The changing nature of work, with ever shorter deadlines and greater levels of work intensity, coupled with a continuous process of reorganisation to compete in a global marketplace, as well as the uncertainties caused by economic recession has contributed to these risks across Europe.

A holistic approach to the promotion of mental wellbeing and protection of mental health is required. Evidence from meta analysis supports actions at both an organisational and individual level.

Actions are required at an organisational level to better identify risks to health, and invest in measures such as an improved workplace culture, improved communication and opportunities for feedback, better line management, more manageable workloads, flexible working arrangements and opportunities for career development.

Measures can also be targeted at individuals to help build their resilience and ability to cope with stressful situations. Employees also need to take some responsibility for maintaining their health; they may also work in partnership with employers to develop a mentally healthy workplace environment.

Cost effective actions to support employees with mental health problems and aid a return to work can be identified

Rates of employment for people with long term mental health problems in Europe remain much lower than in the general population, or even compared with some groups with physical disabilities.

Cost effective actions to help individuals with long standing mental health problems obtain employment on the open labour market in Europe can be highlighted; these include individual placement and support schemes.

Active labour market strategies to help individuals with long standing mental health problems return to work should be mindful of the need to have flexible benefit systems so that individuals do not worry about not being able to regain social welfare benefits if a job does not work out. Taxation systems also need to be flexible enough to provide individuals with a financial incentive to engage in part time work if they choose to do so.

Measures to better implement anti-discrimination legislation, as well as to provide advice and support to employers can also help to improve inclusion in the labour market.

Supports from health and social security systems for workplace health promotion and occupational health services are limited in many European countries, especially those with tax funded health care systems.

There is a good case for improved partnership working between health and social security systems, the social partners, occupational health services, individuals with lived experience of poor mental health, employers and employees to facilitate more investment in measures to protect mental health and wellbeing in the workplace.

Support from government is particularly needed to stimulate actions in small and medium sized enterprises.

A wide range of information on good practices to promote and protect mental health and well-being at work is to be found on the websites of a number of international organisations and European networks.

Background paper: a primer on mental health and well-being in the workplace

1. Introduction

This background paper examines policy and practice issues for mental health and well-being in all types of workplace. By mental well-being the paper refers to 'a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society' [1]. In addition, an individual's stock of 'mental capital', that is their 'cognitive ability; their flexibility and efficiency at learning; and their 'emotional intelligence', or social skills and resilience in the face of stress' [2], can also play a key role in enhancing mental wellbeing at work [3]. All effective prevention of excess psychosocial stress, promotion of mental health, return to work activities and inclusive employment activities can contribute to mental capital and mental well-being.

It begins by providing a brief overview of important benefits of promoting and protecting mental health in general, before focusing specifically on benefits within the workplace. As the document will indicate, social security systems in nearly all member states are responsible for paying long term sickness benefits; health care systems will also have to address many of the consequences of serious mental and physical health problems that potentially might be prevented, or at least identified early in workplaces; national, regional and local governments are of course also major employers. Despite these vested interested in health at work, as Annex 1 suggests, financial support from the health and social welfare systems for workplace health promotion, including occupational health services, appears modest at best in most countries. All of this would suggest that there is a case for promoting increased co-operation and partnership working between national health systems, social insurers, social welfare systems, the social partners and individual employers/employees in helping to promote and protect better mental health and well-being in workplace settings.

The report recognises that being in employment in a good working environment is beneficial to health, but acknowledges that many workplaces are now in *an accelerating* cycle of restructure and change; some of impacts on mental health of this continuous process of change are highlighted. It looks at what is known about effective actions to promote mental well-being, protect mental health, provide support for people in the workplace identified as having mental health problems, and help those people with mental health needs who have experienced exclusion and/or limited opportunities to be in paid employment. It notes additional challenges to be faced during an economic downturn where unemployment rates, job insecurity and job demands might all be on the increase.

Better mental health at work is essential for the implementation of the European Union's "Europe 2020" agenda with its objective of smart, sustainable and inclusive growth. One of the goals of this agenda is to have 75% of all adults of working age in employment. Initiatives at national and EU level, alongside dialogue with the social partners to promote and protect mental health at work can be identified, but more can be done. Going forward many of the measures that need to be considered in workplaces are not medical in nature; they concern actions to alter the working environment so as to better empower employees, improve line management practices, promote better communication throughout the workplace and ensure a good balance between work and family life. Employers, trade unions and different government departments also have key roles to play in helping to mitigate any adverse effects of the restructuring and reorganisation that has always been a feature of workplaces.

Moving towards more full and inclusive employment not only requires investment in workplace mental health promotion, but also in measures to help people with mental health problems remain in work, as well as labour activation and implementation of anti-discrimination measures to help individuals with long standing mental health problems return to work. As the paper will indicate, rates of employment for those with long standing mental health problems remain low in all countries.

In addition to public health, ethical and value driven reasons for promoting mental health at work, there is also an economic case for action. Examples of challenges and actions that can be taken to improve mental health and well-being in the workplace, both by employers, occupational health services, and other stakeholders in health services, social security systems and elsewhere are given.

2. Why should we be interested in mental health and well-being?

Promoting mental well-being and protecting good mental health is a critical element of any public health policy. There is an emerging evidence base suggesting that actions to promote and improve mental well-being are associated not only with immediate improvements in health, but also with a reduced risk of developing mental health problems in future [4].

No-one is immune from the risk of poor mental health. One in four EU 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. Recent data from a Eurobarometer on Mental Health, published in October 2010, reported that 15% of respondents aged 15 or over in the EU sought help from a mental health professional because of a psychological or emotional problem during the previous year, while 7% reported being prescribed antidepressants [5].

The personal costs of poor mental health are substantial. Poor mental health can have many impacts: it can lead to a loss of employment, restrictions on future career opportunities, impacts on family relationships, an increased risk of homelessness and an increased risk of contact with criminal justice systems. In addition the development of mental health problems is also associated with an increased risk

of physical health problems [6]. People with depression, for example, are at a three to fourfold increased risk of developing cardiovascular diseases. Overall the economic costs associated with the many impacts of poor mental health, excluding dementia and conditions affecting children, have been estimated to have a cost equivalent to more than € 2,000 per annum for every European household.

3. Why should we be interested in mental health at the workplace?

This section sets out a number of reasons why society as a whole should be interested in mental health at the workplace. As Box 1 indicates there are many reasons for drawing specific attention to mental health and well-being within workplaces. Work is a fundamental aspect of life. We simply cannot leave our mental health at the door of the workplace. Employment in a good working environment is beneficial to physical and mental health. Moreover, as highlighted in the background paper prepared for the previous EU Pact conference on promoting social inclusion and combating stigma for better mental health and well-being in Lisbon [7], for people who have experienced poor mental health, maintaining or returning to employment can also be a vital element in the recovery process, helping to build self esteem, confidence and social inclusion [8].

Box 1: The case for investing in mental health at work

Contributing to population health goals

Addressing the psychosocial impact of the changing nature of work and organisational restructuring

Promoting inclusion in the workforce

Economic impacts on business

Economic impacts for governments and society

Better mental health and well-being at the workplace can also have positive impacts for business. A better working environment can help motivate workers, which may have benefits for employers in terms of productivity, staff morale and external perceptions of the business as a good place to work. A healthy working environment will mean less staff absenteeism and staff turnover. It can help avoid interpersonal conflicts and causes for complaints by workers. Workplaces can, for instance, be mindful of the importance to their employees of maintaining a healthy balance between work and family responsibilities [9]. A healthier working environment can help governments avoid some of the costs associated with absenteeism and withdrawal from the labour market.

3.1 Contributing to population health goals

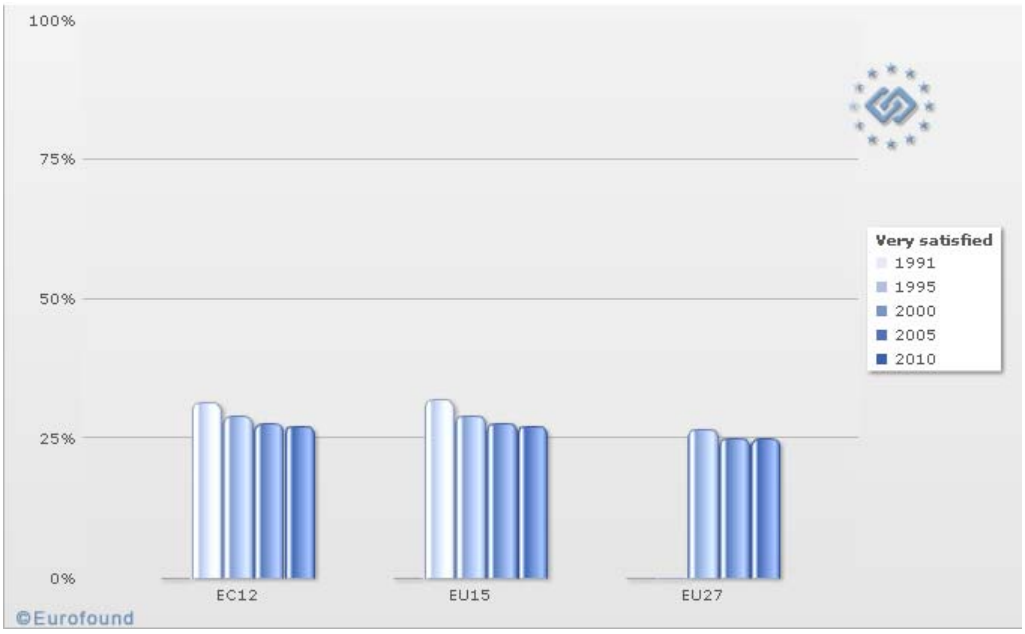
Mental health promoting actions that take place within the workplace can contribute to general population health goals. In the EU as a whole almost two thirds of the adult population are in employment [10]. From a public health perspective the workplace is an important setting where health promoting activities can take place. Actions at work also provide an opportunity for the early identification of risk factors for poor health. This public health approach means that action in the workplace is much more than simply focusing on the prevention of mental health problems that may be linked to a poor work environment; it is also about those non work-related problems that may become visible and sometimes exacerbated within some working environments. Preventive measures in the workplace that help avoid mental health problems also have economic benefits, both for health systems (as treatment costs are avoided) and for social security systems that may have to pay disability benefits to those people who have to leave the labour market.

3.2 The psychosocial impact of the changing nature of work and organisational restructuring

While some levels of stress and high demands of work can be good for health, it has long been recognised that a poor workplace environment can have an adverse impact on health and lead to excess levels of what psychologists call psychological distress, which in turn can lead to the development of poor mental and physical health. Many models and theories have been put forward to explain the reasons for psychological distress [11]. One key theory suggests that the level of stress at work experienced by an individual depends on the interaction between three different elements of the psychosocial work environment: demand, control and support [12]. Jobs characterised by a combination of high workload demands and insufficient control of the situation by the employee are most likely to lead to psychological distress. The level of support that an individual receives from their line manager can however act as a buffer: individuals who feel valued may be at lower risk of experiencing psychological distress.

Another potential explanation for psychological distress may be an imbalance between efforts and rewards in the workplace [13]. High efforts and low rewards increase the risk of psychological distress and poor mental health. Individuals may not feel that they are receiving a high enough salary for work, but equally they may feel that they are being taken for granted or not held in high esteem by colleagues and managers. Figure 1 illustrates that overall satisfaction with working conditions has declined among employees over the course of European Working Conditions Surveys.

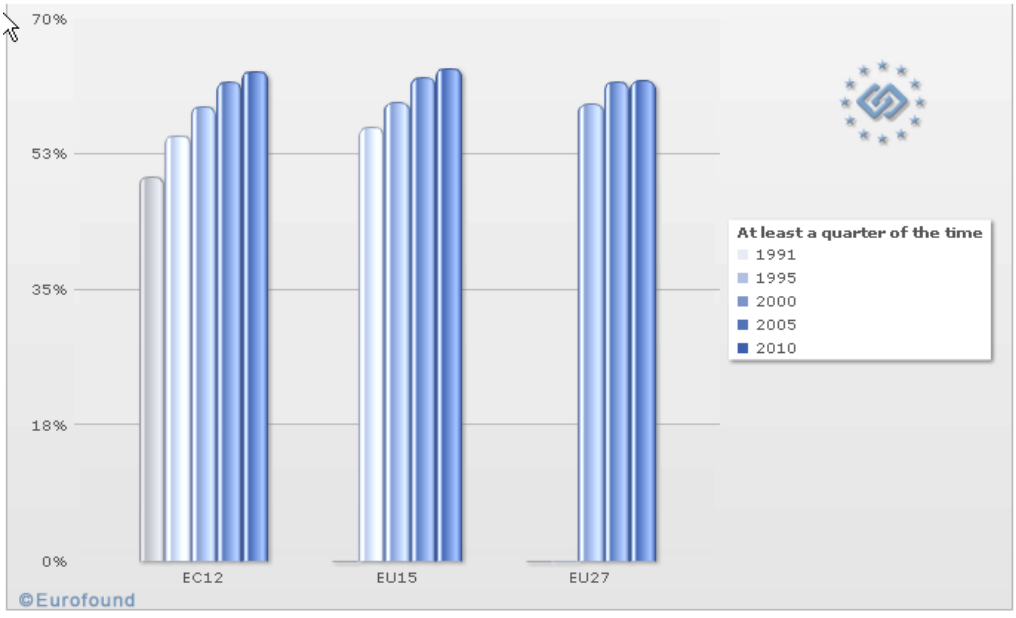
Figure 1. How satisfied are you with working conditions in your main paid job? (q76)



Source: European Working Conditions Survey 2010

The changing nature of the way in which we all work in the 21st century is another reason for taking action. We have indicated that a poor psychosocial working environment, for instance including unrealistic high demands on staff, low opportunity to contribute to decision making, poor promotion prospects, poor management, inequality insecurity and the threat of harassment or even violence, increases the risk of poor mental health, particularly depression and anxiety. Jobs increasingly involve working to tight deadlines as results of the European Working Conditions Survey 2010 indicate (Figure 2). The increase in working to tight deadlines has been particularly pronounced for women.

Figure 2: Does your job involve working to tight deadlines? (q45b) 1991- 2010



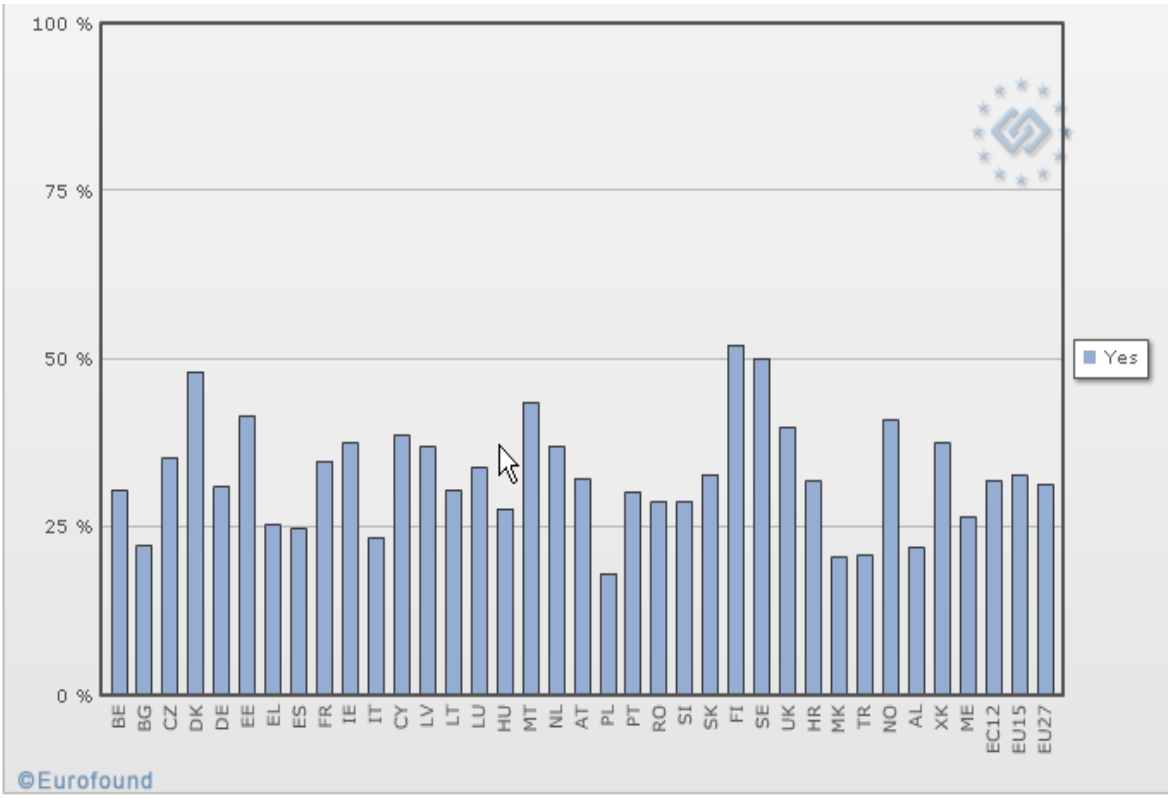
Source: European Working Conditions Survey 2010

A poor working environment can increase the risk of psychosocial stress, which is itself a predictor of future depression and anxiety [14]. Vulnerabilities to psychosocial stress, burnout and mental health problems are becoming more challenging as the nature of work in Europe continues to change, moving away from traditional occupations towards service sector jobs with high levels of demand and work intensity. The boundaries between home life and work are also becoming blurred.

As the European Working Conditions Survey 2010 indicates, at least 20%, and in some countries (Sweden and Finland) more than 50% of those surveyed, had experienced substantial restructuring or reorganisation in their workplaces over the previous three years (Figure 3). There is a continuing shift away from heavy industry and agriculture towards the service sectors and the knowledge economy (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). As Figures 4 and 5 indicate, mental health problems are much more common in service sector occupations such as banking, education and public administration than they are in heavy industry or construction [15, 16], although this may also in part be due to dominance of men working in these sectors, given higher prevalence rates of depression and anxiety in women. There has also been a change in the composition of the European workforce which now better reflects demographic changes in society, not only accommodating more women, but also older workers, new migrants and those who shift between employment sectors when skill requirements change. All of these groups may be at greater risk of mental health problems.

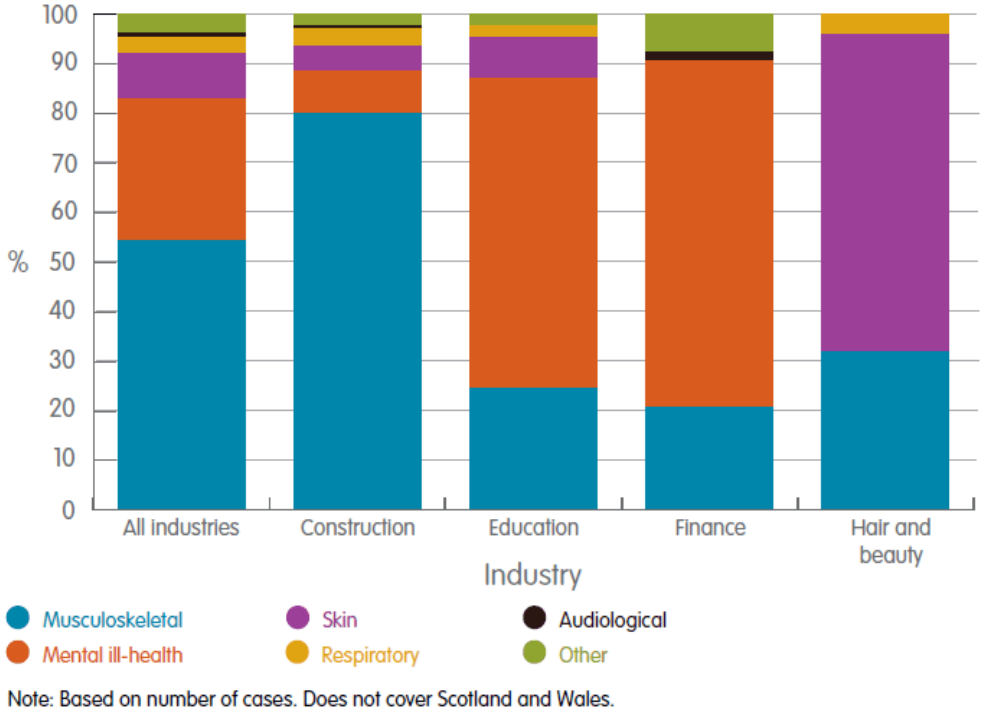
The situation may be compounded by new working practices, such as temporary and contract employment arrangements that may be in place, This may be intended to help adapt economies to the challenges of competing in a global marketplace, but one consequence may be a feeing of increased job insecurity, for instance where there is a possibility of outsourcing tasks to locations outside Europe. Restructuring can also increase job demands and workload which increases the chances of burnout out and poor mental health [17].

Figure 3: Has there been substantial restructuring or reorganisation in your workplace in the past three years? (q15b)



Source: European Working Conditions Survey 2010

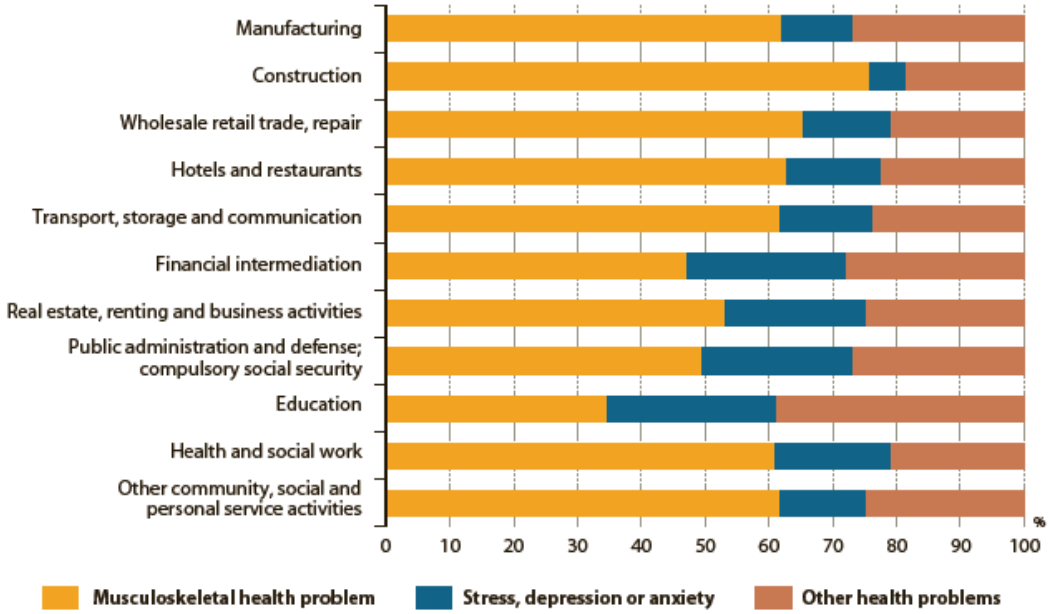
Figure 4: Work related illness by selected industries in England 2007



Note: Based on number of cases. Does not cover Scotland and Wales.

Source: Black. C. Working for a Healthier Tomorrow, 2008 [15]

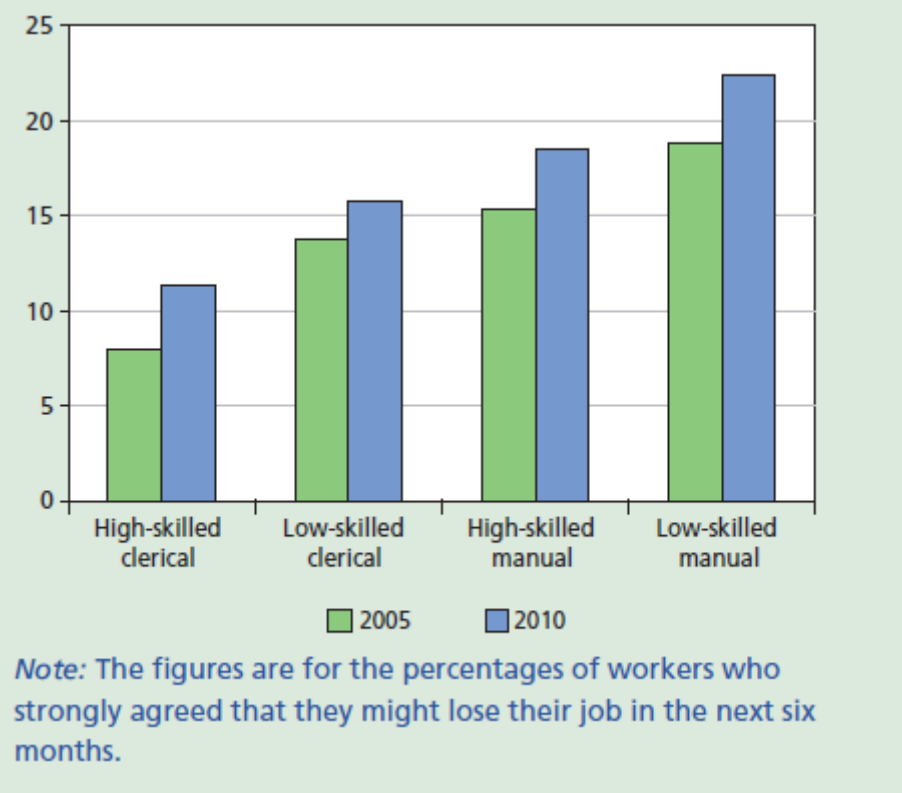
Figure 5: Contribution of musculoskeletal health problems, *stress, depression or anxiety disorders* and other health problems to overall work-related health problems in employees in EU 27 (excluding France) in 2007*..*



Source: Eurostat Labour Force Survey 2007 [16]

Protecting the mental well-being of employees may be particularly important during a time of economic transition and restructuring. Historically economic downturns and consequent increases in unemployment have been associated with an increase in poor mental health [18, 19]. No one can be unaware of the current challenging economic environment. Fears over jobs and downsizing in both the public and private sectors are important risk factors for psychosocial stress and mental health problems. They compound the challenges that are always faced by continuous change and restructuring. As Figure 6 illustrates with data from the European Working Conditions Survey 2010, feelings of job insecurity are increasing for all types of employment [20].

Figure 6: Perceived job insecurity by type of work in the EU-27 2005 and 2010



Source: European Working Conditions Survey 2010 [20]

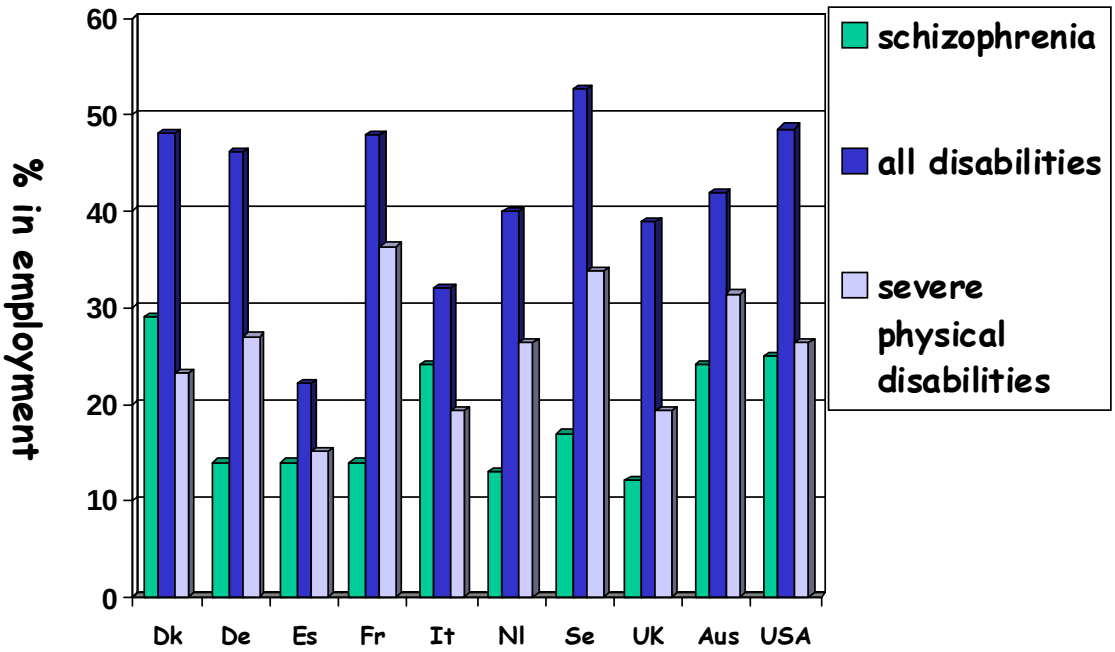
In the UK, for example, where the public sector in particular is subject to future significant cuts and efficiency savings, over a quarter of employees are now reporting an increase in their hours, a rise of 7% since the recession, compared to a 2% rise in the private sector. 20% of all employees now think they are 'likely' to lose their jobs, a rise of 11% since spring 2009 [14].

Europe needs to maintain a well educated and productive workforce to help maintain the region's competitiveness. How can the mental health of employees be better protected at a time where individuals may be fearful over their long term employment prospects? How can the mental well-being of those who inevitably will have to change their job and/or potentially experience even long periods of unemployment be protected? Can early action in the workplace prior to any downsizing help individuals to cope with change? Maintaining and/or strengthening resilience to adversity may be critical to a restructuring of Europe's economy.

3.3 Tackling social exclusion

Work is critical to tackling social exclusion. We know quite a lot about the employment rates of people with mental health problems. The previous conference on tackling stigma and promoting social inclusion highlighted the low rate of participation in the labour force of people with enduring mental health problems [7]. Research indicates that the majority of individuals with severe mental health problems want to work in regular employment settings, with up to 90% of users of psychiatric services wanting to enter or return to work [21]. Despite this, individuals with mental health problems can experience multiple barriers to both obtaining and maintaining employment. In the EU as a whole almost two thirds of the adult population are in employment [10], ranging from 54% in Malta to 77% in the Netherlands. However rates of employment for people with all types of mental illness lie between 18% and 30%. As we can see in Figure 7, rates between 10 % and 30 % of people with schizophrenia are in employment; this is lower than the rate for all disabilities. There are marked variations between countries with Denmark and Italy having much higher rates (similar to Australia and the US) compared with other countries like Germany, France and the UK [22].

Figure 7: Employment rates of people with schizophrenia and physical disability in selected countries



Source: Kilian and Becker, 2007 [22]

Barriers to employment include stigmatising attitudes towards people with mental health problems, by some employers and employees. Employers may be reluctant to take on individuals with known mental health problems believing that they are likely to be less productive or more disruptive in the workplace

[23, 24]. Some employers discriminate against applicants who declare a history of psychiatric treatment. People with mental health problems may thus be reluctant to enter employment for fear of having to disclose their condition and of how their mental health history might be perceived [25].

In contrast with physical disabilities, firms may lack the technical knowledge and awareness of what is required to accommodate people with mental health problems in the workplace. For example, surveys in Ireland and Scotland respectively reported that 75 % and 70 % of employers respectively agreed that they did not know enough about the law regarding mental health in the workplace [26, 27]. They may also receive insufficient support and disability awareness information to help accommodate people. This may also reflect a lack of capacity or understanding about the needs of people with mental health problems among public employment services.

Other factors highlighted in the background paper produced for Lisbon [28] include the difficulty in enforcing anti-discrimination legislation across the EU. The social protection system may inadvertently act as a barrier to employment. A lack of flexibility and heavy bureaucracy in some social welfare systems can discourage individuals from seeking work. They may worry that if they obtain and then subsequently lose a job, that there may be substantial delays before being able to reclaim benefits, which might cause significant financial hardship.

3.4 Economic impacts on business

Investing in improving the overall level of well-being within the workplace can have multiple benefits to employers. The workplace can provide a healthy culture and environment that is psychologically supportive to the workforce, helping to foster and maintain well-being. Not only can improved levels of psychological and physical well-being be associated with better workplace performance, but they can also help improve the level of staff retention, improve employee-employer dialogue, encourage greater levels of creativity and innovation and enhance the reputation of the workplace.

One example of this can be seen in a survey of nearly 29,000 employees across 10 industries in 15 countries worldwide, including Denmark, France, Germany, Norway, Sweden and the UK. The survey looked at the relationship between wellness and business effectiveness [29, 30]. 91 % of employees in the survey were working in the private sector. Participants were asked to self-report on attitudes, performance and conditions directly related to the effectiveness of their organisation. It found that in organisations where health and well-being were perceived by employees to be well managed organisational performance was more than 2.5 times greater than in those organisations where health and well-being were poorly managed.

72% of those who rated their organisation highly for actively promoting health and well-being (including work/life balance) also rated it highly for encouraging creativity and innovation. This was equivalent to almost a fourfold increase in creativity and innovation, compared with a sevenfold decrease in

companies where health and well-being were poorly managed. Companies where health and well-being were poorly managed were also four times less likely to retain staff talent within a 12 month period compared to companies with a good approach to health and well-being [29].

Businesses across Europe are also having to contend with increasing levels of absenteeism and "presenteeism" (poor performance while at work due to excess stress and mental health problems [31, 32]. Chronic health problems, in particular excess stress, depression and anxiety related problems are on the rise, particularly in view of current economic conditions where employees may not have high levels of confidence in job security. In Belgium and the Netherlands a human resources company, Securex, conducts annual surveys of employees to monitor aspects of their mental health and well-being. Employees having to cope with severe stress were considerably less likely to perform well (See Box 2) [33].

Box 2: Annual survey of stress in Belgian workplaces in 2008.

In Belgium in 2008 more than 40 % of the 1,500 survey respondents experienced undue stress at work. It also found that 60 % of employees, who receive little or no support from their superior, are frequently stressed within the workplace, whereas this rate reaches only 32 % for the employees who receive much assistance and support from their superior. It noted that 18 % of the employees suffering from considerable stress were likely to perform less well within their organisations compared to 7 % of those without undue stress.

Source: [33]

A mentally unhealthy workforce has adverse economic consequences for business, as well as for governmental budgets. Absenteeism from work for all reasons has been estimated to have a cost equivalent to 2.5% of GDP in the European Union [4]. Employers will usually be directly responsible for paying at least some of the costs of sickness benefits to their employees; in addition there will often also be substantial costs imposed on social security systems. Remarkably it should be noted that work commissioned by the European Foundation for the Improvement of Living and Working conditions has found that it is still extremely difficult to assess the extent to which costs of absence fall on employers rather than on social security systems in most European countries; moreover cross country comparison are difficult to make [31].

Overall estimates of cost to employers vary; the cost per employee in an English context in 2007 was in estimated to be more than € 1,200 [23]. There can be substantial immediate productivity losses due to sickness absenteeism and early retirement. Where there is a loss of highly skilled workers due to poor mental health, additional recruitment and training costs are also incurred by employers. In a minority of

countries public and private sector employers will also bear some of the costs of long-term sick leave payments. Poor levels of psychosocial health are also associated with reduced performance at work. This is commonly known as presenteeism. It remains difficult to measure and few estimates of costs have been made, although some studies suggest that its impact may be as much as five times greater than the costs of absenteeism alone [34, 35].

There can also be reputational and legal impacts of a mentally unhealthy workplace. 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 seen, 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 can be a detrimental impact on morale and staff loyalty. The image of a business may also be adversely affected if it is not seen to have a diverse workforce, including people living with enduring mental health problems. Poor mental health and excess work-related stress can also increase the risk of accidents due to human error; this in turn could lead to litigation and compensation claims in some circumstances.

3.5 Achieving economic goals for government and society

Better well-being at work can also have major benefits for governments and wider society [2]. In most EU countries (See Annex 1) government is responsible for paying long term sickness benefits for people absent from work because of poor mental health. Publicly funded health care systems will also have to invest resources in dealing with any long term adverse health impacts, some of which could have been avoided through better workplace health promotion initiatives. They might also be better managed through earlier identification; again the workplace is a key setting when health problems can become visible. Better actions in the workplace can also help reduce the risk of individuals with stress and mental health problems withdrawing from the labour market.

It can help individual nations and the EU in achieving goals around economic growth and global competitiveness. An improvement in productivity in the workplace contributes to economic performance within nations. Improvements in workplace productivity are also associated with improved return on investment. In the private sector this is likely to increase the level of profit achieved by companies, and thus the tax revenue that may be raised for the public purse. It can also help companies maintain or improve their competitiveness in the face of steep global competition, often from employers in other parts of the world who compete on the basis of low production costs rather than quality.

For the public sector, improved efficiency through improved workplace productivity is likely to improve the level of return on each euro invested in public sector organisations such as health and education providers. At a time when public sector resources are constrained, improving productivity levels, often with fewer financial resources, is a situation that many European countries now have to contend with.

The protection and promotion of mental health at the workplace can thus make a vital contribution to the implementation of the European Union's "Europe 2020" agenda with its objective of smart, sustainable and inclusive growth. This is especially necessary to achieve one of the specific objectives of the agenda: raising the employment rate of the population, between the ages of 20 and 64 years, from the current 69% to at least 75%. Moving towards more full and inclusive employment not only requires investment in workplace mental health promotion, but also in measures to help people with mental health problems remain in work, as well as labour activation and implementation of anti-discrimination measures to help individuals with long standing mental health problems return to work.

4. What are the socio-economic impacts of poor mental health in the workplace?

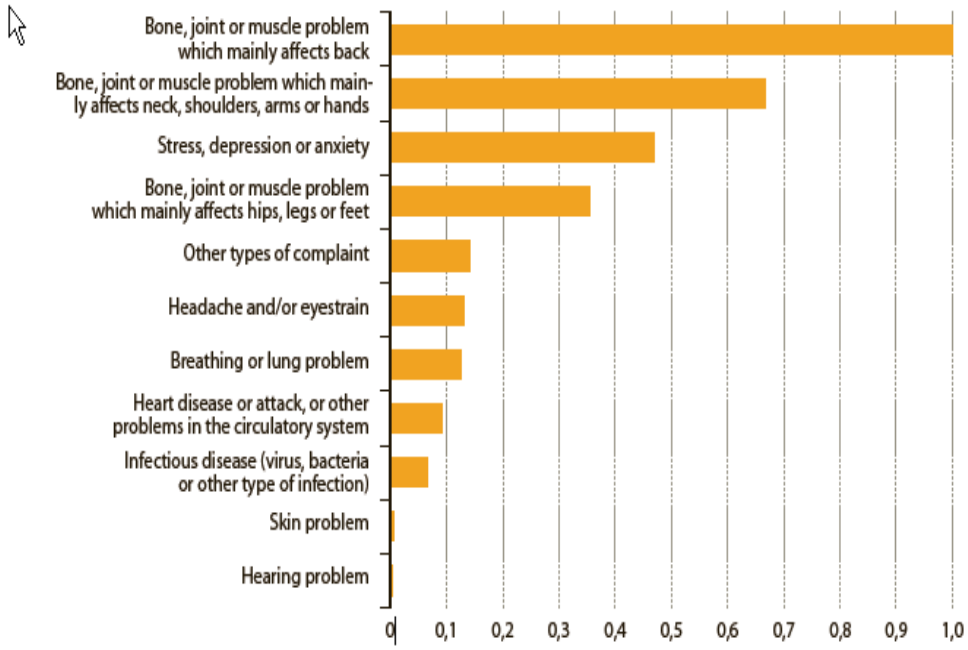
This increased focus on promoting mental well-being and tackling psychosocial stress and mental health problems within the workplace comes at a time when we know more about the economic costs of not taking action to protect mental health at work. Typically at least two-thirds of the costs of common mental health problems, including depression and anxiety disorders are for lost productivity. This may be due to poor performance while at work, sick leave or early retirement on the grounds of poor mental health, as well as exclusion from the workplace due to discrimination linked to an individual's mental health status. The total costs of depression alone in the European Economic Area were estimated to be €136.3 billion (2007 prices). The majority of these costs, €99.3 billion per annum, were linked to productivity losses [36, 37]

These impacts on productivity can be much higher than with many major physical health problems. For example, in the EU the impacts on productivity of cardiovascular disease were much lower at €36.1 billion (2007 prices) [38]. Nonetheless the increased risks of developing physical health problems, including cardiovascular disease and diabetes, compared to the general population, can also further increase work absenteeism. 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 potential risk for work-related stress in other team members.

4.1 Absenteeism, unemployment and long term disability claims

Absenteeism from work for all reasons has been estimated to have a cost equivalent to 2.5 % of GDP in the European Union [31]. Overall data from the European Labour Force Survey 2007 ad hoc module on accidents at work and work-related health problems indicates that stress, depression and anxiety problems were the third most common group of serious health problems reported by employees in a twelve month period (Figure 8) [16]. Musculo-skeletal problems are major contributors to the costs of absenteeism from work and were more commonly reported, although some of these are also likely to be stress-related [39].

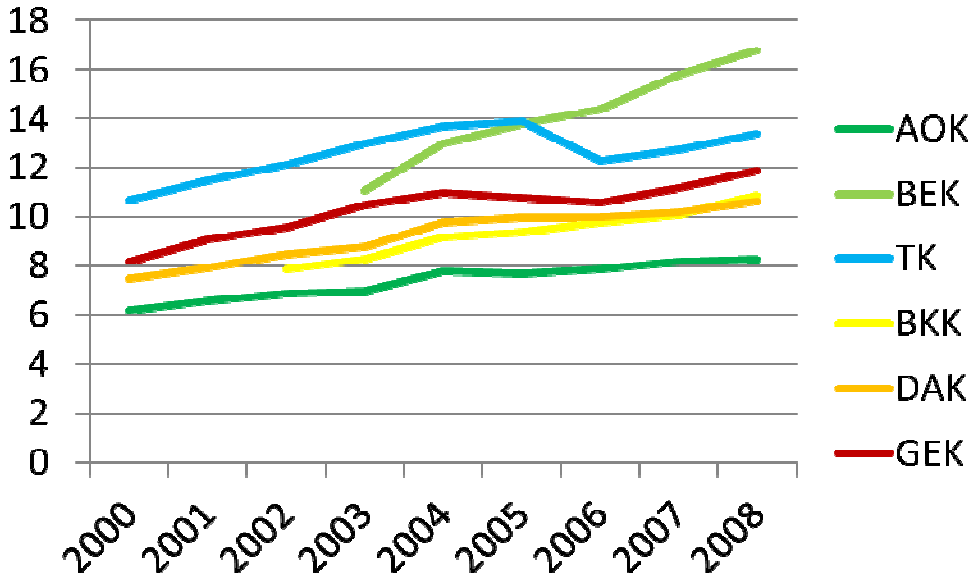
Figure 8: Relative occurrence of health problems as the most serious health problem for all employees in previous 12 month period in EU-27



Source: Eurostat, 2010 [16]

Across Europe the levels of absenteeism, unemployment and long term disability claims due to psychosocial 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. In all countries this will have significant economic implications for social welfare systems. Figures for short term absenteeism have been steadily increasing: As Figure 9 indicates, in Germany work absence days related to mental disorders have steadily risen since 2000 in all major statutory health insurance companies. On average, almost 12% of all sick leave days were caused by mental disorders, which is about twice as much as 1990 [40].

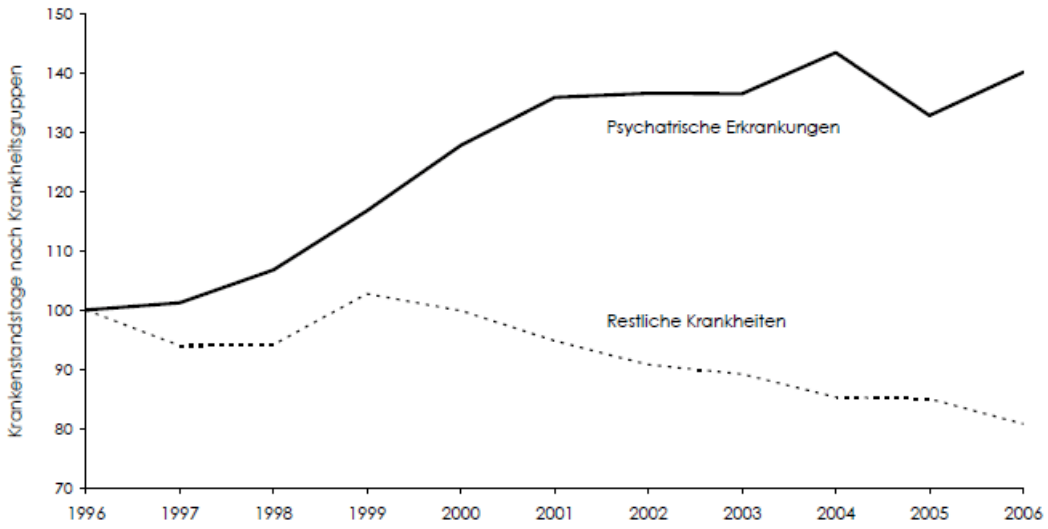
Figure 9 Mental health problems as % of all reasons for absenteeism reported by major statutory health insurance companies in Germany 2000 - 2008



Source: Bundespsychotherapeutenkammer 2010 [40]

Data from Austria also suggest the impact of mental health problems on sick leave has grown while sick leave for all other health problems has decreased over a ten year period (Figure 10) [41]. The authors of this Austrian report further noted that some physical health problems, such as allergies, lower back pain and stomach disorders, may be linked to poor mental health. Common to the situation reported in other European countries, this duration of absenteeism increased more for women (72%) than men (37%) [42]. This may, in part, reflect the fact that women often have to contend both with employment and also with household responsibilities such as looking after children or ageing parents.

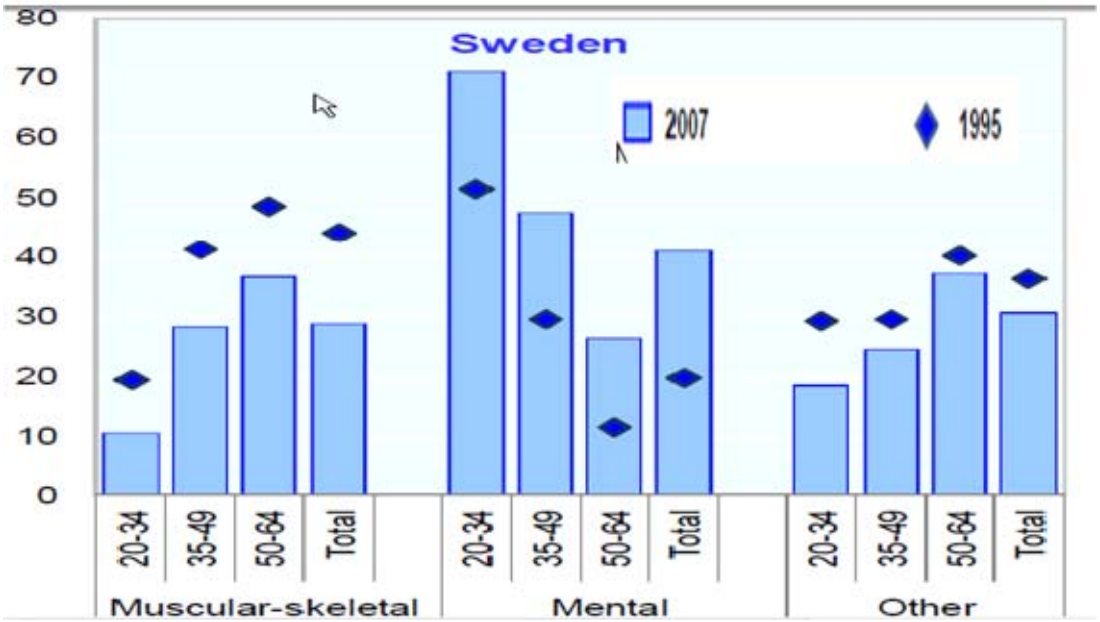
Figure 10: Trends in sick leave days taken in Austria 1996 - 2006



Note: Upper line refers to psychiatric disorders and the lower line to all other diseases. Source: Leoni & Mahringer, 2008 [41]

Upward trends in disability benefit claims can also 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 mental or behavioural disorder; by 2003 this accounted for 35% of all registrations [32].

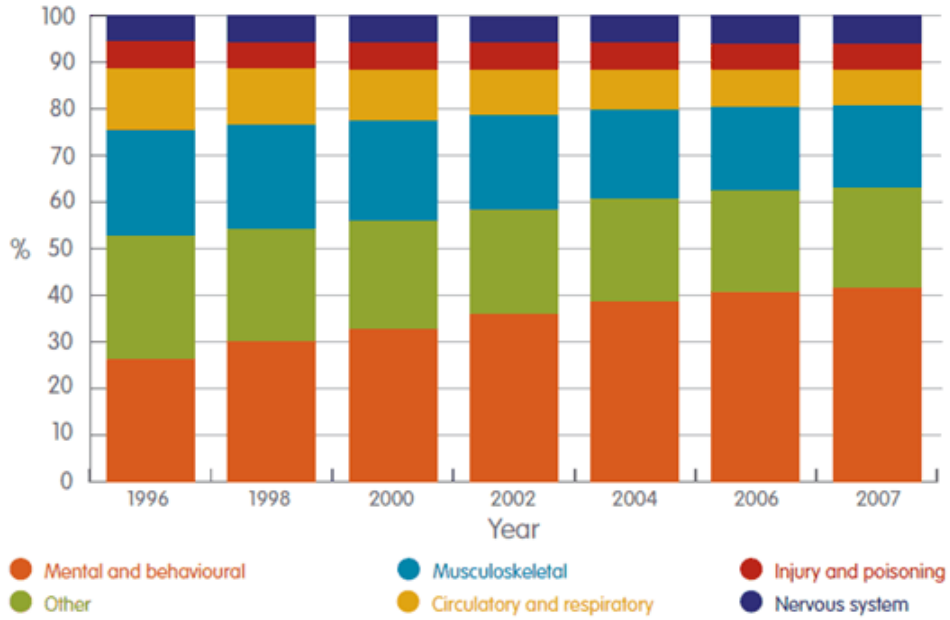
Figure 11: Changes in inflows to disability benefit claims in Sweden by health reason and age, 1995 and 2007.



Source: OECD [43]

As Figure 11 indicates, between 1995 and 2007 the share of the inflow to disability benefits in Sweden due to mental health problems doubled from 20% to 40% of all claims. The figures for people aged between 20 and 34 are particularly stark, with 70% of all new disability benefit claims due to mental health problems in 2010. The total cost of long term disability benefits for mental health problems alone can be greater than the total costs of unemployment benefits, as is the case in Great Britain (England, Scotland and Wales) where 40% (€3.9 billion) of all long term disability benefit payments in 2007 were due to mental and behavioural disorders [44]. This is an increase in the share of all disability claims from 25% in 1996 to 40% by 2007 (Figure 12).

Figure 12: Trends in claims for long term disability benefits in Great Britain 1996 - 2007

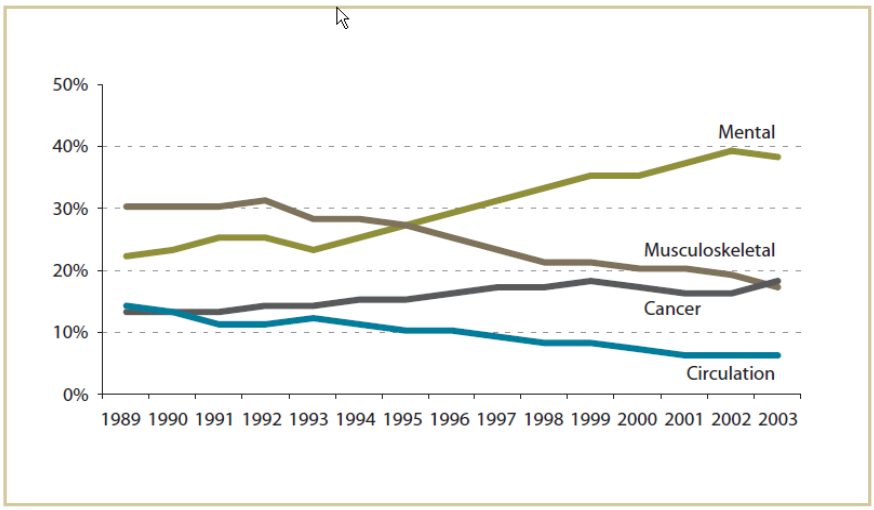


Source: Black, 2008 [15]

4.2 Premature retirement

Across most of Europe evidence can be found of an increase in the level of sick leave due to mental health problems. 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 13). By 1996 poor mental health was the leading reason for early retirement. In Austria by 2006 almost 27% of all early retirements were due to mental health problems, an increase from 21% in 2001 [45]. Another estimate from the Organisation of Austrian Social Insurance Funds suggested that nearly 29% of all early retirements were due to mental health problems in 2007 [46].

Figure 13: Trend in reasons for early retirement on health grounds in Germany



Source: German Federal Health Monitoring (2007)

5. Policy and practice developments

All of these impacts suggest an imperative for taking action and there has been some recognition of the importance of promoting well-being and tackling mental disorders at work in recent years at both EU and national level. The Framework Directive 89 / 391/EEC on occupational safety and health states that "*employers have a duty to ensure the safety and health of workers in every aspect related to the work*". Promoting mental health is also one of the priorities of the Community strategy 2007-2012 on health and safety at work. Furthermore, under their dialogue at EU-level, social partners concluded a Framework Agreements in 2004 on the prevention of work-related stress [47] and, in 2007, a further one on harassment and violence at work, which are to be implemented under the responsibility of social partners in the Member States. However such non-binding agreements may take time to make a difference. A recent survey of 75 occupational safety and health experts from across the EU found that only 17.3% of respondents felt that the Framework Agreement on Stress has been implemented effectively, while only 29% believed it has had any impact on actions to tackle work-related stress [48].

A recent survey by the European Working Conditions Observatory indicates there is evidence of considerable and growing attention to the issue of well-being at national level, together with targets and programmes promoting the issue. They found that nine countries have formal strategies for the management of employee health that include governments and social partners, but concluded that well-being is not on the agenda at all in another nine countries (Table 1). While it is the case that there is substantial diversity in the priority given to workplace health promotion across Europe (e.g. See Annex 1), this latter statement is probably too strong, as the absence of a formal national strategy does not mean that the issue is not under consideration. Careful detailed scrutiny of progress across all EU countries is required to help determine the best ways in which to incentivise different stakeholders to pay more attention to mental health and well-being at work.

Table 1: State of development of well-being (including return to work) policies in the EU and Norway in 2010

Broad pattern	National examples
Developed at national and social partner or company level	Austria, Belgium, Czech Republic, Germany, Denmark, Finland, Ireland, Norway, Portugal
Mainly national strategy	Bulgaria, Greece, Slovakia
Emergence, not institutionalised	UK
Slow emergence	Spain, France, Sweden, Slovenia
Some limited emergence	Hungary, Lithuania
Not on agenda	Cyprus, Estonia, Italy, Luxembourg, Latvia, Malta, Netherlands, Poland, Romania

Source: European Foundation for the Improvement of Living and Working Conditions, 2010 [31]

In terms of employers, many large companies now have well-being programmes in place; increasingly mental health may have an important role in these programmes. At a supra-company level, the network CSR Europe launched a toolkit on well-being at the workplace in 2008, developed by a working group of member companies. The toolkit includes recommendations for action to promote mental well-being and examples of good practices. There are also sector specific actions, such as the recent publication of non-binding guidelines on "Good Work. Good Health" between the social partners (ETNO and Uni Europa) of the European telecommunication sector, a sector which itself undergoing tough restructuring. The European Network for Workplace Health Promotion (ENWHP) has also been implementing, with support from the EU Health Programme, the "Move Europe" campaign with is focus on mental health, after a previous campaign addressing nutrition, physical activity, smoking cessation and stress. Data on good practices can also be found in a variety of locations, including the ENWHP website, the European Agency for Safety and Health at Work (See Annex), and the EC funded Promenpol website (www.mentalhealthpromotion.net). The World Economic Forum (WEF) made well-being at the workplace a central issue of its 2010 annual meeting in Davos.

However, most of these welcome initiatives have been restricted to large, often multi-national employers and much remains to be done. The European Network for Workplace Health Promotion recently made a call in its Edinburgh Declaration for 'European Employers, Employees, Trades Unions, Intermediaries and Governments, to give greater emphasis to workplace mental health promotion, and to implement measures to protect and improve mental health and wellbeing at work' [49].

Much of the policy focus on workplace health is still largely just on traditional aspects of occupational safety and health. While occupational health and safety measures based on risk assessment are a necessary element of any well-being at work strategy, risk is a too narrow focus. Not enough attention is paid to public health and well-being in general. Another challenge can be the fragmentation in public sector responsibility for workplace health. As indicated in our review of EU Member States (Annex 1), workplace health may in different countries be a responsibility of either (or both) ministries of health and labour – good co-ordination and flexible funding arrangements – are challenges that have to be faced. Social welfare systems may also have to look at whether sickness and long term disability benefits may sometimes inadvertently act as a disincentive to return to work. A recent report published by the OECD in November 2010 suggests more can be done to improve the flexibility of tax and benefit systems to help reduce these disincentives [50]

6. What do we know about actions to promote mental health and well-being in the workplace?

It is important to remember that effective mental health promotion in the workplace is one critical component of an overall strategy to improve well-being at work and public health in general. Health and well-being should be embedded within the culture of the workplace. Measures to promote better mental

wellbeing and address factors that contribute to undue work-related stress and poor mental health ideally should be embedded within an overarching framework for wellness and health promotion in the workplace. A sustainable approach to wellness at work that can have benefits for both employers and employees will need not only to address psychological health but other issues including promoting a healthy workplace environment and good level of engagement between employers and employees, actions to foster general healthy lifestyle promotion and measures that are targeted towards physical health [30].

It is also important to remember that it is increasingly difficult to ignore the environment outside of the traditional workplace when thinking about measures to promote mental health and well-being at work. New technologies and flexible working arrangements mean that the overlap between work and private life has become even greater. Work does not always happen at designated workspaces, nor within specific working hours. In addition to actions by employers individuals also have a role in maintaining their health and well-being. This means that self-management capabilities gain even more importance. The concept of health literacy, defined as the capacity to make sound health decisions in the context of every day life [51], may also be one way to deal with this important aspect of any overall approach to wellness in the workplace. This need for personal motivation and self management of health factors is also important for those individuals who may currently be out of work, if they are to maintain their level of workability.

Table 2: Elements of a sustainable workplace health and well-being programme

Areas for action	**Examples of issues to be addressed**
Lifestyle	physical activity, nutrition, weight management, alcohol use, tobacco use, sleep, risky behaviours
Mental Health	stress, abusive behaviour, harassment, anxiety, depression, resilience
Physical Health	musculoskeletal, cardiovascular, medical history, general health
Engagement	commitment, satisfaction, advocacy, pride, workplace factors

Source: Dornan A, Jane-Llopis E, 2010 ***[30]***

While in this background paper we focus largely on actions intended to have a direct impact on mental health, it should be noted that all four of the areas for action in the workplace can make a positive contribution to mental health. Indeed, this section of the paper provides some examples of the benefits of

programmes for mental well-being, that are directed towards health as a whole, or physical health in particular.

We now know quite a lot about effective actions to promote mental health at the workplace in different contexts from effectiveness reviews of well evaluated studies [52-54]. Guides from a variety of organisations on components of effective stress management, mental health and well-being strategies have been published [55-57]. In some cases national policies and action plans to encourage greater investment in workplace mental health and well-being have been developed. Later in section 9 we will also further consider the increasing evidence based demonstrating the cost effectiveness of some of these approaches.

A large body of literature has been published over the past decades on mental health and well-being at workplaces. In particular, psychological research helped to develop a better understanding of the links between work organisation and mental well-being or illness. For instance, this research emphasised the importance of addressing the roots of mental health problems rather than only focusing on the symptoms, such as increased work absenteeism or disability.

What is clear from published literature is that a wide range of interventions and approaches are available, and that no-one approach will fit all circumstances. Moreover, approaches that have proved effective in some contexts may need adaptation in order to be effective in other settings, such as in different countries or in different sectors of employment. Rather than relying on action or set of actions alone, workplaces will need to develop an overarching framework in which they will seek to protect mental health [58].This should not only take account of other elements of an overall wellness strategy as indicated in Table 2, but it also should consider what mix of interventions and strategies can be used to specifically address mental health and well-being.

Actions can be concerned with promotion of mental well-being and universal prevention of mental health problems; targeted actions for individuals/workplaces at high risk or poor mental health; support for those identified with poor mental health who are currently at work; and support for those individuals who have been excluded from work because of poor mental health. Responsibility for implementation of these actions does not rest with employer alone. Stakeholders such as the health system, *occupational* health departments, social welfare organisations, trade unions and people with lived experience of poor mental health at work can play critical roles in helping to facilitate interest and uptake in actions measures to promote and protect mental health and well-being at work. These issues are discussed later in Sections 12 and 13.

Three interlinked sets of actions

While there are many different ways of conceptualising actions, essentially they all involve three key and interlinked elements at the workplace (Box 4). These actions can also be classified as being targeted at individuals, groups of workers or the work organisation as a whole [54].

Box 4: Components of a framework for promotion of mental health and well-being at work

1. Actions to raise awareness of the importance of mental health and well-being, as well as to assess and monitor potential risk factors for stress and poor mental health at work.

2. Actions taken at an organisational level to promote mental well-being and an emphasis on taking early action to prevent the development of stress and poor mental health in specific at risk groups, providing an environment that is supportive to those individuals who have experienced poor mental health in the workplace, and finally measures to help make it easier for people with enduring mental health problems that may have experiences discrimination and exclusion from employment, to enter and/or return to work.

3. Actions taken at the level of the individual to promote mental well-being and to take a salutogenic perspective towards the prevention of stress and poor mental health, providing individuals with resources and supports to help maintain their wellbeing, and a sense of coherence to help them make use of these supports when required. There can also be individually tailored supportive actions for each individual who has experienced poor mental health in the workplace to help maintain employment, and finally measures to help make it easier for people with enduring mental health problems that may have experiences discrimination and exclusion from employment, to enter and/or return to work.

As Box 4 indicates, a first essential step is to raise awareness of the importance of well-being, and determine the level of mental health, through measurement and routine assessment at both an individual and organisational level. This may require a culture change so that well-being is seen as a core business

goal. Approaches to achieving this can vary considerably depending on the nature of the employment sector and the type of employee – e.g. managerial versus manual etc. Health and well-being reports might be regular prepared for senior management, as recommended in a review of the national health system in England [56]. Mental health awareness might be included in staff induction and management development training.

It is also necessary to undertake risk assessment for stress and poor mental health at work, for instance looking at job content, working conditions, terms of employment, social relations at work, health, wellbeing and productivity [59], Tools and checklists are available to help organisations identify risk factors for excess stress and poor mental health. Guides such as the UK Health and Safety Executive Management Standards for stress provides information to workplaces on the characteristics and culture of workplaces where work-related stress can be effectively managed [57]. The six standards look at the demand of workloads, control over how individuals do their work, support from the employer organisations, line managers and colleagues, relationships between staff, understanding of role in the workplace and how change is communicated in the workplace. Actions can then be implemented at an organisational level to counter against any problems identified in the workplace. Surveys might also be undertaken as part of measures to identify baseline for risk in different workplace settings. The results of any risk assessment exercise can then be used to design measures both at an organisational level, as well as targeted at specific individuals so as to counteract these risks. Risk assessment can also be compared with services and supports available, thus identifying potential gaps in what is needed.

We now look at different specific types of workplace mental health promoting actions, the balance between different approaches and information on their effectiveness. Workplace actions can take many forms. Box 5 provides information on some of the most commonly identified approaches at both an organisational and individual level [58, 59].

Box 5: Organisational level actions (environmental)

Risk assessment
Selection and placement programmes
Training and education programmes for managers and staff
Modifications to physical working environment
Modifications to working conditions, e.g. flexible working hours
Improved employer –employee communication
Providing procedures for complaints and feedback to line managers
Job modification
Promoting tolerance, security and justice at the workplace

Promoting worker control and pride over end products
Ensuring rewards for good performance
Ensuring career progression opportunities
Addressing fears and over job insecurity *and actual risks of redundancy*
Identify and learn from past failures and successes in workplace health promotion

Actions targeted at individuals (behavioural)
Providing individuals with clear job descriptions
Modifying workload – more time to complete tasks
Cognitive behavioural therapy (CBT)
Relaxation and meditation training
Exercise programmes
Biofeedback
Journaling
Time management training, including conflict resolution and problem solving skills
Goal setting

6.1 Measures targeted at the level of the organisation

Taking actions at an organisational level to promote psychosocial health is critical to good mental wellbeing in the workplace. The organisation of work, as well as the role of managers, is of critical importance. It is insufficient to rely solely on actions targeted at individuals who are subsequently identified as being at risk of having poor mental health. It is important to know what organisational stressors are and how to deal with them [59, 60]. Many actions are of a social rather than medical nature and 'focus on the creation of working conditions in which employees can work in a healthy fashion, and in which they are stimulated to lead an active and healthy life [61]. They seek to limit/prevent environmental and working conditions that may contribute to undue levels of work-related stress as well as promoting actions that may help promote well-being [58].

One important issue concerns leadership. Good leadership and management style can help promote a good working environment [62]. As noted by the Standing Committee of European Doctors, the training and coaching of managers is an important driver for business and organisational change. A positive attitude towards employees and improvements in individual coping mechanisms are important aspects of leadership [63]. Training programmes may focus on improving working methods and using innovation to reduce strain. They can also include training for managers to be better able not only to recognise stress and poor mental health in the workplace [55], but also to ensure fair treatment of employees, employing good conflict resolution skills and having a more participative approach to management. As Giga et al. note [58] it may be 'job specific, looking at role issues, ambiguity, and workload, but issues such as career development, relationships, and domestic problems may also need to be covered'.

Selection and placement programmes are intended to ensure when individuals first apply for jobs that they have their skills can be matched with the types of tasks and demands that need to be addressed. Specific characteristics of the working environment may require modification for instance issues concerned with excessive noise, poor air quality including exposure to chemicals, uncomfortable working temperature and poor lighting to ergonomic measures.

Job modification can also be used. Increased control over the tasks of a job can help mitigate the risk of excess stress, even where there may be job insecurity [64]. Individuals might be given more responsibility to help improve the satisfaction of working what might be a simple and perhaps repetitive task. This might for instance include having a role in monitoring quality, being involved in the planning process, as well as the creation of independent teams of workers [14]. Workloads and working time might also be modified; this could for instance include lowering unrealistic requirements, the introduction of flexible working hours to help maintain work-family life balance, options for job share, the provision of child-care facilities or ensuring that workers use up their annual holiday entitlements. Career progression mechanisms to allow personal and professional development can be put in place. There should be opportunities for staff to raise concerns about their roles and responsibilities, workload and career opportunities. Interventions at the level of the organisation to improve mental health literacy may also help to promote mental health and prevent depression [65]. Poor knowledge of health risks has substantial economic costs; individuals with higher levels of health literacy are more likely to have healthier behaviours [66], in contrast to those with low skills [67]. In Switzerland the costs to the health care system alone of poor health literacy have been estimated to be between CHF 1.5 and 2.3 billion per year [68].

Some professions or workplaces as a whole are likely to be exposed to what sometimes may be unavoidable stressful situations, such as the police and other emergency services, teachers, health care workers and air traffic controllers. Research looking at more than 2,100 staff in a large Australian bank found that levels of psychosocial distress were significantly greater in those employees who had to interact with the public more than 25 times a week. These employees were suggested to be a group that could be targeted for support [69]. Other actions can include actions to improve employee-employer relationships and level of communication; this can also help in developing better organisational interventions and in facilitating uptake and participation in various mental health promotion and stress prevention programmes. Bullying can have an adverse impact on mental health at work. Measures can also be taken to promote positive behaviours at work to avoid conflict and ensure fairness, with systems in place both to report and resolve complaints.

Not all situations have to stressful and careful assessment of risk is required. Interestingly, shift work, representing a working condition widely perceived as stressful for physical and mental health appears not to be directly associated with impaired well-being, assessed by the Work Ability Index (WAI). In two independent studies in nurses, other characteristics of the working environment and the nature of

nursing itself were more influential on WAI than working time patterns [70, 71]. A study in manufacturing industry workers in Germany compared two different rotating shift patterns with day work only. The authors found the expected influence of age on decreasing WAI, but no differences across the working time schedules [72]. These findings indicate that even such factors of work organisation, which are potentially qualifying as mental stressors, may need scrutinizing first before they are identified as promising targets for changes.

6.2 Measures targeted at individuals

Interventions targeted at individuals can again take many forms [73]. Most interventions targeted at individuals are focused on stress management and or prevention of depression and anxiety. Stress management training provides skills to recognise stress, its causes and ways to tackle/ prevent it. Many of the following interventions, such as cognitive behavioural interventions, will be delivered by a trained instructor on a one to one basis or in small groups; this will be supplemented by self teaching materials including the use of computerised learning facilities. Some interventions such as meditation or relaxation therapies also lend themselves entirely to self learning. Where training is required one recent review reported that the average length of most interventions was 7.4 weeks with 7.5 treatment sessions each lasting between one and two hours [74] .

Among the most popular of approaches used are various types of meditation, relaxation and breathing techniques. These low cost interventions are intended to help individuals reduce adverse reactions to stress. When meditating an individual focus on a single thought so as to reduce other stressful thoughts, while relaxation therapies are about the controlled release of muscle tension.

Biofeedback training is also used to help individuals recognise the way in which their muscles react to stress. As with relaxation therapy one aim of training is to get individuals to trigger relaxation responses, as well as control involuntary stress responses. Participants are aided in controlling their reaction by looking at information from electronic monitors during the training process. Individuals might also use journals to record stressful events, so as to identify triggers for stress and think about future ways to avoid and/or better manage stress[75] .

Cognitive–behavioural interventions can be used to help employees to become more aware about the role of their thoughts and emotions in managing stressful events and have skills to modify thoughts to improve ability to cope. These interventions are intended to change individuals' appraisal of stressful situations and their responses to them. Actions such as time management skills may be used as a support for cognitive behavioural interventions. Other actions can focus around improving time management skills to help individuals cope with the stressful time pressures. This can include advice and training in prioritising tasks, problem solving, delegation of work tasks and conflict resolution.

Exercise programmes can help provide a physical release from stress and tension; they can also provide an outlet for releasing anger and hostility. These can of course be developed as part of general health promotion programmes, rather than specifically to promote mental well-being. For instance a study of Scottish health care workers, reported that those receiving help to increase active commuting behaviours, had significantly greater improvement in mental health status compared to a comparator group who did not make use of the active commuting programme [76]. Interventions targeted to harmful alcohol use and smoking can also have benefits for mental health.

Examples of approaches to mental health in the workplace combining actions at both the organisational and individual level in Europe can be identified, as in the case of a manufacturing company in the Czech Republic (Box 6).

Box 6: An example of a mental health in the workplace project in a manufacturing company in the Czech Republic

In the Czech Republic, F.X. Meiller Slany Ltd manufactures skip trucks (vehicles with tipping bodies). A 'Mental Health at Workplace' project that has taken place during the economic recession, aimed to support employees by inviting them to evaluate the company's working conditions, organisational and social processes. All relevant suggestions for improvement from all staff at all levels in the company were continually checked, evaluated and executed. Not only did these efforts help the company to deal with the economic threat, but also, helped to enhance a spirit of loyalty, partnership, open communication and feelings of well-being among all participants.

In addition, employees at all levels successfully took a course to help them identify and cope with stress. This involved social skills, relaxation techniques and being more aware of risks for other staff and family members. In addition to trying to maintain a healthy working environment, the company looks at issues such as workload, enabling professional growth, creating an environment with good interpersonal relationships and most importantly trying to align the work and family lives of all employees.

7. What do we know about the effectiveness of these interventions?

One robust way of determining whether an intervention works or not is to be able to pool effectiveness data from a number of different studies looking at interventions in what is known as a meta-analysis. This reduces the risk of bias or contextual anomaly that may be seen if relying on information on the effectiveness of different individual programmes and interventions in different settings.

Several such reviews have looked at workplace mental health promotion. A first thing to note is that they, along with other analysis, indicate that despite calls for actions at both the organisational and individual level, most workplace programmes tend to concentrate on individual programmes to manage stress [58]. For instance, one recent systematic review of evaluations of interventions to prevent mental health problems in the workplace identified 24 studies published between 2001 and 2006, of which 22 included measures targeted at individuals, 14 at groups of workers and 12 at the organisational level. Only eight of these interventions were targeted at all three groups [52].

Many reasons have been put forward for this: it may be that mental health and psychosocial stress are perceived by some organisations to be down to the individual alone rather than recognise the importance of the working environment [58]. It may be perceived to be less disruptive to business and less costly to focus on individual actions alone. The relative lack of evidence from experimental controlled studies on the effectiveness of organisational interventions, and thus a perception that organisational interventions are not 'evidence-based', may also be a factor [54, 74].

Recent meta-analyses consistently indicate that there are effective workplace actions to promote and protect mental health. Most of these appear to be targeted at individuals; the lack of data on the effectiveness (or otherwise) of organisational interventions may reflect challenges in evaluation. Organisational studies tend to focus on outcomes such as absenteeism or staff turnover and may not include measures of change in stress, depression or anxiety.

One meta-analysis brings together the results of 36 different studies, involving 55 different workplace primary or secondary prevention stress-management programmes delivered to more than 2,300 participants [74]. It focused solely on interventions evaluated in randomised controlled trials that could be identified in period between 1976 and 2006. Two thirds of these studies were conducted in the US, and 59% of study participants were women. 24 studies were targeted at groups rather than individuals, but only five stuies looked at organisational level interventions. 56% of studies included cognitive behavioural therapy and 69% relaxation and meditation techniques. More than one third of studies had four or more individual intervention components.

Overall the study reported a medium effect size measuring standard mean differences in interventions compared to control groups using a measure known as Cohen's d of 0.53. In addition, when looking at the effectiveness of different specific interventions cognitive behavioural interventions were reported to have strong levels of effectiveness, with medium levels of effectiveness for relaxation and meditation interventions; combinations of different interventions had a small but statistically significant effect size. The review supported and strengthened the conclusions of an earlier review of 48 studies which has also indicated moderate effectiveness of cognitive behavioural therapy, relaxation/meditation interventions and multi-component programmes [77].

This is also consistent with the results of another recently published meta-analysis that was able to pool data from 17 rigorous workplace health promotion interventions looking at preventing and/or reducing symptoms of depression or anxiety disorders. It included both studies with a direct focus on depression and anxiety disorders, as well as more general workplace health promotion programmes with an indirect focus on mental health, where one of the outcomes measured was the impact on depression and anxiety disorders [53]. The review reported small but positive impacts of these interventions on symptoms of depression (Standard Mean Difference (SMD) 0.28, 95% Confidence Interval (CI) 0.12–0.44) and anxiety (SMD 0.29, 95% CI 0.06–0.53).

Both programmes that focused explicitly on depression and anxiety, as well as those focusing on health promotion more generally were found to be similar in their effectiveness. Interventions included aerobic and weight training exercise, stress management programmes, including actions to help in coping and identify causes of stress, ergonomic modifications, information and advice on reducing psychological stress, emotional learning and biological feedback, cognitive behavioural therapy, workplace counselling, as well as meditation and other relaxation techniques.

Interestingly the study also suggested that the overall effectiveness of a programme decreased as treatment components were added, so that single interventions appeared to be most effective. However this may be due to differences in the resource intensity of some interventions. Investment in cognitive behavioural interventions may reduce the level of resources available for other interventions, which may mean that they have not been implemented as well.

8. Why is it important to make the economic case for managing psychosocial risks at work?

In addition to determining what works, for whom and in what circumstances, it is important to also identify how much any investment in promoting mental well-being promotion and/or protecting mental health will cost. Economic evaluation compares changes in costs, compared with usual practice, with changes in outcomes (such as well-being or mental health status). Are any extra costs associated with the new well-being intervention worth improvement in outcomes achieved? Might it even be the case that an extra investment today would lead to improved outcomes and reduced costs to business and the public purse, e.g. health and social welfare departments?

Despite the benefits of action major economic barriers to mental health promotion efforts in workplaces across Europe can be found. These can include the ability, particularly for small and medium sized enterprises, to finance and sustain workplace health promotion initiatives. There may be limitations in human and technical capacity to deliver services in some countries and/or in specific employment sectors. The '*European Survey of Enterprises on New and Emerging Risks*' (ESENER) [78] carried out by the European Agency for Safety and Health at Work, shows that 79% of European managers voice their concern about stress at work, and around 40% are concern about violence and harassment at work

(more than 50% in health and social work as well as in education). However, less than 30% of EU organisations have procedures in place to deal with stress, workplace violence and harassment. While among bigger enterprises (250+) this percentage grows to 40-50%, for smaller workplaces it stays at around 20% (10-19 employees) or 25-30% (20-49 employees). Among the measures taken to deal with psychosocial risks, 'provision of training' (58%) and 'changes to the way work is organised' (40%) are reported to be the most frequent.

The reasons why establishments are motivated to address psychosocial risks – or why they fail to do so – are moderated by a variety of factors, such as compliance with laws and regulations, rationality, understanding of business benefits or costs, orientation towards values and norms, etc. The ESENER reveals that 42% of management representatives consider it more difficult to tackle psychosocial risks, compared with other Occupational Safety and Health issues. The sensitivity of the issue (53%) and lack of awareness (50%) are the main barriers for dealing effectively with psychosocial issues. Lack of expertise and lack of technical support or guidance on how to manage psychosocial risks have been reported especially by smaller enterprises. Among those establishments which report having procedures in place, the major reason for addressing psychosocial risks is 'fulfilment of legal obligation' (63% of respondents in the EU-27), followed at considerable distance by 'requests from employees or their representatives' (36%). The area in which this information or support would be most useful is 'how to design and implement preventive measures' (91%), followed by 'how to include psychosocial risks in risk assessments' (83%) and 'how to deal with specific issues such as violence, harassment or stress' (77%).

One global survey of senior or mid-level professionals with responsibility for corporate health or wellness strategy in 1,248 organizations based in 47 countries, representing more than 13 million employees also looked at the use of the wellness programmes by employers. It reported that less than half (49%) of all organisations surveyed outside the United States had any type of wellness programme in place. In Europe a focus on improving the psychosocial work environment was not found to be among the five most popular elements of wellness focused programmes, albeit it was acknowledged to be one five fastest growing workplace well-being activities. Overall the survey suggests that the focus remains on physical health; concern about potential pandemic influenza meant that immunisation was most common activity in Europe in 2010 [79] .

A key question that can then be asked is whether it is worth health and social security systems investing more resources in collaboration with business and employees for better workplace mental health promotion? What are the costs and benefits of such an investment? Demonstrating that there are economic benefits to be realised by one or more different stakeholders, including health care funders and social welfare systems may provide a powerful persuasive argument to encourage investment. From a health system perspective, if better mental health and well-being at work help reduce the need for the use of future health care services to treat avoidable mental and physical health problems, this may provide a justification for health service funders to invest funds in workplace health, perhaps supporting existing occupational health services. A similar argument might be made by social welfare systems if

better well-being and mental health at work means that there is a reduction in the need to pay out disability and/or sickness related benefits to individuals who have left work because of mental health or stress-related problems.

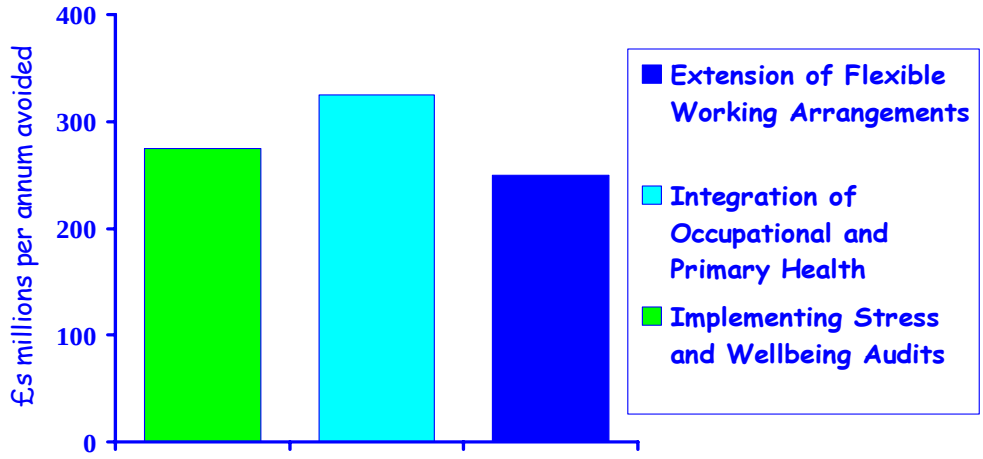
9. What do we know about the economic case for promoting positive mental well-being and protecting mental health in the workplace?

While the costs to business and to the economy in general of poor mental health have the focus of attention, in contrast there has been less attention on the opportunities and benefits of promoting positive mental health in the workplace. The workplace is a good place to promote better mental and physical well-being.

There are benefits, not only through actions to prevent work-related psychosocial stress and mental health problems, but also non work-related problems that may become visible and sometimes exacerbated within the working environment. Maintaining good mental health in the workplace can also help boost business productivity and at the same time help the EU achieve its 2020 agenda goals for economic growth and global competitiveness. Workforces enjoying a high level of mental well-being will be better able to cope with the demands and stresses of the future workplace. Better mental well-being can also help reduce the risk of physical health problems that can also impact on workplace performance.

The economic case for action is good. Early actions to tackle stress and mental health problems in workplaces also have economic benefits. For instance, work undertaken by the National Institute of Clinical Excellence in England suggests that these actions could reduce productivity losses to employers by 30%; overall for a 1,000 employee company there would be a net reduction in costs in excess of €300,000 [80]. The UK Foresight study on Mental Capital and Well-being also reported substantial economic benefits that could arise from investment in stress and well-being audits, better integration of occupational and primary health care systems and an extension in flexible working hours arrangements which in turn can help individuals maintain a balance between work and family life [1]. These savings would equate to almost €900 million per annum (Figure 14).

Figure 14: Potential annual net economic savings in the UK through implementation of mental well-being measures in the workplace



Source: Adapted from Foresight Mental Capital and Wellbeing Project, 2008 [1]

Avoiding absenteeism in the workplace can also mean that business and public sector organisations can avoid the costs associated with having to hire temporary staff to provide cover, or avoid unnecessary delays in providing services. A recent review of the health and well-being of health care employees in England reported that if absence levels might be reduced to those *seen* in the private sector, then more than 15,000 additional staff would be available every day to treat patients. This it was estimated would amount to an annual cost saving to the English National Health Service of £500 million per annum [56].

Most data on cost effectiveness has been concerned with various stress management programmes. A meta-analysis of 36 robustly evaluated stress management interventions reported that there were significantly associated with improvements in workplace productivity [74]. A controlled study of stress management programme, which made use of biofeedback and was targeted at prison officers in the US, not only led to an improvement in psychological well-being and physical health, but also to improvements in productivity levels in the workplace and a reduction of more than 20% or $1,200 per worker per year in health care costs [81].

There have been a number of economic assessments of general health promotion and wellness programmes particularly in a US context where employers are usually directly responsible for the health care costs of their employees. Some of these studies report both stress and/or mental health related outcomes in addition to looking at impacts to business in terms of productivity, absenteeism and staff

turnover. Some of these programmes, if well implemented, have shown significant cost effectiveness [82], as for instance in the case of a multi-component workplace based health promotion programme in England [83] (Box 7).

Box 7: Business benefits from investment in a multi-component workplace health promotion programme [83]

A controlled evaluation of a multi-component health promotion programme for office based employees of Unilever PLC in the UK was conducted. Participants were provided with a personalised health and wellbeing report ; personal health areas in need of improvement were highlighted, and practical suggestions as to how to achieve the recommended changes were given. Participants also gained access to a personalised lifestyle web portal that included articles, assessments, and interactive online behaviour-change programmes. Participants also received tailored emails every two weeks on relevant personal wellness topics, as well as packs of information and seminars on key health topics.

The evaluation reported that participants had 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 economic benefits of participation in general well-being programmes were also recently estimated in a UK context. From a business perspective alone, they can have a substantial return on investment in such a workplace health promotion programme of €9 for every € invested. In addition there would be further economic benefits to the health and social security systems from a reduction in health problems (mental and physical developing in the workplace) [84].

10. What do we know about effective and cost effective actions to help people with mental health problems remain in employment?

In addition to actions concerned with well-being promotion and stress/ mental health problem prevention there is also a critical need to invest in actions to help individuals who have already been impacted by work-related stress and other mental health problems. There is also a body of evidence that has rightly looked at actions to help individuals with common mental health problems such as depression and anxiety disorders who may already be on sick leave return to work. Again there is a growing body of work demonstrating both the effectiveness and cost effective of these interventions. In some setting Employee Assistance Programmes may be an umbrella vehicle for some of the aid and supports set out below.

Specialist occupational health physicians and psychologists can play a key role in providing services. Counselling can 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.

A number of studies have suggested that cognitive behaviour therapy can also be effective in treating people with stress and/or mental health problems. Structured cognitive behavioural therapy (CBT) might be provided for 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. For example, in a small study of health care workers who had recently experienced stress related absenteeism from work, it was found that those employees who made use of a computerised version of CBT had significantly better term improvements in symptoms of depression and anxiety compared to a comparator group of employees receiving standard care [85].

Much of the economic analysis undertaken to date has been done in the United States where, unlike Europe, employers have long had an incentive to invest in workplace health promotion, as they are often responsible for the health care costs of their employees. There is good evidence from a number of robust cost effectiveness studies that have looked at the use of improved care management, including psychotherapy and medications that the costs of running the programmes are more than outweighed by the savings made in terms of lower levels of absenteeism, better performance at work and higher rates of job retention [86]. Many firms will have positive returns on investment in these programmes; these will be greatest where firms rely on team working or are charged penalties for not making deadlines [87].

In the US individuals who were identified through a workplace screening programme and then subsequently received cognitive behavioural therapy 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 [88]. 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.

Similarly a recent economic analysis modelling the costs and benefits of investment in screening for depression followed by enhanced care in a UK context suggests that the intervention is highly cost effective. Over a two year period the rate of return to a 500 employee company paying for the programme would be in the region of €5 for every €1 spent. In the second year costs to the health service equivalent to half the cost of the intervention programme would also be saved [89]. Other data from both a European and Australian perspective are currently being collected [90].

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. Return to work plans should include issues such as disclosure in order to deal with potential stigmatisation and discrimination.

11. What do we know about effective and cost effective actions to help people with mental health problems enter/ return to employment?

We have indicated that employment can be an important element in improving the mental health of the population in general. For people already living with mental health needs, employment can be a key element in the recovery process. Health and social security organisations can play a major role in both funding and delivering supports to help in the return to employment on the open labour market. They and other public sector organisations, can also lead by example in promoting inclusive recruitment practices and providing supports to help improve mental well-being. New legislation in Belgium (http://www.psy107.be/site/site.asp -"Vers de meilleurs soins en santé mentale par la réalisation de circuits et de réseaux de soins") foresees the creation of networks of care for people with mental health needs; these networks include employment agencies, to help ensure that they get all the support and help they need to re-enter employment.

The new Belgian legislation which will come into force in January 2011 (article 107)- (http://www.psy107.be/site/site.asp - "Vers de meilleurs soins en santé mentale par la réalisation de circuits et de réseaux de soins ») and which foresees the creation of networks with all kind of instances: health, social etc. and – important for us - also the employment agencies, to ensure that people with mental health problems get all the necessary and possible support, also to re-enter employment after sick leave due to their problems

Considerations on how to provide opportunities for young adults are also of key importance. Young people are increasingly likely to find it difficult to get a job in the current economic climate where young unemployment rates are very high. This in turn increases their risk of having poor mental health.

The public sector is a major employer in all EU countries. It can lead by example, through demonstrating that it has inclusive recruitment practices. It can also help to promote awareness of the important expertise and insights that individuals with mental health problems can bring. For instance, public health and social care organisation might explicitly hire people who have lived with mental health problems in order to work within community mental health or supported employment teams.

There is strong evidence that the most effective way of helping individuals obtain and maintain employment is through the use of Individual Placement and Support (IPS) interventions which seek to place individuals directly into open employment as soon as possible and then subsequently provide them with support from employment advisors (also known as job coaches) for as long as necessary. Longstanding evidence from outside Europe indicates that these schemes appear to be both more effective and cost effective than the use of traditional vocational rehabilitation schemes where individuals receive training within a sheltered environment, prior to seeking any employment [91].

The six country EC-funded EQOLISE study provides evidence that the approach can also work in a European context. It suggested that IPS doubles access to work of people with psychotic illnesses, without any evidence of increased relapse (Box 8). However, its effectiveness is not independent of external circumstances, particularly local unemployment rates [92, 93].

Box 8: Individual Placement and Support (IPS) to promote inclusive employment

Under the European EQOLISE project, 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 31 in 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. There were also economic benefits to the health system: time spent in hospital in the IPS group was also half that in the vocational service group. This "Evidence Based Supported Employment" model has been adopted in several EU Member States as the method of choice for supporting people with severe mental health problems to enter employment.

The context and way in which supported employment schemes are implemented will also be critical to their success. One scheme evaluated in the Netherlands did not appear to have a major impact on employment rates, but this was in part due to a lack of employment specialists involved in implementing the schemes, challenges in funding projects that crossed the health/labour policy divide, and problems in managing the schemes. Facilitators identified included better integration of supported employment schemes into mental health teams [94]. Another recent study in London also highlighted the importance of integration with mental health services and the disincentives to take up employment due to inflexibility in the benefits system [95] .

Other actions that can also be taken to help facilitate employment include steps to provide employers, particularly in smaller organisations and those without human resources departments, increase awareness of relevant disability and anti discrimination laws. Trade unions and other employee

organisations can also be made better aware of these requirements so that they understand and do not resent more flexible working conditions that may be given to people with poor mental health [96]. The extent to which employers are recruiting people with mental health needs may be monitored; legal proceedings may be taken in situations where discrimination can be identified. The adverse publicity alone of any legal case may act as a spur to an employer to adopt inclusive recruitment practices. One potential way of addressing concerns over disclosure of health status may be for EU Member States to build on experience from the US where any pre-employment questionnaire can only ask about health status where it is directly relevant to the job in question [97]. There are also opportunities to share experiences between different countries on how successful legislation has been in reducing discrimination against people with mental health problems and what might this mean for the drafting and implementation of new legislation.

Both public and private employment services across Europe have a critical role to play, both in helping jobseekers with mental health needs, and also supporting employers. Personalised assessment of needs either directly by public employment services, or contracted to specialist employment advisors is an important step which can also increase chances of an individual obtaining employment [98]. This is one element of the “Pathways to Work” approach introduced by the previous UK government. This scheme included interviews with employment so-called specialists to provide advice and support as part of a process of helping return individuals to employment [99].

One key action that is also critical to return to work is to have a more flexibility built into social protection systems. Systems should help encourage individuals to seek work if they so wish, but also ensure that benefits can be reclaimed quickly if employment does not work out. Any legislation that prohibits individuals in receipt of a disability benefit from seeking work should be repealed. Equally individuals should be able to take on part time work without fear of having all their additional wages deducted from any benefit they receive. This would help remove disincentives to take up part time work as a route back to full time employment. This issue of disincentives in the tax and benefit systems was one of many issues highlighted in the recently signed European Social Partners Joint Framework Agreement on Inclusive Labour Markets.[100]

12. What do we know about effective actions to protect the mental health of people who experience a change in their employment status?

Workplaces continue to change. There can be adverse impacts on the physical and mental health of employees and those that lose their jobs as a result of restructuring, as set out in a background paper to the recent Belgian Presidency conference on ‘*Investing in well being at work - addressing psychosocial risks in times of change*’ [17]. In some cases restructuring can mean a reduction in the workforce of a company, perhaps as a result of a merger or an acquisition. Psychosocial distress can increase as a result – individuals may find they have higher workloads and less control over their jobs; there may also

be a perceived imbalance between efforts and rewards because of the feeling of job insecurity that people may experience. The report also indicated that those managers who may have to take responsibility for change management and restructuring can also be adversely effected if they are involved in making colleagues redundant.

Measures can be taken to protect the mental health of individuals and help them cope with change, as well as help them develop the new skills required to obtain further employment. Simple steps can include better communication and transparency in the process; data from organisations in Hungary and Sweden reported that more than 40% and 27% of individuals had not received any advanced notification of an employers plans for downsizing [101]. The mental health and well-being of individuals who do not receive such support has been shown in recent European work to be poorer than those that do; this difference can persist even after individuals find new employment.

In addition to these ongoing changes, firms may also need to reduce their costs when the economic climate is poor. Measures such as temporary reduced working hours or a reduction in salaries, while not attractive to employees, can have less harmful effects on health and well-being compared with the loss of employment. Other approaches that may be considered could include offering short term sabbaticals from work which may provide opportunities for new life experiences, while still retaining a lower level of salary. Employees might, for instance, be offered support to pursue an educational course or undertake some voluntary sector work. In this way firms can retain their skilled staff, rather than having to go through a new process of hiring. This has, for example, been practiced successfully during the present economic crisis by the SCANIA Company, with the support of the European Social Fund.

13. What measures might health care, social security organisations, social partners and international networks take to help facilitate greater investment in workplace mental health and well-being?

There are additional economic benefits that may be gained by health and social security systems from having more mentally healthy workforces in Europe. The paper has highlighted some of the economic costs of poor mental health that could be avoided if poor mental health can be prevented, or if early action (as a result of identification at the workplace of non-work related poor mental health) can be taken. In addition, although as yet difficult to quantify, governments in general are likely to benefit from improved mental well-being at work (through increased revenue from company taxes), if this does indeed lead to improvements in productivity.

As this paper and the accompanying annex indicate, interest in mental health at work has clearly increased in much of Europe, but there are significant gaps. Publicly funded health care systems, ministries responsible for funding disability and unemployment benefits, ministries of labour, education and continuous learning can play powerful roles in different country settings. Yet in most countries in

Europe the role of the health ministry in particular remains modest. Yet as noted in the Foresight Project on Mental Capital and Wellbeing, there may be economic benefits to be gained through better integration of primary care in particular, with occupational health services.

Yet state funding for occupational health services, as well as the extent to which occupational health services are available, vary considerably across Europe. As Annex 1 indicates, countries dominated by social health insurance systems may be more likely to have some funding for occupational health services and workplace well-being initiatives. In many countries dominated by tax funded health care systems examples of significant permanent funding for workplace health promotion services are very limited.

Greater supports for occupational health services from tax or social insurance funded health care systems can help in the provision of a range of appropriate services in workplaces. As this paper notes, many of the approaches need to promote and protect mental health at work should be implemented at an organisational level. These are largely social in nature; focusing on issues such as management practices and workplace culture. Governments might also consider incentivising companies, perhaps through tax breaks, to invest in actions to address workplace mental health at an organisational level. Currently in most European countries, long term sickness benefits remain the responsibility of social welfare systems; adjusting these systems so as to potentially place more responsibility on employers for some of these costs might also perhaps increase the priority given to mental health in the workplace. Such a development would require careful consideration of the potential impacts on business and also any adverse impacts it might have on the willingness of employers to recruit individuals with a history of health problems. Nonetheless it is clear from experience in North America that investment in workplace health promotion measures will increase when business has an economic incentive to do so [102].

Many good practices in workplace health promotion are to be found in large private companies or in large public sector organisations. Another particular area for action therefore may be to provide financial incentives for small business to invest in mental health promotion activities. Without such incentives it may not be feasible for them to implement effective programmes. In England the National Institute for Health and Clinical Excellence (NICE) has recently recommended that organisations such as the National Health Service and local authorities may collaborate with small and medium sized enterprises, so as to allow them access to public sector occupational health services [55]. There are a number of different repositories of examples of good practice to prevent psychosocial risks and promote mental health at the workplace, as for instance at (http://osha.europa.eu/en/practical-solutions/case-studies). Given the economic and health costs of unemployment, health, social security and other government departments responsible for education and life long learning may also wish to look at ways that they can help firms during any period of restructuring.

Any initiative by health and social security stakeholders to facilitate more actions to promote wellbeing at work should not be at the expense of labour market activation mechanisms to help support people with long term mental health problems from having an opportunity to obtain work in competitive employment. There is an ever growing body of evidence on the effectiveness of return to work interventions; work is generally good for health but it is also helpful in providing a source of income and status in society that can help empower individuals. In terms of designing and promoting a healthy working environment for people who are living with mental health problems, much can be learnt from the lived experience of people who have experienced poor mental health in the workplace, or who have sought to return/enter the labour market after having experienced poor mental health. Guides on this issue can be identified.

Regardless of differences in formal system structures, there is a need for all social partners, existing occupational health services and workplaces to work in partnership with government to help facilitate greater implementation and uptake of workplace mental health and well-being actions, support for individuals with mental health problems in the workplace, as well as help ensure that initiatives such as supported employment do indeed promote more inclusive employment [103]. While not by itself sufficient, social partners should work towards the implementation of procedures to address psychosocial health risks in organisations at an organisational level, as a necessary element of workplace mental health promotion, making use of accepted tried and tested practical guidance, as for instance from the Health and Safety Executive in the UK. In practice this could mean support for greater involvement of workers in workplace risk assessment, given the experience that workers have of their own workplaces. Social partners can also work with governments and the EU to help foster an exchange of best practices as regards psychosocial risk assessment and the transferability of approaches between national contexts; raise awareness on workplace risk assessment to include psychosocial hazards; foster co-operation with other relevant stakeholders on this issue and organise training courses.

The exchange of good practices, among enterprises and EU Member States, is also a means of providing useful support for the conception of solutions to meet common or even special chal-lenges. This process should, naturally, also include international organisations such as the World Health Organization (WHO), the International Labour Organisation (ILO) and the Organisation for Economic Co-operation and Development (OECD), as well as non-governmental organisations and service user or self-help associations.

An important role in providing support for workplaces is also played by the European Agency for Safety and Health at Work, as well as the European Foundation for the Improvement of Living and Working Conditions, working together with the corresponding structures in the Member States.Networks such as the European Network for Workplace Health Promotion (ENWHP), Business Europe and the European Business Network for Social Responsibility (CSR Europe), or initiatives such as the Workplace Wellness Alliance of the World Economic Forum (WEF), can also support the dissemination of good practices to promote mental health and well-being at the workplace.

14. Conclusions

Employment in a good working environment is beneficial to physical and mental health. In the EU as a whole almost two thirds of the adult population are in employment [10]. Ensuring a high degree of mental health will allow Europe to meet its economic and social challenges, while further advancing its aims of competitiveness and social cohesion. From a public health perspective the workplace is an important setting where health promoting activities can take place. Actions at work also provide an opportunity for the early identification of risk factors for poor health. Nonetheless poor work environments can increase the risk of excess levels of stress, potentially leading to poor mental health.

A holistic approach to action to promote and protect mental health and well-being is required. It requires actions to improve the structure and organisation of workplaces, as well as investing in measures to strengthen the ability of individuals to cope with daily stressors. Much of this action is social in nature, it is about a better workplace culture, improved communication, better line management, flexible working opportunities to protect the work-life balance and opportunities for career development and rewards. But it is also about individuals also taking responsibility for their health, given that much of the out time remains outside the working environment.

The economic costs of poor mental health provides one powerful reason for mainstream health services and social security agencies to play a greater role in workplace health promotion, in partnership with occupational health services, social partners and workplaces. Strengthening awareness of the business case for workplace mental health promotion will also help. Financial mechanisms, such as the extent to which companies are responsible for paying long term sickness benefits, might also be considered. The personal and economic benefits of helping to promote a more inclusive workforce can also help foster greater investment in active labour market strategies. Equally highlighting the effectiveness of measures and business case for investment in actions to help retain staff who have experienced poor mental health can also be a powerful aid to action at work. After all, work is a fundamental and positive aspect of life. We simply cannot leave our mental health and well-being at the door of the workplace.

References

1. Foresight Mental Capital and Wellbeing Project. *Final project report*, London: Government Science Office, 2008.
2. Beddington J, Cooper C L, Field J, et al. *The mental wealth of nations.* Nature 2008; **455**(7216):1057-60.
3. Cooper C L. *The changing nature of work: enhancing the mental capital and well-being of the workplace.* Contemporary Social Science 2009; **4**(3):269-275.
4. Keyes C L, Dhingra S S, Simoes E J. *Change in level of positive mental health as a predictor of future risk of mental illness.* Am J Public Health 2010; **100**(12):2366-71.
5. TNS Opinion and Social. *Eurobarometer 73.2. Mental Health*, Brussels: European Commission, 2010.
6. Harris E, Barraclough B. *Excess mortality of mental disorder.* Br J Psychiatry 1998; **173**:11-53.
7. McDaid D. *Routes to Recovery: Employment and meaningful activities*. in *Promoting Social Inclusion and Combating Stigma for better Mental Health and Well-being*, C. O'Sullivan, Editor. 2010, Brussels: European Commission.
8. Perkins R, Farmer P, Litchfield P. *Realising ambitions: better employment support for people with a mental health condition*, London: Department for Work and Pensions, 2009.
9. Finnish Institute of Occupational Health. *Work-family balance. Available at http://www.ttl.fi/en/working_career/work_family_balance/pages/default.aspx*, Helsinki: Finnish Institute for Occupational Health, 2010.
10. Eurostat. *Total employment rates in the EU 27 in 2009.*, Luxembourg: Eurostat, 2010.
11. Levi L, Bartley M, Marmot M, et al. *Stressors at the workplace: theoretical models.* Occup Med 2000; **15**(1):69-106.
12. Karasek R A, Theorell T. *Healthy work: Stress, productivity, and the reconstruction of working life*, New York: Basic books, 1990.
13. Siegrist J. *Adverse health effects of high effort - low reward conditions at work.* Journal of Occupational Health Psychology 1996; **1**:27-43.
14. Chandola T. *Stress at work*, London: The British Academy, 2010.
15. Black C. *Working for a healthier tomorrow*, London: Department for Work and Pensions, 2008.
16. Eurostat. *Health and safety at work in Europe. 1999-2007. 2010 edition*, Luxembourg: Publications Office of the European Union, 2010.
17. Kieselbach T, Nielsen K, Triomphe C E. *Psychosocial risks and health effects of restructuring*, Brussels: Commission of the European Communities, 2010.
18. Anderson P, Stuckler D, Basu S, McDaid D. *Impact of economic crises on mental heath*, Copenhagen: World Health Organization, 2011.
19. McDaid D, Knapp M. *Black-skies planning? Prioritising mental health services in times of austerity.* British Journal of Psychiatry 2010; **196**(6):423-424.
20. European Foundation for the Improvement of Living and Working Conditions. *Changes over time – First findings from the fifth European Working Conditions Survey*, Dublin European Foundation for the Improvement of Living and Working Conditions, 2010.
21. Grove B. *Mental health employment - shaping a new agenda.* Journal of Mental Health 1999; **8**:131-140.
22. Kilian R, Becker T. *Macro-economic indicators and labour force participation of people with schizophrenia.* Journal of Mental Health 2007; **16**(2):211-222.
23. Manning C, White P. *Attitidues of employer to the mentally ill.* Psychiatric Bulletin 1995; **19**:541-543.
24. Rinaldi M, Hill R. *Insufficient concern*, London: Merton Mind, 2000.
25. See Me Scotland. *See me so far: a review of the first four years of the Scottish anti-stigma campaign*, Edinburgh: See Me Scotland, 2006.
26. National Economic and Social Forum. *Mental Health and Social Inclusion*, Dublin: NESF, 2007.
27. Shaw Trust. *Mental Health: The Last Workplace Taboo*, Chippenham: Shaw Trust, 2006.
28. O'Sullivan C, Thornicroft G, Layte R, et al. *Promoting Social Inclusion and Combating Stigma for Better Health and Wellbeing. Background Document to the European Commission Thematic Conference in Lisbon*, Brussels: European Commission, 2010.
29. Wang H, Samson K. *Wellness and productivity management: a new approach to increasing performance*, Philadelphia: Right Management Inc, 2009.
30. Dornan A, Jane-Llopis E, *The Wellness Imperative: creating more effective organisations* 2010, World Economic Forum: Geneva. p. 20.
31. Edwards P, Greasley K. *Absence from work*, Dublin: European Foundation for the Improvement of Living and Working Conditions, 2010.

32. McDaid D. *The economics of mental health in the workplace: what do we know and where do we go?* Epidemiol Psichiatr Soc 2007; **16**(4):294-8.
33. ZebraZone. *Stress au travail. Belgique 2008. Available at http://www.zebrazone.eu/be/*, Brussels: Securex, 2008.
34. Sainsbury Centre for Mental Health. *Mental health at work: developing the business case*, London: Sainsbury Centre for Mental Health, 2007.
35. Sanderson K, Andrews G. *Common mental disorders in the workforce: recent findings from descriptive and social epidemiology.* Can J Psychiatry 2006; **51**(2):63-75.
36. McDaid D, Zechmeister I, Kilian R, et al. *Making the economic case for the promotion of mental well-being and the prevention of mental health problems*, London: London School of Economics and Political Science, 2008.
37. 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.
38. Leal J, Luengo-Fernandez R, Gray A, Petersen S, Rayner M. *Economic burden of cardiovascular diseases in the enlarged European Union.* Eur Heart J 2006; **27**(13):1610-9.
39. Bevan S, Quadrello T, McGee R, Mahdon M, Vavrovsky A, Barham L. *Fit For Work? Musculoskeletal Disorders in the European Workforce*, London: The Work Foundation, 2009.
40. Bundespsychotherapeutenkammer (Federal Chamber of Psychotherapists in Germany). *Komplexe Abhängigkeiten machen psychisch krank – BPtK-Studie zu psychischen Belastungen in der modernen Arbeitswelt. Available at http://www2.bptk.de/uploads/psychische_erkrankungen_im_fokus_der_berichte_der_krankenkassen.pdf*, Berlin: Bundespsychotherapeutenkammer, 2010.
41. Leoni T, Mahringer H. *Fehlzeitenreport 2008: Krankheits- und unfallbedingte Fehlzeiten in Österreich. Available at http://www.wifo.ac.at/wwa/servlet/wwa.upload.DownloadServlet/bdoc/S_2008_FEHLZEITENREPORT_2008_34220$.PDF*, Vienna: Österreichisches Institut für Wirtschaftsforschung, 2008.
42. Zechmeister I. *Financing Mental Health Systems: Austria.*, London: Mental Health Economics European Network 2004.
43. Gomes A, Llena-Nozal A, Prinz C. *Sickness, Disability and Work: Breaking the Barriers. Sweden: Will the recent reforms make it?* 2009, Paris: OECD.
44. Department of Work & Pensions. *Incapacity benefit payments in Great Britain, 2007*, London: Department of Work & Pensions, 2007.
45. Biffl G, Leoni T, Mayrhuber C. *Arbeitsplatzbelastungen, arbeitsbedingte Krankheiten und Invalidität. Available at http://www.wifo.ac.at/wwa/servlet/wwa.upload.DownloadServlet/bdoc/S_2009_INVALIDITAET_35901$.PDF*, Vienna: Österreichisches Institut für Wirtschaftsforschung, 2009.
46. Hauptverband der der österreichischen Sozialversicherungsträger. *Statistisches Handbuch der österreichischen Sozialversicherung 2008*, Vienna: Hauptverband der der österreichischen Sozialversicherungsträger, 2008.
47. European Social Partners. *Framework Agreement on Work-Related Stress (08/10/2004)*, Brussels, 2004.
48. Ertel M, Stilijanow U, Iavicoli S, Natali E, Jain A, Leka S. *European social dialogue on psychosocial risks at work: benefits and challenges.* European Journal of Industrial Relations 2010; **16**(2):169-183.
49. European Network for Workplace Health Promotion. *The Edinburgh Declaration on the Promotion of Workplace Mental Health and Wellbeing. Available at http://www.enwhp.org/fileadmin/downloads/Publications/Edinburgh_Declaration.pdf*, Edinburgh: European Network for Workplace Health Promotion, 2010.
50. Prinz C, Singh S, Kim H, Llena-Nozal A, Gomes A, Slootmaekers V. *Sickness, Disability and Work: Breaking the Barriers*, Paris: OECD, 2010.
51. Kickbusch I, Maag D. *Health Literacy.* 2008, San Diego: Academic Press, 204-211.
52. Corbiere M, Shen J, Rouleau M, Dewa C S. *A systematic review of preventive interventions regarding mental health issues in organizations.* Work 2009; **33**(1):81-116.
53. Martin A, Sanderson K, Cocker F. *Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms.* Scand J Work Environ Health 2009; **35**(1):7-18.
54. Semmer N K. *Stress Management and Wellbeing Interventions in the Workplace in Mental Capital and Wellbeing: Making the most of ourselves in the 21st century State-of-Science Review: SR-C6. Available at http://www.bis.gov.uk/assets/bispartners/foresight/docs/mental-capital/sr-c6_mcw.pdf*, London: Government Office for Science 2008.
55. National Institute for Health and Clinical Excellence. *Promoting mental wellbeing through productive and healthy working conditions: guidance for employers. Available at http://www.nice.org.uk/nicemedia/live/12331/45893/45893.pdf*, London: NICE., 2009.
56. Boorman S. *NHS Health and Wellbeing. Final report*, London: Department of Health, 2009.

57. Health and Safety Executive. *Managing the causes of work related stress. A step by step guide using the Management Standards*, London Health and Safety Executive,, 2007.
58. Giga S I, Cooper C L, Faragher B. *The development of a framework for a comprehensive approach to stress Management interventions at work.* International Journal of Stress Management 2003; **10**(4):280-296.
59. Levi L, Levi I, *Guidance on work-related stress. Spice of life or kiss of death?* 2000, Commission of the European Communities: Brussels.
60. Cooper C L. *The changing nature of work: workplace stress and strategies to deal with it.* Med Lav 2006; **97**(2):132-6.
61. Van der Vliet J. *Seeing the social side.* Public Service Review: Health 2009(20):2-3.
62. Kelloway K E, Barling J. *Leadership development as an intervention in occupational health psychology.* Work and Stress 2010; **24**(3):260-279.
63. Standing Committee of European Doctors. *Mental health in workplace settings: fit and healthy at work*, Brussels: Standing Committee of European Doctors,, 2009.
64. Schreurs B, van Emmerick H, Notelaers G, de Witte H. *Job insecurity and employee health: The buffering potential of job control and job self-efficacy.* Work and Stress 2010; **24**(1):56-72.
65. Couser G P. *Challenges and opportunities for preventing depression in the workplace: a review of the evidence supporting workplace factors and interventions.* J Occup Environ Med 2008; **50**(4):411-27.
66. Bopp M, Minder C E. *Mortality by education in German speaking Switzerland, 1990-1997: results from the Swiss National Cohort.* Int J Epidemiol 2003; **32**(3):346-54.
67. Eichler K, Wieser S, Brugger U. *The costs of limited health literacy: a systematic review.* Int J Public Health 2009; **54**(5):313-24.
68. Spycher S. *Ökonomische Aspekte der Gesundheitskompetenzen. Konzeptpapier im Auftrag des Bundesamtes für Gesundheit*, Berne, 2006.
69. Hilton M, Whiteford H. *Interacting with the public as a risk factor for employee psychological distress.* BMC Public Health 2010; **10**:435.
70. Camerino D, Conway P M, Sartori S, et al. *Factors affecting work ability in day and shift-working nurses.* Chronobiol Int 2008; **25**(2):425-42.
71. Fischer F M, Borges F N, Rotenberg L, et al. *Work ability of health care shift workers: What matters?* Chronobiol Int 2006; **23**(6):1165-79.
72. Yong M, Nasterlack M, Pluto R P, Elmerich K, Karl D, Knauth P. *Is health, measured by work ability index, affected by 12-hour rotating shift schedules?* Chronobiol Int 2010; **27**(5):1135-48.
73. Stein F. *Occupational stress, relaxation therapies, exercise and biofeedback.* Work 2001; **17**(3):235-245.
74. Richardson K M, Rothstein H R. *Effects of occupational stress management intervention programs: a meta-analysis.* J Occup Health Psychol 2008; **13**(1):69-93.
75. Alford W K, Malouff J M, Osland K S. *Written emotional expression as a coping method in child protective services officers.* International Journal of Stress Management 2005(12):177-187.
76. Mutrie N, Carney C, Blamey A, Crawford F, Aitchison T, Whitelaw A. *"Walk in to Work Out": a randomised controlled trial of a self help intervention to promote active commuting.* J Epidemiol Community Health 2002; **56**(6):407-12.
77. van der Klink J J, Blonk R W, Schene A H, van Dijk F J. *The benefits of interventions for work-related stress.* Am J Public Health 2001; **91**(2):270-6.
78. Rial González E, Cockburn W, Irastorza X. *European Survey of Enterprises on New and Emerging Risks*, Bilbao: European Agency for Health and Safety at Work, 2010.
79. Buck Consultants. *Global Wellness Survey 2010*, San Francisco: Buck Consultants, 2010.
80. National Institute for Health and Clinical Excellence. *Promoting mental wellbeing at work: business case. Available at http://www.nice.org.uk/nicemedia/live/12331/46023/46023.PDF*, London: NICE., 2009.
81. McCraty R, Atkinson M, Lipsenthal L, Arguelles L. *New hope for correctional officers: an innovative program for reducing stress and health risks.* Appl Psychophysiol Biofeedback 2009; **34**(4):251-72.
82. Ozminkowski R J, Ling D, Goetzel R Z, et al. *Long-term impact of Johnson & Johnson's Health & Wellness Program on health care utilization and expenditures.* J Occup Environ Med 2002; **44**(1):21-9.
83. Mills P R, Kessler R C, Cooper J, Sullivan S. *Impact of a health promotion program on employee health risks and work productivity.* Am J Health Promot 2007; **22**(1):45-53.
84. McDaid D, King D, Park A, Parsonage M. *Promoting wellbeing in the workplace*. in *Mental Health Promotion and Prevention: the Economic Case*, M. Knapp, D. McDaid, and M. Parsonage, Editors. 2011, London Department of Health.
85. Grime P R. *Computerized cognitive behavioural therapy at work: a randomized controlled trial in employees with recent stress-related absenteeism.* Occup Med (Lond) 2004; **54**(5):353-9.

86. Wang P S, Simon G E, Kessler R C. *Making the business case for enhanced depression care: the National Institute of Mental Health-harvard Work Outcomes Research and Cost-effectiveness Study.* J Occup Environ Med 2008; **50**(4):468-75.
87. Lo Sasso A T, Rost K, Beck A. *Modeling the impact of enhanced depression treatment on workplace functioning and costs: a cost-benefit approach.* Med Care 2006; **44**(4):352-8.
88. Wang P S, Simon G E, Avorn J, et al. *Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial.* JAMA 2007; **298**(12):1401-11.
89. McDaid D, King D, Parsonage M. *Workplace screening for depression and anxiety disorders*. in *Mental Health Promotion and Prevention: the Economic Case*, M. Knapp, D. McDaid, and M. Parsonage, Editors. 2011, London Department of Health.
90. van Oostrom S H, Anema J R, Terluin B, de Vet H C, Knol D L, van Mechelen W. *Cost-effectiveness of a workplace intervention for sick-listed employees with common mental disorders: design of a randomized controlled trial.* BMC Public Health 2008; **8**:12.
91. Campbell K, Bond G R, Drake R E. *Who Benefits From Supported Employment: A Meta-analytic Study.* Schizophr Bull 2009.
92. Burns T, Catty J, Becker T, et al. *The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial.* Lancet 2007; **370**(9593):1146-52.
93. Burns T, White S J, Catty J. *Individual Placement and Support in Europe: the EQOLISE trial.* Int Rev Psychiatry 2008; **20**(6):498-502.
94. van Erp N H, Giesen F B, van Weeghel J, et al. *A multisite study of implementing supported employment in the Netherlands.* Psychiatr Serv 2007; **58**(11):1421-6.
95. Howard L M, Heslin M, Leese M, et al. *Supported employment: randomised controlled trial.* Br J Psychiatry 2010; **196**(5):404-11.
96. Thornicroft G. *Actions speak louder…..Tackling discrimination against people with mental illness*, London: Mental Health Foundation, 2006.
97. Wheat K, Brohan E, Henderson C, Thornicroft G. *Mental illness and the workplace: conceal or reveal?* Journal of the Royal Society of Medicine 2010; **103**:83-86.
98. Daguerre A, Etherington D. *Active labour market policies in international context: what works best? Lessons for the UK.*, London: Department for Work and Pensions, 2009.
99. Warrener M, Graham J, Arthur S. *A qualitative study of the customer views and experiences of the Condition Management Programme in Jobcentre Plus Pathways to Work*, London Department for Work and Pensions, 2009.
100. European Social Partners. *Framework Agreement on Inclusive Labour Markets (25/03/2010)*, Brussels, 2010.
101. Brenner M H. *Health impact of economic restructuring and unemployment in Europe. Presentation at Belgian Presidency conference on psychosocial stress in the workplace. Available at http://www.emploi.belgique.be/uploadedFiles/Eutrio/events/HarveyBrenner.pdf*, Brussels, 2010.
102. Dewa C S, McDaid D, Ettner S L. *An international perspective on worker mental health problems: who bears the burden and how are costs addressed?* Can J Psychiatry 2007; **52**(6):346-56.
103. Cooper C L, Dewe P. *Well-being - absenteeism, presenteeism, costs and challenges.* Occup Med (Lond) 2008; **58**:522-524.

ANNEX I

A SNAPSHOT FOR WORK HEALTH PROMOTION FUNDING AND POLICY ACROSS THE EUROPEAN ECONOMIC AREA

Annette Bauer and David McDaid

Preamble

This document was prepared as an Annex for the European Pact for Mental Health and Well-being conference in Berlin on promoting mental health and well-being ar work to gain some greater knowledge in how far health promotion at the workplace is currently prioritised by different EU governments. Financial means provided by the State and regulation mechanisms provide an important indication of the consistency and sustainability that has been applied to workplace based health promotion approaches[1]. Within the very short time schedule for this work we reviewed literature that was available in English, German and Spanish at an European and country level including policy papers, information on countries' government websites, research papers and resources from international networks, in particular the European Network for Work Health Promotion. We identified three resources that were particularly relevant for this exercise and which we used extensively in the development of the table, namely

- *European Agency for Safety and Health at Work (2010), Economic incentives to improve occupational safety and health: a review from the European perspective, Luxembourg.*
- *Hämäläinen R M (2008), The Europeanisation of occupational health services: A study of the impact of EU policies, The Finnish Institute of Occupational Health – People and Work Research Reports 82, Helsinki, Finland.*
- *Hämäläinen R M (2006), Workplace Health Promotion in Europe – The role of national health policies and strategies, The Finnish Institute of Occupational Health, Helsinki, Finland.*

A range of experts in the field were consulted on this topic and information from these personal communications proved particularly useful. We would like to acknowledge the contribution of the following persons and organisations: Dr Gregor Breucker from the Department for Health promotion at the BKK Bundesverband in Germany, Dr Richard Wynne from Work Research Centre in Ireland; Dr Eija Stengard from National Institute of Health and Welfare (THL) in Finland, Dr Jaana Lerssi-Uskelin, Finnish Institute of Occupational Health, Dr Kristinn Tómasson Administration of Occupational Safety and Health, Iceland; Dr Isabelle Burens and Dr Segoléne Journoud from the French National Agency for the Improvement of Working Conditions (ANACT), Dr Taavi Lai and Dr Eda Marisalu from the University of Tartu in Estonia, Dr Luis Salvador-Carullla from PsiCost, Spain, Professor Heinz Katschnig, Austria,

Our classification of EU Member States was taken from the European Agency for Safety and Health at Work which separates between two types of social security systems, whilst acknowledging that de facto most systems will be mixed but leaning more strongly towards one end of the spectrum. Whereas the Beveridge model is largely tax financed, the Bismarckian model is funded largely by social insurance contributions. For example, the United Kingdom and Scandinavian countries are closer to the Beveridge model, while continental Northern Europe follows a Bismarckian model. The systems in Spain, Portugal, Italy and Greece have been moving from insurance-based to predominantly tax-based financed systems. In Eastern Europe, most countries reformed their systems towards the Bismarckian model.

Despite our best efforts we recognise that information presented in this snapshot will sometimes show inaccuracies and inconsistencies. We will be continuing to work further on this subject and would therefore very much welcome any comments and suggestions that help to draw a fuller and up-to-date picture of the existing situation. For this purpose or other enquiries please contact David McDaid at D.Mcdaid@lse.ac.uk.

[1] There are of course other non-financial aspects to WHP including peer pressure and reputation which play a particularly important role at the international level.

A. Does the government provide any funding or subsidy for Workplace Health Promotion (WHP)/ or Occupational Health and Safety (OHS)?
This question is aimed at understanding which sources of government funding exist for Workplace Health Promotion including Mental Health Promotion. This refers to the extent to which WHP is prioritised in social security laws, OHS and health insurance packages. For countries, where no specific funding source could be identified, arrangements for Occupational Health Services were explored whereby at the bare minimum public insurance payments cover occupational accidents and diseases[2]. This often included the provision for at least basic occupational health services and research. A further distinction was made by looking at how far insurance covered those diseases only of a strict 'occupational' nature where a wider scope was implemented (in some instances covering mental illness). As mentioned earlier, this analysis was restricted to information that we could obtain in a very short period of time.

Belgium (*Bismarckian social security system)*
- Occupational Disease Fund (on a pay-as-you-go basis) which covers low back pain, vaccination for Hep A and B, Prevention/Experience Fund, Diversity Plans. - Several funding sources for WHP programmes.
Bulgaria *(Bismarckian social security system)*
Occupational Accidents and Professional Disease Fund of the National Insurance Institute with risk prevention focus as defined in the Code for the Obligatory Public Insurance (COPI).
Czech Republic *(Bismarckian social security system)*
Social security scheme covers occupational risks and diseases.
Denmark *(Beveridgean social security system)*
Labour Market Occupational Disease Fund which covers listed occupational diseases.
Germany *(Bismarckian social security system)*
Fixed minimum amount of just below 3 Euros for WHP activities (which need to be different from health and safety services that are already the employer's responsibility). Tax incentives for occupational health promotion since 2009 whereby employers can write off EUR 500 per worker and year.
Estonia *(Bismarckian social security system)*
The Estonian health insurance fund covers occupational accidents and diseases. No subsidy for WHP.
Greece *(Beveridgean social security system)*
No specific insurance against occupational accidents or diseases.
Spain *(Beveridgean social security system)*
Grants and subsidies for occupational health and safety programmes including preventative action.
France *(Bismarckian social security system)*
FACT (Fonds pour l'amélioration des conditions de travail , = fund for working conditions improvement) for participative projects that take human factors and working conditions into account including occupational risks prevention ,awork agreements, work hardness, etc.
Ireland *(Beveridgean social security system)*
No state funded Occupational Health Services and no specified funding for WHP for employers but state funded personnel concerned with advocating and advising WHP at a national and regional level.
Italy *(Beveridgean social security system)*
The Legislative Decree 81/2008 charges employers on issues related to workplace health promotion, which can be implemented on a voluntary basis. Funding schemes are available for OHS.
Cyprus *(Beveridgean social security system)*
Employers Liability Law for insurance against accident claims.
Latvia *(Bismarckian social security system)*
Substitute for income in the event of illness from the State Social Insurance Agency ; no separation is made between occupational accidents or diseases.
Lithuania *(Bismarckian social security system)*
Prevention fund for OHS managed by the State Social Insurance Fund Board (SODRA) In the event of occupational accident or disease, the sickness fund pays.
Luxembourg *(Bismarckian social security system)*
Accident insurance covers all work-related accidents and illnesses.

[2] There are only a few countries where the insurance cover only includes accidents at work.

Hungary *(Bismarckian social security system)*
Occupational accidents and diseases covered by the insurance system for sickness, invalidity and survivors.
Malta *(Beveridgean social security system)*
Occupational accidents and diseases covered by the social security system, no separation between accidents and diseases
Netherlands *(Bismarckian social security system)*
Once-only subsidy for employers that implement OHS initiatives. Legal framework of social insurance system leaves some leeway for employers to invest into prevention of occupational diseases.
Austria *(Bismarckian social security system)*
Yes – some funding from federal and provincial, sickness funds, occupational accidents insurance, pension funds and chambers of commerce. Health Promotion Act 1998 concerned with the financing of health promotion projects through the Fund for a Healthy Austria (FGÖ) with a focus on health promotion at the workplace; declared priorities of the Fund from 2008 are on mental health promotion at the workplace including reducing stress and improving work life balance.
Poland (Bismarckian social security system)
Occupational diseases are regulated in the Regulation of the Council of Ministers since 2002; The document contains a list of diseases and describes the procedures for reporting and diagnosing occupational diseases.
Portugal (Beveridgean social security system)
Occupational diseases covered by state pool; insurance covers occupational diseases covered in the national diseases schedule
Romania (Bismarckian social security system)
National Insurance Fund for accidents occupational diseases managed by the government and social partners with some leeway to consider funding for prevention
Slovenia (Bismarckian social security system)
Occupational risks covered by the National Health Fund and the National Pension and Invalidity fund which are funded from employer's contributions. The level of contribution varies according to the frequency of accidents at work.
Slovak Republic (Bismarckian social security system)
Occupational diseases covered from a list of 47 diseases by the statutory accident insurance.
Finland (Beveridgean social security system)
There are some governmental sources for research and development activities. In Finland, occupational health services are based on the Occupational Health Service Act of 1978 (amended in 1991 and 2001). The employer is obligated by law to organise occupational health services for the employees. The employer is reimbursed half of the OHS costs from the Social Insurance Institution. The OHS must contain at least preventive services, but also curative services are available.
Sweden *(Beveridgean social security system)*
Social insurance and work-related rehabilitation organised by the Swedish National Social Insurance Board. Employers have an obligation pay the full sickness benefits for the first two weeks and a proportion (15 percent) thereafter unless the employee receives rehabilitation or continues working part time; also proposal that employers who achieve fewer sick leaves will be rewarded with lower insurance payments
Norway *(Beveridgean social security system)*
United Kingdom *(Beveridgean social security system)*
No specific funding of occupational health services. Some schemes for WHP
Iceland *(Beveridgean social security system)*
Workplace health promotion falls under the "voluntary" part of the obligation of both government and companies and is as such not on a formal plan but will fall on individual governmental offices, public or private companies when such services are provided. Other occupational health services i.e. involving inspection, information, and research is funded to certain extent in the annual financial bill to the Administration for Occupational Health and Safety.

B. Who is responsible for paying long-term sickness leave?
- How the government has defined employers' responsibility for paying sickness leave will feed into employers' economic calculations for investing in WHP including mental Health. Policies in this area are influenced by business sustainability considerations, in particular in the case small or middle sized organisations. In countries where long-term sickness is covered by the social insurance system, employers are less likely to perceive a financial advantage of investing in the wellbeing of their employees. This is particularly true in the common case where insurances contributions are independent from the number of occupational accidents or diseases that occur at the individual workplace.

Belgium (*Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employers pay social security contributions for sickness payments.
Bulgaria *(Bismarckian social security system)*
Employers' contribution to the social security scheme for sickness payments. Code for the Obligatory Public Insurance (COPI) defines public insurance regulations for sickness.
Czech Republic *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employers' contribution to the social security scheme for sickness payments.
Denmark *(Beveridgean social security system)*
Generally, the employer has an obligation to pay sickness benefits to the employee for 21 days counted from the first day of sickness. Some exemptions have been introduced to the rule.
Germany *(Bismarckian social security system)*
Employer pays 70 percent contribution to short-term (4 to 8 days) sickness leave. Long-term sick leave is covered by the sickness fund. Employer's contribution to the social security insurance for sickness payments.
Estonia *(Bismarckian social security system)*
Estonian Health Insurance Fund covers short-term sickness. Disability pension for long-term incapacity whereby the employer is required to contribute to this if the accident or disease was work related.
Greece *(Beveridgean social security system)*
Long-term sickness covered by the insurance system for sickness, invalidity and survivors.
Spain *(Beveridgean social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to the social security insurance for sickness payments.
France *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Ireland *(Beveridgean social security system)*
No national legislation that requires employers to pay sick leave. It will be defined in an organisation's policy for which period the employee is covered.
Italy *(Beveridgean social security system)*
The Italian National Institute for Social Security provides sickness benefits in case of long term sickness absence or benefits in case of work-related disability.
Cyprus *(Beveridgean social security system)*
Long-term sick leave is covered by the social security system.
Latvia *(Bismarckian social security system)*
Long-term sick leave is covered by the State Social Insurance Agency. Employer's contribution to social security insurance for long-term sickness payments.
Lithuania *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Luxembourg *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Hungary *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security

insurance for long-term sickness payments.
Malta *(Beveridgean social security system)*
Long-term sick leave is covered by the social security system.
Netherlands *(Bismarckian social security system)*
Continuation of Wage Payments during Sickness and Gatekeeper Improvement Act require the employer to encourage employees to return to work after illness – if the return is unsuccessful, the employer pays 70 percent of the employees salary for two years.
Austria *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Poland *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Portugal *(Beveridgean social security system)*
Long-term sick leave is covered by the privately funded social security system. The state does not contribute to social security.
Romania *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Slovenia *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Slovak Republic *(Bismarckian social security system)*
Long-term sick leave is covered by the social security system. Employer's contribution to social security insurance for long-term sickness payments.
Finland *(Beveridgean social security system)*
Long-term sick leave is covered by the social security system. Company contributions depend on length of leave is and size company.
Sweden *(Beveridgean social security system)*
Employers have an obligation pay the full sickness benefits for the first two weeks and a proportion (15 percent) thereafter unless the employee receives rehabilitation or continues working part time; government plans to reward employers who achieve fewer sick leaves with lower insurance payments.
Norway *(Beveridgean social security system)*
Long-term sick leave covered by social security fund.
United Kingdom *(Beveridgean social security system)*
Long-term sick leave covered by social security fund.
Iceland *(Beveridgean social security system)*
The employers are obliged to pay for between 3 to 12 months sick leave (depending on the organisation). After that period, state or union based sickness funds provide benefits and disability funds for permanent incapacity.

C. Which government departments are responsible for WHP and/or OHS?

- The way policies are formulated and implemented in the EU country will decide whether WHP is incorporated into legislation, into policies and/or strategy documents. In principle, two directions from which WHP can be taken forward, one is from the Ministry of Labour (or its equivalent) with a stronger focus on occupational health and safety in its narrow sense or from the Ministry of Health, which sees the workplace as an important setting for targeting the health and wellbeing of the adult population.

- Work-based strategies for health require multidisciplinary collaboration between a range of government disciplines such as labour, health, social services, health and social insurance, human resource management and occupational health and safety. It is important to understand which precautions countries take to address this coordination problem between government departments.

- Other stakeholders play an important role especially with industrial associations, trade unions, research, training and (OH) service institutions. Enumerating those was considered beyond the scope of this snapshot.

Belgium (*Bismarckian social security system)*
- Authority for WHP lies with the Federal State Secretary on Work Organisation and Wellbeing at Work under the Ministry of Employment and Labour. - Whilst labour policy issues are regulated at federal and regional level, health promotion is in the responsibility of regional governments only. - Experience Fund.
Bulgaria *(Bismarckian social security system)*
Department for 'Healthy and Safe Workplaces' and Department for Environmental and Occupational Health under the umbrella of the National Centre for Public Health Protection.
Czech Republic *(Bismarckian social security system)*
Ministry for Labour and Social Affairs, National Institute of Public Health has responsibility for basic prevention and hosts the Centre for Occupational Health.
Denmark *(Beveridgean social security system)*
- The Working Environment Council with inspection role and works with trade safety committees and consulting institutes to implement policies. - Ministry of Employment, Ministry of Social Affairs and Ministry of Economics and Business are responsible for supervising insurance system. - WHP is taken forward by the National Centre for Workplace Health promotion and the National Health Board.
Germany *(Bismarckian social security system)*
- Ministry of Labour and Social Affairs is responsible for workforce protection. - The Ministry of Health is responsible for overseeing the implementation of regulations on WHP. - The Insurance Inspectorate (the so called Medical Service) with responsibility for supervising insurance companies in recording their WHP activities.
Estonia *(Bismarckian social security system)*
- Estonian Labour Market Board, the Ministry of Social Affairs and the National Institute for Health development (under the Ministry for Social Affairs). - Department of Public Health, Health Board - Advisory Committee on Working Environment with coordination function.
Greece *(Beveridgean social security system)*
- Centre for Occupational Health and safety (KYAE) under the Directorate for Employment and Social protection and the General Directorate of Working Conditions and Health. - Labour Inspectorate.
Spain *(Beveridgean social security system)*
Government health and occupational safety agencies have responsibilities at national and regional levels[3]. The implementation responsibility lies with Labour Health Committees at the regional governments. The Occupational Health Directorate.
France *(Bismarckian social security system)*
- Three ministries with responsibility for health promotion and development and implementation: the Ministry of Labour, Employment and Social Cohesion, the Ministry of Labour Relations and the Ministry of Health - The Higher Council of the Prevention of Occupational Risks (COCT) is responsible for consultation about working conditions with social partners. - WHP National Work Executive, the so called Direction Generale du Travail, is in charge of the implementation. - National agency (ANACT) and regional offices (ARACT) to facilitate the implementation.
Ireland *(Beveridgean social security system)*
WHP is in the responsibility of the Ministry for Health and Children, and the Health Services Executive (HSE); responsibility for labour inspection and data collection lies with the Health and Safety Authority (HSA), legislative responsibility lies with the Department of Enterprise and Innovation (former Labour Department)
Italy *(Beveridgean social security system)*
No government department holds specific responsibility for WHP. The Ministry of Health and regional governments responsible for promoting of health and healthy lifestyles at the workplace, with main focus on food, physical activity and tobacco smoke. Strategies are implemented by local health agencies and

[3] Benach J et al (2004)

employers. Prevention Services and Occupational Health and Safety Units run under the Ministry of Health.
Cyprus *(Beveridgean social security system)*
Department of Labour Inspection under the Ministry of Labour and Social Insurance.
Latvia *(Bismarckian social security system)*
- Labour department (under the Ministry of Welfare) has authority over OHS policy. - Other departments involved in OHS include Social Protection, Environmental Health and Health department. - The State Labour Inspectorate administrates the Law on State Social Insurance.
Lithuania *(Bismarckian social security system)*
- The Ministry of Social Security and Labour is responsible for OHS policy. - The State Labour Inspectorate certifies employers that have acceptable standards on ASH prevention which enables them to tender for state subcontracts.
Luxembourg *(Bismarckian social security system)*
- The Labour and Mines Inspectorate (under the Ministry of Labour and Employment) is responsible for the implementation of the legislation concerning working conditions and the protection of all employees with the exception of those in the public service. - The Ministry of Health supervises process by which employer has the duty to undertake a risk assessment of the work place and to address gaps by action including WHP projects. - A Standing Committee for Labour and Employment was established which is led by social partners to take account of workers' wellbeing. National strategies implemented through regional and local administration
Hungary *(Bismarckian social security system)*
- National Institute of Occupational Health - National Institute of Health Development (under the National Medical Officer) works in collaboration with the county organisations of The National Public Health and Medical Officer's Service - Health education network under the Minister of Public Welfare and Labour
Malta *(Beveridgean social security system)*
- Department of Social Security (under the Ministry for the Family and Social Solidarity)
Netherlands *(Bismarckian social security system)*
- Ministry of Social Affairs and Employment, and Labour Inspectorate - Ministry of Public Health - Ministry of Health, Welfare and Sports - National Institute for Public Health and the Environment.
Austria *(Bismarckian social security system)*
The Federal Ministry for Social Security and Generations (BMSG) – Safety and health legislation through the Ministry of Labour, Social Affairs and Consumer Protection
Poland (Bismarckian social security system)
- Ministry of Labour - National Labour Inspectorate to check insurance compliance of companies - Ministry of Health
Portugal (Beveridgean social security system)
Ministry of Finance controls insurance companies
Romania (Bismarckian social security system)
- The Ministry of Labour, Social protection and Family - The Ministry of Health
Slovenia (Bismarckian social security system)
No information found
Slovak Republic (Bismarckian social security system)
No information found
Finland (Beveridgean social security system)
Ministry of Social Affairs and Health, Department for Promotion of Welfare and Health
Sweden (Beveridgean social security system)
- The Ministry of Health and Social Affairs - The Ministry of Industry, Employment and Communication - Swedish Association of Local Authorities and Regions
Norway
National Institute for Occupation Health under the Ministry of Labour and Social Inclusion
United Kingdom (Beveridgean social security system)
The Health and Safety Executive is the national regulatory body responsible for promoting the cause of

better health and safety at work within Great Britain and works in collaboration with the local governments
Iceland
Ministry of Welfare has general responsibility; at an operational level the Administration for Occupational Health and Safety is responsible, National Institute for Health development (under the Ministry of Social Affairs)

D. Is there a national policy on WHP and does it include Mental Health?

- Although the term national policy is used, other examples of national and regional political legislation and regulations referring to WHP were included too. Not included in the analysis were frameworks and agreements driven at the European level.

- Particularly for countries where no policy focus on WHP could be identified, we looked at policies around OHS. The question was in particular the degree to which the regulative framework for OHS had a preventative character. This was then likely to be correlated with the extent to which mental health promotion is covered at the moment and provide a signal for how close the country is in moving towards developing a work-related mental health agenda.

Belgium (*Bismarckian social security system)*
'Longer at Work on Better Life' addresses WHP through continuous improvement of the work environment
Bulgaria *(Bismarckian social security system)*
No information found
Czech Republic *(Bismarckian social security system)*
No information found
Denmark *(Beveridgean social security system)*
Work Environment 2010 policy
Germany *(Bismarckian social security system)*
- Health promotion as a comprehensive approach recognised in social insurance law (Paragraph 20, SGB V) and incorporated into federal legislation. - Statutory health insurance organisations are legally required to offer WHP services and to support the Statutory Accident Insurance Funds in preventing work-related health hazards. - Key vehicles for implementation at an organisational level are health circles, work groups and company reports. - National Guideline for Prevention defines what can be provided as part of WHP and is legally binding
Estonia *(Bismarckian social security system)*
- Occupational health and safety strategy 2009-13 - Action Plan for Development of Estonian National Health 2008-20 - Action Plan for Growth and Jobs 2008-11
Greece *(Beveridgean social security system)*
- No specific up-to-date regulation (Occupational Risk Contribution from 1961) - Main sickness fund takes charge of registering occupational accidents and diseases and has issued a list of occupational diseases and in the process of amending according to European recommendations
Spain *(Beveridgean social security system)*
- Preventive services regulations (1997) and Prevention of Occupational Hazards Act 2003 with a detailed prevention plan, identified resources and inspection regulation - Legislation from 31/1995 covers occupational health and safety including aspects of physical and mental health. - There is no specific law for mental health or health promotion at the workplace; however, the national mental health strategy requires the planning and monitoring of mental health promotion services to prevent stress and mental illnesses at workplaces.
France *(Bismarckian social security system)*
- Health and Security at Work Policy

- National Plan for Health at Work 2005-09 which aims to improve the prevention of occupational risks and emphasis on health
Ireland *(Beveridgean social security system)*
- WHP incorporated into the National Health Promotion Strategy 2000-2005 with consideration given to working conditions and job design, the wider determinants of health and wellbeing. - Public Health Act (2004) within responsibility of the Health Service Executive. - Safety, Health and Welfare at Work Act 2005 which is the legal framework for occupational health and safety –implementation is not specified (enabling rather than binding)
Italy *(Beveridgean social security system)*
The national policy on occupational safety and health (Legislative Decree 81/2008) on health and safety in the workplace, contains some demands to employers to have the direct responsibility on WHP, suggesting to develop actions and interventions for promoting workplace health. The regulation indirectly requires the employers to focus also on the workers mental health through preventive actions and interventions at the organizational and individual level.
Cyprus *(Beveridgean social security system)*
Health and Safety at Work Acts 2007.
Latvia *(Bismarckian social security system)*
OHS system regulated in Labour Protection Law 2001.
Lithuania *(Bismarckian social security system)*
Law on Social Insurance of occupational Accidents and Diseases 1999.
Luxembourg *(Bismarckian social security system)*
Annual work plan and targets by the Labour Inspectorate with a focus on the prevention of risk factors but also includes action concerning WHP.
Hungary *(Bismarckian social security system)*
Labour Safety Act concerns occupational health and safety (1993), other regulations regarding insurance, social security and pensions National Public Health programme
Malta *(Beveridgean social security system)*
- Occupational Health and Safety Authority Act 2000 - Social Security Act
Netherlands *(Bismarckian social security system)*
- Working Conditions Act 1990 and Working Hours Act provide legal foundation for OHS. - Healthcare prevention strategy ('Living Longer in Good Health') includes WHP. - Policies carried forward in agreements with employer organisations on OHS and work health promotion activities. - Other government strategies e.g. Public Health Future Explorations (2002) include action against work-related stress
Austria *(Bismarckian social security system)*
- In 2001, WHP was adopted into the Austrian Labour Constitution Act; the 50th amendment for the General Social Insurance Law (ASVG) defined health promotion as the legal obligation of the sickness funds whereby health promotion has been defined broadly and includes prevention; - Health Promotion Act 1998 (GfG) concerned with the financing of health promotion projects through the Fund for a Healthy Austria (FGÖ) with a focus on health promotion at the workplace; declared priorities of the Fund from 2008 are on mental health promotion at the work place including reducing stress and improving work life balance
Poland (Bismarckian social security system)
- Sanitary Inspection Act, Occupational Accident Act 2002 and Act in Occupational Medicine Services - Regulation of the Council of Minsters sets out list of occupational diseases covered and the procedures by which those should be reported - National Labour Inspectorate to check insurance compliance of companies. - Mental Health Act covers work-related stress.
Portugal (Beveridgean social security system)
- New legislation from 1997 whereby occupational diseases funded by state pool which operates on a pay-as-you-go basis whereas occupational accidents is taken on by private insurers
Romania (Bismarckian social security system)
- WHP covered in Policy and Strategy in the Field of Occupational Health and Safety 2004-7 - WHP also incorporated in the National Strategy of Public Health 2004, National Programme of Risk Factors in the Work Environment 2002, National Strategy of Health Services
Slovenia (Bismarckian social security system)
Occupational accidents and diseases covered by general health insurance and pension and invalidity

insurance
Slovak Republic (Bismarckian social security system)
Legislation exists via minimum requirements of OSH List with occupational diseases covered by insurance
Finland (Beveridgean social security system)
- WHP and prevention of mental disorders incorporated into legislation in particular in the agenda of Occupational Health 2015[4] and Strategies for Social Protection 2010; WHP centred around peoples' ability to work throughout their lives - Health 2015 Public Health with focus on creating a healthy work environment including mental health. - Related policies: Agreement between the central labour market parties in Finland 1990, Amendment of Labour Protection Act 1997 and the Occupational Health Services Act 2001.
Sweden (Beveridgean social security system)
WHP defined in 1997[5], Government Action for Work Health 2004 Legislation which requires employers to present information about absenteeism and sick leave as part of the annual reports
Norway
- Lillestrøm Declaration 2002 describes the health promoting work place; new act on the environment introduced in 2005 which incorporates objectives on health promoting work environment - New Working Environment Act from 2006 regulates Health & safety Committees and aims to prevent occupational risks including psychosocial risk factors - Health and Safety at Work Strategy 2007-13 - Strategic plan of action to community action in the field of health 2008-11 has one priority area on occupational diseases
United Kingdom/ England (Beveridgean social security system)
- Health and Safety at Work Act only covers OHS but not WHP; 'The Health and Safety of Great Britain'; provides guidance and resources on health promotion including mental health - Department of Health policies set out importance of workplace environment for health and wellbeing and have taken on responsibility for WHP - Department of Work and Pensions: Review by Dame Carol Black
Iceland
- No specific plan for WHP

[4] And in earlier legislation (Peltomaeki et al, 2003)

[5] See Menckel & Oesterblom 2002, Thomsson & Menckel 1997

References and useful Websites

Baltic Sea Network on occupational Health and Safety http://www.balticseaosh.net/index.php

Benach J, Amble M, Menéndez M, Muntaner C (2004) “Occupational health politics in Spain: problems, actions and priorities”, In: TUTB Newsletter, National case studies, available online *http://hesa.etui-rehs.org/uk/newsletter/files/2004-22p32-41.pdf*

European Food Safety Authority http://www.efsa.europa.eu/

European Network for Work Health Promotion http://www.enwhp.org/

European network for Mental Health Promotion http://www.mentalhealthpromotion.net/

European Trade Union Institute http://www.etui.org/

International Labour Organisation http://www.ilo.org/global/lang--en/index.htm

Menckel E and Österblom L (2002), Managing Workplace Health. Sweden meets Europe. National Institute for Working Life. Stockholm. 2002

Sirje Vaask, Tagli Pitsi, (2010) "Potential to promote healthy eating in Baltic workplaces", International Journal of Workplace Health Management, Vol. 3 Iss: 3, pp.211 – 221

Thomsson H and Menckel E (1997), Workplace health promotion - the concept from a Swedish point of view. Stencil. Arbetslivsinstitutet. Stockholm. 1997

World Health Organisation http://www.who.int/en/

Workplace Health Promotion Network http://www.whpn.org/