EU COMPASS FOR ACTION
ON MENTAL HEALTH AND WELL-BEING

MENTAL HEALTH IN THE WORKPLACE IN EUROPE

- Position Paper -

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1. Introduction

This paper provides scientific background information on mental health in the workplace, while it also incorporates input from Member States and European stakeholders, in line with Deliverable 6 and task 3 of the EU Compass tender commissioned by Chafea/DG SANTE. The paper will support the work of the EU Group of Governmental Experts on Mental Health and Well-being on this theme and will constitute the foundation of a thematic position paper which will be shared for consultation with Member States and relevant non-governmental stakeholders. The paper will explain the issue at stake, provide a description of the situation and challenges, a brief summary of recent activities and good practices at EU-level and in Member States and finally, propose recommendations for action.

The need to include mental health among the first priorities of the public health agenda has been increasingly recognised by the European Union since the launch of the Commission's Green Paper on Improving Mental Health in 2005. This recognition is based on the growing evidence and awareness about the magnitude of mental health problems in European countries which impose a heavy toll on individuals, society and the economy, representing a significant share of the EU's burden of disability (European Framework for Action on Mental Health and Wellbeing, 2016). On the other hand, positive mental health and well-being result in a broad range of impacts in terms of social cohesion, economic progress and sustainable development in the EU. Mental health is a human right and the EU's mental capital is a key resource for its success as a knowledge-based society, its ability to realise its strategic social and economic policy objectives and to promote and protect the well-being of its population (European Framework for Action on Mental Health and Wellbeing, 2016).

Mental health describes a level of psychological well-being or the absence of a mental disorder. Probably the most well-known definition of mental health is that of the World Health Organization (WHO) that defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. According to WHO (1948), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The definition of mental health as the

absence of mental health disorders is a more conservative one. Mental health disorders can be classified according to generally acknowledged classifications like DSM (Diagnostic and Statistical Manual of Mental Diseases) or ICD (International Classification of Disease). Cultural differences, various types of assessment and competing professional theories all affect how 'mental health' is defined. This paper adopts a more inclusive definition of mental health and as such will not focus solely on (the absence of) mental health disorders but a positive state of psychological well-being. Well-being at work is defined as individuals' ability to work productively and creatively, to engage in strong and positive relationships, fulfilment of personal and social goals, contribution to community, and a sense of purpose.

This approach underlines the need to address mental health in its totality by recognising interrelationships among risks to mental health, sub-threshold conditions of poor psychological health and well-being (such as stress) that may not have yet resulted in a diagnosed mental health disorder but may severely affect their expression, and diagnosed mental health disorders. According to this perspective, efforts to tackle mental ill health should seek to put in place policies and practices that will tackle a wider range of risk factors to mental health by appropriate interventions. These should prioritise prevention and tackling problems at source while also developing awareness and facilitating treatment and rehabilitation. This paper will discuss how this comprehensive approach should be applied with reference to mental health in the workplace.

1.1 Work and mental health

It is generally accepted that 'work is good for you', contributing to personal fulfilment and financial and social prosperity (Cox et al., 2004; Waddell & Burton, 2006). There are economic, social and moral arguments that, for those able to work, 'work is the best form of welfare' (Waddell & Burton, 2006) and is the most effective way to improve the well-being of these individuals, their families and their communities. Moreover, 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 (Perkins, Farmer, & Litchfield, 2009). A better working environment can help improve employment rates of people who develop mental health problems. Not doing this puts additional costs on

governments who have to provide social welfare support for people who would prefer to be in employment.

There is also growing awareness that (long-term) worklessness is harmful to physical and mental health. However, there has also been increased awareness that work is generally good for your health and well-being, provided you have ‘a good job’ (Langenhan, Leka & Jain, 2013; Waddell & Burton, 2006). Good jobs are obviously better than bad jobs, but bad jobs might be either less beneficial or even harmful. A substantial body of evidence is now available on work-related risks that can negatively affect both mental and physical health with an associated negative effect on business performance and society (WHO, 2008). Although risks in the physical work environment can have a direct negative effect on mental health, that is accentuated by their interaction with risks in the psychosocial work environment. In addition, psychosocial hazards (also often termed work organisation characteristics or organisational stressors) have been shown to pose significant risk and have a negative impact on mental health and physical health, mainly through the experience of work-related stress (WHO, 2008, 2010). As a result, a growing incidence of work-related mental diseases has been observed, and as well as increased absence from work and early retirement due to mental illness in most European countries (European Framework for Action on Mental Health and Wellbeing, 2016).

Promoting mental health at work has become a vital response to these challenges since the workplace is both a major factor in the development of mental and physical health problems but also a platform for the introduction and development of appropriate preventive measures. As will be discussed in this report, these can range from the introduction of statutory regulation to voluntary workplace health promotion measures aiming at prevention, treatment and rehabilitation, including occupational integration (European Framework for Action on Mental Health and Wellbeing, 2016).

1.2 Scope of this paper

This paper is part of the wider project of The EU-Compass for Action on Mental Health and Wellbeing that supports the work of the EU-Group of Governmental Experts on Mental Health and Wellbeing through the preparation of four scientific papers. The aim is to develop these

scientific reports in collaboration with the Group and under consultation of non-governmental stakeholders into consensus papers.

The EU-Compass for Action on Mental Health and Wellbeing (2016) is a mechanism to collect, exchange and analyse, information on policy and stakeholder activities in mental health and collect examples of good practices from EU countries and stakeholders on an ongoing basis.

The scope of this paper is to provide a conceptual framework to inform policy makers about specific issues in relation to mental health and well-being in the workplace, through a collection and critical analysis of research and administrative data, including recent scientific papers published in peer-reviewed journals. The paper aims to present the evidence base in relation to the promotion of mental health and well-being in the workplace and the implementation of appropriate interventions. The paper will also describe good practices emerging from the literature and outline principles and recommendations for action in this area.

2. Methodology

Data for this report on mental health in the workplace has been collected from the following sources of information:

1. Surveys among member states from the EU Compass for Mental Health and Wellbeing;
2. The thematic report of the Joint Action on Mental Health and Wellbeing on mental health at the workplace;
3. The 2014 EU report 'Evaluation of policy and practice to promote mental health in the workplace in Europe';
4. The report of World Health Organization European Office on Policies and Practices for Mental Health in Europe. Meeting the challenges;
5. Reports produced by the World Health Organization on mental health and occupational health;
6. Reports produced by the European Agency for Safety & Health at Work;
7. Reports produced by the European Foundation for Living & Working Conditions;
8. Reports produced by the International Labour Organization;
9. A European literature review focused on meta-reviews, meta-analyses, reviews, scientific papers, published in peer-reviewed journals, reporting research on prevalence of mental ill health in the workplace, associated impact, prevention and protection interventions, and good practices in this area at the organisational, sectoral, and national level;

10. A review of grey literature and policy briefings describing best practices in Europe overall and within European countries aimed at promoting mental health and well-being in the workplace.

3. Mental health in the workplace – Situation in Europe

3.1 Mental health, the workplace and associated impacts

Mental health disorders

Starting with existing evidence on mental health disorders in particular, evidence from the WHO suggests that nearly half of the world's population is affected by mental illness at some point of their life with an impact on their self-esteem, relationships and ability to function in everyday life. While the Mental Health Foundation (2007) states that mental health problems directly affect about a quarter of the population in any one year. Global estimates by WHO (2017) indicate that 4.4% of the global population suffer from depressive disorder, and 3.6% from anxiety disorder.

A systematic review of studies considering prevalence of mental disorders in the EU-27, Switzerland, Iceland and Norway was conducted by Wittchen et al. (2011). The authors suggest that approximately 38.2% of the EU population suffer from a mental disorder each year. The most frequent disorders are anxiety disorders (14%), insomnia (7%), major depression (6.9%), somatoform (6.3%), alcohol and drug dependence (>4%), ADHD (5%) in the young, and dementia (1–30%, depending on age). Depression was found to be the most disabling condition. Only a small percentage of people experience more severe mental illnesses such as schizophrenia. In fact, depression and anxiety are termed by many as 'common mental disorders'. No substantial country variations have been identified in the prevalence of mental disorders (Wittchen et al., 2011).

According to a recent European Parliament report (2016), gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society, and their susceptibility and exposure to specific mental health risks. Gender differences occur particularly in the rates of common mental disorders such as depression or anxiety. Mental health problems, which are

different from psychiatric disorders, vary across genders: women have higher rates of depression and anxiety (referred to as internalising disorders) and men have higher rates of substance abuse and antisocial disorders (referred to as externalising disorders). Because of a variety of factors, primarily concerning different gender roles and gender inequalities, depression is approximately twice as prevalent among women as it is among men (European Parliament, 2016).

People with a severe mental disorder are too often far away from the labour market, and need help to find sustainable employment (OECD, 2012). The majority of people living with a common mental disorder are employed but many are at greater risk of job loss and permanent labour market exclusion than colleagues without these problems. This has worsened in the recent economic climate. Evans-Lacko et al. (2013) found that the gap in unemployment rates for individuals in Europe with and without mental health problems, significantly increased after the onset of the economic recession. This gap was especially pronounced for males, and individuals with low levels of education.

Employment rates in people with common mental disorders are 60-70%, compared with 45-55% for those with severe mental disorders but more than 70% for people with no mental disorder (Matrix, 2013). Data suggests that 55% of people with mental health problems make unsuccessful attempts to return to work, and of those who return, 68% have less responsibility, work fewer hours and are paid less than before (Mental Health Foundation, 2007; OECD, 2012). McIntyre et al. (2011) and the OECD (2012) conclude that the annual income of individuals affected by depression is reduced by approximately 10% compared with unaffected employees.

The estimates for the proportion of the workforce in Europe that may be living with a mental health problem at any one time range from one in five (OECD, 2012) to two in five (Wittchen et al., 2011), with a lifetime risk of at least two in five (OECD, 2012). In the EU-27 it was found that 15% of citizens had sought help for a psychological or emotional problem, with 72% having taken antidepressants (European Commission, 2010).

The shares of sickness absence and early retirement for mental health problems have increased across Europe over the past few decades. The Eurobarometer (European Commission, 2010) presents EU wide statistics on positive and negative feelings more closely reflecting mental well-

being. It shows that mental ill-health impacts on sickness absence and indicates that in 2010, EU citizens felt less positive and more negative than they were in 2005/2006. The increase is thought to be due to reduced social stigma and discrimination against people with mental illness leading to greater recognition of previously hidden problems, rather than a true increase in prevalence (OECD, 2012; Wittchen et al., 2011). However mental health problems are still considered relatively unrecognized, underdiagnosed and untreated (OECD, 2012).

Work-related stress

As previously underlined, this paper adopts a holistic perspective of mental health and considers psychological well-being and not only mental health disorders. This means that attention has to also be paid to sub-threshold conditions of poor psychological health and well-being that may not have yet resulted in a diagnosed mental health disorder. For example, issues such as stress are particularly important in these considerations since there is abundant evidence that prolonged exposure to unmanageable pressure can result to stress that might, in turn, result in several more severe mental health problems (WHO, 2010). In line with this evidence, the OECD (2012) stresses that while challenges in helping to reintegrate people with severe mental health problems are one important focus of attention, there is a strong argument for more policy emphasis to be placed on addressing common mental disorders and sub-threshold conditions with more emphasis on preventive rather than just reactive strategies. The workplace is ideal for such preventive actions to be put in place since individuals spend at least one third of their lifetime at work.

One of the key states of sub-optimal mental health that can have severe consequences is work-related stress. Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope (WHO, 2003). The European Commission (2002) defined stress as the pattern of emotional, cognitive, behavioural and physiological reactions to adverse and noxious aspects of work content, work organisation and work environment. In the framework agreement on work-related stress (European Social Partners, 2004), stress is defined as a state, which is accompanied by physical, psychological or social complaints or dysfunctions and which results from individuals feeling unable to bridge a gap with the requirements or expectations placed on them. The ESENER survey (EU-OSHA, 2010, 2015) showed that within the EU, work-related stress is of some or major concern in nearly 80% of establishments. At the same time,

less than 30% of organisations in Europe have procedures for dealing with workplace stress.

According to the 6th European Working Conditions Survey (Eurofound, 2016), the overall average well-being score for workers in the EU28 is 69 – three points higher than in 2010 (measured by the WHO-5 Wellbeing Index). Men score slightly higher than women (70 compared to 68). And younger workers (those aged under 35) score higher than older workers (aged 35 and over) – 70 compared to 68 (for both older age groups). Overall, 6% of workers have a score that indicates they are at risk of mental health problems (below 28), with more women than men being at risk (7% compared to 5%). 26% of workers think that their health is negatively affected by their work. Some 27% of workers said they were absent for health reasons for five or more days in the 12 months prior to the survey: this was the case for 28% of women and 25% of men.

EU-OSHA (2009) reports that there are significant differences in stress prevalence across Europe. The highest levels of stress were reported in Greece (55%), and in Slovenia (38%), Sweden (38%), and Latvia (37%), and the lowest levels were noted in the United Kingdom (12%), Germany, Ireland, and the Netherlands (16%) as well as in the Czech Republic (17%), France and Bulgaria (18%). Looking more specifically at data from the UK as an example, the 2009 Psychosocial Working Conditions survey indicated that around 16.7% of all working individuals thought their job was very or extremely stressful (Packham & Webster, 2009). Estimates from the Labour Force Survey in 2013-14 suggest that the total number of cases of work-related stress, depression or anxiety accounts for 39% of all cases of work-related illnesses, where work-related illness relates to conditions which people think have been caused, or made worse, by work. While the 2009 Austrian Employee Health Monitor revealed that 42% of white-collar workers taking early retirement do so because of work-related psychosocial disorders (EU-OSHA, 2014).

Impact of psychosocial hazards and mental ill health

Several reviews studying the relations between psychosocial factors at work and major depression, as well as with less severe common mental disorders (e.g. Bonde, 2008; Kuoppala et al., 2008; Netterstrom et al., 2008) conclude that psychosocial factors in the workplace, including mental workload, are related to an elevated risk of subsequent depressive symptoms

or a major depressive episode. The large majority of results from more than a dozen prospective investigations confirm elevated risks of depression amongst employees experiencing work-related stress, and odds ratios vary between 1.2 and 4.6, depending on type of measure, gender and occupational group under study (e.g. Bonde, 2008; Ndjaboué, Brisson, & Vézina, 2012). The ILO has acknowledged that psychosocial hazards can cause an occupational disease, i.e. mental and behavioural disorders (ILO, 2016). However, mental health disorders like depression are not generally acknowledged as an occupational disease in lists of occupational diseases in most countries (European Commission, 2013).

Other reviews indicate that psychosocial risks that may cause mental health problems, are also systematically and causally related to other kinds of health outcomes such as physical health problems (e.g. Briggs et al., 2009; Da Costa & Viera, 2009) as well as cardiovascular morbidity and mortality (e.g. Kivimaki et al., 2012) and diabetes (De Hert et al., 2011). The majority of at least 30 reports derived from prospective studies document elevated odds ratios of fatal or non-fatal cardiovascular (mostly coronary) events amongst those reporting job strain, effort-reward imbalance or organisational injustice (e.g. Tsutsumi & Kawakami, 2004; Eller et al., 2009; Kivimäki et al., 2007, 2012; Marmot, Siegrist, & Theorell, 2006).

A review by WHO (2010) outlined studies across world regions detailing the detrimental impact of psychosocial hazards on workers' physical, mental and social health. This can also increase the risks of further work absenteeism, as noted in several reviews (e.g. Allebeck & Mastekaasa, 2004; Dekkers-Sanchez et al., 2008; Duijts et al., 2007). It has been calculated that each case of stress-related ill health leads to an average of 30.9 working days lost (Mental Health Foundation, 2007). In addition, a reduction in physical and psychological health through the experience of stress can cause suboptimal performance that may lead to accidents and to other quality problems and reduced productivity, thereby augmenting operational risks (e.g. Nahrgang et al., 2011).

A mentally unhealthy workforce has adverse economic consequences for business. Even very minor levels of depression are associated productivity losses (Beck et al., 2011). Where there is a loss of highly skilled workers due to poor health, additional recruitment and training costs may be incurred by employers (McDaid, 2007). Sickness absence may also lead to an increased workload and potential risk for work-related stress in remaining team members. In addition to

absenteeism, businesses have to contend with presenteeism - poor performance due to being unwell while at work (e.g. Aronsson, Gustafsson, & Dallner, 2000; McDaid, 2007). It remains difficult to measure although some studies suggest that its impact may be as much as five times greater than the costs of absenteeism alone (Sanderson & Andrews, 2006). Presenteeism is also itself a strong predictor of future poor mental and physical health (Leineweber et al., 2012; Taloyan et al., 2012) which may imply additional costs where employers are responsible for paying the health care costs of their employees.

Not only are improved levels of psychological and physical well-being 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 that are vital to dynamic business and enhance the reputation of the workplace (Michaels & Greene, 2013; Robertson & Cooper, 2011; Wang & Samson, 2009).

3.2 The cost of mental ill health

EU-OSHA (2014) reports that the total cost of mental health disorders in Europe is €240 billion/per year of which €136 billion/per year is the cost of reduced productivity including absenteeism and €104 billion/per year is the cost of direct costs such as medical treatment. Reduced performance due to psychosocial problems may cost twice that of absence.

The cost of absenteeism and premature mortality for depression in 30 European countries were estimated to be €109 billion in 2010 while costs for all anxiety disorders accounted for a further €88 billion (Olesen et al., 2012). Another study by Matrix (2013) estimated that the total costs of work-related depression alone in the EU-27 are nearly €620 billion per year. The major impact is suffered by employers due to absenteeism and presenteeism (€270 billion), followed by the economy in terms of lost output (€240 billion), the health care systems due to treatment costs (€60 billion), and the social welfare systems due to disability benefit payments (€40 billion). In high-income countries, governments are usually responsible for paying the majority of long term sickness and disability benefits for people absent from work because of poor mental health. As the Matrix analysis indicates, there are substantial costs to welfare systems when individuals leave work because of poor mental health.

From as early as 2000, EU-OSHA (2000) reported that studies suggest that between 50% and 60% of all lost working days have some link with work-related stress leading to significant financial costs to companies as well as society in terms of both human distress and impaired economic performance, amounting to a yearly cost of about 3-4% of GNP. Another report by EU-OSHA (2009) summarised the economic costs of work-related stress illnesses. It reported that in France, between 220,500 and 335,000 (1-1.4%) people were affected by a stress-related illness which cost the society between €830 and €1.656 million; in Germany, the cost of psychological disorders was estimated to be EUR 3,000 million.

According to the latest estimates in the UK, losses due to work-related stress, depression or anxiety amounted to the equivalent of 9.9 million days, representing forty-three per cent of all working days lost due to ill-health during the period 2014/2015 (EU-OSHA, 2014). A study by the Centre for Mental Health considered health and social care costs, output loses, and human costs, estimating the total cost of mental health in the UK to be approximately £105 billion in 2009/2010 (CMH, 2010).

In Spain, it was estimated that between 11 % and 27 % of mental disorders can be attributed to working conditions (UGT, 2013). The direct health cost of mental and behavioural disorders attributable to work was estimated to be between €150 and €372 million in 2010. This represented 0.24 % to 0.58 % of total health expenditure in Spain for that year. Men accounted for almost two thirds of the overall cost. In the case of substance abuse-related disorders, the total cost of which was calculated to be over €35 million, men accounted for almost four-fifths of the total. The cost of anxiety disorders, higher for women, was nearly €15 million. According to the same report, the number of days of sick leave caused by temporary mental illness attributable to the workplace environment was 2.78 million in 2010, which is equivalent to a cost of €170.96 million. Furthermore, it has been calculated that of the 17979 deaths related to mental health problems (including suicide and self-harm) in Spain in 2010, 312 could be attributed to working conditions. Calculation of the 'years of potential life lost' indicated that the cost of premature mortality that could be attributed to the work ranged between €63.9 and €78.9 million.

Another study concluded that the 'social cost' of just one aspect of work-related stress (job strain) in France amounts to at least two to three billion euros, taking into account health care

expenditure, spending related to absenteeism, people giving up work, and premature deaths (Trontin et al., 2010). While in Germany, the direct and indirect cost of job strain were estimated to be €29.2 billion annually (Bodeker & Friedrichs, 2011). This included €9.9 billion in direct costs (prevention, rehabilitation, maintenance treatment and administration) and €19.3 billion in indirect costs (lost working years through incapacity, disability and premature death).

3.3 Scientific evidence on workplace mental health promotion intervention programmes

Public health interventions are often classified as primary, secondary or tertiary prevention (Lamontagne et al., 2007; Bhui et al., 2012). A distinction can also made between organisational, task/job level and individual orientations. Primary interventions are proactive by nature; the aim is to prevent exposure to a known risk factor and in this way prevent harmful effects to emerge. They may also aim to enhance an individual's tolerance or resilience. Secondary interventions aim to reverse, reduce or slow the progression of ill-health and preclinical conditions or to increase individual resources. These secondary approaches may include both early detection and early treatment with the aim of reducing the severity or duration of symptoms and to halt or slow the further development of more serious and potentially disabling conditions. Finally, tertiary interventions are rehabilitative by nature, aiming at reducing negative impacts and healing damages. They aim to treat and manage an existing diagnosed condition and minimize its impact on daily functioning through approaches such as rehabilitation, relapse prevention, by providing access to resources and support, and by promoting reintegration in the workforce (WHO, 2008). This section will review the latest evidence on these different types of mental health promotion interventions.

Cancelliere et al. (2011) conducted a systematic review and best evidence synthesis on the effect of workplace health promotion programmes on presenteeism. Fourteen studies were accepted (4 strong and 10 moderate studies). These studies contained preliminary evidence for a positive effect of some workplace health promotion programmes. Successful programmes offered organizational leadership, health risk screening, individually tailored programmes, and a

supportive workplace culture. The review highlighted that various types of interventions, directed both at the organisational and at the individual level, led to positive outcomes.

A review of reviews by Bhui et al. (2012) assessed the effectiveness of individual, organisational and mixed interventions on two outcomes: mental health and absenteeism. In total, 23 systematic reviews including 499 primary studies were analysed; there were 11 meta-analyses and 12 narrative reviews. Meta-analytic studies found a greater effect of individual interventions on individual outcomes. Organisational interventions showed mixed evidence of benefit. Organisational programmes for physical activity showed a reduction in absenteeism. The findings from the meta-analytic reviews were consistent with the findings from the narrative reviews. Specifically, cognitive-behavioural programmes produced larger effects at the individual level compared with other interventions. Identified gaps in the literature included studies of organisational outcomes like absenteeism, the influence of specific occupations and size of organisations, and studies of the comparative effectiveness of primary, secondary and tertiary prevention.

Tan et al. (2014) conducted a systematic review and meta-analysis of universal interventions in the workplace with a focus on depression. Nine workplace-based randomised controlled trials (RCTs) were identified. The majority of the included studies utilized cognitive behavioural therapy (CBT) techniques. Results indicated that a range of different depression prevention programmes produce small but overall positive effects in the workplace. When analysed separately, universally delivered CBT-based interventions significantly reduced levels of depressive symptoms among workers. Some individual studies were able to demonstrate larger effect sizes. For example, Tsutsumi et al. (2009) found that when a team-based participatory intervention was used to improve workplace stress reduction, there was significant deterioration of general health scores in the control group while the intervention group remained the same, with an overall moderate effect size. Interestingly, this study was also the only intervention based at the organisational level, as opposed to all other studies that were based at the individual level, suggesting the benefits of organisational level approaches deserves further attention.

Montano, Hoven and Siegrist (2014) conducted a systematic review of the effects of organisational-level interventions specifically on employees' health. Thirty-nine intervention

studies published between 1993 and 2012 were included. Success rates were higher among more comprehensive interventions tackling material, organisational and work-time related conditions simultaneously. The authors recommend that to increase the number of successful organisational-level interventions in the future, commonly reported obstacles against the implementation process (for example, lack of organisational commitment, lack of training) should be addressed in developing these studies.

Enns et al. (2016) conducted a scoping review of reviews on mental health promotion in the general population. Five reviews of mental health promotion interventions in the workplace were included. Again this scoping review found that very few interventions addressed aspects of the environment that might reduce the stress load (and thus the need for coping strategies) on individuals. The scoping review identified as an exception the review by LaMontagne et al. (2007) which included studies that modified aspects of the work environment in order to reduce or eliminate job stressors. The authors of the scoping review conclude that a focus on resilience, while important, should not distract from prevention efforts that involve creating environments that are more supportive of mental health by reducing risk factors in the work environment.

A meta-review by Public Health England published in 2016 found moderate evidence that individually directed approaches can reduce burnout and work-related stress. One of the most rigorous reviews of randomised control trials of workplace interventions to reduce stress showed small but positive outcomes of person-directed programmes. For example, there was reasonable evidence that staff training and workshops can be effective for preventing symptoms of burnout. These might include stress awareness courses with a focus on coping. Another individual level intervention, cognitive-behavioural therapy, showed positive (but modest) effects and was observed to produce greater effects than other types of workplace intervention, such as relaxation and meditation techniques. Mindfulness based interventions cited in one systematic review were found to be effective for reducing negative psychological effects of the working environment. However, there was little evidence to suggest that this intervention was any more effective than other stress management approaches such as relaxation. Overall there was only moderate evidence that individually oriented interventions produce positive results in relation to burnout and stress prevention in workplaces.

Again, fewer intervention studies were identified that had an organisational focus. However, one review suggested that organisationally focused interventions produced longer-lasting positive effects than those individually oriented. The authors argue that while further empirical work is required to validate this, the evidence suggests that modifications to aspects of the organisation's culture and working practices should be considered in addition to those delivered at the individual level to create stronger effects in relation to burnout prevention. Alterations to workload or changes to working practices were demonstrated to reduce stressors and factors that can lead to burnout. Where managerial involvement and support for these interventions were found, there was a greater likelihood of positive effects.

A meta-review by Joyce et al. (2016) systematically examined and synthesized the research evidence regarding the effectiveness of primary, secondary and tertiary workplace mental health interventions for anxiety and depression disorders. Relevant reviews were identified via a detailed systematic search of academic and grey literature databases and were subjected to a rigorous quality appraisal (using the AMSTAR assessment). Twenty review articles were deemed to be of moderate or high quality, which together analysed 481 primary research studies.

Moderate evidence was identified for enhancing employee control and promoting physical activity. Stronger evidence was found for CBT-based stress management although less evidence was found for other secondary prevention interventions, such as counselling. Strong evidence was also found against the routine use of debriefing following trauma. Tertiary interventions with a specific focus on work, such as exposure therapy and CBT-based and problem-focused return-to-work programmes, had a strong evidence base for improving symptomology and a moderate evidence base for improving occupational outcomes.

The authors point to the large body of academic literature demonstrating a range of work-based risk factors for mental health, including job strain, psychological demands, job control, social support, organisational justice, perceived job dissatisfaction, organisational change, job insecurity and employment status (e.g. Stansfeld & Candy, 2006; Netterstrom et al., 2008; Nieuwenhuijsen et al., 2008; Ndjaboue et al., 2012). Given the range of identified risk factors, they were surprised that only one work-related risk factor, job control, has been the subject of multiple reasonable quality intervention trials. They argue that while attempting to modify known work-based risk factors makes theoretical sense, in practice such activities require

substantial cooperation from employers, who will need to balance the economic costs of changing the way their organisations operate against the potential benefits for their employees. In practice, the meta-review demonstrates that many workplaces have opted for attempting to enhance their workers' resilience rather than modifying risk factors. However, the meta-review did not identify any reviews of sufficient quality examining the effectiveness of workplace resilience training. While there are some promising results emerging (Tan et al., 2014), the overall effectiveness of resilience training needs to be examined in more detail before wide scale use of such interventions can be fully supported.

Furthermore, the increasing evidence for the effectiveness of lifestyle modification, specifically increasing levels of physical activity, is in keeping with epidemiological evidence linking increased rates of depression amongst inactive or obese individuals (Teychenne et al., 2008; Rivenes et al., 2009; Harvey et al., 2010). Given that levels of both leisure and workplace physical activity have continued to decrease over recent decades in most developed countries (Foresight, 2007), the authors support that lifestyle interventions may become an increasingly important part of future workplace mental health prevention strategies. The majority of published reviews examining secondary prevention interventions focused on individuals who report stress-related symptoms. A large number of studies have suggested that employees who report high levels of work stress are at a greater risk of developing a range of mental and physical health conditions such as depression, anxiety, hypertension and heart disease (ILO, 2016). The systematic meta-review by Joyce and colleagues (2016) identified that many of the more popular approaches to stress management, such as counselling, have limited evidence base in terms of efficacy. In contrast, CBT-based stress management interventions produced substantial benefits in terms of symptom reduction, but this did not translate to notable improvements in work-related outcomes such as absenteeism and productivity.

Tertiary interventions with a specific focus on the workplace, such as exposure therapy, and CBT-based return to work programmes had evidence for improving work-related outcomes such as absenteeism. The authors argue that these findings add weight to the assertion that symptoms and occupational functioning are not always closely linked and that standard symptom-focused treatment in isolation may not be adequate (Harvey & Henderson, 2009). In order to promote functional recovery, the treatment of depression or anxiety disorders requires

an integrated approach that incorporates functional goals, such as return to work or exposure to work triggers, from the outset.

Overall, these findings demonstrate that there are empirically supported interventions that workplaces can utilise to aid in the prevention of common mental ill health as well as facilitating the recovery of employees diagnosed with depression and/or anxiety, however there are gaps in the literature in relation to interventions addressing risk factors in the work environment to prevent mental health problems from occurring. Further research is necessary to examine interventions addressing risk factors in the work environment (for example, promoting a positive and supportive organisational culture and organisational justice, increasing employee control and participation, introducing teamwork where appropriate) in combination with interventions at the individual level (for example, cognitive-behavioural therapy, physical activity and problem-focused return-to-work programmes). A common perception of organisational level interventions is that they are associated with the largest organisations as they have available resources and suitable work environments for intervention. However a study by Kim et al. (2014) showed a comprehensive programme to be effective in a medium sized company. A systematic review and guidelines around workplace interventions published by the British Occupational Health Research Foundation (BOHRF) in 2005 highlighted this point and demonstrated moderate evidence that amongst preventive interventions, multimodal approaches utilizing more than one technique simultaneously, tended to produce better results.

Three meta-analytic studies published very recently in 2017 have shed further light on the evidence base. The first is a systematic meta-review of the evidence linking work to the development of common mental health problems, specifically depression, anxiety and/or work-related stress (Harvey et al., 2017). 37 review studies were identified, of which 7 were at least moderate quality. Three broad categories of work-related factors were identified to explain how work may contribute to the development of depression and/or anxiety: imbalanced job design, occupational uncertainty, and lack of value and respect in the workplace. Within these broad categories, there was moderate level evidence from multiple prospective studies that high job demands, low job control, high effort-reward imbalance, low relational justice, low procedural justice, role stress, bullying and low social support in the workplace are associated with a greater risk of developing common mental health problems.

The second study (Madsen et al., 2017) identified published cohort studies from a systematic literature search and obtained 14 cohort studies with unpublished individual-level data. The meta-analysis included 6 published studies with a total of 27461 individuals and 914 incident cases of clinical depression; and 120221 individuals and 982 first episodes of hospital-treated clinical depression from unpublished datasets. Job strain was found to be associated with an increased risk of clinical depression in both published and unpublished datasets. Further individual participant analyses showed a similar association across sociodemographic subgroups and after excluding individuals with baseline somatic disease. The association was unchanged when excluding individuals with baseline depressive symptoms. It was concluded that future intervention studies should test whether job strain is a modifiable risk factor for depression.

Finally, the last study (Rugulies & Madsen, 2017) was a systematic review and meta-analysis of published prospective cohort studies examining the association of effort-reward imbalance at work (ERI) at baseline with onset of depressive disorders at follow-up. The aim of this review was to determine whether employees exposed to ERI at work have a higher risk of depressive disorders than non-exposed employees. Eight eligible cohort studies were identified, encompassing 84963 employees and 2897 new cases of depressive disorders. Seven of the eight studies suggested an increased risk of depressive disorders among employees exposed to ERI.

Overall, this new evidence adds to the need address risk factors in terms of working conditions and work design to develop healthy work environments that will prevent the onset of mental ill health. As discussed earlier, interventions in the workplace should address work environment risk factors and not only individual employee characteristics and behaviours.

3.4 Evidence on the cost-effectiveness of workplace mental health promotion interventions

From an economic perspective, robust data is available indicating a return on investment at the level of mental health promotion in the workplace. The review of Westgaard and Winkel (2011) is one indicating the effectiveness of risk management and a way to improve risk management in complex organisational contexts. However, most of existing economic literature has focused on the case for interventions targeted at individuals rather than organisational level interventions. This is perhaps not surprising, as there have been few controlled trials of

organisational workplace health promoting interventions, let alone interventions where mental health components can be identified, and even fewer where information on the costs and consequences of the intervention are provided (Corbiere et al., 2009).

In research conducted for the Health and Safety Executive (HSE) in the UK to evaluate their approach to reducing workplace stress (the Management Standards), several benefits were found (HSE, 2006). Improvements in the six risk factors identified by the HSE led to improved performance (measured both objectively and subjectively), lower absenteeism, reduced turnover intention, better team performance, and fewer work withdrawal behaviours.

Turning to what is known about the economic case for workplace health promotion, there is a substantial body of evidence, albeit of variable quality, on the business case for workplace health promotion programmes in general, including mental health specific actions. For instance, an evaluation by the “Initiative Gesundheit & Arbeit / iga” (Initiative for Health and Work) of several hundred studies concluded that costs can be reduced and the health of workers improved through properly constructed and implemented health promotion initiatives. A reduction in absenteeism rates and associated costs of between 12% and 36% was achieved through such measures. The ‘return on investment’ ranged between 1:4.9 and 1:10.1 for the costs of absenteeism and between 1:2.3 and 1:5.9 in respect of health care costs avoided (Kleinschmidt, 2013).

Many of the interventions evaluated appear to generate sufficient benefits to outweigh the costs (Knapp et al., 2011; Matrix, 2013; McDaid & Park, 2011, 2014; National Institute for Health and Care Excellence, 2008). Matrix (2013) estimated that the net range of economic benefits generated by workplace mental health promotion programmes and mental disorder programmes over a 1 year period can range between €0.81 to €13.62 for every €1 of expenditure in the programme. These values fall within those estimated by other authors for similar types of programmes (Knapp et al., 2011; National Institute for Health and Care Excellence, 2008).

Modelling analysis of a comprehensive approach to promote mental well-being at work, quantifying some of the business case benefits of improved productivity and reduced absenteeism was also produced as part of guidance developed by NICE. It suggested that

productivity losses to employers as a result of undue stress and poor mental health could fall by 30%; for a 1,000 employee company there would be a net reduction in costs in excess of $473,000 (National Institute for Health and Care Excellence, 2009).

One of the challenges however, particularly for SMEs, is that the costs of these types of interventions may be still quite high, and mechanisms for shared funding and creation of incentives may need to be implemented. Employers are not always aware of business benefits, since only a relatively small percentage of employers and their representatives indicate that they manage psychosocial risks because of a decline on productivity or high absence rates (EU-OSHA, 2010, 2015).

4. Relevant activities in the EU and in the Member States

Due to the situation in relation to mental health in Europe and its associated impacts at various levels, several actions have been taken both at EU level and in the Member States. These actions include the introduction of occupational health and safety legislation and the development of other forms of policies and national initiatives. Some reviews of these various activities have also been published (see for example, Leka et al., 2015).

Starting with activities at the EU level, there have been various activities by the European Commission, and in particular health and labour directorates. In the context of the Green Paper on Improving Mental Health (2005), the European Pact for Mental Health (2008) and the Joint Action on Mental Health and Wellbeing (2013-16), the European Commission has supported several European projects and initiatives that contributed to this objective by promoting research, strengthening networks, mapping of resources and practices, and developing recommendations and guidelines, that included mental health in the workplace. Thematic conferences on mental health in the workplace took place and a consensus paper was developed in 2008 (McDaid, 2008). Reviews and recommendations were specifically produced through the Joint Action on Mental Health and Wellbeing. Furthermore, the EU Compass for Action on Mental Health and Well-being that aims to support actions that address challenges in mental health in Europe through monitoring and disseminating activities on mental health in the European Union, also placed specific focus on mental health in the workplace. As an example, a 2014 project in the EC health programme focussed on participation to healthy workplaces and inclusive strategies in the work sector.

EU legislation that covers psychosocial risks has existed since 1989 (Directive 89/391/EEC, the European Framework Directive on Safety and Health of Workers at Work). Twenty additional daughter directives include provisions in relation to psychosocial risks and mental health in the workplace. Several pieces of guidance have been produced by the European Commission since 1999. More recently, a review of policies and practices on mental health in the workplace, which included occupational health and safety legislation as well as other types of policies and initiatives, was published by the European Commission in 2014 (European Commission, 2014). This also included the publication of 'Promoting mental health in the workplace: Guidance to

implementing a comprehensive approach' as well as an interpretative document of EU legislation in relation to mental health in the workplace[1].

The European Agency for Safety & Health at Work supported various initiatives including the publication of a good practices report in 2011. Furthermore, a campaign on Healthy Workplaces Manage Stress was implemented by EU-OSHA in 2014-15 through which several tools and guidance documents were developed, also for small enterprises. Reports on the basis of the ESENER survey have provided important information on the management of psychosocial risks in European enterprises to supplement reports published by the European Foundation for the Improvement of Living and Working Conditions detailing the perspective of the European workforce on their working conditions. In addition, the EU-Strategic Framework on Health and Safety at Work 2014-2020 has mental health identified as one of its priorities.

The Committee of Senior Labour Inspectors (SLIC) implemented a campaign on psychosocial risks at work in 2012 which produced guidance in this area for inspectors in the EU. The European Social partners negotiated and concluded framework agreements on work-related stress (2004), harassment and violence at work (2007), and inclusive labour markers (2010).

The European Commission's Social Agenda emphasises the role of Corporate Social Responsibility (CSR) in addressing the employment and social consequences of economic and market integration and in adapting working conditions to the new economy. CSR is defined by the European Commission as "the responsibility of enterprises for their impacts on society" [COM (2011) 681]. Human rights are an important aspect of CSR. The EU has endorsed the UN Guiding Principles on Business and Human Rights in its 2011 CSR strategy, which define what companies and governments should do to avoid and address possible negative human rights impacts by business. In January 2017, the European Commission held a conference on the European Pillar of Social Rights which included discussions on fair working conditions for all, tackling poverty, the future of work and social protection and the social dimension of the Economic and Monetary Union.

[1] See: https://osha.europa.eu/en/legislation/guidelines/interpretative-document-implementation-council-directive-89391eec-relation

The EU2020 Strategy aim of inclusive growth means fostering a high-employment economy delivering economic, social and territorial cohesion. This is reflected in the Flagship Initiatives “An Agenda for new skills and jobs” and "European Platform against Poverty", focusing on employment, skills, quality of jobs and working conditions, as well as vulnerable groups and combating social exclusion and discrimination. One of the four priorities identified in the “agenda for new skills and jobs” is better job quality and working conditions. The agenda emphasises that “there is no trade-off between quality and quantity of employment: high levels of job quality in the EU are associated with equally high labour productivity and employment participation. Working conditions and workers’ physical and mental health need to be taken into account to address the demands of today’s working careers, which are characterised by more transitions between more intense and demanding jobs and by new forms of work organisation.

Various activities have taken place also in Member States. The Joint Action for Mental Health and Wellbeing thematic report on mental health at the workplace provides many examples as does the EU Compass report on good practices in mental health and well-being. Examples of activities include the introduction of national legislation in Belgium (Royal Decree of 17 May 2007; Royal Decree of 10 April 2014) concerning the prevention of psychosocial load caused by work, including violence, harassment and sexual harassment at work; and psychosocial risk assessment. In the UK, a national policy was implemented in 2004, the ‘Management Standards for Work-related Stress’, which has been adapted and is used in Italy. A Mental Health Strategy was developed in Scotland and in Norway. In Finland, a Wellbeing at Work Network was established. In Germany, the psyGA ‘Taking the Stress out of Stress: Mental Health in the World of Work’ programme was implemented, as well as the ‘Protection and fortification of health in the case of work-related mental load’ programme of the Joint German OSH Strategy 2013-18. In the Netherlands many initiatives have been implemented including the Work & Health Covenants and catalogues, Stress Prevention at Work (SP@w), and DISCovery: tailored work-oriented intervention to improve employee health and performance. In Slovenia, the Fit for Work workplace health promotion programme was implemented, as well as a programme on mental health in the workplace during restructuring. In France, the ‘Taking Stock’ programme was implemented as well as Collective work situation analysis as a leverage for quality of life.

More recently, the EU Compass for Action on Mental Health and Wellbeing annual report 2016 reports that work-based programmes have been initiated in Norway (focusing on the prevention

of mental illness) and Croatia (research and education on psychosocial risks at the workplace) (Caldas de Almeida et al., 2016). In the UK the Department of Health and the Department of Work and Pensions developed the Joint Health and Work Unit to support people with mental illnesses in obtaining and retaining employment. In the Netherlands, there was a new project of the Ministry of Social Affairs and Labour to raise awareness, prevent stigmatization, and help solve mental health issues in the workplace. In Austria, the Safety and Health at Work Act is being promoted that is an important step in the promotion of mental health and the prevention of mental disorders in the workplace. In Finland, employment support for people with mental disorders has been developed.

5. Best practices

As discussed in the previous section, numerous examples of good practice exist in Europe addressing mental health in the workplace at various levels – from legislation development to inspection, to policy and strategy development, to the development of tools and guidance, and the establishment of support networks and workplace services. It is impossible to cover the multitude of these good practices in this report so a small selection of these examples is provided here based on good practices identified in key reports such as those produced through the Joint Action for Mental Health and Wellbeing. [2]

Finland – The Well-being Guild of Entrepreneurs

The Guild model was disseminated in Finland between 2012-16. It was developed by an NGO with the support of the health sector and the labour sectors. The main objective of the Guild project was to support the mental well-being of small and medium-sized entrepreneurs and ensure that they have the skills and resources to take early action in case of onset of mental health problems. In line with the model, veteran entrepreneurs and well-being experts advised entrepreneurs in small and medium-sized companies on sustainable well-being. The core activities were two-fold:

- a two-day course on welfare (applied mental health first aid); and
- the Guild's peer group activities, in which expert and peer support were used to develop participants´ self-knowledge, stress management skills, and ability to handle loneliness.

Peer group discussions focused on coping and on problems related to everyday life and work. This has helped entrepreneurs understand their own coping and identify risks related to mental well-being. Over six hundred entrepreneurs took part in the Well-being Guild of Entrepreneurs, with about two thirds of participants being women.

Germany - "Mental Health in the World of Work" (psyGA - Psychische Gesundheit in der Arbeitswelt)

[2] In addition to these best practices the Compass mechanism will identify and select best practices and publish a dedicated brochure which will include best practices on mental health in the workplace

The project "Mental Health in the World of Work" (psyGA - Psychische Gesundheit in der Arbeitswelt) is promoted by the German Federal Ministry of Labour and Social Affairs. The Federal Association of Company Health Insurance Funds (BKK Bundesverband) is responsible for the project management. The project aims to reduce mental stress and to promote mental health in the workplace. The target group are entrepreneurs, managers, employees in the Human Resources and Health Promotion departments, company medical officers and members of the work council. In order to increase the awareness about the importance of mental health and the exchange of know-how and experiences in this field, the project combines a topic-oriented knowledge base with good practice and tools for practitioners to promote mental health in the workplaces: self-assessment tools, guidelines for managers and employees, an audiobook and an e-learning tool. The internet portal www.psyga-transfer.de provides information about the project and the results. The dissemination in different workplace settings is implemented by 16 co-operation partners.

The Netherlands – SP@W: Stress Prevention at Work

The SP@W project aims to develop a strategic approach to stress which is practical, integrated and customized. The 'integrated strategy' is a roadmap to identify and deal with stress in the workplace. The comprehensive strategy consists of three components:

- A roadmap through which companies choose a customized approach, implement and evaluate.
- A learning network of companies that makes it easy to learn from experiences of other companies. Organisations from all sectors participate in the network, organised in three regions, that meets three times per year.
- The digital Occupational Stress platform which is an important resource containing useful instruments and information about effective stress interventions.

The knowledge partners in this project are VU University Medical Center, TNO, Tranzo, Trimbos and HAN University. More information is available at: http://www.stresspreventionatwork.nl/

UK – Individual Placement and Support for Employment (IPS)

Individual Placement and Support (IPS) first started in the UK in 1995 at South West London and St George's Mental Health NHS Trust. It has now spread across the UK and is still ongoing. The practice was initiated by the health and social sector and is categorised as a campaign and service delivery method. It focuses on both action and research. The objective of *IPS* is to enable people with severe and/or chronic mental ill health to enter and/or remain in the competitive labour market. *IPS* has been shown to be more effective the more closely it follows these eight principles:

1) it aims to get people into competitive employment;
2) it is open to all those who want to work;
3) it tries to find jobs consistent with people's preferences;
4) it works quickly;
5) it brings employment specialists into clinical teams;
6) employment specialists develop relationships with employers based upon a person's work preferences;
7) it provides time unlimited, individualized support for the person and their employer; and
8) benefits counselling is included.

The concrete results of *IPS* show that more than twice the number of people joined paid employment than with any other methodology, as has been confirmed by numerous randomised control trials. More information is available at:
https://www.centreformentalhealth.org.uk/individual-placement-and-support

Sweden - Organisational and social work environment (AFS 2015:4) provisions

The Swedish Work Environment Act clearly states that employers are obliged to prevent psychological health problems just like they are obliged to prevent accidents and physical illness. Yet while the Swedish Work Environment Authority provides plenty of detailed rules for how to prevent physical injuries, there has so far not been any similar binding rules covering risks to psychological health. The new provisions about the organisational and social work environment, which come into effect on 31 March 2016, regulate knowledge requirements, goals, workloads, working hours and victimisation. The provisions have been developed in consultation with the labour market partners, and have a focus on preventive work environment management. These regulations concretise the Swedish Work Environment Act,

which is a general legislation, and clarify – as well as supplement – the systematic work environment management that all employers are obliged to carry out. Further information is available at:

https://www.av.se/en/work-environment-work-and-inspections/publications/foreskrifter/organisatorisk-och-social-arbetsmiljo-afs-20154-foreskrifter/

6. Conclusions and Recommendations

Mental health represents a priority in the EU. As this paper has discussed, there is a well-documented impact of mental ill health for individuals, organisations and society. Since it is imperative to prevent mental health problems from occurring, protect the mental health of the population, and promote positive psychological well-being, interventions should be implemented in suitable contexts offering cost-effectiveness and wider reach. The workplace represents such an important context where the implementation of appropriate interventions can help promote sustainability, inclusion and growth in the EU. It is imperative for organisations and governments to recognise the workplace as both a major factor in the development of mental and physical health problems and as a platform for the introduction and development of effective preventive measures, utilising the coordinated input of external agencies (European Commission, 2016a).

This paper has analysed the current situation in the EU and associated impacts. It has also identified actions taken at EU and Member State level to promote mental health in the workplace, highlighting some best practice examples. The review has also highlighted certain areas that need addressing.

As is evident there are many sources of data on mental health in the workplace from various sources. Especially at EU level, it is important that the various sources of data are considered critically in their totality. This will not only allow appropriate comparisons, trends and benchmarks to be identified, but also co-ordinated action in key priorities to be implemented. To do so, better co-ordination between various sectors at EU level (especially health, labour, and social security) is required, as also highlighted by the Joint Action on Mental Health and Wellbeing. To achieve this a European Platform can be established that will bring key stakeholders together to co-ordinate action and ensure smart use of resources to achieve priorities.

The scientific evidence highlights three important issues. The first is that the literature includes studies of interventions that address mainly individual outcomes. Since multi-modal

approaches, including measures implemented at organisational level are acknowledged to be important, it is essential for these types of studies to be promoted and evaluated. However, such evaluation of organisational level interventions should include both process and outcome aspects, in order to capture effects that could otherwise go unnoticed (Nielsen & Randall, 2013; Semmer, 2006). The primary aim of interventions should be prevention through addressing risk factors in the work environment although resilience building, return-to-work and rehabilitation should also be pursed on the basis of good practice evidence. Particular focus should also be placed on programmes aiming to integrate individuals affected by mental ill health in the workforce by providing appropriate support.

The second issue that the literature highlights is the lack of studies in small and medium-sized enterprises. These enterprises are widely acknowledged to be in need of appropriate support in terms of awareness and action implementation when it comes to mental health in the workplace. They should continue to represent a priority in efforts across the EU while at the same time publicising existing good practices where available (e.g. EU-OSHA's OiRA tool).

The third issue is the relatively big accumulation of evidence on mental ill health and negative impacts and comparatively less evidence on the impact of positive psychological wellbeing in a healthy work environment. Further research can address this by expanding the range of factors and outcomes studies include to also tell the positive story of well-being, flourishing, vitality and sustainability.

A lot of action has also been taken at policy level, with the introduction of legislation, strategies and policies across Member States. It is important to share good practices and invest in their evaluation so that experience sharing across Member States is promoted in the EU. This will again require collaboration across sectors to achieve maximum benefit. Policies – especially health and policies and labour and social policies – working with social partners and relevant institutions (healthcare and occupational health and safety) can facilitate improvements in individual organisations by helping to develop supportive infrastructures (European Commission, 2016a). A European Platform aiming to enhance co-ordination at EU level could serve to bring together all key stakeholders in this context. The involvement of EU networks will also be beneficial to this end (European Commission, 2016b). This level of co-ordination and collaboration is also needed at national and local level to achieve optimal results.

One important area where further improvement can be achieved is legislation relevant to mental health in the workplace. Despite the fact that EU legislation in occupational health and safety covers such issues since 1989, here still appears to be confusion across stakeholders. To this end, the promotion of the newly developed interpretative document of the implementation of the 1989 Framework Directive on health and safety in relation to mental health in the workplace should be useful. A second area as regards legislation is in relation to human rights. It is important to integrate the new concepts introduced by the Convention on the Rights of Persons with Disabilities into national mental health legislation. However, it is also important to remember that statutory measures alone cannot overcome the challenges posed. Depending on the specific national social security structures, an active involvement of the health policy sector is necessary to efficiently and effectively shape the interfaces that exist between early detection and primary prevention, secondary and tertiary prevention as well as treatment and rehabilitation, including occupational reintegration (European Commission, 2016a).

On the basis of the above conclusions, as well as those included in key reports by the European Commission (both by DG Sante and DG Employment, Social Affairs & Inclusion), and its agencies (e.g. EU-OSHA) in this area the following recommendations can be made in relation to mental health in the workplace in the EU.

1) Establish a European Platform to promote cooperation among key stakeholders in the fields of healthcare, occupational health and safety and support for the unemployed building on existing structures and experiences.

2) Develop coordinated strategies for occupational health and safety and workplace health promotion at EU and national level, translated into joint general guidance and recommendations.

3) Improve the interface within healthcare and social security systems to accelerate the re-integration of employees into the workforce with appropriate support.

4) Disseminate good risk management practices in enterprises, including psychosocial risk management.

5) Promote systematic comprehensive multi-modal approaches and practices which combine improvements in working conditions and lifestyle factors that are evidence based.

6) Strengthen the evidence base by investing in the implementation and evaluation of organisational level interventions; studies in small and medium-sized organisations; studies examining positive mental health and wellbeing and associated outcomes; and policy evaluation studies.

7) Address the specific needs of micro, small and medium sized enterprises in relation to the adoption and implementation of good workplace mental health promotion practices, tools and guidelines, through coordinated action of key stakeholders.

8) Promote the interpretative document of Council Directive 89/391/EEC to clarify legal requirements for employers and other key stakeholders in Europe.

9) Strengthen existing monitoring systems in the EU (such as the European Working Conditions Survey, the European Survey of Enterprises on New & Emerging Risks, DG Sante monitoring surveys) to allow better monitoring and benchmarking across members states.

10) Showcase further the positive benefits of a healthy work environment for business and societal sustainability, raising awareness on the positive impact of good mental health and the need for fighting stigmatization.

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