



Evaluation of policy and practice to promote mental health in the workplace in Europe

Final Report

Partners:

Prevent
London School of Economics
TNO
University of Nottingham
Work Research Centre

Authors:

Stavroula Leka, Aditya Jain; University of Nottingham
Irene Houtman; TNO Work & Employment
David McDaid, A-La Park; London School of Economics
Veronique De Broeck; Prevent
Richard Wynne; Work Research Centre

Disclaimer

The content of this report represents the views of the contractor and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission.

Table of Contents

Executive Summary	7
Study objectives.....	7
Mental health as a positive state of psychological well-being	7
Mental ill health has a profound impact on individuals, organisations and society but awareness on the positive impact of good mental health also needs to be raised.....	7
A notable 'policy evolution' on mental health in the workplace in the EU but not without challenges	8
A mixed picture across member states but with several good practice examples	9
The status quo implies questionable progress	9
Views on the best way forward differ across countries and stakeholders	9
The cost of inaction outweighs the cost of action	10
SMEs, experience sharing and assessing impact.....	10
Further guidance	11
Key recommendations.....	11
1. Aim and objectives	12
2. Mental health in the workplace	12
2.1 What is mental health and psychological well-being?	12
2.2 Prevalence of mental health problems	13
2.3 Mental health in the workplace	16
2.3.1 Determinants of mental health in the workplace	16
2.3.2 The impact of poor mental health in the workplace.....	21
2.3.3 The case for promoting mental health in the workplace.....	27
3. Methodology	33
3.1 The conceptual approach.....	34
3.2 The scope of the methodology.....	35
3.3 The overall approach: Methods, instruments and analysis for each task.....	36
3.3.1 Task 1: Definition of types of legislation to be included	36
3.3.2 Task 2: Review of acts from an agreed list	37
3.3.3 Task 3: Identification and description of gaps in legislation/ policies and implementation	41
3.3.4 Task 4: Analysis of scenarios	41
3.3.5 Task 5: Preparation of a guidance document and an interpretative document of Council Directive 89/391/EEC	43
4. Evaluation of the policy context in the EU/EFTA countries.....	45
4.1 Eu policy framework review	45
4.1.1 Regulatory instruments of relevance to mental health and psychosocial risks in the workplace at the European level	46
4.1.2 Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace.....	58
4.1.3 The effectiveness of existing policy initiatives for promoting mental health and psychosocial risk management in the workplace	101
4.2 Identification and description of policy gaps	110
4.3 The national policy context in relation to mental health in the workplace: A European review.....	127
4.3.1 Case study analysis of national policy initiatives.....	128
5. Establishment of baseline scenario.....	129
6. Establishment of alternative scenarios	131
6.1 Results of the Delphi study	133
6.1.1 The first Delphi round	134
6.1.2 The second Delphi round	136
6.2 The strengths and weaknesses for the main scenarios	145
6.2.1 Strengths and weaknesses of non-binding EU-initiatives	145

6.2.2	Strengths and weaknesses of new EU-legislation.....	146
6.2.3	Strengths and weaknesses of providing a technical update.....	146
6.2.4	Strengths and weaknesses of combining or consolidating EU directives 147	
6.2.5	Strengths and weaknesses of maintaining the status quo	147
6.3	Assessing the costs and benefits of the different policy scenarios	147
6.3.1	Results	148
6.3.2	Developmental costs.....	151
6.3.3	Potential buy-in.....	152
6.3.4	Assessing the costs of implementation.....	153
6.3.5	Conclusions on policy scenarios and economic impact	157
7.	Recommendations	158
8.	References	163

List of tables

Table 1: Psychosocial hazards in the workplace	17
Table 2: Returns on investment from workplace mental health promotion and mental disorder prevention programmes	30
Table 3: Legislation type and potential gaps	35
Table 4: Regulatory instruments of relevance to mental health and psychosocial risks in the workplace at the European level	48
Table 5: Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace	81
Table 6: Evaluation of the impact of Framework Directive 89/391 in 15 EU member states (pre-2004)	103
Table 7: Results of the implementation of the European Framework Agreement on Work-related Stress.....	106
Table 8: Summary of key milestones achieved in EU member states, Iceland, Norway, and Turkey in relation to the implementation of the framework agreement on harassment and violence at work in 2008-2010	108
Table 9: Policy scorecard – key facets and scoring criteria	111
Table 10: Policy Scorecard – Regulatory instruments of relevance to mental health and psychosocial risks in the workplace at the European level.....	112
Table 11: Policy Scorecard – Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace	120
Table 12: Delphi responses by country – Round 2	136
Table 13: Response by country cluster	137
Table 14: Response by type of relevant stakeholder	137
Table 15: Response by relevant stakeholder by type and country cluster.....	138
Table 16: Priorities in scenario ratings (N=55).....	139
Table 17: Average rating of the scenarios by country cluster (N=55)	139
Table 18: Average rating of the scenarios by type of relevant stakeholder (range 5-1; best –worst)	140
Table 19: A ranking of types of non-binding EU initiatives on mental health when selected as preferred choice (N=27-31).....	143
Table 20: Non-binding EU initiatives by country cluster (ratings from 5 (most preferred) to 1 (5th in preference) (N=29-31)	144
Table 21: Non-binding EU initiatives by stakeholder type (ratings from 5 (most preferred) to 1 (5th in preference) (N=29-31)	145
Table 22: Potential costs associated with different policy scenarios	151

List of figures

Figure 1: An illustration of trends in sickness absence for poor mental health versus all other causes of sickness absence for the DAK sickness fund in Germany	14
Figure 2: Retirement event associated with improvement in fatigue and depressive symptoms (GAZEL study)	16
Figure 3: Trends in work intensification, control and learning opportunities in EU-15 (% workers)	19
Figure 4: Reasons for disability benefit claims in Britain 2008 – 2012.....	25
Figure 5: Duration of employment and support allowance claims in Britain 2008 – 2012	26
Figure 6: New claims for sickness compensation in Sweden 2003-2012.....	27
Figure 7: Estimation of annual benefits to UK economy through workplace mental health and wellbeing promotion.....	33
Figure 8: Potential for health and economic gains through modest improvements towards better mental health and wellbeing at work.....	155

Executive Summary

Study objectives

Tender N° VT/2012/028 concerned a study service contract to establish the situation in EU and EEA/EFTA countries on mental health in the workplace, evaluate the scope and requirements of possible modifications of relevant EU Safety & Health at Work legislation and elaborate a guidance document to accommodate corresponding risks/concerns, with a view to ultimately ensure adequate protection of workers' mental health from workplace related risks. On the basis of the above brief, the current study had three objectives: The first was to provide the European Commission with information on the situation in the EU and EFTA countries of mental health in the workplace. This required an in depth analysis of the current EU legal framework on workers' health and safety protection. The second objective was to develop a range of scenarios, and identify the pros and cons of each with the ultimate objective of providing a sufficiently robust information base on which the Commission may rely in order to consider policy options aiming to ensure that workers are effectively protected from risks to their mental health arising from workplace related conditions and/or factors. Finally, the third objective was to develop guidance to help employers and workers alike fulfil their obligations, namely those explicitly provided for by Framework Directive 89/391/EEC, with the overarching objective of making sure that mental health is considered an inescapable element of any occupational safety and health (OSH policy) and practical measures.

Mental health as a positive state of psychological well-being

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, "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 report adopts a more inclusive definition of mental health and as such does not focus solely on (the absence of) mental health disorders but a positive state of psychological well-being. The focus of the report is mental health in the workplace.

Mental ill health has a profound impact on individuals, organisations and society but awareness on the positive impact of good mental health also needs to be raised

This study commenced with a review of the magnitude of mental health concerns in the workplace in Europe and the impact of mental ill health on individuals, organisations and society. The prevalence of mental ill health in the workplace, including poor psychological well-being is widespread across all EU/EFTA countries and there are indications that this will only increase due to exposure to risk factors such as job insecurity, work intensification and organisational restructuring. In addition, the impact of mental ill health is profound on individuals, organisations and society as a

whole. At the individual level, exposure to psychosocial risks can result not only to poor psychological health and well-being but also to physical problems such as cardiovascular disease. These problems challenge participation in the workforce and performance through absenteeism and presenteeism. Discrimination and social exclusion against those affected by mental health disorders still remain a problem exacerbating the situation. At the organisational level, evidence indicates that mental ill health and poor psychological well-being affect business performance through absenteeism, presenteeism, reduced job satisfaction and organisational commitment, a poor work climate and human error. Additional costs are incurred by businesses in terms of hiring and training costs as well as reduced productivity and innovation. At societal level, there are associated costs to national social security and benefit systems, national economies and challenges on healthcare systems. These trends are projected to continue in the future. The negative impact of poor mental health in the workplace is now undisputed. However, further awareness needs to be raised on the positive impact of good mental health on sustainability at individual, organisational and societal level as a means of achieving the Europe 2020 goals.

A notable 'policy evolution' on mental health in the workplace in the EU but not without challenges

The second step of the study was a policy review at EU level with a focus on both regulatory and voluntary policy instruments, detailing the 'history' of policy evolution in this area in the EU. This was supplemented by a gap analysis. Employment, including OSH, legislation as well as public health legislation address the issue by placing emphasis on prevention through tackling risk factors and preventing discrimination. However some challenges have been identified. Although, for example, a common legal framework in the EU exists in relation to mental health in the workplace through the Framework Directive 89/391/EEC which covers all types of risk to workers' health, there still appears to be limited awareness of this provision both by employers and other key stakeholders. The situation seems to be negatively exacerbated further by the fact that the Framework Directive does not include specific terminology in relation to mental health in the workplace (for example it only refers to broad areas from which risk factors can arise, such as work organisation, and does not include terms such as work-related stress or psychosocial risk). From the review and gap analysis presented on regulatory and voluntary policy initiatives it can be observed that: a. there is lack of clarity and specificity on the terminology used; and b. although the different instruments/initiatives are based on related paradigms, very few of them provide specific guidance on managing risks in relation to mental health in the workplace to enable organisations (and especially small and medium-sized enterprises - SMEs) to implement a preventive framework of action. Several additional policy instruments of a non-binding nature have clarified the relevance and application of the Framework Directive in this area such as the framework agreement on work-related stress. The EC guidance on risk assessment also includes useful detail in this area. The gap analysis conducted in this study concerned both regulation and non-binding policies. It showed that a number of non-binding policies have been developed at EU level which provide specific guidance in this area while several gaps are evident in legislation at EU level. In light of this, it would be advisable to revisit the content of the Framework Directive in relation to psychosocial risks and mental health in the workplace to provide further clarity and harmonise terminology across other key OSH legislation accordingly. Two guidance documents developed through this project aim to partly address this issue. The review also showed that there is more scope for better co-ordination at EU institutional level in this area.

A mixed picture across member states but with several good practice examples

The third step of this study was the review of policies at national level in the EU/EFTA countries which highlighted that legislation in this area is more specific in several member states with many cases of updated legislation in recent years. Specific legislation refers directly to psychosocial risks, work-related stress, mental health in the workplace, harassment and bullying. It also makes clear reference to risk assessment for psychosocial risks as an employer responsibility. Other initiatives such as strategies and campaigns as well as social partner agreements were also identified. In addition, we conducted a case study analysis, including interviews with key stakeholders, of different types of policy instruments and initiatives which showcased several examples of good practice that have been implemented in individual, or even across, member states. These have helped tremendously in clarifying the legal framework and employer and employee responsibilities. An example is the Management Standards for work-related stress in the UK that have been adapted in Italy. Awareness raising of these initiatives and sharing of good practices across the EU has only recently started to materialise to some extent and there is far more scope in learning from these good practices and even exploring the feasibility of promoting a more unified approach at EU level. To do so, existing monitoring systems in the EU (such as the European Working Conditions Survey by Eurofound and the European Survey of Enterprises on New & Emerging Risks by EU-OSHA) will have to be strengthened to allow better benchmarking across member states. A more co-ordinated action plan would be beneficial at EU level, clarifying requirements (both in employment and public health policies) and the case for mental health promotion in the workplace and drawing upon good practice efforts within specific countries. In addition, monitoring across the EU and between and within Member States should be further developed by refining existing systems. A specific issue to be considered is the inclusion of mental health disorders in lists of occupational diseases in EU countries. Without effective monitoring and dedicated reporting, knowledge at the Community level about the rate of progress would be weak.

The status quo implies questionable progress

According to our analysis, if the status quo as concerns the policy context to mental health in the workplace is maintained, it is likely that a number of activities will continue to take place across the EU/EFTA countries in this area given the impact of mental ill health on individuals, organisations and society. However, there is uncertainty as to whether they will achieve the desired outcomes, especially since preventive actions still seem to be lacking across countries. Continuation of EU activities as currently set would not necessarily lead to an improvement of the situation, given the progress achieved so far, nor would it necessarily lead to greater awareness in relation to the vital importance of mental health in the workplace. Although this option would not imply any additional administrative costs, or require re-orientation of funds from other policies, it bears the significant and undisputed cost of inaction.

Views on the best way forward differ across countries and stakeholders

To explore additional scenarios at EU level, developed through our review of policies, the next step in the study included the development and evaluation of several scenarios on policy options in relation to mental health in the workplace in the EU on the basis of a Delphi study including interviews and an online survey. Our analysis

indicates that the views of key stakeholders across countries on the various policy scenarios (maintaining the status quo; introducing non-binding EU initiatives; combining or consolidating EU Directives; providing a technical update of existing EU legislation; developing EU legislation in this area) differ. Overall, non-binding EU initiatives were most often preferred, which may reflect the view from stakeholders that additional legislation may be difficult to develop whilst well-designed non-binding measures have been shown to help improve the focus on mental health in the workplace in some country contexts. The scenario on 'developing a technical update of existing legislation' ranked overall second, whereas 'combining or consolidating EU Directives' ranked third.

Differences across countries were as follows: 'non-binding EU initiatives' were on average most preferred in Southern Europe and UK & Ireland. Interestingly, in new member states this scenario shared first place with the scenario on 'developing new EU legislation'. In Northern EU countries, 'developing new EU legislation' was the most preferred scenario. While Continental country respondents preferred a 'technical update of existing legislation'. The differences in preference were more pronounced for the different stakeholder groups as compared to country clusters. Experts and professionals preferred 'non-binding EU-initiatives' the most. Employee representatives and policy makers in some countries (particularly labour inspectorates) most strongly preferred 'developing new EU legislation', whereas employer representatives most often preferred the 'status quo'. Regarding different non-binding EU scenario options, the different stakeholders expressed a preference for further awareness raising campaigns, closely followed by developing and implementing national strategies on mental health in the workplace, and introducing management standards.

The cost of inaction outweighs the cost of action

Furthermore, we proceeded to conduct economic analysis of the different options which indicated the availability of very little information on the costs of implementing different scenarios. Although qualitatively it appears that none would incur substantial development costs, some, e.g. a new directive, would take considerably longer to develop. The costs of implementation are likely to vary considerably; and would depend on uptake and also on the existing infrastructure and resources in member states. While it is difficult to determine the actual costs of implementation, it is clear from our review of the evidence on the cost effectiveness of workplace health promotion programmes that the economic returns overall are likely to be greater than the costs of investment. Much of these benefits will be gained by enterprises but there are also benefits to health and social welfare systems and to the economy as a whole. It should also be noted that many of these economic analyses are likely to be conservative as most only look at the benefits of a reduction in absenteeism and/or presenteeism and do not consider other benefits to business including better creativity and innovation, greater staff retention, and public image of the company. There are also additional wider benefits to society if workplace actions promote better mental health as this also helps protect against the risk of physical health problems. In addition, these scenarios do not normally take a human rights perspective to the promotion of mental health which would favour further action in this area.

SMEs, experience sharing and assessing impact

It should also be noted that most of the schemes that have been evaluated have been implemented in large enterprises; regardless of any policy scenario chosen, it would

be important to put further emphasis on measures to support small and medium-sized enterprises to actively implement good practices in the workplace. There are also potential economic benefits to governments and insurers that can be realised if they support occupational health services and other workplace mental health promotion actions in companies that would not otherwise be able to provide these services. Generating further evidence base on the effectiveness of actions in the European context and learning from various actions implemented across Europe would be a good way forward. In addition, assessing the impact of different strategies on an ongoing basis to help inform future implementation practice is important.

Further guidance

The final steps of this project focused on the development of two guidance documents. The first is an interpretative document of the implementation of Council Directive 89/391/EEC in relation to mental health in the workplace. This interpretative document aims to reiterate, in particular to employers and anyone with relevant responsibilities in organisations, the formal requirements of Council Directive 89/391/EEC as regards mental health in the workplace. The second is a guidance document on how to implement a comprehensive approach for the promotion of mental health in the workplace. It is hoped that these two documents will clarify legal requirements and good practice in this area further for employers and other key stakeholders in Europe.

Key recommendations

- Revisit the content (coverage and terminology) of Council Directive 89/391/EEC to include clear reference to psychosocial risks and mental health in the workplace.
- Promote the interpretative document of Council Directive 89/391/EEC to clarify legal requirements for employers and other key stakeholders in Europe.
- Promote the guidance document on how to implement a comprehensive approach for the promotion of mental health in the workplace.
- Harmonise coverage and terminology in relation to psychosocial risks and mental health in the workplace across all key pieces of OSH legislation.
- Consider the inclusion of mental health disorders in the list of occupational diseases at EU level.
- Continue to promote both regulatory and non-binding initiatives to raise awareness and promote good practice.
- Co-ordinate action at EU institutional level in this area to achieve maximum impact.
- Raise awareness on the positive impact of good mental health and its association with sustainability as a means of achieving the Europe 2020 goals.
- Strengthen existing monitoring systems in the EU (such as the European Working Conditions Survey by Eurofound and the European Survey of Enterprises on New & Emerging Risks by EU-OSHA) to allow better monitoring and benchmarking across members states.
- Publicise lessons learnt from good practices implemented in member states to motivate action across the EU.
- Place further emphasis on measures to support small and medium-sized enterprises to actively implement good practices in the workplace.

1. Aim and objectives

Tender N° VT/2012/028 concerned a “study service contract to establish the situation in EU and EEA/EFTA countries on Mental Health in the Workplace, evaluate the scope and requirements of possible modifications of relevant EU Safety & Health at Work legislation and elaborate a guidance document to accommodate corresponding risks/concerns, with a view to ultimately ensure adequate protection of workers’ mental health from workplace related risks”. On the basis of the above brief, the current study had three objectives:

- The first was to provide the European Commission with information on the situation in the EU and EFTA countries of mental health in the workplace. This required an in depth analysis of the current EU legal framework on workers’ health and safety protection.
- The second objective was to develop a range of scenarios, and identify the pros and cons of each with the ultimate objective of providing a sufficiently robust information base on which the Commission may rely in order to consider policy options aiming to ensure that workers are effectively protected from risks to their mental health arising from workplace related conditions and/or factors.
- Finally, the third objective was to develop a guidance document to help employers and workers alike fulfil their obligations, namely those explicitly provided for by Framework Directive 89/391/EEC, with the overarching objective of making sure that mental health is considered an inescapable element of any occupational safety and health (OSH) policy and practical measures.

The study addresses the situation across the EU, in individual EU Member States and countries which form part of the European Economic Area. This report will first present a summary of the evidence in relation to mental health in the workplace across European countries. It will then proceed to present an analysis of the relevant policy framework, identifying current gaps that need to be addressed. A series of case study analyses will then be used to identify scenarios for the future of EU mental health policy. These scenarios will be evaluated on the basis of a cost-benefit analysis and recommendations on the way forward will be offered. Finally, the report will detail the development of the Guidance document foreseen by the Commission as well as an interpretative document of Framework Directive 89/391/EEC in relation to this area. It is hoped that these two documents will help advance good practice in promoting mental health in the workplace and preventing associated risks in European workplaces.

2. Mental health in the workplace

2.1 What is mental health and psychological well-being?

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 report 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.

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 not focus on particular problems in isolation, such as depression for example, but 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. This report and associated guidance documents will discuss how this comprehensive approach can be applied with reference to mental health in the workplace.

2.2 Prevalence of mental health problems

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 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.

A systematic review of studies considering prevalence of mental disorders in the EU-27, Switzerland, Iceland and Norway was conducted by Wittchen et al. (2012). 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).

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.

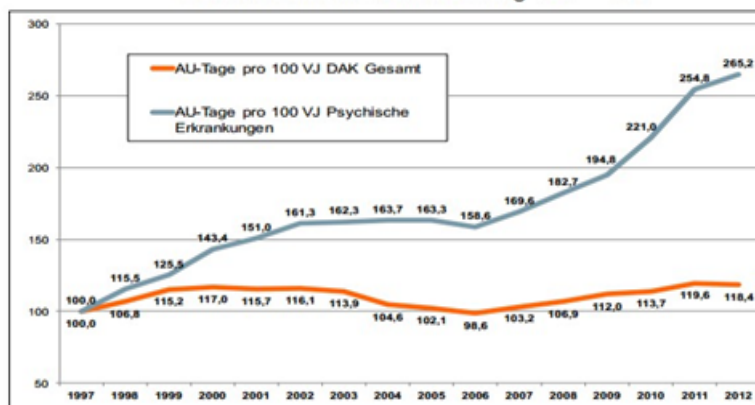
The estimates for the proportion of the workforce in Europe that may be living with a mental health problem at any one time range from one in five (OECD, 2012) to two in five (Wittchen et al., 2011), with a lifetime risk of at least two in five (OECD, 2012). In the EU-27 it was found that 15% of citizens 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 (EC, 2010a) 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. Figure 1 provides one illustrative example of this in Germany where days absent from work due to mental health problems continued to rise at a sharp rate over the period 1997 to 2012 in contrast to largely stable rates of absence for all other causes of sickness absence.

Figure 1: An illustration of trends in sickness absence for poor mental health versus all other causes of sickness absence for the DAK sickness fund in Germany

Higher levels of absenteeism

Abbildung 23: Entwicklung des Fehltagevolumens aufgrund psychischer Erkrankungen im Vergleich mit dem AU-Gesamtvolumen. Indexdarstellung 1997 = 100



Quelle: AU-Daten der DAK-Gesundheit 1997-2012

DAK Gesundheit 2013

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).

As previously underlined, this report takes a more 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 time 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, 2003a). 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 (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. According to the Fourth European Working Conditions survey, carried out in 2005, out of those workers who report that work affects their health, 20% of workers from the first 15 EU member states and 30% from the 12 new member states believed that their health is at risk because of work-related stress (Eurofound, 2007). The 2005 survey results indicated a reduction in stress levels reported for overall EU-27 figures; however the reduction in reporting exposure to stress occurred mainly in some of the EU-15 countries, while new member states still reported high levels of exposure – more than 30% (EU-OSHA, 2009).

At the national level, 1.2 million workers in Austria, for example, report suffering from work-related stress associated with time pressure. In Denmark, 8% of employees report being 'often' emotionally exhausted. In Germany, 98% of works councils claimed that stress and pressure of work had increased in recent years and 85% cited longer working hours. In Spain, 32% of workers described their work as stressful (Koukoulaki, 2004). In 2003, three out of five employees stated that they were frequently confronted with urgent situations and were more often than before required to interrupt one task to perform another leading to increased pressure and work-related stress (Eurofound, 2007). The European Agency for Occupational Safety and Health (2009) reports that there were 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). According to the 2008/09 Labour Force Survey, an estimated 415,000 individuals believed that they were experiencing work-related stress at a level that was making them ill, (HSE, 2010). The latest estimates from the Labour Force Survey show that the prevalence of stress in 2011/12 was 428,000 cases (40%) out of a total of 1,073,000 cases for all work-related illnesses. The industries that reported the highest rates of total cases of work-related stress (three-year average) were human health and social work, education, public administration and defence. The occupations that reported the highest prevalence rates of work-related stress (three-year average)

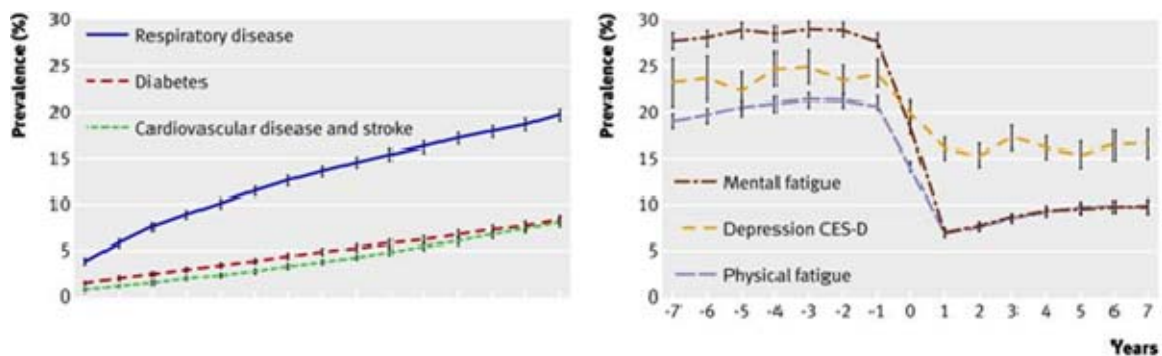
were health professionals (in particular nurses), teaching and educational professionals and caring personal services (in particular welfare and housing associate professionals). The main work activities attributed by respondents as causing their work-related stress, or making it worse, were work pressure, lack of managerial support and work related violence and bullying (HSE, 2013). In addition, in 2011/12 there was an estimated incidence of 86,000 male and 135,000 female cases of work-related stress based on the Labour Force Survey. This compares to an estimated prevalence of 175,000 cases of work related stress amongst males and 253 000 cases of work related stress amongst females (HSE, 2013).

2.3 Mental health in the workplace

2.3.1 Determinants of mental health in the workplace

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' (Deacon, 1997; King & Wickam-Jones 1999; Mead, 1997) 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.

Figure 2: Retirement event associated with improvement in fatigue and depressive symptoms (GAZEL study)



Source: Westerlund et al. (2010)

There is also growing awareness that (long-term) worklessness is harmful to physical and mental health, so it could be assumed the opposite must be true – that work is beneficial for health. However, that does not necessarily follow (Waddell & Burton, 2006). 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. In fact, a recent study by Westerlund et al. (2010) shows an improvement in fatigue and depressive symptoms associated with the retirement event, especially for those exposed to the worst work environment (Figure 2).

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, mainly through the experience of work-related stress (WHO, 2008, 2010). These hazards (see Table 1) are closely associated with the changing nature of work.

Table 1: Psychosocial hazards in the workplace

Job content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work
Workload & work pace	Work overload or under load, machine pacing, high levels of time pressure, continually subject to deadlines
Work schedule	Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours
Control	Low participation in decision making, lack of control over workload, pacing, shift working, etc.
Environment & equipment	Inadequate equipment availability, suitability or maintenance; poor environmental conditions such as lack of space, poor lighting, excessive noise
Organisational culture & function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on, organisational objectives
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support, violence, harassment, bullying
Role in organisation	Role ambiguity, role conflict, and responsibility for people
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems

Source: WHO, 2008

Due to globalisation and migration of workers, technological changes and a shift in the labour market towards more knowledge and service work, increased demands in terms of tight deadlines, increased work complexity and mental load, and an increase in violence and harassment have become more prevalent (e.g. Houtman et al., 2008; McDaid, 2008; McDaid & Park, 2014). Ongoing globalisation, a term which refers to the integration of national and regional economies, has led to increased competition between commercial organisations, to a shift in the type of business operations in which those companies are engaged, and to extensive outsourcing of activities, primarily to low-wage countries. Flanagan (2006) examined the effects of globalisation on working conditions (hours, remuneration and safety) and supports that it is possible to contend that globalisation has led to a flexibilization of the work process, with more part-time employment, temporary employment and independent contracting of staff (as reported by EU-OSHA, 2007; Kawachi, 2008). Houtman and Van den Bossche (2010) confirmed that based on Eurostat data there had indeed been

a significant increase in the number of employees holding temporary contracts within the EU. In 1990, the figure for the European average was 10% which by 2009 had risen to 14% of the total workforce. It may be that restructuring processes may have been partly a cause of this.

Restructuring itself has been on the increase due to the economic crisis since 2007/2008. This development results in higher levels of job insecurity in organisations, leaving a lot of people unemployed. However, restructuring cannot only be considered a serious threat to individual health for those who lose their job (the 'direct victims') but also to their immediate environment (e.g. Kieselbach et al., 2009). In addition, evidence during the past two decades showcases the impact of restructuring on the so-called 'survivors' as concerns health, well-being, productivity, and organisational commitment. For the survivors, continuing fears over job security and downsizing in both the public and private sectors remain important risk factors for work-related stress and mental health problems (Campbell, Worrall, & Cooper, 2000; Cheng et al., 2005).

In November 2012 almost 26 million people were unemployed in the EU, 18 million of whom were from EU-17 countries. Compared with 2011, the unemployment rates increased in 18 member states. The surge of unemployment creates tension and negatively impacts public perceptions for social welfare, job security, and financial stability. Increased job insecurity reflects the fear of job loss or the loss of the benefits associated with the job (e.g. health insurance benefits, salary reductions, not being promoted, changes in workload or work schedule). It is one of the major consequences of today's turbulent economies and is common across occupations, and both private and public sector employees (Ferrie et al., 2001; Sverke et al., 2002). One recent meta-analysis using data from more than 42 studies covering 20 million people suggests that the risks of premature mortality are greatest in the first ten years of unemployment, in men and in younger people (Roelfs et al., 2011). These results are also supported by a meta-analysis showing a link between long term unemployment and suicide, particularly in men (Milner et al., 2013).

Increased unemployment has given rise to different forms of flexible and temporary employment, also through the introduction of relevant policies such as flexicurity. Flexicurity is an integrated strategy for enhancing flexibility and security in the labour market. It attempts to reconcile employers' need for a flexible workforce with workers' need for security (EC, 2007). However, several studies have warned of the possible negative outcomes of new types of work arrangements, highlighting that they could be as dangerous as unemployment for workers' health (Benach & Muntaner, 2007).

A second key development is the tertiarisation of the labour market, manifested in increased demand for staff in the services sector and reduced employment opportunity in industry and agriculture. In fact, this development became apparent in the early years of the twentieth century but in recent decades may well have been reinforced by globalisation, since the outsourcing of manual labour to low-wage countries left only, or predominantly, the service economy elsewhere. This labour market shift can be seen at both the national and the European level (EU-OSHA, 2007; Peña-Casas & Pochet, 2009).

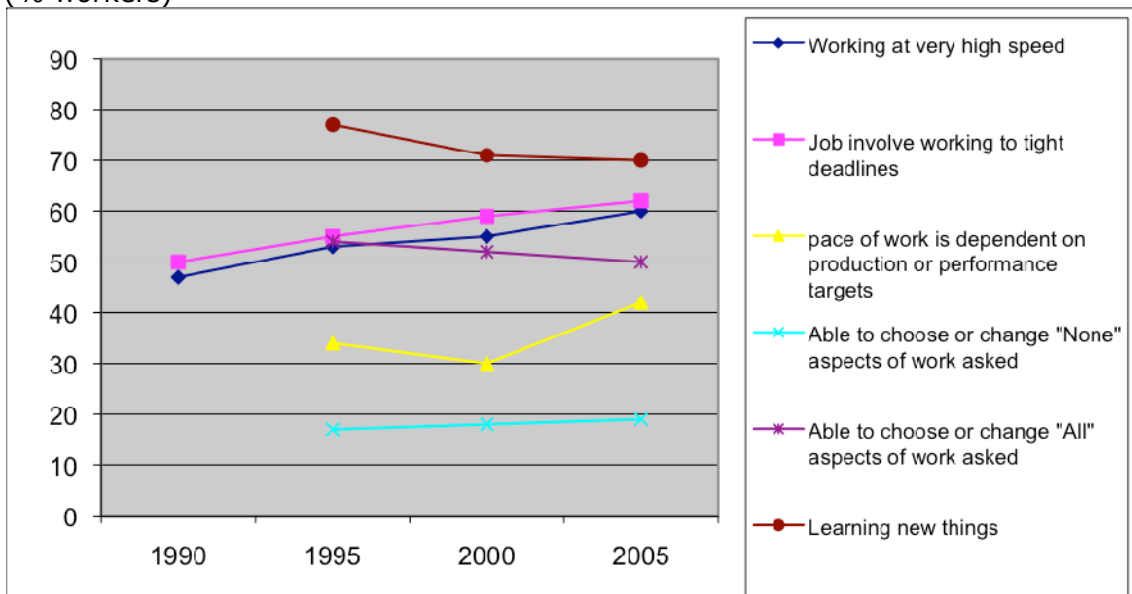
The third key development relates to technological advancement and the emergence of the computer and the internet, which has led to many changes and innovations in work processes. Many forms of manual work have become obsolete and staff must now offer different skills and qualifications (Joling & Kraan, 2008). Moreover, we have seen the introduction of 'new work', a term which amongst others refers to telework,

i.e. working from home or a location other than the traditional office. This results in blurring the border line between 'working' and 'private' life.

All the changes outlined above have been accompanied by the prevalence of new and emerging types of risk to workers' health and safety (EU-OSHA, 2010) and perhaps the most widely acknowledged of these new challenges are psychosocial risks (EU-OSHA 2007; NIOSH, 2002), also commonly referred to as organisational stressors or work organisation characteristics, which are linked to such workplace problems as work-related stress, workplace violence and harassment (Cox, 1993; WHO, 2003a).

In particular, many of these risks to mental health are increasing or are becoming more prominent for a larger group of the EU-workforce. Data from the European Working Conditions Survey (EWCS) confirm that the work of many European employees is getting more intensive, while control or choice at work is stable or slightly declines and learning opportunities at work decline (Figure 3). Greenan, Kalugina and Walkowiak (2013) also found evidence of a decreasing average trend in the quality of working life in the EU-15 over 1995-2005: physical strain increased, whereas at the same time technical and customer constraints became more intense.

Figure 3: Trends in work intensification, control and learning opportunities in EU-15 (% workers)



Source: EWCS (2005)

In addition, the fifth European Working Conditions survey in 2010 showed that in EU-27 countries, 4.1% of all respondents (3.9% of men and 4.4% of women) had been subjected to bullying or harassment at work in the past year. There was a wide variation between countries; the highest prevalence of bullying or harassment was found in France, Belgium, Austria and Finland. National studies on the prevalence of bullying and harassment can also be found in many European countries (for an overview see Zapf et al., 2010). In the same study, in total 5% (5.1% of women, 4.9% of men) of the respondents reported having been subjected to threats and humiliating behaviour at work in the last month. In many countries, women were more often subjected to threats and humiliating behaviour at work than men. For example, in Norway 10% of female and 5.9% of male respondents reported that they had been subjected to threats and humiliating behaviour at work in the last month.

The same situation was seen also e.g. in Denmark, Estonia, Finland, Latvia, and the Netherlands.

In recent decades an increasing diversification of the workforce can also be observed, due to significant changes in employment patterns (Kompier, 2006; Zahm, 2000), increased worker mobility (EU-OSHA, 2007) the increase of active participation of women in the paid workforce, growing use of migrant workers and the ageing workforce (Leka et al., 2008). Pronounced gender differences in employment patterns can be observed, the result of a highly segregated labour market based on gender (Burchell, Fagan, O'Brien, & Smith, 2007; Fagan & Burchell, 2002; Vogel, 2003). Gender segregation refers to the pattern in which one gender is under-represented in some jobs and over-represented in others, relative to their percentage share of total employment (Fagan & Burchell, 2002). A growing body of evidence indicates that a high level of gender segregation is a persistent feature of the employment structure globally (Anker, 1998; Burchell, et al., 2007; Fagan & Burchell, 2002; Kauppinen & Kandolin, 1998; Rubery & Fagan, 1993; Rubery, Smith, & Fagan, 1999).

Broadly speaking, women's jobs typically involve caring, nurturing and service activities for people, whilst men tend to be concentrated in management and the manual and technical jobs associated with machinery or physical products (EU-OSHA, 2002). Research also suggests that the lower levels of women in high powered positions in companies may also be partly due to their greater aversion to competition compared to men. Overtly competitive workplaces not only can be a factor in stress and poor mental well-being at work, but they may also discourage participation by women. Ultimately this decreases the chances of women succeeding in competition for promotions and more lucrative jobs (Niederle & Vesterlund, 2007).

Consequently, because men and women are differently concentrated in certain occupations and sectors, with different aspects of job content and its associated tasks, they are exposed to a different taxonomy of work-related risks (Burchell, et al., 2007; EU-OSHA, 2002; Fagan & Burchell, 2002). For example, women are more frequently exposed to emotionally demanding work, and to work in low-status occupations with often restricted autonomy, as compared to men (EU-OSHA, 2002). This differential exposure can result in differential impacts on occupational ill health for men and women (EU-OSHA, 2002). For example, evidence suggests that men are three times more likely than women to have serious accidents at work (EUROSTAT, 1999); whilst women are more likely to report work-related upper limb disorders, work-related stress, infectious diseases and skin problems (EU-OSHA, 2002). Women do not freely accept lower paid less high-powered jobs in order to have more flexibility in responsibilities at home; one recent survey of more than 17,000 workers in 17 high income countries found that women had less control than men over hours or work and opportunities for promotion. They also reported higher levels of stress and exhaustion at work than men. The greater number of women in a profession, the lower these differentials are (Stier & Yaish, 2014).

Migration of workers from developing countries to developed countries or from poorer to more affluent developed countries is also increasing. In general, migrant workers tend to be employed in high risk sectors, receive little work-related training and information, face language and cultural barriers, lack protection under the destination country's labour laws and experience difficulties in adequately accessing and using health services. Common stressors include being away from friends and family, rigid work demands, unpredictable work and having to put up with existing conditions (Magana & Hovey, 2003). In addition, ethnic minority migrants have been found to have different conditions in comparison to white migrants, and to report lower levels

of psychosocial well-being (Shields & Price, 2003). Women migrants represent nearly half of the total migrants in the world and their proportion is growing. They often work as domestic workers or caregivers while men often work as agricultural or construction workers (ILO, 2010a).

In industrialised nations, population ageing has been a prevalent trend in the past decades (Ilmarinen, 1999, 2006). The way work is designed and organised has changed substantially with a growth in contingent or 'precarious' work and an increase in part-time work, home-based work, telework, multiple job-holding and unpaid overtime. These changes might make it increasingly difficult for older workers to gain or maintain employment, and such employment may entail inferior and unhealthy working conditions. These recent changes in work design and management have also been accompanied by changes in worker protection; for example, a decline in union density and collective bargaining, some erosion in workers' compensation and public health infrastructure and cutbacks in both disability and unemployment benefits – again contexts which are unlikely to favour vulnerable workers, such as older workers (Quinlan, 2004). As such older workers may be affected by increased exposure to certain psychosocial hazards; decreased opportunities to gain new knowledge and develop new skills; less support from supervisors, and discrimination in terms of selection, career development, learning opportunities and redundancy (Chui, Chan, Snape & Redman, 2001; Griffiths, 1997; Maurer, 2001; Molinie, 2003).

2.3.2 The impact of poor mental health in the workplace

Impact on individuals

A number of large-scale studies of stress have been conducted in Europe with the data suggesting that, overall, stress accounts for up to 30% of all work-related illness (Hoel et al., 2001). The prevalence of work-related stress presents a significant burden on the workforce of developed countries, and the incidence appears to be steadily increasing over time (Eurofound 2007).

To date there have been 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, Laaminpää, & Vaino, 2008; Netterstrom et al., 2008). They 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).

For example, in the Whitehall II study, a longitudinal study conducted in the UK (Stansfeld, et al., 1999) demands at work were found to increase the risk of psychiatric disorders, whilst social support and high decision authority decreased the relative risk. Additionally, high efforts and low rewards were associated with increased risk of psychiatric morbidity. This also held true on the association with poor health functioning in the Whitehall II study (Kuper et al., 2002a; Kivimaki et al., 2007; Stansfeld et al., 1998).

Other recent 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). For example, Rosengren and colleagues from the INTERHEART study (2004) examined the association of psychosocial risk factors with risk of acute myocardial infarction in 24,767 participants from 52 countries. A case-control design was used with 11,119 patients with a first myocardial infarction and 13,648 age-matched (up to 5 years older or younger) and sex-matched controls from 262 centres in Asia, Europe, the Middle East, Africa, Australia, and North and South America. Data for demographic factors, education, income, and cardiovascular risk factors were obtained by standardised approaches. Stress was assessed by four simple questions about stress at work and at home, financial stress, and major life events in the past year. Additional questions assessed locus of control and presence of depression. Findings indicated that people with myocardial infarction (cases) reported higher prevalence of all four stress factors. Overall, concerning cardiovascular disease, 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 (Tsutsumi & Kawakami, 2004; Eller et al., 2009; Kivimäki et al., 2007, 2012; Marmot, Siegrist, & Theorell, 2006). Overall, risks are at least 50% higher amongst those suffering from stress at work compared to those who are not.

A review by WHO (2010) outlines 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). Employment rates are significantly reduced in case of presence of a mental disorder: 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 people with mental health problems can find jobs as easily as the general population, but are unable to keep their jobs, 55% 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 ILO has acknowledged that psychosocial hazards can cause an occupational disease, i.e. mental and behavioural disorders. However, mental health disorders like depression are not generally acknowledged as an occupational disease in lists of occupational diseases in most countries (EC, 2013).

Impact on organisations

Studies have shown the direct and indirect effect of a poor psychosocial work environment on absenteeism, productivity, job satisfaction and intention to quit (see for example, Kivimaki et al., 2003; Michie, 2002; Spurgeon, Harrington & Cooper, 1997; Vahtera, Pentti & Kivimaki, 2004; van den Berg et al., 2009). 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. Barling

et al., 2002, 2003; Bjerkan, 2010; Nahrgang et al., 2011; Rundmo, 1992, 1995; Vinnem et al., 2010).

A mentally unhealthy workforce has adverse economic consequences for business. In some countries employers will be directly responsible for paying at least some of the costs of sickness benefits to their employees for a specified period of time. There can be substantial immediate productivity losses due to sickness absenteeism. 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 and few estimates of its 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 (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). One example of this can be seen in a survey of nearly 29,000 employees across ten industries in 15 countries around the world. The survey looked at the relationship between wellness and business effectiveness (Dornan & Jane-Llopis 2010; Wang & Samson, 2009). 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. The survey 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 they were perceived to be 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 an almost fourfold increase in creativity and innovation, compared with a sevenfold decrease in companies where health and well-being were perceived to be poorly managed. This is unsurprising as several factors associated with health and well-being have been linked to employee creativity (Amabile & Conti, 1999; Amabile, Conti, Coon, Lazenby, & Herron, 1996; Amabile, Goldfarb, & Brackfield, 1990; Axtell, Holman, Unsworth, Wall, & Waterson, 2000). 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 wellbeing (Wang & Samson, 2009).

Customer loyalty may also be lost if high rates of absenteeism and presenteeism result in poor quality of service, while companies which have a good reputation may generate goodwill among (potential) customers as well as employees (Suter et al., 2007). The ESENER study showed that within the EU, 26% of employers indicate that they manage psychosocial risks because of concern for their reputation (EU-OSHA, 2010).

Impact on society

Studies suggest that between 50% and 60% of all lost working days have some link with work-related stress (EU-OSHA, 2000) leading to significant financial costs to companies as well as society in terms of both human distress and impaired economic performance. In 2002, the European Commission reported that the yearly cost of work-related stress and the related mental health problems in the 15 Member States of the pre-2004 EU, was estimated to be on average between 3% and 4% of gross national product, amounting to €265 billion annually (Levi, 2002). A report by EU-OSHA summarised the economic costs of work related stress illnesses. It reported that in France, between 220,500 and 335,000 (1% to 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 (EU-OSHA, 2009).

Estimates from the UK Labour Force Survey indicate that self-reported work-related stress, depression or anxiety accounted for an estimated 11.4 million lost working days in Britain in 2008/09 (HSE, 2010). This is an increase from earlier estimates, which indicated that stress-related diseases are responsible for the loss of 6.5 million working days each year, costing employers around €571 million and society as a whole as much as €5.7 billion. A study by the Centre for Mental Health considered health and social care costs, output losses, and human costs, estimating the total cost of mental health in the UK to be approximately £105 billion in 2009/2010 (CMH, 2010).

In Sweden in 1999, 14% of the 15,000 workers on long-term sick leave reported the reason to be stress and mental strain; the total cost of sick leave in 1999 was €2.7 billion (Koukoulaki, 2004). In the Netherlands, Koningsveld et al. (2003) calculated that costs of absenteeism and disability amounted to €12 billion. The largest costs related to work-related sick leave and disability, mainly caused by psychological and musculoskeletal disorders, each accounting for about 22% (€3 billion) of the total costs. Evidently, absenteeism and disability, due to psychological and musculoskeletal disorders, are a major problem in Dutch society costing the Dutch 3% their total GNP. A more recent 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 a review of the cost of work-related stress, the European Agency for Safety and Health at Work reported that in Germany, the cost of psychological disorders was estimated to be €3 billion (EU-OSHA, 2009).

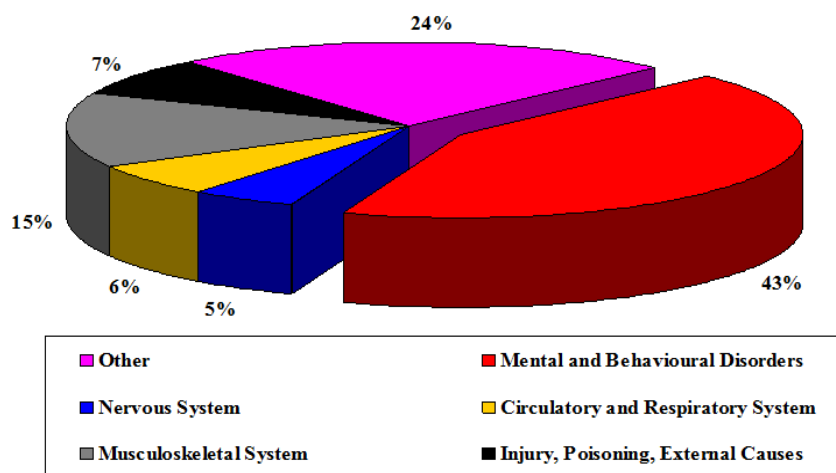
Better mental health and well-being at work can have major benefits for governments and wider society (Beddington et al., 2008) as they imply reduced rates of absenteeism, presenteeism and consequently less poor health. If, as we have indicated, better mental health at work is associated with improved productivity this, in turn, contributes to the economic performance of EU nations. Improvements in workplace productivity may increase the level of profit achieved by the private sector and thus additional tax revenues may be raised for the public purse. In the public sector, improved efficiency through improved workplace productivity may be achieved; something that is very important given the pressure on public expenditure in many countries. The ILO has also shown across several countries that, as health and safety performance decreases, so too does economic competitiveness (ILO, 2006). It is likely that a similar relationship would exist for the case of mental health.

Protecting and promoting mental health at work also has implications for health care systems. Better well-being at work can reduce the need for publicly funded health care systems to deal with the consequences of some adverse mental and physical health events that may have been better identified and avoided through early intervention at work. This, in turn, suggests that there should be better co-ordination and co-operation between occupational health and general health services.

Better mental health at work can also help avoid some of the wider costs to the economy of poor mental health in the population. Typically, at least two-thirds of the costs of common mental health problems are for lost productivity. As discussed, mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work (OECD, 2012). If we just look at the impacts of absenteeism and premature mortality for depression, the costs are substantial, and 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). This, however, is an underestimate of the total costs of poor mental health at work; a more comprehensive analysis would include lost opportunities for innovation and creativity, poor performance while at work, sick leave or early retirement on the grounds of poor mental health, stigmatisation and bullying at work, and exclusion from the workplace due to these negative attitudes. On top of this, there will be additional impacts on families of people who are affected.

Another study by Matrix (2013) estimated (for a certain scope and conditional to numerous assumptions) 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 usually are 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.

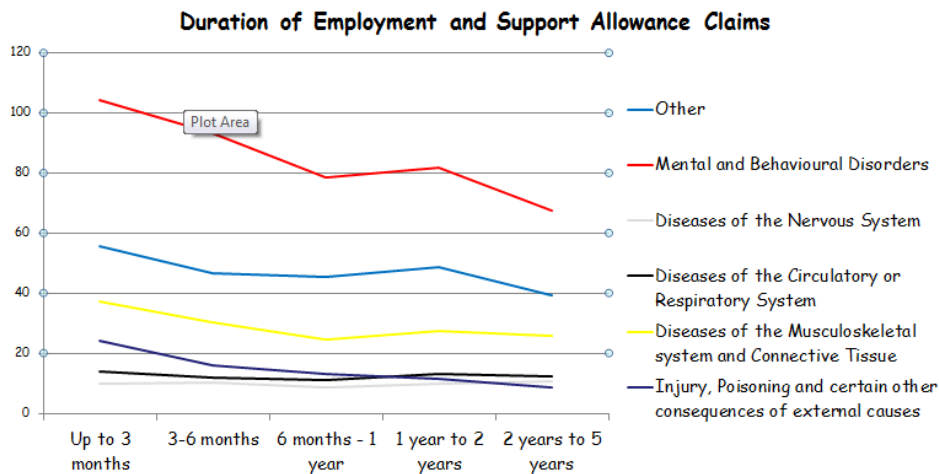
Figure 4: Reasons for disability benefit claims in Britain 2008 – 2012



Source: Department of Work and Pensions (2013)

Levels of absenteeism, unemployment and long term disability claims due to stress and mental health problems have been increasing in high income countries; 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 (OECD, 2012). They now account for about one-third in all newly benefit claims in OECD countries and tend to be long lasting. This can be illustrated by looking at the case of Britain (England, Scotland and Wales only) in Figure 4 where it can be seen that 43% of all disability benefits for the period 2008 to 2012 were due to mental and behavioural disorders (Department of Work and Pensions, 2013). As Figure 5 shows, not only are there many more disability claims related to mental health problems compared with other health problems, there are also greater numbers of people who have been claiming benefits for between two and five years.

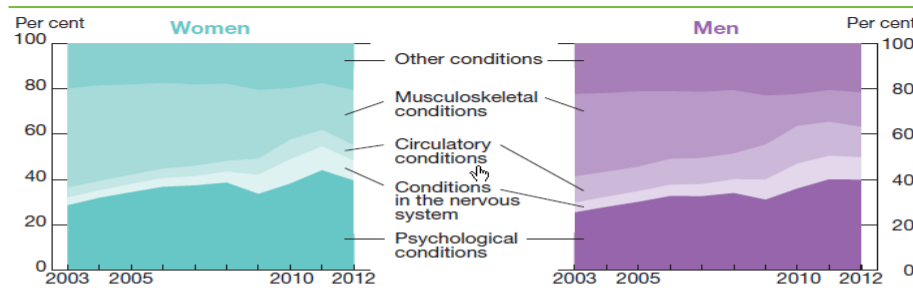
Figure 5: Duration of employment and support allowance claims in Britain 2008 – 2012



Source: Department of Work and Pensions (2013)

In Sweden there have been a number of policy efforts in recent years to help reduce the number of people moving to long term disability benefits through measures to place greater responsibility on employers to help their employees return to work and also to ensure that public employment services actively help those who have been out of work for longer time periods to find alternative employment. This has been relatively successful with respect to musculoskeletal health problems but has had much less impact on psychological conditions which accounted for 40% of all new sickness compensation claims in 2012 (Figure 6).

Figure 6: New claims for sickness compensation in Sweden 2003-2012



Newly granted sickness compensation by type of diagnosis. Conditions of the musculoskeletal system or connective tissues represented the most common types of diagnoses for people who were granted new sickness compensation until 2005. Since 2006, psychological conditions have represented the most common types of diagnoses. Psychological conditions accounted for 40 per cent of new sickness compensation among both women and men in 2012.

Source: Swedish Social Insurance Authority (2013)

2.3.3 The case for promoting mental health in the workplace

The discussion of costs and benefits presented thus far is of little consequence unless there are actions that can be taken to realise better mental health and thus reduce associated impacts. Many different effective interventions have been identified (Corbiere et al., 2009; Kuoppala et al., 2008; Martin et al., 2009). Actions can be implemented at both an organisational level within the workplace and/or targeted at specific individuals. The former includes measures to promote awareness of the importance of mental health and well-being at work for managers, risk management for stress and poor mental health, for instance looking at job content, working conditions, terms of employment, social relations at work, modifications to physical working environment, flexible working hours, improved employer–employee communication and opportunities for career progression. Actions targeted at individuals can include modifying workloads, providing cognitive behavioural therapy, relaxation and time management training, exercise programmes, and goal setting.

Both approaches have been evaluated in the literature, albeit with a focus on individual level intervention due to the relative ease of both implementing and evaluating these type of intervention. Cognitive behavioural therapy (CBT) has been particularly focussed on with consistent positive findings. Several reviews conclude that CBT can be effective for reducing negative outcomes of work stressors (Van der Klink et al., 2001; Richardson & Rothstein 2008). Moreover an analysis of 109 reviews showed that CBT was effective for reducing the impact of workplace stressors as well as mental health disorders (Hoffmann et al., 2012). This conclusion is supported by a Cochrane review which yielded similar findings (Marine et al., 2006). Reviews and meta-analysis of other individual focussed interventions also suggest that this level of intervention can be effective (Arnetz et al., 2013; Theeboom et al., 2014).

The findings regarding organisational level interventions are somewhat harder to interpret due to mixed results. A few reviews of studies have noted positive outcomes (Taris, 2003; LaMontagne et al., 2007). However, a systematic review by NICE (2008), evaluating organisational approaches to improving mental wellbeing,

suggested that findings were not so clear cut. Taking into account the quality of the study, they noted that it was difficult to form valid conclusions on whether organisational interventions are effective due to the confounding nature of study quality. Due to the nature of organisational level intervention, it is often more complicated to implement and evaluate these interventions which may partially explain the variance in findings (Semmer, 2006). More recent studies (which have presumably addressed issues in earlier research) have yielded more positive conclusions. A study of interventions in eight organizations which also assessed process elements (e.g. implementation) as well as outcomes, concluded that the intervention had a positive impact on participants' demands and resources which are causally related to mental health in the workplace (Jenny, et al. 2014). Despite these positive findings, there are still cases of inconclusive findings. A systematic review by Montano et al. (2014) of 39 studies found that only half documented positive findings.

These may be down to implementation of intervention as noted, but also down to evaluation of interventions. Semmer (2006) notes that there are many problematic practices in evaluating organisational level interventions. The author suggests that because organisational level interventions tend to measure organisational level outcomes (which are harder to measure and influence) they tend to be evaluated less positively. It should be noted that individual level interventions rarely measure organisational outcomes (Cooper & Cartwright, 1997; Richardson & Rothstein, 2008). Indeed when they do, organisational interventions have been found to outperform individual focussed initiatives (LaMontagne et al., 2007; Randall & Nielsen, 2010).

Similarly, due to practical limitations, evaluation is often conducted with short time lags. However, there is often not enough time for the intervention to have an effect on complicated organisational outcomes (such as productivity) which are being measured. When studies have considered long term impact, organisational level interventions have been shown to be effective, and again more so than individually targeted initiatives (LaMontagne et al., 2007). Other important factors which may cause organisational interventions to be evaluated less favourably include methodological issues, process concerns, and compensatory mechanisms (Semmer, 2006). Indeed in a series of innovative studies which also considered what was driving the final outcomes, organisational interventions were shown to be effective if the process of implementation was not compromised (Randall et al., 2005; Randall et al., 2007)

Overall it would appear that organisational interventions can be effective. Randall and Nielsen (2010) and Nielsen et al. (2010) document several variables which can be controlled in the design of the study to maximise the likelihood of success including employee participation, the necessity of a steering group, readiness for change, management support and communication. Moreover, Montano et al. (2014) found that there was a marginally higher chance of success when organisations engaged in several organisational level modifications simultaneously compared to just a single intervention. 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.

Finally, it is important to note that theory suggests that a combined approach (of individual and organisational approaches) would be most likely to be effective (Randall & Nielsen, 2010). Indeed research has also supported this notion. For example, Bond et al. (2008) found that psychological flexibility moderated the success of an organisational intervention. Individually targeted interventions can target such

variables, allowing individuals to maximise the benefits gained from organisational changes, and thus are important (van der Klink et al., 2001). In a review of several types of approach, Awa et al. (2009) found that combined approaches had the greatest effect on the prevention of burnout and associated symptoms, for example.

From an economic perspective robust data, scientifically validated, is already available indicating a very interesting 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, as discussed, most of existing economic literature has focused on the case for interventions targeted at individuals rather than organisational level interventions (Bhui et al. 2012; Cancelliere et al., 2011; Corbiere et al., 2009; Hamberg-van Reenen, Proper, & van den Berg, 2012; Matrix, 2013; McDaid & Park, 2011; Richardson & Rothstein 2008). 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 part this may reflect challenges in evaluating organisational level actions, but it will also be due to commercial sensitivities and a reluctance of employees and trade unions to participate in evaluations that assess workplace performance.

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. It is now readily accepted that organisational level intervention is a necessary requirement of a holistic and effective approach to tackling the underlying risks to mental health in the workplace (Van der Klink et al., 2001; WHO, 2010).

In a case study of the HSE Management Standards used to inform this report, some positive impacts for individual companies were identified. For instance looking at the home shopping retailer QVC, absenteeism rates decreased by 20% in the year following the introduction of the management standards in 2009, while 40% of employees surveyed believed that the companies Health & Wellbeing programme has had a positive impact on their lives outside of QVC. More than 50% believe it has had a positive impact upon their work life balance and 70% indicated that it has had a positive influence upon their health awareness.

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). Quite recently, 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).

This is also reflected in workplace case studies, for instance all companies interviewed in the Matrix economic project (Table 2) stated that employing mental health programmes resulted in significant positive impacts on employee wellbeing, reduced absenteeism, and increased productivity.

Table 2: Returns on investment from workplace mental health promotion and mental disorder prevention programmes

	Without programme	Universal		Targeted		Treatment	
		Workplace Improvement (WI)	Acceptance & commitment therapy (ACT)	Stress Management (SM)	Email CBT (ECBT)	Exercise (Ex)	CBT
Effects							
Effect on depression rate	-	-34%	-80%	-45%	-25%	-72%	-43%
Programme costs							
Cost of programme per person	-	€ 15.8	€ 68.2	€ 487.8	€ 478.0	€ 722.8	€ 1,204.9
Cost of programme	-	€3bn	€11bn	€14bn	€14bn	€11bn	€18bn
Opportunity cost of recipients' time	-	€28bn	€22bn	€4bn	€2bn	€4bn	€2bn
Costs by sector							
Healthcare system	€63bn	€56bn	€46bn	€61bn	€62bn	€44bn	€52bn
Social welfare system	€39bn	€38bn	€36bn	€39bn	€39bn	€36bn	€37bn
Economy	€242bn	€229bn	€212bn	€237bn	€239bn	€209bn	€222bn
Employers	€272bn	€235bn	€186bn	€257bn	€263bn	€178bn	€215bn
Total costs	€617bn	€558bn	€480bn	€593bn	€603bn	€467bn	€527bn
Benefits							
Net benefit	-	€28bn	€103bn	€6bn	-€3bn	€135bn	€70bn
Net benefit per person	-	€ 171	€ 631	€ 202	-€ 90	€ 9,125	€ 4,708
Benefit-cost ratio by sector							
Healthcare system	-	€ 2.94	€ 1.60	€ 0.20	€ 0.11	€ 1.80	€ 0.64
Social welfare system	-	€ 0.47	€ 0.26	€ 0.03	€ 0.02	€ 0.29	€ 0.10
Economy	-	€ 5.03	€ 2.73	€ 0.37	€ 0.21	€ 3.12	€ 1.12
Employers	-	€ 3.36	€ 5.66	€ 0.81	€ 0.47	€ 8.42	€ 3.04
Overall benefit-cost ratio	-	€ 11.79	€ 10.25	€ 1.41	€ 0.81	€ 13.62	€ 4.91

Source: Matrix (2013)

In this modelling analysis, data on the effectiveness of interventions was combined with information on the costs of delivery. Several different interventions were considered. Among universal programmes, 'workplace improvement' included both supervisors and employees to identify the potential risk factors for poor mental health conditions (Tsutsumi, 2009). The programme consisted of a training workshop for facilitators, an education workshop for supervisors and three workshops to examine the work environment and to make necessary modifications, at a cost of €16 per person. The programme was assumed to reduce depression rates by 34% in the population with no mental disorders. The ratio between benefits and costs was 11.79:1, which can be regarded as good value for money.

A three-session Acceptance and Commitment Therapy (ACT) with therapists who taught how to accept feelings and physical sensations without avoiding them, showed the greatest reduction by 80% in depressive symptoms (Bond, 2000). ACT cost €68 per person. There was an 80% reduction in depression among people without any mental health problems. The intervention generated €10.25 benefits for every €1 investment.

The stress management (SM) programme consisted of one session for stress management, one for muscle relaxation techniques, lasting 2 hours for each session, and additional follow-ups with a therapist by email for counselling (Mino, 2006). It cost €488 per person. The depression rates could be reduced by 45% in people with stress. Although the cost-benefit ratio was 1:1.41, the benefit-cost ratios for each sector was less than 1. This means this programme may not be a very good use of resources.

The Electronic cognitive behavioural therapy programme was delivered by a therapist via email over 7 stages of CBT on a weekly basis over 7 weeks (Ruwaard, 2007). The intervention cost €478 per person. A decrease in depression by 25% could be achieved among people with stress. For every €1, the return was €0.81. This intervention did not show a good value for money. In a sensitive analysis, to make the programme financially attractive, the cost of the intervention would be decreased to €239 per person with a 50% reduction in depression. In a longer time, the model looking at a 5-year period, the benefit and cost ratio was 1.56. It suggests the electronic CBT would be more cost-effective from a long-term perspective.

The personalised exercise programme with two sessions per week, lasting 50 minutes each session, cost €723 per person over 10 weeks (de Zeeuw, 2010). The programme yielded a 72% decrease in depressive symptoms among individuals diagnosed with mental disorders. For every €1 spent, the programme produced €13.62, which can be considered as a very good return on investment. The benefits generated through the intervention to promote physical activity would exceed the costs of the programme. The problem solving therapy with CBT had 7 sessions, lasting 45 minutes per session (Lexis, 2011). The intervention cost €1,205 per person at a 43% reduction among people with mental disorders. The benefit-cost ratio was 4.91.

Other recent studies include work from Japan where Yoshimura and colleagues (2013) examined the economic costs and benefits of mental disorder prevention programmes as a primary prevention strategy in the workplace. The costs for the work environment improvement intervention were 7,660 yen per worker and the monetised benefits ranged from 15,200 to 22,800 yen per person. The benefit-cost ratio were from 1.98 to 2.97. In other words, for every 1 yen spent, the return on investment would be 2 to 3 yen. The personalised stress management intervention cost 9,708 yen per employee and the monetary benefits were from 15,200 to 22,920 yen per person. The benefit to cost ratios ranged from 1.56 to 2.36. The education programme for supervisors cost 5,209 yen and benefits ranged between 4,400 and 6,600 yen per person. The benefit to cost ratio varied between 0.8 and 1.26. Ultimately, the most attractive option would be the work environment improvement programme, with the highest return on investment among the three types of the workplace mental health promotion programmes evaluated.

In Canada, Dewa and Hoch (2014) explored the potential cost-effectiveness of a collaborative care model to promote return to work by employing a decision analytical modelling approach. From a company's perspective, in order to make the programme a worthwhile investment, it should decrease disability episodes by a minimum of 7

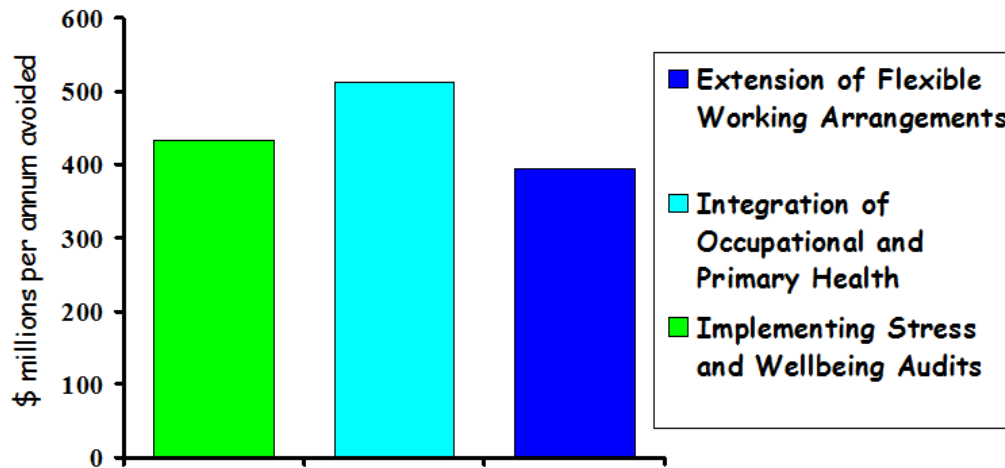
days in people with short-term disability associated with a mental health problem. This was a modest target outcome and in the economic analysis, there was a high chance (85%) of the intervention being cost-effective, with benefits exceeding costs.

This is also reflected in workplace case studies, whereby all the companies interviewed in the Matrix project stated that employing mental health programmes resulted in significant positive impacts on employee well-being, reduced absenteeism, and increased productivity. 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).

The economic benefits of participation in general well-being programmes were also modelled in a UK context. Implementing a multi-component wellness programme similar to that shown to be effective in the US (Mills et al., 2007), from a business perspective alone, can have a substantial return on investment of \$9 for every \$1 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) (McDaid et al., 2011). Another case study conducted for the HSE (2005) showed positive findings in a county council. Following a 'quality of working life' initiative, sickness absence levels fell from 10.75 days to 8.29 days representing a saving of approximately £1.9 million over two years. This was yielded from an investment totalling £390,000 resulting in a saving of approximately £1.5 million. The case study also reveals how difficult it is to conduct accurate cost benefit analyses as several other benefits were not factored in, such as better outcomes in the Council's "People Strategy". This also implies that the cost benefit analysis is in actuality an underestimate.

Work on some benefits of mentally healthy workplaces was also prepared for the UK Foresight study on Mental Capital and Wellbeing. As Figure 7 shows, this suggests that substantial economic costs could be avoided every year through investment in stress and well-being audits (\$434 million), better integration of occupational and primary health-care systems (\$513 million) and an extension in flexible working hours arrangements (\$394 million) (Department for Business, 2008). In terms of other organisational interventions, there appears however to be no economic analysis looking at the benefits of better training of line managers to recognise risk factors for poor well-being, even though this is one of the key recommendations made on effective interventions at work (National Institute for Health and Care Excellence, 2009).

Figure 7: Estimation of annual benefits to UK economy through workplace mental health and wellbeing promotion



Source: Department for Business (2008)

The available evidence discussed so far has built up the business case for promoting mental health in the workplace through appropriate actions at different levels. One of the challenges, 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 (17%) or high absence rates (11%) (EU-OSHA, 2010). It can also be argued that some governments have not taken enough action to encourage work in SMEs.

However, the business case is only part of the argument. It should also not be forgotten that there is a moral and ethical argument to promote mental health in the workplace that falls within the remit of corporate social responsibility (Jain, Leka & Zwetsloot, 2011). The Seoul Declaration on Safety and Health at Work (ILO, 2009) asserts that entitlement to a safe and healthy work environment is a fundamental human right. It follows that this should be protected through responsible practices at the policy and business levels and efforts have been made through corporate social responsibility initiatives to address these issues, including psychosocial risks (Jain, Leka & Zwetsloot, 2011; Jain, Ripa & Herrero, 2014; Leka & Jain, 2013). As such the legal and policy framework in the EU addresses risks to mental health in the workplace as well as discrimination and social exclusion. An extensive review of this framework both at EU and national level will be presented after the methodology followed in this study is detailed.

3. Methodology

The methodological framework used in the current study covers five main tasks, as outlined in the call for tender:

- Task 1: Elaboration of a methodological framework for the review of the current situation on 'mental health at the workplace' in the EU/EFTA countries, including an EU-OSH and national legal framework review
- Task 2: Reviews of acts from an agreed list
- Task 3: Identification and description of legislative/policy and implementation gaps
- Task 4: Analysis of scenarios
- Task 5: Preparation of a guidance document and associated materials

The methodological framework consists of the following components:

- The conceptual approach to the study
- The scope of the methodology
- The overall methodological approach, including the methods, instruments and analysis to be used in each task

Within each of the components, the methodology includes both a technical element that specifies the theoretical basis for the work that was carried out as well as a procedural element that details the activities and instruments used within the study.

3.1 The conceptual approach

Mental health in the workplace is legitimately the concern of three main approaches. The first approach is that of OSH, which focuses on workplace risks to mental health and their control. The second approach is that of workplace health promotion (WHP) which comes from within the public health approach. Both of these approaches are concerned with preventing damage to mental health and with the promotion of good mental health and well-being. A third approach is concerned with the workplace response to the situation where an employee has had a mental health breakdown. Here returning the individual to work and retaining them in their job is in focus, often using the disability management (DM) approach to achieve these aims.

The focus of the call for tender for the current project was situated within the OSH tradition, and so primary attention is placed on OSH in this study. However, it is not always possible to disentangle workplace mental health initiatives into pure OSH related interventions, any more than there are pure WHP or DM interventions. In addition, initiatives (legislative and otherwise) in some countries on such issues as absence management, (e.g. the Netherlands and the UK), workplace health promotion (e.g. in Germany, the 'Sickness Funds' must undertake health promotion at work) and maintaining 'work ability' (Finland) all deal with the various manifestations of mental health in the workplace to some degree.

There are also international initiatives and publications that go beyond an exclusive OSH focus. Therefore the focus of the conceptual approach of this study is within the OSH tradition and specifically on the impact that hard and soft law initiatives have on workplace practice. Nevertheless, the project acknowledges these other types of activity, especially in the context of the case studies that were collected.

3.2 The scope of the methodology

Leading on from the conceptual approach, the scope of the methodology includes the review of acts from an agreed list. The reviewed acts in this study were agreed by the European Commission and include:

- EU legislation as defined in the call for tender
- Other EU initiatives of a non-legislative nature
- National OSH legislation/regulation
- Other national OSH initiatives of a non-legislative nature
- ILO instruments
- National/regional/sectoral OSH agreements
- WHP policies where applicable
- The interface between mainstream health systems and OSH

This review is followed by an identification and description of gaps in legislation/policies and implementation. It was identified that there is a range of potential types of gaps in legislation or relevant policies in general. These relate mainly to the level of specificity of reference to mental health, how broad the concept of mental health used is, and coverage of risks to mental health as well as preventive actions. A broad framework (Table 3) used for classifying these gaps is the following:

Table 3: Legislation type and potential gaps

<p>High specificity, broad concept of mental health No gaps Broad definition, specifically defined, but no implementation measures Broad definition, specifically defined, but dependence on (conditionality) other legislation Broad definition, specifically defined, but 'get-out' clauses available</p>	<p>High specificity, narrow concept of mental health Limitation of the legislation to specific forms of mental health problem Limitation of the legislation to specific types of working conditions Exclusion of non-work-related mental health conditions</p>
<p>Low specificity, broad concept of mental health Being covered generally, but not specifically Reference to well-being, but not mental health Limited reference to workplace factors Not being covered by the general objective of the legislation</p>	<p>Low specificity, narrow concept of mental health Reference to OSH risks, but not general mental health promotion aspects Lack of explicit reference to mental health Being covered in principle, but not being operationalised Being ineffectively covered due to implementation gaps or dependence on other legislation Mental health not being covered by general objectives Legislation assumes that mental health is the same as physical health</p>

Other types of gaps relate to whether the issue is covered at all by legislation. The gap analysis was followed by an analysis of scenarios. The examination of scenarios included in this study considered:

- Their socio-economic costs and consequences from the perspectives of the public purse, business and employees
- Implications for existing legislation/regulation and other relevant policies
- Implications for monitoring/inspection

The final task involved the preparation of guidance. The key features of the guidance include:

- The guidance was drafted within the risk management model
- It addresses prevention, monitoring and control
- It addresses differences between mental and physical health assessment methods
- It promotes a comprehensive approach by showcasing how OSH, WHP and DM can be integrated
- It presents a range of good practice approaches
- It cross-references other existing key guidance in this area.

In addition to the Guidance, at the request of the Commission, an interpretative document of Council Directive 89/391/EEC in relation to mental health in the workplace was developed. This document indicates the formal requirements of the Directive as regards mental health in the workplace and also cross references other key documents and clarifies the relevance to mental health in the workplace of other existing Directives.

3.3 The overall approach: Methods, instruments and analysis for each task

3.3.1 Task 1: Definition of types of legislation to be included

The methodological framework was agreed with the Commission as specified below. This task defined the range of legislation and initiatives to be covered as part of the study, including the main health and safety instruments put in place by the Commission, as outlined in the call for tender. In addition, other Commission led instruments and activities were examined with regard to assessing their suitability for inclusion in the study, in particular, the initiatives of DG Sanco, e.g. the Mental Health Pact as well as the EU Thematic Conference on Promoting Health and Well-being held in Berlin. It should be noted that initiatives undertaken by DG Sanco, *inter alia*, tend to have broader remit than health and safety – they are concerned with mental health issues as they are manifested in the workplace, rather than solely with the prevention of occupational risks. The approaches of mental health promotion and rehabilitation are especially relevant here. Further initiatives, both regulatory and non-binding were included by various organisations.

The study also identified and characterised relevant approaches at national level. The review covered all main legislative instruments while going in more in-depth analysis of specific initiatives in the form of case studies. To ensure that local expertise was utilised at national level to identify relevant legislation and initiatives across countries, the Consortium worked in collaboration with a network of national correspondents. They assisted the Consortium in achieving a thorough understanding of the national situation, identify key instruments and initiatives of relevance and liaise with further stakeholders at national level. Specific criteria were set by the Consortium in agreement with the Commission for inclusion of instruments and initiatives (see below).

3.3.2 Task 2: Review of acts from an agreed list

An EU-OSH legal framework review was conducted in order to adequately ensure that the EU-OSH legal framework does not avoid the tackling of the 'mental health at the workplace' dimension, and to ascertain, whether existing legislative provisions, national measures and instruments of implementation address such concerns, to which workers may be exposed. The instrumentation developed within the project as part of the descriptive and analytic framework for mental health related legislation and initiatives was used in the review. This task also included collection of information from all countries on relevant national level legislation and other policies and initiatives.

There is limited data, particularly validated data that could be considered consensual by all stakeholders that would enable a full review of the adequacy of the EU-OSH legal framework as to its effectiveness relative to potential mental health in respect of workplace specific risks. Therefore the establishment of a methodological framework and assumptions allowed a coherent assessment of collated relevant pieces of EU-OSH specific legislation.

Bearing in mind the risk management models and systems implicit in EU-OSH legislation, the review of policies and initiatives addressed aspects that relate to coverage of exposure, risk assessment, preventive actions, outcomes, and supportive structures. The following criteria were used:

- Type of policy (hard or soft law)
- Terminology concerning basic concepts
- Coverage of exposure factors in relation to mental health
- Coverage of mental health problems and related outcomes
- Coverage of risk assessment aspects in relation to mental health
- Coverage of preventive actions (at primary, secondary and tertiary level) for mental health

Additional aspects considered were:

- Aim: what is the policy/initiative intended to do, e.g. to manage risks, to promote employee mental (and physical) health
- Targets: who are the targets of the measure, e.g. public and/or private sector employers, employees, statutory agencies, service suppliers, etc.?

- Operationalisation: how does the measure set out to achieve its intended impact? What actions and tools are specified for its implementation?
- Responsible actors: who has responsibility for putting the measure into practice, e.g. the employer, trade unions or an agency external to the workplace?
- Implementation and enforcement aspects: what is the extent of existing implementation as well as anticipated implementation and enforcement possibilities
- Monitoring: to what extent is the impact of the measure monitored, e.g. are there trend statistics available to assist in the review of the impact? Who is responsible for monitoring?
- Outcomes: is there information on the outcomes of the measure? How do different stakeholders perceive the measure? What are the consequences of implementation and non-implementation (e.g. penalties/fines or awards)?

The above criteria were useful both for the review and evaluation of legislation and other types of initiatives at EU and national level. On the basis of the agreed criteria, a Policy Analysis Template was developed. This was completed using collected qualitative and quantitative information as available. Any Act included in the list was the object of an individual assessment as to its suitability and potential candidacy for being amended in the light of the concluded need to take account of a mental health in the workplace perspective.

In addition, a Policy Scorecard was developed early in the project that was updated at set intervals throughout its lifetime. This was shorter than the Policy Analysis Template and aimed at comprehensively and concisely presenting the following kinds of elements:

- Description of the main characteristics of the legislation/policy/initiative
- Level – EU/national/regional/sectoral
- Comprehensiveness
- Number and types of gaps

The following methods were used to complete this task:

- Review of policy documents, including mainstream mental health policy as well as OSH policy
- Review of scientific literature
- Review of grey literature at EU level (including stakeholder initiatives)
- Review of ILO OSH country profiles
- Consultation with European Commission
- Consultation with key networks such as ENWHP, ENMHP, HIRES and PEROSH
- Case study analysis

The consultation process sought further information on legislation and initiatives at national level. The aim at national level was also the identification of case studies around different types of initiatives (not only focussing on hard law) that were analysed in order to gain a better understanding of different policy options and scenarios. The case studies played a crucial role in the project as they were used for three main purposes:

- Scenario analysis, i.e. analysis of different approaches to dealing with mental health at work so that conclusions could be drawn regarding the effectiveness, costs and cost effectiveness of ways to deal with mental health at work within the context of OSH.
- Illustration – the case studies were used for illustrative purposes in relation to the guidelines that were produced.
- Gathering of stakeholder views – An important part of each case study involved gathering stakeholder views – this fed into the overall consultation process both in the scenario and the guideline development work.

A network of national correspondents played a key role in relation to collecting information at national level. Contact was made with members of the European Network for Workplace Health Promotion and agreement for their participation in the project was obtained. In the case that a suitable national correspondent was not identified through this network, the Consortium sought additional correspondents through other networks it has access to, such as the EU-OSHA Focal Point Network, the HIREN Network and the PEROSH Network.

National correspondents were provided with a data collection instrument (Data collection instrument for national correspondents) that was developed by the Consortium and included the following dimensions:

- Overall summary of situation in relation to the policy context for mental health at work, making reference to relevant legislation as well as other policies and initiatives
- Types of policies to be described
- Dimensions of policies to be described
- Criteria for case study selection
- Key stakeholders
- Suggested data sources

On the basis of the policy and literature reviews conducted by the Consortium and the information provided by the national correspondents, a number of case studies were selected for further in-depth analysis. The procedure for selecting case studies was as follows:

- National correspondents were issued with a set of criteria for identifying potential case studies.
- National correspondents provided an overview of the national policy framework in relation to mental health in the workplace, identifying key hard and soft law initiatives (as relevant) and proposing potential case studies for inclusion (these consisted of short descriptions). National correspondents also identified key stakeholders at country level for further consultation in the remaining activities of the project.
- The project team assessed these case study proposals using previously specified and agreed criteria (see below) as well as taking into account the need to ensure that a full range of case study types are represented. A selection of case studies that present different approaches and are being promoted by different stakeholders was made by the Consortium for further analysis.
- Further information was collected in relation to the selected case studies through documentary sources and, in addition, stakeholder interviews were conducted with

the previously identified key stakeholders (these included social partners, the scientific community, practitioners, national, regional and local authorities in the member states, NGOs). These enabled the identification of success factors and challenges associated with the initiatives that assisted in the development of scenarios in the next stage of the project.

- A synthesis of the collected information enabled conclusions to be drawn and criteria for the development of scenarios to be developed.

The case studies varied with regard to the amount and type of information that was available, but each aimed to collect the following types of information:

- Descriptive information – This refers to information concerning such parameters of an initiative as its scale, aims, activities, stakeholder involvement, and methodology.
- Evaluative information – where available, information on the outcomes and impacts of the case were obtained. This enhanced the quantification element of the scenarios. This element included stakeholder opinion on the effectiveness, generalisability and practicality of the case study initiative.

A complete structure for the case studies was agreed with the Commission in the light of agreement of the overall methodology for the project. A set of criteria for case study selection was developed as part of the project methodology that included:

- Clear targeting of mental health issues at work
- Availability of sufficient information for description and analysis purposes
- Clear basis in legislation/regulation (though they may extend beyond the provisions of legislation/regulation)
- Scale – initiatives should have sufficient scale to ensure that generic conclusions can be drawn from them
- Coverage of exposure factors in relation to mental health
- Coverage of mental health problems and related outcomes
- Coverage of preventive actions (at primary, secondary and tertiary level) for mental health
- Coverage of risk assessment aspects in relation to mental health
- Coverage of administrative infrastructure for risk assessment and prevention in mental health
- Availability of outcome related information
- National initiatives
- Regional initiatives
- Sectoral initiatives
- Initiatives specifically targeted at small and medium-sized enterprises

In targeting the number of case studies required, three considerations were of importance – the need to achieve good geographical across countries; the need to ensure that relevant national initiatives were covered; and the need to ensure that the highest quality information was available to the project.

Different types of analysis were employed as part of this task. Text analysis employed in relation to documentation was based on content analysis. In content analysis, data analysis starts with reading all data repeatedly to achieve immersion and obtain a sense of the whole. Then, data are read word by word to derive codes by first highlighting the exact words from the text that appear to capture key concepts. Next, notes are made by the researchers on their initial analysis. As this process continues, labels for codes emerge that are reflective of more than one key concept. These often come directly from the text and are then become the initial coding scheme. Codes then are sorted into categories based on how different codes are related and linked. These emergent categories are used to organize and group codes into meaningful clusters (Hsieh & Shannon, 2005). In addition to text analysis, the developed Policy Analysis Templates allowed further analysis to be employed both in relation to individual policies and across them. They also allowed gap analysis to be employed in a more systematic way (see Task 3). Case study analysis (Yin, 2009) was employed in relation to the collected case studies. Stakeholder interviews were included in these case studies and data was analysed using thematic analysis (Braun & Clarke, 2006) to ensure key themes/issues in relation to the policies/initiatives in question were captured.

3.3.3 Task 3: Identification and description of gaps in legislation/ policies and implementation

This task analysed the information collected at EU and national level employing gap analysis that focussed on the following aspects:

- Reference to mental health in the workplace in the objectives/scope of the policy
- Coverage of exposure (risk) factors in relation to mental health in the workplace
- Coverage of mental health problems/disorders at work and related outcomes
- Coverage of risk assessment aspects in relation to mental health in the workplace
- Coverage of preventive actions in relation to mental health in the workplace

Conclusions were summarised globally in tabulated form, using the developed Policy Scorecard. This provides an 'instant snapshot' of the outcome of the analytical exercise in its globality. The analysis of legislation and other policy initiatives conducted provided the basis for the scenarios and the guidance development.

At the end of this task a baseline scenario was developed that included:

- a. An overview of the problem at EU level, and, where relevant, in individual member states and EFTA/EEA countries, together with an estimation of likely future trends.
- b. A thorough description of the current context and challenges, and demonstration of the necessity and added value of EU action on this issue from an OSH perspective.

3.3.4 Task 4: Analysis of scenarios

The starting point for this task was the baseline scenario and the synthesis of findings as well as the proposed scenario types and issues addressed in the scenarios.

Based on the conclusions arrived in the previous stages of the project, future scenarios were elaborated. The scenarios were justified and drawn not only on the conclusions of the EU-OSH legal framework review, but also, on the consultation of relevant stakeholders. When seeking national member state positions, this was done on a tri-partite model including the views of governments, workers and employers in each member state. A Delphi-method was used in order to both construct alternative scenarios and obtain feedback from stakeholders in all member states and EFTA/EEA countries and at EU level on their feasibility, potential socio-economic consequences and administrative costs. This informed the subsequent development of cost benefit analyses which set out impacts of implementation of different scenarios.

The Delphi method is a structured communication technique with which opinions of (in this case) stakeholders are collected iteratively in different rounds. The Delphi method was originally used as a forecasting method which relied on a panel experts, but it has also been used in policy research to collect opinions of stakeholders and experts in order to prioritize, and at the same time to arrive at more consensus through several consultation rounds. In between rounds, the opinions, ratings and other responses of participants are fed back to all involved in the Delphi exercise (e.g. EU-OSHA, 2007; Van der Beek et al., 1997).

The Delphi was conducted in two rounds including interviews and an online survey. In the first round, a questionnaire was developed and tested by in-depth interviews with relevant stakeholders in a restricted number of countries. The selection of 4 countries (the UK, Germany, Slovenia and the Netherlands) was guided by the results of the evaluation of the EU Framework Agreement on work-related stress (see also Table 7, results of the implementation of the European Framework Agreement on Work-related Stress, in this report). Interviews were held in countries that ranged from having implemented substantial efforts and either having implemented national collective agreements or non-binding initiatives, to countries where social partners were moderately active to not active at all.

In these four countries, when possible, interviews were held with employer and employee representatives, policy makers or experts, knowledgeable in the area, either as researcher or in a more practical role (occupational physician, psychiatrist, psychologist, researcher/consultant/ occupational mental health specialist, labour inspectorate etc). In total 22 interviews took place, including one with a representative at EU-level. In-depth interviews were held with eight stakeholders from Germany, seven stakeholders from the UK, four stakeholders from Slovenia and four stakeholders from the Netherlands.

The content of the questionnaire was guided by the scenarios identified. All five scenarios (from status quo to the development of new legislation were presented and experts were invited to discuss each scenario along the line of (1) has that scenario been addressed in their country, and if yes, how, (2) its strengths and weaknesses, (3) the potential effectiveness and costs of this scenario, and (4) other contextual factors required to be in place for the implementation of this scenario (in their own country or potentially in other countries).

Based on the findings of this first round, the interview was restructured into a shortened online questionnaire. In this second round, the web-link to the online survey was sent to relevant stakeholders in each country who were asked to respond (see Annex 9.6). The members of the Advisory Committee on Safety and Health at Work (ACSHW) were invited to participate in the survey. Use was made of personal

networks as well as contacts through PEROSH, EWCO and the European Networks for Workplace and Mental Health. The Delphi was thus a structured way of consultation with the stakeholders, and a tool for impact assessment.

The analyses performed were mostly descriptive. The main aim was to assess priorities in policy scenarios and identify strengths and weaknesses of these policies. The priorities and strengths and weaknesses were additionally split by country and country cluster (using the Esping-Andersen classification) as well as the type of relevant stakeholder (i.e. policymaker/inspectorate, employer representative, employee representative, expert/professional, insurers). Responses in this second round of the Delphi on the costs of the different options were taken into account in our cost-benefit analysis of the different scenarios.

Our work, had a strong emphasis on determining the economic impacts of scenarios. We know from past research of the major impacts of poor mental health (Dewa, McDaid & Ettner, 2007; Dewa & McDaid, 2010; McDaid, 2011). In addition to obtaining information from experts on potential costs and benefits of these scenarios, we also made use of desk based research methods to identify any relevant work looking at the costs of the implementation of legislation and/or soft regulations. We also sought to obtain information on some of the specific examples of actions being implemented in different member states, through the interviews and consultations with stakeholders at national level, in addition to our desk based work.

In terms of outcomes we drew on previous work conducted by McDaid (2011) to estimate the economic benefits (and costs) to business, employees, civil society and the public purse in specific workplace or sector settings. We also sought to obtain information on the potential impacts of scenarios on business innovation.

3.3.5 Task 5: Preparation of a guidance document and an interpretative document of Council Directive 89/391/EEC

The Commission requested the development of a Guidance document and, in addition, an Interpretative document of Council Directive 89/391/EEC in relation to mental health in the workplace, to supplement the analysis presented in this report. The Guidance document (Annex 9.11) aims to help all relevant stakeholders to better address potential risks of relevance to mental health in the workplace. In particular, the guidance document aims to assist employers to carry out a risk assessment in relation to mental health in the workplace while promoting a comprehensive approach. The specific aims of the Guidance are:

- To situate the management of mental health issues in the workplace (prevention, promotion and return to work) within the context of the Framework Directive and related legislation;
- To raise awareness of the importance of mental health and wellbeing management in the workplace;
- To provide practical assistance to employers on managing the issue of mental health in the workplace;
- To provide practical examples of how this can be done through the medium of case studies;
- To provide reference to other relevant sources of guidance, research and policy information.

The interpretative document of the implementation of Council Directive 89/391/EEC in relation to mental health in the workplace (Annex 9.12) contains non-binding guidance intended to help national authorities and stakeholders interpret the provisions of the Council Directive 89/391/EEC in relation to mental health at work. The interpretative document was developed following a thorough review of relevant policy documents, a review of scientific literature and consultation with stakeholders. The document also provides a list of other Directives which complement the provisions of Council Directive 89/391/EEC explaining their relevance to mental health in the workplace.

The methods used in the development of the guidance documents involved:

1. Identification of relevant existing guidance and good practice examples in the area of workplace mental health

This was done through a focused literature review, i.e. a search through specific OSH sources, e.g. national OSH agencies, National Public Health agencies, the EU-OSHA website, the EU Compass for Action on Mental Health and Well-being website, the ENMHP portal as well as drawing upon the knowledge of the project partners. In addition, the national correspondents were asked to identify any relevant guidelines and examples of good practice in use in their own countries. In identifying representative examples of good practice, different industry settings, workplace exposure scenarios, gender and diversity issues were taken into consideration.

2. Drafting of guidance documents

First drafts of the guidance documents were produced which were commented upon by the project partners. They were then circulated for wider comment by stakeholders and the Commission.

3. User consultation

User consultation was a key element in ensuring that products represent and are consistent with the views and needs of target stakeholders. This was achieved with the use of existing networks and by relying on the good contacts that national correspondents have with stakeholders in the participating countries. Four main forms of consultation were undertaken:

Following the development of first drafts of the Guidance document and the Interpretative document, a workshop was organised in Brussels on the 24th of July 2014 to disseminate and validate their content. Representatives of the Commission, the Social Partners, the Parliament and relevant Agencies and NGOs (e.g. EU-OSHA, Eurofound, and Mental Health Europe) were invited to take part. Forty participants registered for the workshop. The list of participants is enclosed in Annex 9.9 and the programme of the workshop in Annex 9.8.

Two rounds of discussion were organised during the workshop. The first focussed on the policy options identified while the second sought feedback on the Guidance document, the interpretative document and a website to disseminate the project findings and outputs.

In addition, a feedback questionnaire (Annex 9.10) was developed and sent to the participants both prior and after the Workshop. The Guidance document was also

reviewed by relevant networks, such as the European Network for Workplace Health Promotion (ENWHP) and the European Network for Mental Health Promotion (ENMHP). The national correspondents that participated in this study invited representatives of the Social Partners, OSH Agencies, Government Ministries and national experts to take part to a national validation exercise of the developed Guidance. The Interpretative document was reviewed by the Commission.

4. *Final drafting of guidance and interpretative document*

The feedback obtained from the consultation was considered together with feedback received by the Commission and the two documents were amended appropriately.

4. Evaluation of the policy context in the EU/EFTA countries

The Consortium conducted an EU-OSH policy framework review in order to establish whether the “mental health in the workplace” dimension is adequately covered, and to ascertain, whether existing legislative and other policy provisions, national measures and instruments of implementation, address such concerns, to which workers may be exposed.

4.1 Eu policy framework review

Prevention is the guiding principle for OSH legislation in the EU. The Framework Directive 89/391/EEC on Safety and Health of Workers at Work lays down employers’ general obligations to ensure workers’ health and safety in every aspect related to work, ‘addressing all types of risk’. On the basis of the Framework Directive, a series of individual directives have been since adopted. The Framework Directive with its general principles continues to apply in full to all areas covered by the individual directives, but where individual directives contain more stringent and/or specific provisions, these special provisions of individual directives prevail (EC, 2004).

It contains general principles concerning the prevention of occupational risks, the protection of safety and health, the elimination of risk and accident factors, the informing, consultation, balanced participation in accordance with national laws and/or practices and training of workers and their representatives, as well as general guidelines for the implementation of the said principles. The Directive applies to all sectors of activity, both public and private. However, it is not applicable where characteristics peculiar to certain specific public service activities, such as the armed forces or the police, or where certain specific activities in the civil protection services, inevitably conflict with it. The Directive establishes the minimum requirements for OSH further allowing Member States to establish more protective provisions in their national legislation. Member States are committed under the Treaty on the Functioning of the European Union – (Article 151 TFEU), to encourage improvements

in conditions in this area and to harmonizing conditions while maintaining the improvements made.

Risks relevant to mental health, termed psychosocial risks, and their management are among employers' responsibilities as stipulated in the Framework Directive as it obliges employers to address and manage all types of risk in a preventive manner and to establish health and safety procedures and systems to do so. In addition to the Framework Directive, a number of policies and guidance of relevance to mental health have been developed and are applicable to the European level. These include both legally binding instruments (such as EU regulations, Directives¹, decisions, and national pieces of legislation), and other 'hard' policies (such as ILO conventions) developed by recognised national, European and international organisations as well as non-binding/voluntary policies (or 'soft' policies) which may take the form of recommendations, resolutions, opinions, proposals, conclusions² of EU institutions (Commission, Council, Parliament), the Committee of the Regions and the European Economic and Social Committee, as well as social partner agreements and frameworks of actions, and specifications, guidance, campaigns etc. initiated by recognised European and international committees, agencies and organisations.

The next sections present a review of EU level legislation and other policy initiatives, examining examples of both hard and soft law instruments that have been used to protect and promote mental health in the workplace in EU/EFTA countries.

4.1.1 Regulatory instruments of relevance to mental health and psychosocial risks in the workplace at the European level

Table 4 presents regulatory instruments of relevance to mental health and psychosocial risks applicable to the EU member states. Even though each of these regulations addresses certain aspects of mental health and/or the psychosocial work environment, it should be noted that the terms 'mental health', 'stress' and 'psychosocial risks' are not mentioned explicitly in most pieces of legislation (Leka et

¹ Article 288 Treaty on the Functioning of the European Union (TFEU) states that, "to exercise the Union's competences, the institutions shall adopt regulations, directives, decisions, recommendations and opinions".

- A regulation shall have general application. It shall be binding in its entirety and directly applicable in all Member States.
 - A directive shall be binding, as to the result to be achieved, upon each Member State to which it is addressed, but shall leave to the national authorities the choice of form and methods.
 - A decision shall be binding in its entirety. A decision which specifies those to whom it is addressed shall be binding only on them.
 - Recommendations and opinions shall have no binding force.
-
- A recommendation allows the institutions to make their views known and to suggest a line of action without imposing any legal obligation on those to whom it is addressed.
 - An opinion is an instrument that allows the institutions to make a statement without imposing any legal obligation on those to whom it is addressed. It can be issued by the main EU institutions (Commission, Council, Parliament), the Committee of the Regions and the European Economic and Social Committee. While laws are being made, the committees give opinions from their specific regional or economic and social viewpoint.
 - Communication: In its Communications the European Commission expresses its opinions and proposals to Member States and other EU institutions, and commits itself to take action to foster the objectives of the Communications.

Council resolution: A Council resolution is a non-binding statement from the Council of the European Union, where the Council defines objectives and makes political declarations.

² See footnote 1

al., 2011a). The main example in this respect is the Framework Directive 89/391/EEC on Safety and Health of Workers at Work. Even though the Directive asks employers to ensure workers' health and safety in every aspect related to work, 'addressing all types of risk at source', it does not include the terms 'psychosocial risk' or 'work-related stress'. However, it does require employers to 'adapt the work to the individual, especially as regards the design of workplaces, the choice of work equipment and the choice of working and production methods, with a view, in particular, to alleviating monotonous work and work at a predetermined work-rate, developing a coherent overall prevention policy which covers technology, organization of work, working conditions, social relationships and the influence of factors related to the working environment'.

The Directive further specifies 'that health surveillance should be provided for workers according to national systems. Particularly sensitive risk groups must be protected against the dangers which specifically affect them'. In this sense, there is an indirect reference to, and provision for, risks related to mental health at work. This is also the case for the Directive on organisation of working time (93/104/EC), while the Council Directive on work with display screen equipment (90/270/EEC), actually refers to 'problems of mental stress' in the context of risk assessment.

The European Court of Justice in various judgements also emphasises the importance of assessing all risks. For instance, in what concerns the duty on the employer to evaluate risks, the Court held, in case C 49/00 (Commission v. Italy) that this includes all risks (which encompass psychosocial risks). The Court held as follows: "It must be noted, at the outset, that it follows both from the purpose of the Directive, which according to the 15th recital, applies to all risks, and from the wording of Article 6 (3) a) thereof, that employers are obliged to evaluate all risks to the safety and health of workers".

The Court went further and explained that: "It should also be noted that the occupational risks which are to be evaluated by employers are not fixed once and for all, but are continually changing in relation, particularly, to the progressive development of working conditions and scientific research concerning such risks." The Court further highlighted that a general formal indication in the national law of the obligation of the employer to take measures to protect the physical and mental health of workers was not sufficient and that the national legislation must also reflect the specific obligation to evaluate all the risks to the health and safety of workers.

Table 4: Regulatory instruments of relevance³ to mental health and psychosocial risks in the workplace at the European level

Focus	Instrument	Content / Selected Excerpts
General occupational safety and health at work	Directive 89/391/EEC the European Framework Directive on Safety and Health at Work	According to the Directive, employers have “a duty to ensure the safety and health of workers in every aspect related to work”. They have to develop “a coherent overall prevention policy.” Some important principles are: “avoiding risks”, “combating the risks at source”, “adapting the work to the individual”. “The employer shall implement the measures (...) on the basis of the following general principles of prevention: (...) adapting the work to the individual, especially as regards the design of work places, the choice of work equipment and the choice of working and production methods, with a view, in particular, to alleviating monotonous work and work at a predetermined work-rate and to reducing their effect on health. (...) developing a coherent overall prevention policy which covers technology, organization of work, working conditions, social relationships and the influence of factors related to the working environment”.
	C155 Occupational Safety and Health Convention (ILO), 1981 (ratified in 15 EU member states)	The Convention states that, “Each Member shall, in the light of national conditions and practice, and in consultation with the most representative organisations of employers and workers, formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment”.

³ Mental health and/or psychosocial risk in the workplace referred to in the objectives/ scope of the instrument, or in clauses relating to exposure factors, risk assessment, preventive actions, mental health problems/ disorders at work and related outcomes.

		<p>The policy should take into account, “relationships between the material elements of work and the persons who carry out or supervise the work, and adaptation of machinery, equipment, working time, organisation of work and work processes to the physical and mental capacities of the workers”.</p>
	<p>C187 Promotional Framework for Occupational Safety and Health Convention (ILO), 2006 (ratified in 12 EU member states)</p>	<p>The Convention states that “In formulating its national policy, each Member, (...) in consultation with the most representative organisations of employers and workers, shall promote basic principles such as assessing occupational risks or hazards; combating occupational risks or hazards at source; and developing a national preventative safety and health culture that includes information, consultation and training”. “(...) the principle of prevention is accorded the highest priority”.</p>
<p>General workplace requirements</p>	<p>Directive 89/654/EEC concerning the minimum safety and health requirements for the workplace (first individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p> <p>Directive 2009/104/EC concerning the minimum safety and health requirements for the use of work equipment by workers at work (second individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC) [replacing Directive 89/655/EEC]</p>	<p>This Directive “lays down minimum requirements for safety and health at the workplace”. It covers aspects of the physical working environment which include, “Ventilation of enclosed workplaces (...), room temperature (...), Natural and artificial room lighting (...)”.</p> <p>The Directive highlights the employer’s obligation to, “take the measures necessary to ensure that the work equipment made available to workers in the undertaking or establishment is suitable for the work to be carried out or properly adapted for that purpose and may be used by workers without impairment to their safety or health”.</p> <p>Article 7 of the Directive covers ‘ergonomics and occupational health’, which states that, “The</p>

		<p>workplace and position of workers while using work equipment and ergonomic principles shall be taken fully into account by the employer when applying minimum health and safety requirements”.</p>
	<p>Directive 89/656/EEC on the minimum health and safety requirements for the use by workers of personal protective equipment at the workplace (third individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>The Directive specifies that, “All personal protective equipment must: (a) be appropriate for the risks involved, without itself leading to any increased risk; (b) correspond to existing conditions at the workplace; (c) take account of ergonomic requirements and the worker's state of health(...)”.</p>
<p>Sector specific workplace requirements</p>	<p>Directive 93/103/EC concerning the minimum safety and health requirements for work on board fishing vessels (thirteenth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>The Directive “lays down minimum safety and health requirements applicable to work on board [fishing] vessels”.</p> <p>It stipulates that, “the workers' living quarters and facilities, (...) should be such as to provide adequate protection against weather and sea, vibration, noise and unpleasant odours from other parts of the vessel likely to disturb the workers during their period of rest”.</p>
	<p>Directive 92/91/EEC - concerning the minimum requirements for improving the safety and health protection of workers in the mineral-extracting industries through drilling (eleventh individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>This Directive “lays down minimum requirements for the safety and health protection of workers in the mineral-extracting industries through drilling”.</p> <p>It stipulates that “Workplaces must be so organized as to provide adequate protection against hazards. (...). Workstations must be designed and constructed according to ergonomic principles taking into account the need for workers to be able to follow operations taking place at their workstations. Where workstations are occupied by lone workers, adequate supervision or means of communication must be provided”.</p>

	<p>Directive 92/104/EEC on the minimum requirements for improving the safety and health protection of workers in surface and underground mineral-extracting industries (twelfth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>This Directive lays down minimum requirements for the safety and health protection of workers in the surface and underground mineral-extracting industries.</p> <p>It also stipulates that “Workplaces must be so organized as to provide adequate protection against hazards. (...). Workstations must be designed and constructed according to ergonomic principles taking into account the need for workers to be able to follow operations taking place at their workstations. Where workstations are occupied by lone workers, adequate supervision or means of communication must be provided”.</p>
	<p>Directive 92/57/EEC on the implementation of minimum safety and health requirements at temporary or mobile construction sites (eighth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>This Directive, “lays down minimum safety and health requirements for temporary or mobile construction sites”.</p> <p>It states that, “Where the safety or health of workers, in particular because of the type of activity carried out or the presence of more than a certain number of employees as well as the remote nature of the site, so require, workers must be provided with easily accessible rest rooms and/or accommodation areas. Rest rooms and/or accommodation areas must be large enough and equipped with an adequate number of tables and seats with backs for the number of workers concerned”.</p>
<p>Physical work environment – hazard specific</p>	<p>Directive 90/270/EEC on the minimum safety and health requirements for work with display screen equipment (fifth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>This Directive lays down the minimum safety and health requirements for work with display screen equipment. It states that, “Employers shall be obliged to perform an analysis of workstations in order to evaluate the safety and health conditions to which they give rise for their workers, particularly as regards possible risks to eyesight, physical problems and problems of mental stress”.</p>

	<p>Directive 2010/32/EU implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU</p>	<p>This Directive implements the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector. One of its principles states that "The employer has a duty to ensure the safety and health of workers in every aspect related to the work, including psycho-social factors and work organisation".</p> <p>It further specifies, that "Risk assessments shall take into account technology, organisation of work, working conditions, level of qualifications, work related psycho-social factors and the influence of factors related to the working environment."</p> <p>"Prevent the risk of infections by implementing safe systems of work, by: (a) developing a coherent overall prevention policy, which covers technology, organisation of work, working conditions, work related psycho-social factors and the influence of factors related to the working environment (...)"</p>
	<p>Directive 90/269/EEC on the minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers (fourth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)</p>	<p>This Directive lays down minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers. It places responsibility on the employer to, "take care to avoid or reduce the risk particularly of back injury to workers, by taking appropriate measures, considering in particular the characteristics of the working environment and the requirements of the activity (...)"</p>
<p>Working time</p>	<p>Directive 2003/88/EC concerning certain aspects of the organisation of working time (consolidates and repeals Directive 93/104/EC)</p>	<p>"This Directive lays down minimum safety and health requirements for the organisation of working time". It applies to, "minimum periods of daily rest, weekly rest and annual leave, to breaks and maximum weekly working time; and certain</p>

		aspects of night work, shift work and patterns of work”.
	<p>C175 Part-time Work Convention (ILO), 1994 (ratified in 9 EU member states)</p>	<p>The Convention requires signatories to take measures to, “ensure that part-time workers receive the same protection as that accorded to comparable full-time workers in respect of: the right to organize, the right to bargain collectively and the right to act as workers’ representatives; occupational safety and health; and, discrimination in employment and occupation”.</p>
	<p>Directive 97/81/EC concerning the framework agreement on part-time work</p>	<p>The purpose of this Directive is to implement the Framework Agreement on part-time work. The agreement provides, “for the removal of discrimination against part-time workers and to improve the quality of part-time work”.</p>
	<p>Directive 99/70/EC concerning the framework agreement on fixed-term work</p>	<p>The purpose of the Directive is to put into effect the framework agreement on fixed-term contracts, The agreement seeks to, “improve the quality of fixed-term work by ensuring the application of the principle of non-discrimination; establish a framework to prevent abuse arising from the use of successive fixed-term employment contracts or relationships”.</p>
	<p>Directive 2000/79/EC concerning the European Agreement on the Organisation of Working Time of Mobile Workers in Civil Aviation.</p>	<p>The purpose of this Directive is to implement the European Agreement on the organisation of working time of mobile staff in civil aviation. It requires employers to take necessary measures, “to ensure that an employer, who intends to organise work according to a certain pattern, takes account of the general principle of adapting work to the worker”.</p>
	<p>Directive 2002/15/EC on the organisation of working time of persons performing mobile road transport activities</p>	<p>This Directive establishes, “minimum requirements in relation to the organisation of working time in order to improve the health and safety protection of persons performing mobile road transport</p>

		activities”.
Discrimination	Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin	“The purpose of this Directive is to lay down a framework for combating discrimination on the grounds of racial or ethnic origin, with a view to putting into effect in the Member States the principle of equal treatment”.
	Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation	“The purpose of this Directive is to lay down a general framework for combating discrimination on the grounds of religion or belief, disability, age or sexual orientation as regards employment and occupation, with a view to putting into effect in the Member States the principle of equal treatment”.
Equal treatment for men and women	Directive 2002/73/EC on equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions (amending Directive 76/207/EEC)	The Directive states that, “Member States shall actively take into account the objective of equality between men and women when formulating and implementing laws, regulations, administrative provisions, policies and activities”, “conditions for access to employment (...) including promotion”, “access to all types and to all levels of vocational guidance (...)” and as regards, “employment and working conditions, including dismissals, as well as pay as provided for in Directive 75/117/EEC (...)”.
	Directive 2006/54/EC on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation	“The purpose of this Directive is to ensure the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation. To that end, it contains provisions to implement the principle of equal treatment in relation to: access to employment, including promotion, and to vocational training; working conditions, including pay (...)”.

Maternity and related issues	<p>C 183 Maternity Protection Convention (ILO), 2000 (ratified in 13 EU member states)</p>	<p>The Convention states that, “Each Member shall, (...) adopt appropriate measures to ensure that pregnant or breastfeeding women are not obliged to perform work which has been determined (...) to be prejudicial to the health of the mother or the child (...)”.</p>
	<p>Directive 92/85/EC on pregnant workers, women who have recently given birth, or are breast-feeding</p>	<p>The purpose of this Directive is to implement measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or who are breastfeeding.</p> <p>It states that, “In consultation with the Member States and assisted by the Advisory Committee on Safety, Hygiene and Health Protection at Work, the Commission shall draw up guidelines on the assessment of the chemical, physical and biological agents and industrial processes considered hazardous for the safety or health of workers (...). These guidelines shall also cover, “movements and postures, mental and physical fatigue and other types of physical and mental stress connected with the work done by workers (...).</p>
	<p>Directive 2010/18/EU implementing the revised Framework Agreement on parental leave (repealing Directive 96/34/EC)</p>	<p>This Directive puts into effect the revised Framework Agreement on parental leave concluded on 18 June 2009 by the European cross-industry social partner organisations (BUSINESSEUROPE, UEAPME, CEEP and ETUC). “This agreement lays down minimum requirements designed to facilitate the reconciliation of parental and professional responsibilities for working parents”.</p>
Young people at work	<p>Directive 94/33/EC on the protection of young people at work</p>	<p>This Directive stipulates that The Member States, “shall ensure in general that employers guarantee that young people have working conditions which suit their age. They shall ensure that young</p>

		<p>people are protected against economic exploitation and against any work likely to harm their safety, health or physical, mental, moral or social development (...)".</p> <p>It includes provisions relating to the employer's general obligations, such as protection of the health and safety of young people, and assessment and monitoring of the, "risks to the safety, the physical or mental health or development of young people".</p>
Temporary workers	Directive 91/383/EEC supplementing the measures to encourage improvements in the safety and health at work of workers with a fixed-duration employment relationship or a temporary employment relationship	"The purpose of this Directive is to ensure that workers with an employment relationship (governed by a fixed-duration contract of employment or temporary employment relationships) are afforded, as regards safety and health at work, the same level of protection as that of other workers in the user undertaking and/or establishment".
Informing and consulting employees	Directive 2002/14/EC establishing a general framework for informing and consulting employees in the European Community	The purpose of this Directive is to establish a general framework setting out minimum requirements for the right to information and consultation of employees in undertakings or establishments within the Community. It states, "Information and consultation shall cover (...) information and consultation on decisions likely to lead to substantial changes in work organisation or in contractual relations (...)".
	Directive 2009/38/EC on the establishment of a European Works Council or a procedure in Community-scale undertakings and Community-scale groups of undertakings for the purposes of informing and consulting employees (recast)	The main aim the Directive is to make sure that management informs and consults with members of European Works Councils (EWCs) in exceptional situations that affect the interests of workers, especially in terms of relocation, closure or mass layoffs.
Restructuring	Directive 98/59/EC on the approximation of the laws of	The Directive states, "Where an employer is contemplating

	<p>the Member States relating to collective redundancies</p>	<p>collective redundancies, he shall begin consultations with the workers' representatives in good time with a view to reaching an agreement".</p> <p>"These consultations shall, at least, cover ways and means of avoiding collective redundancies or reducing the number of workers affected, and of mitigating the consequences by recourse to accompanying social measures aimed, inter alia, at aid for redeploying or retraining workers made redundant".</p>
	<p>Directive 2001/23/EC on the approximation of the laws of the Member States relating to the safeguarding of employees' rights in the event of transfers of undertakings, businesses or parts of undertakings or businesses</p>	<p>The purpose of the Directive is to protect employees' rights in case of a 'transfer of an undertaking, business or part of a business to another employer as a result of a legal transfer or merger'. The aim of the Directive is to ensure, as far as possible, that the employment relation continues unchanged with the transferee and that the workers are not placed in a less favourable position solely as a result of the transfer.</p>
	<p>Directive 2008/94/EC on the protection of employees in the event of the insolvency of their employer (repealing Directive 2002/74/EC and Council Directive 80/987/EEC)</p>	<p>This Directive aims, "to provide a minimum degree of protection for employees in the event of the insolvency of their employer. To this end, it obliges the Member States to establish a body which guarantees payment of the outstanding claims of the employees concerned".</p> <p>"It should be ensured that the employees referred to in Directive 97/81/EC concerning the Framework Agreement on part-time work (...), Council Directive 1999/70/EC concerning the framework agreement on fixed-term work (...) and Council Directive 91/383/EEC supplementing the measures to encourage improvements in the safety and health at work of workers with a fixed-duration employment relationship or a</p>

		temporary employment relationship are not excluded from the scope of this Directive”.
--	--	---

It should be noted here that in some EU member states the national regulatory frameworks are more specific than the key EU OSH Directives and do make reference to psychosocial risks and work-related stress. A detailed review and analysis of national level frameworks is presented in section 4.3.

A debate has been taking place in the scientific and policy literatures about the lack of clarity in regulatory frameworks and related guidance on mental health at work and the management of psychosocial risks (e.g. Levi, 2005; Leka et al., 2010; Taris, van der Wal & Kompier, 2010). A recent European Survey of Enterprises on New & Emerging Risks (ESENER) which covered over 28,000 enterprises in 31 countries across Europe has revealed that even though work-related stress was reported among the key OSH concerns for European enterprises, only about half of the establishments surveyed reported that they inform their employees about psychosocial risks and their effects on health and safety and less than a third had procedures in place to deal with work-related stress. The findings of the survey also showed that 42% of management representatives consider it more difficult to tackle psychosocial risks, compared with other safety and health issues. The most important factors that make psychosocial risks particularly difficult to deal with were reported to be ‘the sensitivity of the issue’, ‘lack of awareness’, ‘lack of resources’ and ‘lack of training’ (EU-OSHA, 2010).

Similar findings have also been found in stakeholder surveys, which report that many stakeholders still perceive workplace hazards as primarily relating to physical aspects of the work environment. Furthermore, where issues relating to mental health are reported to be important OSH concerns, there are significant differences among the perception of stakeholders in different countries in the EU (Iavicoli et al., 2004, 2011). These differences in perception (in terms of perspectives, priorities and interests) of mental health at work between social actors, particularly between employers’ organisations and trade unions are a challenge for effective social dialogue on these issues and for the effective implementation of recently introduced voluntary policy initiatives for the management of psychosocial risks such as the European framework agreements on work-related stress and on harassment and violence at work (Ertel et al., 2010).

4.1.2 Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace

In addition to the regulatory instruments reviewed above, a significantly larger number of ‘soft’ policy initiatives of relevance to mental health and psychosocial risks in the workplace have been developed and implemented at the EU level. An EU-OSHA report on workplace mental health promotion cites some of the recent policy documents and initiatives within the EU relevant to mental health at work (EU-OSHA, 2011):

1. Lisbon Strategy: EU goal for economic growth and competitiveness. Targets towards full employment and greater social inclusion
2. Community Strategy on Health and Safety at Work, 2007-2012

3. Commission White Paper "Together for Health"
4. Framework Agreement on Work-related Stress
5. Framework Agreement on Harassment and Violence at Work
6. The Mental Health Pact.

The EU-OSHA report highlights the wide scope of policies in this area, which range from broad EU strategies, public health policies to social dialogue initiatives. In addition to these, other policy initiatives of relevance to mental health and psychosocial risks in the workplace include the setting up of formalised stakeholder committees, EU level campaigns, policies on managing disability, and initiatives by organisations such as the WHO and ILO. This section presents a review of these policies under these key themes⁴.

Early policy initiatives and EU strategies

One of the earliest policy initiatives of relevance, was the Council Decision [COM(90)450] on an action programme which declared 1992 as the 'European Year of Safety, Hygiene and Health Protection at Work', running from March 1992 to March 1993 (EC, 1990). The Community's motives in organising the European year included the need to improve awareness of the content and implications of Community legislation on safety and health. Some of the key messages of the European Year were designed to make workers and employers more aware of hazards in their working life and of ways to alleviate these. Well-being at work was one of the four priority themes and included reference to 'psychological tension/wellbeing/stress'. During the European Year, the European Trade Union Confederation (ETUC) prepared a number of projects to train and inform workers' representatives. These included organising and conducting seminars and colloquia on stress prevention at work (EC, 1993).

In 1995, the Commission submitted a proposal for Council Decision adopting a programme of non-legislative measures to improve health and safety at work [COM(95)282 final]. The proposal included four non-legislative measures to improve safety and health at work. The third action related to the emergence of new health and safety risks. Under this action, the Commission would carry out investigations on important problems, each of which are directly related to mental health and psychosocial risks at the workplace. Some of these were identified as:

- the incidence and control of violence in the workplace where workers, especially in the security business and in sales outlets, are increasingly subject to violent attacks;
- the influence of excessive stress and personal behaviour on the incidence of work accidents, occupational diseases and work-related diseases;
- advantages or disadvantages from the use of particular techniques for the monitoring of the state of health of the workforce (including genetic screening and monitoring) in respect of the ethical, social, psychological and legal consequences concerned;
- the implications for health and safety of new technologies, production techniques, the introduction of modern telecommunications and the resulting increase in homeworking.

⁴ It should be noted that the development and implementation of policy initiatives is often interrelated, involving a number of agencies and stakeholders. The use of the themes is indicative and meant primarily to aid understanding.

The European Parliament in 1996, approved the proposal in the legislative resolution embodying Parliament's opinion on the proposal for a Council Decision adopting a programme of non-legislative measures to improve health and safety at work [COM(95)0282 - C4-0386/95 - 95/0155(CNS)]. The resolution recognised the importance of creating a stimulating and psychologically sound working environment in which human resources are used to best advantage, thus giving the undertaking increased flexibility and greater job satisfaction.

The European Parliament Resolution (A4-0050/1999) on the 21st annual activity report of the Advisory Committee on Safety, Hygiene and Health Protection at Work and the mid-term report on the Community Programme concerning Safety, Hygiene and Health at Work, urged "the Commission to investigate the new problem areas which are not covered by current legislation: i.e. stress, burn-out, violence and the threat of violence by customers and harassment at the workplace". It also noted that, "muscular-skeletal diseases and psycho-social factors constitute the greatest modern threat to workers' health".

Recognising that mental health is an indivisible part of health, the Council of the European Union passed a Resolution (2000/C86/01) on the promotion of mental health, which highlighted the need for enhancing the value and visibility of mental health and to promote good mental health at work. Another Council resolution, passed in 2000, was relevant to psychosocial risks in the workplace. Council Resolution (2000/C218/02), on the balanced participation of women and men in family and working life, called on employers in the public and private sectors, workers and the social partners at national and European level "to step up their efforts to ensure balanced participation of men and women in family and working life, notably through the organisation of working time and the abolition of conditions which lead to wage differentials between men and women".

The Council of the European Union Conclusions (2002/C6/01) on combating stress and depression-related problems called on Member states to, "give due attention to the impact of stress and depression-related problems in all age groups and ensure that these problems are recognised; in this context, give special attention to the increasing problem of work-related stress and depression". It also called on the Commission to, "consider opportunities to prevent stress and depression in the definition and implementation of relevant Community policies and activities which shall complement national policies".

In addition to these specific policies, overarching EU strategies are also relevant to mental health and psychosocial risks in the workplace. This is because such strategies guide actions at the Community as well as the national level. In 2000, at the Lisbon summit of the Council of the European Union, the Council launched the Lisbon Strategy which highlighted the need for Europe to become the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion. In context of generating more and better jobs for Europe: developing an active employment policy, the Strategy called on the Council and the Commission to address, "improving employability and reducing skills gaps, in particular by providing employment services with a Europe-wide data base on jobs and learning opportunities; promoting special programmes to enable unemployed people to fill skill gaps; (...) by exploiting the complementarity between lifelong learning and adaptability through flexible management of working time and job rotation; (...) furthering all aspects of equal opportunities, including reducing occupational segregation, and making it easier to reconcile working life and family life, (...)".

A number of policies, as presented in Table 5, on lifelong learning, promotion of equal opportunities, work-life balance, flexicurity and social inclusion were developed and implemented. In 2007, a Communication from the Commission [COM(2007) 798] set out an initial overview of the results of the negotiations of the new generation of cohesion of policy strategies and programmes for the period 2007-2013. It emphasised that making a success of the new cohesion programmes was critical to realising the Union's overall ambitions for strong economic growth, more and better jobs and a higher standard of living for its citizens, and retained the same three priorities which are at the heart of the growth and jobs strategy, which included creating more and better jobs.

Also in 2007, Communication {SEC(2007) 214-216} from the Commission on Improving quality and productivity at work, set the Community strategy 2007-2012 on health and safety at work. The strategy for health and safety at work 2007-2012 called for a more preventive culture with priority for mental health in the workplace. Through the strategy, the Commission encouraged Member States to incorporate into their national strategies specific initiatives aimed at preventing mental health problems and promoting mental health more effectively, in combination with Community initiatives on the subject, including the employment of persons with a mental disability. The strategy also highlighted, "the importance of negotiations between the social partners on preventing violence and harassment at the workplace and encourages them to draw conclusions from the assessment of the implementation of the European framework agreement on work-related stress".

A European Parliament resolution of 15 January 2008 on the Community strategy 2007-2012 on health and safety at work (2007/2146(INI) while welcoming the strategy called for, "more attention to the causes underlying the development of mental illnesses and to mental health, addiction and psychological hazards at the workplace, such as stress, harassment and mobbing, as well as violence and further calls for greater emphasis to be placed on employer policies for the promotion of good physical and mental health". It considers, "that excessive working hours/insufficient rest periods are a key factor in increased levels of accidents and illnesses at work and calls for a proper balance of work and family life". On a broader level, "it welcomed the Commission's greater emphasis on regulatory simplification and reduction of administrative burdens, and points out that while simplification provides enhanced benefits to citizens, it helps employers and employees to focus on the practical management of health and safety to secure better outcomes; considers it to be of paramount importance that such simplification in no way undermines the level of protection offered to workers".

The resolution also considers, "Corporate Social Responsibility (CSR) to be one of the effective tools to enhance competitiveness, OHS and the working environment and in this aspect encourages the exchange of good practices at local, national and European level among the Member States and globally at multinational level as well as further applying of CSR on a voluntary basis, but as an integrated part of business strategies for development". The Parliament takes the view that, "it is necessary to cooperate with international organisations such as the WTO, the WHO and the ILO, and to ensure that international conventions and agreements on OSH are adopted and implemented by all parties; considers that this is an important factor in maintaining the EU's competitiveness and avoiding the transfer of EU undertakings to third countries in search for a more permissive health and safety environment; considers, furthermore, that this is a question of protecting human rights and should therefore be addressed when negotiating with third countries".

The European Economic and Social Committee in its opinion on the Community strategy 2007-2012 on health and safety at work [COM(2007)62 final] emphasised that, "Healthy and safe work for European citizens as employees is an essential precondition for achieving the objectives of the renewed Lisbon strategy on increased productivity and competitiveness. Community legislation together with national measures ensure the health and safety of employees at work. This is what the new 2007-2012 Community strategy on health and safety at work must put into practice". The Committee welcomed the significant contribution made by the social partners to improving the mental health of workers through their agreements on stress, and on violence and harassment, and called on the agreements to be implemented at national level. While the Committee also welcomed CSR as a method to promote health and safety, it emphasised that CSR cannot take the place of existing and future legal rules.

The Committee agreed with the Commission in its expectations of a more health-conscious attitude on the part of employees; however, it highlighted that this was only possible in the presence of requisite conditions. It delineated, "Precarious and fixed-term contracts, actual working time and constant stress due to fear of losing one's job, ignorance of and lack of information on employees' rights and the disadvantageous situation of migrant workers when they use healthcare services are among the problems which stand in the way of promoting the right attitudes".

The Committee also suggested that the psychosocial and physical repercussions of new fields of work and conditions on employees must be examined using scientific methods; to this end, new indicators must be developed. In addition it was of the opinion that all occupational physicians should be given training to help them diagnose mental stress arising from working conditions and the resulting problems. Finally, the Committee highlighted that in the course of implementing its 2002-2006 strategy for well-being at work, the EU did not fully fulfil its tasks with regard to ensuring a workplace in which mental health is not threatened by stress and depression. The Committee "deplored this and urged the Commission to come up with specific proposals".

In 2013, the Commission launched a public consultation to seek stakeholder views on the implementation of the 2007-12 OSH strategy and on the way forward. The results of the evaluation of the strategy confirmed the value of an EU strategic framework for policy action in the field of OSH and indicated strong stakeholder support for a continuing EU-level strategic approach. The evaluation highlighted the need to review objectives, priorities and working methods to adapt the EU policy framework to changing patterns of work, and new and emerging risks. In proposing a strategic framework on health and safety at work for 2014-20, the Commission took due account of several contributions, in particular those received from the European Parliament, the Advisory Committee on Safety and Health (ACSH), and the Senior Labour Inspectorate Committee (SLIC). The 2014-2020 'OSH strategic framework' was launched in June 2014, which highlights three main challenges which require further policy action. One of these challenges focuses on 'Improving the prevention of work-related diseases by tackling existing, new and emerging risks'. The strategy calls for specific attention to be given to addressing the impact of changes in work organisation in terms of physical and mental health and one of the key actions calls for the identification and dissemination of good practice on preventing mental health problems at work.

OSH and the rights and responsibility agenda

The European Convention on Human Rights (ECHR) was signed in Rome under the aegis of the Council of Europe on 4 November 1950. It established a system of international protection for human rights (and included the establishment of the European Court of Human Rights), whereby individuals received the possibility of applying to the courts for the enforcement of their rights. The ECHR focuses on the protection of civil and political rights, while the Charter of Fundamental Rights (2000/C 364/01) of the European Union goes further to cover workers' social rights, data protection, bioethics and the right to good administration. The EU Charter of Fundamental Rights was solemnly proclaimed by the Nice European Council on 7 December 2000. It is based on the Community Treaties, international conventions, constitutional traditions common to the Member States and various European Parliament declarations. With the entry into force of the Treaty of Lisbon on 1 December 2009, the Charter (as amended in December 2007) received the same legal value as the Treaties and became equally binding. The EU Treaty also provides the legal basis for the Union's accession to the ECHR. This will allow EU law to be interpreted in light of the Convention, and improve the legal protection of EU citizens by extending the protection they enjoy from Member States to acts of the Union.

A number of fundamental human rights included in the chapter are relevant and applicable to mental health at work, already enforced through EU OSH directives and other forms of EU policy. These include the right to fair and just working conditions (article 31), non-discrimination (article 21), equality between men and women (article 23), workers' right to information and consultation within the undertaking (article 27), prohibition of child labour and protection of young people at work (article 32), family and professional life (article 33), integration of persons with disabilities (article 26), right of collective bargaining and action (article 28), protection in the event of unjustified dismissal (article 30). Human rights are an increasingly important aspect of corporate social responsibility. The EU has endorsed the UN Guiding Principles⁵ in its 2011 CSR strategy and has made a commitment to support their implementation.

Over the past decades, economic and socio-political factors in many European countries as well as the enlargement of the European Union (EU) has led to a partial redefinition of the boundaries between the public and the private sector as well as their respective roles in the society. In 2000, at the Lisbon Summit, EU member states took the position that "the European Social Model, with its developed systems of social protection, must underpin the transformation of the knowledge economy" (Vaughan-Whitehead, 2003). The European Commission's (EC) Social Agenda, subsequently supported by the European Council in Nice (EC, 2001), and emphasised the role of 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]. The Commission encourages that enterprises "should have in place a process to integrate social, environmental, ethical human rights and consumer concerns into their business operations and core strategy in close collaboration with their stakeholders". In March 2010, the European Commission in its EU2020 vision for smart, sustainable and inclusive growth made a renewed commitment to "renew the EU strategy to promote Corporate Social Responsibility as a key element in ensuring long term employee and consumer trust" (EC, 2010b), again emphasizing both internal and external dimensions of CSR.

⁵ The UN Guiding Principles on Business and Human Rights define what companies and governments should do to avoid and address possible negative human rights impacts by business.

The internal dimension of CSR includes socially responsible practices concerning employees, relating to their safety and health, investing in human capital, managing change and financial control (Bondy et. al., 2004). It involves organizations dealing with their internal stakeholders. The primary internal stakeholders of any organization are the management and the employees. Therefore, organisational interactions between management and employees dominate discussions on the internal dimension of enterprise responsibility. They include elements like providing an environment for lifelong learning for employees, better information flow, improving the balance between work, family, and leisure, profit sharing and share ownership schemes, as well as job security among others.

CSR and responsible business practices have been reported to an important issue in relation to psychosocial risk management and the promotion of mental health at work (Jain et al., 2011). CSR instruments and standards provide a broad coverage of several psychosocial factors. Since most CSR standards and instruments cover labour dimensions and working conditions (Montero et al., 2009) which include basic labour themes originating from international labour standards and regulations (e.g. ILO fundamental Conventions, Universal Declaration of Human Rights, OECD Guidelines), a number of psychosocial factors are directly or indirectly addressed by these instruments (Jain et al., 2014).

Social Dialogue Initiatives

In the last decades, new 'softer' forms of policy which directly refer to mental health and psychosocial risks have been initiated in the EU through increased stakeholder involvement within such frameworks as social dialogue (Ertel et al., 2010). Actions taken by social partners within the European social dialogue framework, a core element of the European social model (Weiler, 2004), have over the past years played a significant role in recognising the relevance of these issues. Participants in European social dialogue – ETUC (trade unions), BUSINESSEUROPE (private sector employers), UEAPME (small businesses), and CEEP (public employers) - have concluded a number of agreements that have been ratified by the Council of Ministers and are now part of European legislation such as parental leave (1996, revised in 2009), part-time work (1997) and fixed-term contracts (1999).

In the context of the European employment strategy, a part of the Lisbon Agenda, the European Council also invited the social partners to negotiate 'voluntary' or autonomous agreements to modernise the organisation of work, including flexible working arrangements, with the aim of making undertakings productive and competitive and achieving the necessary balance between flexibility and security (EC, 2006). Autonomous agreements implemented by social partners include framework agreements on telework (2002), work-related stress (2004), harassment and violence at work (2007) and inclusive labour markets (2010). An autonomous agreement signed by the European social partners creates a contractual obligation for the affiliated organisations of the signatory parties to implement the agreement at each appropriate level of the national system of industrial relations instead of being incorporated into a Directive (Eurofound, 2011).

In addition to framework agreements, the social partners have also signed a framework of actions for the lifelong development of competencies and qualifications in 2002 and a framework of actions on gender equality in 2005. The European social partners adopted the framework of actions to contribute to the implementation of the Lisbon strategy for economic growth, more and better jobs and social cohesion as well as of the EU legislative framework on equal treatment between women and men.

While the framework of actions for the lifelong development of competencies and qualifications highlights the commitment of the social partners to help employees to improve their employability and career prospects (European Social Partners, 2002), the framework of actions on gender equality is particularly relevant to OSH as each of the four priorities set out in the framework have important direct and indirect implications on how programmes and interventions to manage workers' safety, health and are designed and implemented (European Social Partners, 2005).

Agreements implemented by Council Directive

Framework agreement on prevention from sharp injuries in the hospital and healthcare: In 2009 the European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Public Services Union (EPSU) signed the framework agreement on prevention from sharp injuries in the hospital and healthcare. The agreement aims to: achieve the safest possible working environment for employees in the hospital and healthcare sector, protect workers at risk, prevent injuries to workers caused by all types of sharp medical objects and instruments which are able to cut and/or prick, set up an integrated approach to assessing and preventing risks (including work-related psychosocial risks) as well as to training and informing workers. The agreement was implemented by Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU. The agreement highlighted that the employer has a duty to ensure the safety and health of workers in every aspect related to the work, including psycho-social factors and work organisation.

Framework agreement on parental leave: This framework agreement between the social partners set out minimum requirements on parental leave and time off from work on grounds of force majeure, as an important means of reconciling work and family life and promoting equal opportunities and treatment between men and women. It applies to all workers, men and women, who have an employment contract or employment relationship as defined by the law, collective agreements or practices in force in each Member State. The agreement was implemented by Council Directive 96/34/EC of 3 June 1996 and revised in 2008 and was incorporated into Council Directive 2010/18/EU of 8 March 2010 implementing the revised Framework Agreement on parental leave concluded by BUSINESSSEUROPE, UEAPME, CEEP and ETUC and repealing Directive 96/34/EC.

Framework agreement on part-time work: The agreement sets out the general principles and minimum requirements relating to part-time work. It illustrates the willingness of the social partners to establish a general framework for the elimination of discrimination against part-time workers, to improve the quality of part-time work and to assist the development of part-time work on a voluntary basis and to contribute to the flexible organisation of working time in a manner which takes into account the needs of employers and workers. The agreement was implemented by Council Directive 97/81/EC of 15 December 1997 concerning the Framework Agreement on part-time work concluded by UNICE, CEEP and the ETUC.

Framework agreement on fixed-term contracts: This framework agreement sets out the general principles and minimum requirements relating to fixed-term work, recognising that their detailed application needs to take account of the realities of specific national, sectoral and seasonal situations. The agreement was implemented by Council Directive 1999/70/EC of 28 June 1999 concerning the framework agreement on fixed-term work concluded by ETUC, UNICE and CEEP.

Autonomous agreements implemented by Social partners

Framework agreement on telework: In 2002, the European social partners signed the first autonomous agreement. The framework agreement on telework highlights that teleworkers must enjoy the same level of general protection and rights afforded to other employees. The agreement establishes a general framework for the use of telework in such a way as to meet the needs of employers and workers. The agreement identifies the key areas requiring adaptation or particular attention when people work away from the employer's premises, for instance data protection, privacy, health and safety, organisation of work and training.

Framework agreement on work-related stress: The framework agreement on work-related stress, signed by the social partners in 2004, aims at increasing the awareness and understanding of employers, workers and their representatives of work-related stress. As such it highlights that the responsibility for implementing measures to identify and prevent problems of work-related stress and help to manage them when they do arise rests with the employer. It also places emphasis on participation and collaboration of workers.

Framework agreement on harassment and violence at work: Signed in 2007, the framework agreement on harassment and violence at work aims to increase awareness and understanding of employees, workers and their representatives of workplace harassment and violence, and to provide employers, workers and their representatives at all levels with an action-oriented framework to identify, manage and prevent problems of harassment and violence at work. According to the agreement, enterprises need to have a clear statement outlining that harassment and violence will not be tolerated. The procedures to be followed where cases arise should be included.

Framework agreement on inclusive labour markets: Achieving an inclusive labour market is a multi-faceted challenge and recognised as a key concern by the European social partners. In 2010, the social partners signed the agreement on inclusive labour markets, to maximise the full potential of Europe's labour force and to increase employment rates and to improve job quality, including through training and skills development. The agreement aims to consider the issues of access, return, retention and development with a view to achieving the full integration of individuals in the labour market, increase the awareness, understanding and knowledge of employers, workers and their representatives of the benefits of inclusive labour markets and to provide workers, employers and their representatives at all levels with an action-oriented framework to identify obstacles to inclusive labour markets and solutions to overcome them.

Sectoral Initiatives

Sectoral social dialogue committees have adopted more than 500 joint texts of various kinds, binding to lesser or greater degrees, including agreements to be implemented in the Member States, either by European directives or by customary national procedures. The European social partners in the hospitals, maritime transport, civil aviation and railways sectors have altogether adopted six agreements on working conditions, working time and occupational safety and health which were implemented through Council Directives (EC, 2010c). Between 1999 and 2007, sectoral committees had adopted 29 documents on health and safety issues in addition to other documents relating to health and safety issues (26 on general working conditions, 15 on

employment, 12 on non-discrimination and five on working time) (Pochet et al., 2009).

Interplay with Public Health Policies

The broad strategies and specific policies on occupational safety and health, as presented above, often interact with policies on public health. This interplay allows for the inclusion of issues relating to mental health and psychosocial risks in the workplace in policies on public health (and vice versa). This interplay increases the likelihood of promoting synergy amongst the different policies and thereby promotes co-ordinated or joint actions. Therefore, it is important to review key public health policies of relevance to mental health and psychosocial risks, both generally and in the workplace.

The importance of mental health was highlighted in the Opinion of the Committee of the Regions (CdR 246/94) on the Communication from the Commission and a proposal for a European Parliament and Council Decision on a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health. The Committee of the Regions (COR) maintained that the Commission's proposals for health education objectives should specifically refer to mental health. Any effective Community health education strategy cannot overlook this area which is particularly relevant given that suicide is now one of the major causes of mortality in the EU. It further highlighted the importance of considering "psychological determinant factors such as stress, boredom and alienation (which can also be related to unemployment)".

The European Parliament, approved the Commission proposal, by adopting a legislative resolution embodying Parliament's opinion on the proposal for a European Parliament and Council Decision adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health [COM(94) 0202 - C4-0079/94 -94/0130(COD)]. The Parliament emphasised the importance of support, in cooperation with the social partners, for health education measures and health and safety promotion and prevention measures in the workplace, in relation to prevention of alcohol abuse and tobacco consumption, and nutrition, and in particular support for measures to prevent occupational diseases.

In 1996, Decision No 645/96/EC of the European Parliament and of the Council adopted a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health for the period 1 January 1996 to 31 December 2000. The objective of the programme was to contribute towards ensuring a high level of health protection and comprised actions aimed at encouraging the 'health promotion approach' in health policies of Member States by lending support to various cooperation measures (exchanges of experience, pilot projects, networks, etc.), encouraging the adoption of healthy lifestyles and behaviour, promoting awareness of risk factors and health-enhancing aspects, and encouraging inter-sectoral and multidisciplinary approaches to health promotion, taking account of the socio-economic factors and the physical environment necessary for the health of the individual and the community, especially for disadvantaged groups. The Decision, highlighted the need for provision of support for health education measures in the workplace, particularly in relation to nutrition and the risks involved in tobacco and alcohol consumption, as well as mental health factors, including prevention of stress-related risks.

Communication from the Commission (COM/2000/0285) outlined the health strategy of the European Community. One of the general objectives of the programme included the need to address health determinants through health promotion and disease prevention measures, through support to and the development of broad health promotion activities and disease prevention actions and specific risk reduction and elimination instruments. Main priorities within the objective included seeking to address the high levels of premature deaths and illness in the EU from major diseases, cancer and cardio-vascular diseases, as well as mental illness. This was achieved by focussing on key lifestyle factors, such as smoking, alcohol, nutrition, physical activity, stress and drug abuse, as well as major socio-economic and environmental factors. The Strategy also included the development of health indicators and the creation of a Community network for health data exchange between Member States, and networks in a number of areas in relation to disease prevention and health promotion, including mental health promotion⁶.

Council Resolution 2000/C218/03, on action on health determinants underlined the need for the Community to direct its action towards preventing disease and promoting health. It "welcomed the Commission's commitment to developing a broad health strategy and the presentation of its proposal for a new health programme, containing a specific strand of action aimed at addressing health determinants by means of health promotion and disease prevention underpinned by inter-sectoral policy (...)".

In 2001, the Council of the European Union Conclusions (2001/C175/01) on a Community strategy to reduce alcohol-related harm recognised, "the close link between alcohol abuse and reduced productivity at work, unemployment, social marginalisation (...) and mental illness", and the need to take relevant action by focusing, "on measures with a European added value, taking full account of possibilities offered by the future action programme in the field of public health, but also including measures in policy areas other than public health". While Council Recommendation (2003/488/EC) on the prevention and reduction of health-related harm associated with drug dependence, called on member states to, "promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction".

With a view to starting wide-ranging discussions on Mental Health in Europe, in 2005, the EC launched a Green paper on Improving the mental health of the population: Towards a strategy on mental health for the European Union. The Green Paper called for the promotion of mental health highlighting that, "promotion of mental health and prevention of mental ill health address individual, family, community and social determinants of mental health, by strengthening protective factors and reducing risk factors". It further identified schools and workplaces, where people spend large parts of their time, as crucial settings for intervention. Mental Health Europe (MHE, 2006) welcomed the objectives of the Green Paper and emphasised the need for the EU to develop a comprehensive strategy on the mental health of the population and called for close links between DG Sanco and DG Employment and Social Affairs to promote social inclusion and protecting human rights for people with mental health problems.

⁶ According to the Regulation (EC) No 1338/2008 of the European Parliament and of the Council of 16 December 2008 on Community statistics on public health and health and safety at work, "the harmonised and common data set to be provided shall cover the following list of subjects: health status, including health perceptions, physical and mental functioning, limitations and disability (...) accidents and injuries (...). An accident at work is defined as 'a discrete occurrence in the course of work which leads to physical or mental harm'".

In 2006, the European Economic and Social Committee adopted an opinion (2006/C 195/11) on the Green Paper Improving the mental health of the population – Towards a strategy on mental health for the European Union. The Committee welcomed the proposals in the Green Paper in terms of the action proposed, and emphasised the importance of prevention at the primary, secondary and tertiary levels with the balance between them depending on the particular area concerned.

The 2006, the European Parliament passed a resolution (2006/2058(INI) on improving the mental health of the population - Towards a strategy on mental health for the European Union which, “considers that good working conditions contribute to mental health and calls for employers to introduce ‘Mental Health at Work’ policies as a necessary part of their health and safety at work responsibility, with a view to ensuring the ‘best possible jobs’ for and best possible incorporation into the labour market of persons with mental disorders, and that these should be published and monitored within existing health and safety legislation, while also taking workers’ needs and views into account”. The resolution, “welcomes the social initiatives within social policy and employment policy to promote the non-discriminatory treatment of individuals with mental ill health, the social integration of individuals with mental disabilities, and the prevention of stress in the workplace”. With regard to the EU employment strategy, the resolution emphasises the influence of mental health on employment as well as the influence of unemployment on people’s state of mental health.

Following on from the Green Paper, the Commission launched a White paper in 2007- Together for health - A Strategic Approach for the EU 2008-2013. The White Paper called on the Commission and Member States to work towards the, “Development and delivery of actions on tobacco, nutrition, alcohol, mental health and other broader environmental and socioeconomic factors affecting health”. It also called on the Commission to take, “Measures to promote the health of older people and the workforce (...)”.

In the 2009 Opinion of the European Economic and Social Committee on the White Paper, the Committee welcomed the Commission’s White Paper and also emphasised the correlation between health, economic prosperity and competitiveness, while recognising the rights of citizens to be empowered in their mental and physical health and to the provision of high-quality healthcare. It reiterated that the right to be empowered in mental and physical health and access to mental and physical healthcare is a fundamental right for European citizens and is one of the main pillars of active European citizenship.

Decision 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 established the second programme of Community action in the field of health (2008-13). Building on the achievements of the previous Programme for Community action in the field of public health (2003-08), the new programme aimed to contribute towards the attainment of a high level of physical and mental health and greater equality in health matters throughout the Community by directing actions towards improving public health, preventing human diseases and disorders, and obviating sources of danger to health with a view to combating morbidity and premature mortality.

The Programme highlighted the importance of mainstreaming health objectives in all Community policies and activities, without duplicating work carried out under other Community policies. Coordination with other Community policies and programmes was a key part of the objective of mainstreaming health in other policies. The Decision

specified that, "in order to promote synergies and avoid duplication, joint actions may be undertaken with related Community programmes and actions and appropriate use should be made of other Community funds and programmes, including the current and future Community framework programmes for research and their outcomes, (...), the European strategy for health at work (...).

In 2007, the Commission launched a White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues. The White Paper called on Businesses to, "support the development of healthy lifestyles in the workplace. Together with employee organisations, they should also develop proposals/guidelines for ways in which companies of different sizes can introduce simple, cost-effective measures to promote healthy lifestyles of employees". It recognized that "a worsening trend of poor diets and low physical activity levels across the EU population can be expected to increase future levels of a number of chronic conditions, such as cardiovascular disease, hypertension, type 2 diabetes, stroke, certain cancers, musculo-skeletal disorders and even a range of mental health conditions".

In addition, in 2008, a high level conference hosted by the European Commission launched the European Pact for Mental Health and Wellbeing which recognised that mental health and well-being are a key resource for the success of the EU as a knowledge-based society and economy and for the realisation of the objectives of the Lisbon strategy, on growth and jobs, social cohesion and sustainable development. The purpose of the Pact was to establish an EU-level framework for exchange and cooperation on mental health challenges and opportunities. The Pact had five priorities, with "Mental Health in Workplace Settings" being one of them. It stated that "employment is beneficial to physical and mental health...action is needed to tackle the steady increase in work absenteeism and incapacity, and to utilise the unused potential for improving productivity that is linked to stress and mental disorders" (European Pact for Mental Health and Wellbeing, 2008). The Pact also called on the EC to issue a proposal for a Council Recommendation on Mental Health and Well-being.

In 2009, the European Parliament passed a non-legislative resolution on mental health. The resolution, called on "the Member States to encourage research into the working conditions which may increase the incidence of mental illness, particularly among women"; it called on "employers to promote a healthy working climate, paying attention to work-related stress, the underlying causes of mental disorder at the workplace, and tackling those causes" and it called on "the Commission to require businesses and public bodies to publish annually a report on their policy and work for the mental health of their employees on the same basis as they report on physical health and safety at work" (European Parliament, 2009).

As the key element in the implementation of the Mental Health Pact, a series of thematic conferences were organised between 2009 and 2011 on each of the five priorities. The fifth conference, held in Berlin on 3-4 March 2011, was on the theme 'Promoting Mental Health and Well-being at Workplaces. The conclusions from the conference reiterated that mental health at work is a core element of Europe's social model and highlighted the importance of mental health as an indicator of the quality of social cohesion and the quality of work.

It recognised that within the framework of labour and social policy, both at the European and at the national level, a legal framework is in place, which outlines the responsibility of employers for implementing measures at the workplace to protect and promote mental health and well-being at the workplace. It also recognises the important role in providing support for business played by institutions such as the

European Agency for Safety and Health at Work (EU-OSHA), European Foundation for the Improvement of Living and Working Conditions (Eurofound), working together with the corresponding structures in the Member States.

The Council of the European Union conclusions on 'The European Pact for Mental Health and Well-being- results and future action' (EC, 2011), recognised that the determinants of mental health and well-being, such as social exclusion, poverty, unemployment, poor housing and bad working conditions, problems in education, child abuse, neglect and maltreatment, gender inequalities as well as risk factors such as alcohol and drug abuse are multifactorial, and can often be found outside health systems, and that therefore improving mental health and well-being in the population requires innovative partnerships between the health sector and other sectors such as social affairs, housing, employment and education. It also acknowledged the importance of educational institutions and workplaces as settings for actions in the field of mental health and well-being, as well as the benefits they can gain from such actions for their own objectives.

"The Council Conclusions invited the Member States:

- To make mental health and well-being a priority of their health policies and to develop strategies and/or action plans on mental health including depression and suicide prevention;
- Include the prevention of mental disorders and the promotion of mental health and well-being as an essential part of these strategies and/or action plans, to be carried out in partnership with the relevant stakeholders and other policy sectors;
- Improve social determinants and infrastructure which support mental well-being and improve access to this infrastructure for people suffering from mental disorders;
- Promote, where possible and relevant, community-based, socially inclusive treatment and care models;
- Take measures against the stigmatisation and exclusion of and discrimination against people with mental health problems and to promote their social inclusion and their access to education, training, housing and work;
- Take steps towards greater involvement of the health and social sectors along with social partners in the field of mental health and well-being at the workplace, to support and complement employer-led programmes where appropriate;
- Support activities (e.g. training programmes) that enable professionals and managers particularly in healthcare, social care, and workplaces to deal with matters concerning mental well-being and mental disorders.

The Council Conclusions invited the Member States and the Commission to:

- Build innovative partnerships between the health and other relevant sectors (e.g. social, education, employment) to analyse policy impact on mental health, to address mental health problems of vulnerable groups and the links between poverty and mental health problems, to address suicide prevention, to promote mental health and well-being and to prevent mental health disorders in different settings, such as workplaces and educational settings;
- Managing the evolution of community-based and socially-inclusive approaches to mental health;
- Improving data and evidence on the mental health status in populations;

- Support interdisciplinary research on mental health;
- Make optimal use of the World Mental Health Day at European, national and regional level through appropriate awareness raising actions.

The Council Conclusion invited the Commission to:

- Continue addressing mental health and well-being in partnership with EU health policy and other policy areas;
- Further develop the European Compass for Action on Mental Health and Wellbeing;
- Support Member States, by providing data on the mental health status in the population, and carrying out research on the fields of mental health and its determinants, including the health, economic and social costs caused by mental health problems, taking into account the work done by WHO and OECD;
- Present a report on the outcomes of the Joint Action, including an inventory of evidence-based actions in mental health care, social inclusion, prevention and promotion, as well as a reflection on possible future policy actions as a follow-up to the European Pact for Mental Health and Well-being."

In another relevant policy initiative, on the basis of the Council conclusions (2011/C 359/05) on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours, the Council expressed its commitment to, "accelerate progress on combating unhealthy lifestyle behaviours, such as tobacco use, alcohol related harm, unhealthy diet and lack of physical activity, leading to increased incidence of non-communicable chronic diseases, such as cancer, respiratory diseases, cardiovascular diseases, diabetes and mental illnesses, which are recognised to be important causes of premature mortality, morbidity and disability in the European Union".

Council conclusions (2012/C 396/02) on Healthy Ageing across the Lifecycle recognise "the importance of health promotion, disease prevention and early diagnosis programmes from the early stages of life and throughout the lifecycle (...) the far-reaching burden of morbidity and disabilities caused by chronic diseases such as, cancer, respiratory diseases, cardiovascular and neurovascular diseases, diabetes and mental illnesses, musculoskeletal disorders and problems related to hearing and visual impairment in the population. The Council in its conclusions invites the member states and the commission, "to promote strategies for combating risk factors, such as tobacco use, alcohol related harm, illicit drugs, unhealthy diet and lack of physical activity as well as environmental factors, leading to increased incidence of non-communicable chronic diseases, such as cancer, respiratory diseases, cardiovascular and neurovascular diseases, diabetes, mental illnesses and musculoskeletal disorders".

The Council Recommendation of 26 November 2013 on promoting health-enhancing physical activity across sectors (2013/C 354/01) further emphasised that physical activity, being a prerequisite for a healthy lifestyle and a healthy workforce, contributes to the achievement of key objectives defined in the Europe 2020 Strategy notably with regard to growth, productivity and health. The Council invited the Commission to promote the establishment and functioning of the health-enhancing physical activity monitoring framework, while member states were recommended to monitor physical activity levels and HEPA policies by making use of a monitoring framework and indicators set, which included to indicators for the working

environment – a) schemes to promote active travel to work and b) schemes to promote physical activity at the work place.

While in its conclusions on nutrition and physical activity (2014/C 213/01) the Council of the European Union, invited member states to promote healthy dietary options and work with stakeholders to make them available, easily accessible, easy to choose and affordable for all citizens towards reducing inequalities and provide opportunities and places for daily physical activity at homes, schools and workplaces; and to support initiatives to promote health in the workplace, aiming at facilitating healthy eating habits and integrating physical activity into every day working life.

Another recent relevant development has been in emergence of eHealth⁷ as a means of improving quality of life in the EU. Communication from the Commission (COM/2012/736) on eHealth Action Plan 2012-2020 - Innovative healthcare for the 21st century, highlighted that information and communication technologies (ICT) applied to health and healthcare systems can increase their efficiency, improve quality of life and unlock innovation in health markets. The first eHealth Action Plan was adopted in 2004 (COM/2004/356 final). Since then, the European Commission has been developing targeted policy initiatives aimed at fostering widespread adoption of eHealth throughout the EU. As a means of facilitating uptake ensuring wider deployment of eHealth, during the period 2013-2020, the Commission will leverage the Connecting Europe Facility and the European Regional Development Fund for the large scale deployment of innovative tools, the replicability of good practices and services for health, ageing and wellbeing, with a particular attention to improving equal access to services.

Committees and Campaigns

Senior Labour Inspectors Committee (SLIC)

Created by Commission Decision 95/315/EC of 12 July 1995, the Senior Labour Inspectors' Committee is composed of two representatives of the labour inspectorates from each Member State and is chaired by a representative of the Commission. The Committee submits an annual report on its activities to the Commission, with particular reference to any problem relating to the enforcement or monitoring of secondary Community legislation in the field of health and safety at work. The Commission forwards the report to the Council, the European Parliament, the Economic and Social Committee and the Advisory Committee on Safety, Hygiene and Health Protection at Work.

Following a decision at its plenary session in Lyon (December 2008), the Senior Labour Inspectors Committee on 23 November 2009 organised a thematic day on Supervision of psychosocial risk assessments. The Committee had discussed the role of competent authorities in the area of stress and psychosocial problems at work during the previous Swedish Presidency in 2001. A Working Group with representatives of 12 Member States under the leadership of Sweden planned the campaign during 2011.

⁷ eHealth is the use of ICT in health products, services and processes combined with organisational change in healthcare systems and new skills, in order to improve health of citizens, efficiency and productivity in healthcare delivery, and the economic and social value of health. eHealth covers the interaction between patients and health-service providers, institution-to-institution transmission of data, or peer-to-peer communication between patients and/or health professionals.

In 2012, the SLIC undertook the campaign on psychosocial risks. The goal was to develop an inspection toolkit for targeted interventions on occupational health and safety (psycho-social risks). In all 27 countries participated in the campaign. The campaign highlighted that, "the Framework Directive 89/391/EEC and the social partner agreements constitute a common legal basis for supervision in the area of psychosocial risks"; they concluded that inspections on psychosocial risks are possible in all Member States, however in some cases with some restrictions due to national systems and capacities.

The results from the campaign indicated that the number of workplaces which have included psychosocial risks in the risk assessments has increased. Knowledge of psychosocial risks has also increased among labour inspectors in all countries, while awareness of psychosocial risks at work at the workplaces overall has also increased. As a result of the efforts before and during the campaign, "Tools are now available for all European labour inspections to inspect psychosocial risks at work. Increased knowledge among labour inspectors will in the long run lead to improvements concerning psychosocial risks".

DG Employment provides the secretariat for the SLIC and the Tripartite Advisory Committee on Safety and Health at Work (ACSHW).

Advisory Committee on Safety and Health at Work (ACSHW)

In view of the need to establish a standing body to assist the Commission in the preparation and implementation of activities in the field of safety, hygiene and health protection at work, and to facilitate cooperation between national administrations, trade unions and employers' organisations, the Council of the European Communities, by its Decision of 27 June 1974 (74/325/EEC), set up an Advisory Committee on Safety, Hygiene and Health Protection at Work. This was replaced by Council Decision 2003/C 218/01, on setting up an Advisory Committee on Safety and Health at Work. The Advisory Committee for Safety and Health "shall have the task of assisting the Commission in the preparation, implementation and evaluation of activities in the fields of safety and health at work".

The Committee is a tripartite body made up of full members comprising, for each Member State, two government representatives, two representatives of trade unions and two representatives of employers' organisations. An alternate member is appointed for each full member. The full and alternate members of the Committee are appointed by the Council, which publishes the list of members in the Official Journal of the European Communities, for information purposes. The Committee is chaired by a Member of the Commission or, where he or she is prevented from so doing, by a Commission official designated by the chair. The Committee produces an annual report on its activities, which the Commission forwards to the European Parliament, the Council and the Economic and Social Committee.

The Committee "helps to devise a common approach to problems in the fields of safety and health at work and identify Community priorities as well as the measures necessary for implementing them". It "contributes, alongside the European Agency for Safety and Health at Work, to keeping national administrations, trades unions and employers' organisations informed of Community measures in order to facilitate cooperation and to encourage any initiatives on their part to exchange experience and establish codes of practice".

One of the follow up actions/future initiatives that was highlighted at the Berlin Conference on the conclusion of Mental Health Pact, highlighted the importance of the role of the ACSHW in the Promotion of a European Community Strategy on Safety and Health in the Workplace for the period of 2013 to 2020, with an increased focus on health promotion and the specific area of mental health in the workplace, in collaboration the European Commission, social partners and the governments of Member States.

EU-OSHA Healthy Workplace Campaigns

Running since 2000, the Healthy Workplaces Campaigns (formerly known as "European Weeks for Safety and Health at Work") are one of EU-OSHA's principal tools for raising awareness of issues related to occupational safety and health, and promoting the idea that good health and safety is good for business. The campaigns are now the largest of their kind in the world. The campaigns, each of which is now two years in duration, involve hundreds of organisations from all of the EU Member States, the countries of the European Economic Area, candidate and potential candidate countries. EU-OSHA makes information, practical guides and tools, and publicity material freely available, translated into more than 20 European languages.

The annual European Week for Safety and Health at Work (in October every year) is a particular focus for these events, which can include training sessions, conferences and workshops, poster, film and photo competitions, quizzes, suggestion schemes, advertising campaigns and press conferences. Other highlights of each campaign include the Healthy Workplaces Good Practice Awards competition, which recognises organisations that have found innovative ways of promoting safety and health, and the Healthy Workplaces Closing Summits, which bring health and safety professionals, policymakers, and employers' and employees' representatives together, to share best practice.

Healthy workplaces manage stress 2014-15: The EU-OSHA launched its most recent two year Europe-wide campaign 'Healthy Workplaces Manage Stress' in April 2014. The campaign aims at raising awareness of stress and psychosocial risks in the workplace and encouraging employers, managers and workers and their representatives to work together to manage those risks. The campaign will disseminate and promote the use of simple, practical tools and guidance for managing psychosocial risks and stress in the workplace and also highlight the positive effects of managing psychosocial risks and stress in the workplace, including the business case.

Working together for risk prevention 2012-2013: This focuses on risk prevention, i.e., managing work-related risks with the ultimate aim of reducing the number of work-related accidents and occupational illnesses. Final responsibility for managing risk lies with employers and top management, but their efforts are bound to fail without active worker participation. For these reasons, this campaign places special emphasis on the importance of leadership by top management and owners working in tandem with active worker participation.

Lighten the load (Musculoskeletal disorders) 2007: This campaign sought to promote an integrated management approach to this problem, emphasising the idea that employers, employees and government should work together to tackle MSDs. It emphasised the concept of 'managing the load': considering not just the load being carried, for example, but all of the strains being put on the body by environmental factors, and the pace at which the task is carried out. It also stressed the importance

of managing the retention, rehabilitation and return to work of those who suffer, or have suffered, from MSDs.

Working on stress 2002: This campaign focused on the prevention and management of stress in the workplace.

Turn your back on musculoskeletal disorders 2000: The first of EU-OSHA's campaigns focused on the effective management of the risks of MSDs.

European Year of Mental Health

At its 485th plenary session 13 December 2012, the European Economic and Social Committee adopted an opinion on 'The European Year of Mental Health — Better work, better quality of life', calling for a European Year on Mental health and well-being. It aimed at placing focus on prejudice around mental health problems and psychosocial disabilities, and stigmatisation in society or at work.

The Europe 2020 strategy calls for greater social inclusion of this group and for relevant EU health programmes to be set up with an eye to inclusive and sustainable growth. Furthermore, the UN Convention on the Rights of Persons with Disabilities, which was concluded by the EU as the first ever international human rights instrument, provides a clear set of rights for persons with psychosocial disabilities. An approach based on human rights would be of central importance in the advocated European Year of Mental Health (EC, 2013).

European Year of People with Disabilities, 2003

The year 2003 was declared by the European Council as the European Year of People with Disabilities (EYPD). Although responsibility for overseeing the EYPD campaign and actions at EU level lay with the Commission's Directorate-General for Employment and Social Affairs, it was possible to mobilise all of the services whose work had some connection with disability issues and to ensure that the EYPD was included as a particular priority for action in 2003. Examples include the stepping up of funding of specific projects within the different action programmes in the area of education, training, youth and culture; the adoption by the Commission of a revised Code of Good Practice for the Employment of People with Disabilities (C(2003)4362); actions in the area of relations with the then candidate countries focusing on disability issues; and a number of actions in the area of policy on the information society, including a specific conference on e-accessibility.

Another key action undertaken by the Commission at EU level to support the EYPD was the Corporate Participation Programme. This programme sought to bring large companies on board the EYPD campaign by allowing them to participate in a unique venture and encouraging them to create awareness and support for the EYPD and undertake specific actions. These actions were encouraged with a view to reinforcing already existing positive approaches to disability and with a view to acting in a socially responsible manner towards people with disabilities by promoting employment and training opportunities, developing design-for-all products and services, improving accessibility, etc.

Policies on managing disability

People with disabilities (types of disabilities include mobility/agility, mental/cognitive, hearing, speaking, and visual impairments) are recognised to be one of the most

disadvantaged sections of the society in Europe and continue to face considerable barriers in accessing all aspects of social life. The approach to disability endorsed by the European Union acknowledges that environmental barriers are a greater impediment to participation in society than functional limitations. Barrier removal through legislation, provision of accommodations, universal design and other means, has been identified as the key to equal opportunities for people with disabilities. While responsibility for these issues remains mainly with the Member States, the present scope of Community competence provides for substantial means and added value to achieve better equal opportunities for people with disabilities. The inclusion of disability in 'Directive 2000/78/EC prohibiting direct or indirect discrimination on grounds of religion or belief, disability, age or sexual orientation' provides the basis for a crucial leap forward to promote equal rights for people with disabilities at EU level. A number of 'soft' initiatives have also been developed. Some of these are presented below.

The Communication of the Commission on Equality of Opportunity for People with Disabilities - a New European Community Disability Strategy [COM(96) 406 final] intended to serve as a reference framework for the structured exchange of useful information between the Member States; as a platform to stimulate the clarification of common goals and the identification of best practice; and as a guide for the development and assessment of appropriate measures within the Member States and the Community's own respective spheres of action. It was politically endorsed by the Council and the Member States in a Resolution in December 1996.

The social partners, in May 1999, adopted the Declaration of the European social partners on the employment of people with disabilities. Among others, this Declaration states that "The ETUC, CEEP and UNICE/UEAPME believe that an equal opportunities' approach is the right path to follow in order to improve the employment opportunities of people with disabilities in the open labour market". Discrimination based on factors which are irrelevant to the task in question is socially unacceptable and economically inappropriate. Moreover, the Declaration states "Through actively promoting the employment of people with disabilities, companies can develop previously unexploited resources and increase their potential for innovation". The Declaration ended with a call from the social partners to public authorities, inviting them to "take account of the needs of disabled people in an integrated way in order to create a culture of inclusion rather than separation".

Communication from the Commission (COM/2000/0284) - Towards a barrier free Europe for people with disabilities notes that while disability related activities exist in most Community fields, the focus of this Communication rests upon those EU policies that are of particular importance in the drive towards a 'barrier free society' for disabled Europeans. This Communication therefore places a particular emphasis upon the achievement of a greater synergy between related issues in the fields of employment, education and vocational training, transport, the internal market, information society, new technologies and consumer policy. The Commission proposed to the Council that the year 2003 be declared as the European Year of Disabled Citizens in order to promote society's awareness of disability issues and to provide a catalyst for the introduction of new policies in this regard at all levels of governance. The objective of such a proposal, therefore, is to strengthen the concept of citizenship for people with disabilities.

Opinion of the Committee of the Regions (2001/C144/21) on the EC Communication - Towards a barrier-free Europe for people with disabilities, broadly welcomed the Communication as an important document which will assist in the promotion of equal

opportunities for all disabled persons in the European Union. The Committee highlighted that the quest for synergy in the fields of employment, education and vocational training, transport, the internal market, the information society, new technologies and consumer protection will assist in the promotion of equal opportunities for the disabled. It also welcomed the designation of 2003 as the European Year of Disabled Citizens.

Opinion of the Economic and Social Committee on the "Integration of disabled people in society" (2002/C241/17) called for an action plan to support the mainstreaming of disability in all relevant EU policy areas, inter alia by strengthening current consultation and monitoring mechanisms and by promoting disability awareness among key decision-makers, focusing on possibilities for disabled people. The action plan should also support the establishment of an open method of coordination in the field of disability, based on common outcome indicators that would make it possible to monitor the progress in time of the levels of social inclusion of disabled people. This method would include all relevant areas of disability policy, such as education, vocational training, life-long learning, employment, transport, information society, benefit systems and services for people with complex dependency needs and their families.

The Committee recognised the vast majority of disabled people in working age are able and willing to work. Increasing their capacity to enter the labour market will result in higher employment levels of disabled people, which is a key to ensure their social participation. It acknowledged that Directive 2000/78/EC on equal treatment in the workplace is a useful contribution to the improvement of the employment levels of disabled people, and called for it to be complemented with adequate positive action, in particular by providing adequate support to employers who employ disabled people, including Small and Medium Enterprises, for which these incentives might be specially attractive.

On 3 December 2001, the Council of the European Union approved the decision to declare 2003 the European Year of People with Disabilities. A conference on disability held in Madrid in March 2002 adopted the so-called Madrid Declaration, which established a conceptual framework for the European Year and included a plan of how to achieve the main objectives, as well as concrete suggestions for actions for all relevant stakeholders. To achieve social inclusion of disabled people, a synthesis approach was proposed, based on a combination of anti-discrimination policies and positive action measures.

The Communication from the Commission (COM/2003/0016) – 'Towards a United Nations legally binding instrument to promote and protect the rights and dignity of persons with disabilities' set out the European Commission's position regarding a possible international legally binding instrument being developed by the UN. The Communication explains the UN background to this issue and considers the human rights approach to disability. It presents the potential added value of a UN legally binding instrument. Drawing upon the Community's experience in the field of combating discrimination and the implementation of Directive 2000/78/EC concerning equal treatment in employment and occupation, which includes specific provision for people with disabilities, the Communication outlines the guiding principles that the envisaged instrument should contain. Finally, the Communication signals the Commission's intention to contribute actively to the development of such an instrument, given the Community's competence in the field of combating discrimination.

Other relevant policies which reiterate these messages and call for actions, include the European Parliament resolution on the situation of people with disabilities in the enlarged European Union: the European Action Plan 2006-2007 (2006/2105(INI)), the Opinion of the European Economic and Social Committee on Equal opportunities for people with disabilities (2007/C93/08), Opinion of the European Economic and Social Committee on Harmonised indicators in the field of disability as an instrument for monitoring European policies (2008/C10/20) and the European Parliament legislative resolution of 2 April 2009 on the proposal for a Council directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation (COM(2008)0426 – C6-0291/2008 – 2008/0140(CNS)).

Communication from the Commission (COM/2010/0636) – ‘European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe. The overall aim of this Strategy is to empower people with disabilities so that they can enjoy their full rights, and benefit fully from participating in society and in the European economy, notably through the Single market. Achieving this and ensuring effective implementation of the UN Convention across the EU calls for consistency. This Strategy identifies actions at EU level to supplement national ones, and it determines the mechanisms needed to implement the UN Convention at EU level, including inside the EU institutions. It also identifies the support needed for funding, research, awareness-raising, statistics and data collection. This Strategy focuses on eliminating barriers. The Commission has identified eight main areas for action: Accessibility, Participation, Equality, Employment, Education and training, Social protection, Health, and External Action.

Opinion of the European Economic and Social Committee on ‘People with disabilities: employment and accessibility by stages for people with disabilities in the EU. Post-2010 Lisbon Strategy’(2010/C 354/02) calls for a specific section on disability to be included when the EU 2020 strategy, the Employment Guidelines and the Social Agenda are adopted, to ensure that this aspect is mainstreamed and better coordinated across all Community policies. The Committee supports a market that is inclusive for all, and points out those employment policies for people with disabilities must focus on the entire life process relating to employment ("life-streaming"), and in particular on education, recruitment, staying in employment, and re-employment. Policies aimed at young people with disabilities, together with policies for those disabled as a result of accident or illness, must be a priority in the future EU 2020 strategy and the Commission's new strategy for people with disabilities.

Other policy initiatives

Additional examples of voluntary policy instruments in the form of guidance (and also of relevance to the EU) have been developed by international organisations such as the WHO and the ILO. These include guidance on psychosocial risks at work, work-related stress, violence and psychological harassment (ILO, 1986, 2006, 2012; WHO, 2003a, 2003b, 2007, 2008). In 2010, the WHO developed the Healthy Workplaces Framework, which presents a model for action for employers, workers, policymakers and practitioners, and includes coverage of the psychosocial work environment. In 2005, the WHO office of the European Region launched the Mental Health declaration for Europe which highlighted the responsibility of each country to commit resources to, “prevent risk factors where they occur, for instance, by supporting the development of working environments conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems”. The corresponding Action plan called on countries in the

region to, "Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising". In 2011, this commitment was renewed as part of the WHO European Mental Health Strategy.

However, despite these developments, work-related mental disorders and diseases arising due to psychosocial risks at work had not been recognised until recently. On 25 March 2010, the governing board of the ILO approved a new list of occupational diseases which has been designed to assist countries in the prevention, recording, notification and, if applicable, compensation of diseases caused by work. For the first time mental and behavioural disorders at the workplace have been recognised as occupational diseases, which result from psychosocial hazards. The revised list includes mental and behavioural disorders as, "post-traumatic stress disorder...and...other mental or behavioural disorders...where a direct link is established ... between the exposure to risk factors arising from work activities and the mental and behavioural disorder(s) contracted by the worker" (ILO, 2010b).

In the EU, the list of Occupational Diseases does not specifically address work-related mental disorders and diseases arising due to psychosocial risks at work, even though a number of initiatives have been implemented in relation to this. In 1990, Commission Recommendation (90/326/EEC) concerning the adoption of a European schedule of occupational diseases recommended member states to introduce as soon as possible into their national laws, regulations or administrative provisions concerning scientifically recognized occupational diseases liable for compensation and subject to preventative measures.

In 1996, Communication from the Commission [COM(96) 454 final] concerning the European schedule of occupational diseases indicated that the Member States have made a great effort to comply with the provisions set out in the 1990 recommendation. Even though it recognized that there are diseases in respect of which the epidemiological data collected on an ongoing basis indicate significant links with exposure to certain agents and substances present in specific working environments, the list was not amended.

Commission Recommendation (2003-670-EC) concerning the European schedule of occupational diseases, replaced the 1990 recommendation and expanded the list of diseases and agents. However, none of these covered work-related mental disorders and diseases arising due to psychosocial risks at work.

A report published by the European Commission in March 2013 reviews the situation in relation to occupational diseases in EU member countries and EEA/EFTA states. While it highlights that Mental and behavioural disorders are not covered in the European list of occupational diseases, it specifically refers to diseases caused by psychosocial factors and presents countries which include them in their lists of occupational diseases as follows:

- General formulation in the list of Hungary: diseases caused by psychosocial factors;
- Post-traumatic stress disorders (PTSD) (Denmark) (it should be mentioned that PTSD is compensated in many member states as a result of work accidents);
- Psychoneurosis caused by long-term care of psychopathic people in psychiatric units (Romania);
- Italy reports that between 2005 and 2009 about 400-500 work-related mental disorders each year were compensated under the complementary clause;

- Work-related mental disorders are compensated in the Swedish open system and in some other member states under the complementary clause.
- In addition, mental and behavioural disorders (F: ICD-10) are included in disability registers in Finland. In Latvia, the definition of occupational diseases in Law 17, November 1995 refers to psychological factors in the working environment.

In a related development, in 2004, the Commission set out a Proposal for common rules on the insurance of officials of the European Communities against the risk of accident and of occupational disease (SEC/2004/0414 final). Unlike the schedule of occupational diseases, the proposal includes reference to mental health, for instance “an accident means any sudden occurrence adversely affecting the insured party’s bodily or mental health, the cause or one of the causes of which is external to the victim’s organism”. The proposal also refers to a ‘new proposed schedule’ - the ‘European Assessment Guide and Schedule for Physical and Mental Impairments’.

Table 5 presents a list of voluntary policy instruments, which directly address mental health and psychosocial risks in the workplace. These directly refer to the concepts of psychosocial risk, stress, harassment and violence as well as other related policies that apply to the EU member states.

Table 5: Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace

Focus	Document	Content / Selected Excerpts
Mental Health at Work	Guidance: ILO, 1986 Psychosocial factors at work: Recognition and control	Psychosocial hazards = “interactions among job content, work organisation and management, and other environmental and organisational conditions, on the one hand, and employees’ competencies and needs on the other. Psychosocial hazards are relevant to imbalances in the psychosocial arena and refer to those interactions that prove to have a hazardous influences over employees’ health through their perceptions and experience”.
	R194 revised annex, ILO 2010 Recommendation concerning the List of Occupational Diseases and the Recording and Notification of Occupational Accidents and Diseases	“Post-traumatic stress disorder (...) and (...) other mental or behavioural disorders (...) where a direct link is established (...) between the exposure to risk factors arising from work activities and the mental and behavioural disorder(s) contracted by the worker”.
	WHO Mental health declaration for Europe, 2005 and Mental Health Action Plan for Europe	The Ministerial declaration highlighted the responsibility of each country to commit resources to, “prevent risk factors where they occur, for instance, by supporting the development of working environments

		<p>conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems”.</p> <p>The Mental Health Action Plan for Europe called on countries in the region to, “Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising”.</p> <p>“Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment”.</p> <p>“Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles”.</p> <hr/> <p>WHO Healthy Workplaces Framework, 2010 Healthy workplaces: a model for action: for employers, workers, policymakers and practitioners</p> <p>“The psychosocial work environment includes organizational culture as well as attitudes, values, beliefs and daily practices in the enterprise that affect the mental and physical well-being of employees”.</p> <p>“Examples of psychosocial hazards include but are not limited to: poor work organization (...), organizational culture (...), command and control management style (...), lack of support for work-life balance, fear of job loss related to mergers, acquisitions, reorganizations or the labour market/ economy”.</p> <p>“Psychosocial hazards typically are identified and assessed using surveys or interviews, as compared to inspections for physical work hazards. A hierarchy of controls would then be applied to address hazards identified, including: Eliminate or modify at the source (...) Lessen impact on workers (...), Protect workers by raising awareness and providing training to workers (...)”.</p>
--	--	---

	<p>WHO European Mental Health Strategy, 2011</p>	<p>“There is a need to balance between the economic gain of good mental health in terms of wellbeing and productivity and providing the care people want and need”.</p> <p>The first objective of the mental health strategy states, “Everyone has an equal opportunity to experience mental wellbeing throughout their lifespan, particularly those who are most vulnerable or at risk”.</p>
	<p>Council Resolution 2000/C86/01, on the promotion of mental health</p>	<p>“Considers that there is a need for enhancing the value and visibility of mental health and to promote good mental health, in particular among children, young people, elderly people and at work”.</p>
	<p>Council of the European Union Conclusions, 2003 on Mental health – Conference on Mental Illness and Stigma in Europe: facing up the challenges of social inclusion and equity</p>	<p>The Council of the European Union invites the Commission to, “give specific attention to active collaboration in all relevant Community policies and actions, and in particular in activities relating to employment, non-discrimination, social protection, education and health, in order to reduce stigma and discrimination in relation to mental illness (...)”.</p>
	<p>Council of the European Union Conclusions, 2005 on a Community Mental Health Action – Outcome of proceedings</p>	<p>The Council of the European Union invites the Commission to, “support the implementation of the Declaration and Action plan endorsed by the World Health Organization European Ministerial Conference on Mental Health, in collaboration with the World Health Organization and other relevant international organisations; ensure that integrated impact assessment of future relevant Community legislation takes account of mental health aspects; emphasise the strong links between mental and physical health and drug and alcohol abuse (...)”.</p>
	<p>Green paper – EC, 2005 Improving the mental health of the population: Towards a strategy on mental health for the European Union</p>	<p>“Promotion of mental health and prevention of mental ill health address individual, family, community and social determinants of mental health, by strengthening protective factors and reducing risk factors (...). Schools and workplaces, where people spend large parts of their time, are crucial settings for action”.</p>

	<p>European Parliament resolution (2006/2058(INI)) on improving the mental health of the population. Towards a strategy on mental health for the European Union</p>	<p>“Considers that good working conditions contribute to mental health and calls for employers to introduce ‘Mental Health at Work’ policies as a necessary part of their health and safety at work responsibility, with a view to ensuring the ‘best possible jobs’ for and best possible incorporation into the labour market of persons with mental disorders, and that these should be published and monitored within existing health and safety legislation, while also taking workers' needs and views into account”.</p> <p>“Welcomes the social initiatives within social policy and employment policy to promote the non-discriminatory treatment of individuals with mental ill health, the social integration of individuals with mental disabilities, and the prevention of stress in the workplace”.</p> <p>“With regard to the EU employment strategy, emphasises the influence of mental health on employment as well as the influence of unemployment on people's state of mental health”.</p>
	<p>EC 2007 - White paper - Together for health - A Strategic Approach for the EU 2008-2013</p>	<p>The white paper called on the Commission and Member States to work towards the, “Development and delivery of actions on tobacco, nutrition, alcohol, mental health and other broader environmental and socioeconomic factors affecting health”. It also called on the Commission to take, “Measures to promote the health of older people and the workforce (...)”.</p> <p>“Community-level work includes scientific risk assessment, (...), strategies to tackle risks from specific diseases and conditions, action on accidents and injuries, improving workers' safety (...)”.</p>
	<p>European Pact for Mental Health and Wellbeing, 2008 Together for mental health and wellbeing</p>	<p>“Employment is beneficial to physical and mental health...action is needed to tackle the steady increase in work absenteeism and incapacity, and to utilise the unused potential for improving productivity that is linked to stress and mental disorders”.</p>
	<p>European Parliament resolution T6-</p>	<p>The resolution, calls on “the Member States to encourage research into the</p>

	<p>0063/2009 on Mental Health, Reference 2008/2209(INI), non-legislative resolution</p>	<p>working conditions which may increase the incidence of mental illness, particularly among women”; it calls on “employers to promote a healthy working climate, paying attention to work-related stress, the underlying causes of mental disorder at the workplace, and tackling those causes” and it calls on “the Commission to require businesses and public bodies to publish annually a report on their policy and work for the mental health of their employees on the same basis as they report on physical health and safety at work”.</p>
	<p>EU High-level Conference, Brussels, 2010 - Investing into wellbeing at work: Managing psychosocial risks in times of change</p>	<p>The European Commission together with the Belgium presidency of the Council of the European Union organised a high-level conference on “Investing in well-being at work” looks at the psychosocial risks in time of change. The conference and related papers, “highlighted some of the central issues associated with organizational change, restructuring, health and well-being, and (...) what can be done to prepare organizations and people more effectively for major changes”.</p>
	<p>EU-Conference, Berlin, 2011 - Promoting mental health and well-being in workplaces</p>	<p>“Mental health is an important indicator of the quality of social cohesion and the quality of work. It is also a core element of Europe's social model”.</p> <p>“The protection and promotion of mental health can make a vital contribution to the implementation of the European Union's ‘Europe 2020’ agenda with its objective of smart, sustainable and inclusive growth”.</p> <p>“In the area of mental health, prevention and promotion require a holistic approach which also takes the conditions at the workplace into account (...) – in particular the structure and organisation of workplaces – (...)”.</p>
	<p>Council of the European Union Conclusions, 2011 on 'The European Pact for Mental Health and Well-being- results and future action'</p>	<p>The Council of the European Union invites Member states to, “Take measures against the stigmatisation and exclusion of and discrimination against people with mental health problems and to promote their social inclusion and their access to (...) work”.</p>

		<p>It invites Member States and the Commission to, "Take steps towards greater involvement of the health and social sectors along with social partners in the field of mental health and well-being at the workplace, to support and complement employer-led programmes where appropriate"; "Support activities (e.g. training programmes) that enable professionals and managers particularly in healthcare, social care, and workplaces to deal with matters concerning mental well-being and mental disorders".</p>
	<p>Opinion of the European Economic and Social Committee, 2013 on the European Year of Mental Health — Better work, better quality of life (2013/C 44/06)</p>	<p>"A publicly supported health promotion plan and a modern corporate culture can support people with disabilities and minimise the occurrence of work-related problems".</p> <p>"Proactive stress risk management, based on research into stress factors and their reduction and elimination, should be part of a consistent prevention strategy, in accordance with the Treaty provisions, Framework Directive 89/391/EEC (...) and the Framework agreement on work-related stress (...)".</p> <p>"Bodies should be set up either inside the company or externally to represent the interests of working people with disabilities and mental health issues at the workplace".</p>
	<p>Committee of Senior Labour Inspectors (SLIC), 2012 Campaign on psychosocial risks at work in</p>	<p>The Committee of Senior Labour Inspectors (SLIC) undertook a campaign on psychosocial risks in 2012. The goal was to develop an inspection toolkit for targeted interventions on occupational health and safety (psycho-social risks).</p> <p>"The Framework Directive 89/391/EEC and the social partner agreements constitute a common legal basis for supervision in the area of psychosocial risks (...). In summary, inspections on psychosocial risks are possible in all Member States, in some cases with some restrictions".</p> <p>"(...) the number of workplaces which</p>

		<p>have included psychosocial risks in the risk assessments has increased. Knowledge of psychosocial risks has increased among labour inspectors in all countries. Awareness of psychosocial risks at work at the workplaces has increased”.</p> <p>“Tools are now available for all European labour inspections to inspect psychosocial risks at work. Increased knowledge among labour inspectors will in the long run lead to improvements concerning psychosocial risks”.</p>
	<p>Mental and Physical Health Platform (MPHP) 2009 the Mental and Physical Health Charter and Call for Action</p>	<p>“The links between mental and physical health must be recognised and addressed in all health-related strategies and programmes at EU and national level, including disease-specific and other policies such as social, employment, discrimination, research and education, nutrition, tobacco and alcohol”.</p> <p>“(…) promoting mental (and physical) well-being can help the European Union attain its Lisbon Agenda targets for economic growth and employment”.</p>
	<p>Recommendations from Mental Health Europe (MHE), 2009 Work Programme of the Spanish-Belgian-Hungarian Trio Presidency of the Council of the EU (2010 – 2011)</p>	<p>“MHE emphasises that sustainable support for a (mentally) healthy working life can be achieved by minimizing the precariousness of work contracts and by the provision of a minimum income for everyone to live in dignity. MHE points out that the benefit of a minimum income should not be bound to employment contracts only. People who are (temporarily) unable to work must have a minimum income to cover expenses for their basic needs”.</p>
	<p>The Standing Committee of European Doctors (CPME) Position Paper, 2009 Mental Health in workplace settings "Fit and healthy at work"</p>	<p>“(…) it is important first of all to recognize and identify employees that suffer from mental disorders, either in early stages or when absent from work. Dedicated intervention programs with counselling or other support programs and active rehabilitation is of the greatest importance and should be in place (...). Next to these measures prevention programs are to be installed on both the organisational level as on the individual level. These programs should focus on the creation of working conditions in which employees can work in</p>

		a healthy fashion and in which they are stimulated to live an active and healthy life”.
Work-related stress	EN ISO 10075-1: 1991 Ergonomic principles related to work-load – General terms and definitions	<p>Mental stress = “The total of all assessable influences impinging upon a human being from external sources and affecting it mentally”. Mental stress is a source of mental strain (= “immediate effect of mental stress within individual (not the long-term effect) depending on his/her individual habitual and actual preconditions, including individual coping styles.)”.</p> <p>“There are four main categories of sources of mental stress: task, equipment, physical environment, social environment”. “Impairing (short term) effects of mental stress are: mental fatigue, and fatigue-like states (i.e.: monotony, reduced vigilance, and satiation)”.</p>
	EN ISO 10075-2: 1996 Ergonomic principles related to work-load – Design principles	<p>“Sources of fatigue: intensity of mental workload and temporal distribution of mental workload”.</p> <p>“The intensity of mental workload is affected by the following characteristics: ambiguity of the task goals, complexity of task, requirements, serving strategies, adequacy of information, ambiguity of information, signal discriminability, working memory load, long-term memory load, recognition vs. recall memory, decision support (...)”. Factors of temporal distribution of mental workload include, “duration of working hours, time off between successive work days or shift, time of day, shift work, breaks and rest pauses, changes in task activities with different task demands or kinds of mental workload”.</p>
	Guidance: EC, 1999 Guidance on work-related stress – Spice of life or kiss of death?	<p>“This Guidance provides general information on the causes, manifestations and consequences of work-related stress, both for workers and work organisations. It also offers general advice on how work-related stress problems and their causes can be identified and proposes a practical and flexible framework for action that social partners, both at national level and</p>

		<p>in individual companies, can adapt to suit their own situation. The focus is on primary prevention of work-related stress and ill-health, rather than on treatment”.</p>
	<p>Council of the European Union Conclusions, 2002 on combating stress and depression-related problems</p>	<p>The Council of the European Union invites Member states to, “give due attention to the impact of stress and depression-related problems in all age groups and ensure that these problems are recognised; in this context, give special attention to the increasing problem of work-related stress and depression”.</p> <p>It invites the Commission to, “consider opportunities to prevent stress and depression in the definition and implementation of relevant Community policies and activities which shall complement national policies”.</p>
	<p>Guidance: EU-OSHA, 2002 How to Tackle Psychosocial Issues and Reduce Work-Related Stress</p>	<p>“The aim of this report is to raise awareness of work-related psychosocial issues, to promote a preventive culture against psychosocial hazards including stress, violence and bullying, to contribute to a reduction in the number of workers being exposed to such hazards, to facilitate the development and dissemination of good practice information, and to stimulate activities at the European and Member State levels”.</p>
	<p>Guidance: WHO, 2003 Work Organisation and Stress</p>	<p>“This booklet provides practical advice on how to deal with work stress. It is intended that employers, managers and trade union representatives use this booklet as part of an initiative to educate on the management of work stress”.</p> <p>Guidance is provided on, “the nature of stress of stress at work, the causes and effects of stress, as well as prevention strategies and risk assessment and management methods (...) the role of the organisational culture in this process and the resources to be drawn upon for managing work stress”.</p>
	<p>Guidance: WHO, 2007 Raising awareness of stress at work in developing countries: a modern</p>	<p>“The purpose of this booklet is to raise awareness for employers and worker representatives of work-related stress in developing countries. Work-related stress is an issue of growing concern in</p>

	<p>hazard in a traditional working environment: advice to employers and worker representatives</p>	<p>developing countries due to important developments in the modern world; two of the most significant being globalisation and the changing nature of work”.</p>
	<p>Guidance: WHO, 2008 PRIMA-EF: Guidance on the European Framework for Psychosocial Risk Management: A Resource for Employers and Worker Representatives</p>	<p>“It provides guidance on the European framework for psychosocial risk management (PRIMA-EF) and concerns the management of psychosocial risks at the workplace, aiming at the prevention of work-related stress, workplace violence and bullying. Such a framework, bringing together a number of key issues in the area and providing guidance on them, has so far been lacking and is necessary for employer and worker representatives to take effective action to address the issues of concern”.</p> <p>“The overarching aim of this document is the promotion of the translation of policy and knowledge into practice”.</p>
	<p>Framework Agreement on Work-related Stress, 2004 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP</p>	<p>“Stress is 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”.</p> <p>“Identifying whether there is a problem of work-related stress can involve an analysis of factors such as work organisation and processes (...), working conditions and environment (...), communication (...) and subjective factors (...). “If a problem of work-related stress is identified, action must be taken to prevent, eliminate or reduce it. The responsibility for determining the appropriate measures rests with the employer”.</p>
	<p>Guidance: ILO, 2012 Stress Prevention at Work Checkpoints - Practical improvements for stress prevention in the workplace</p>	<p>This ILO manual “includes easy-to-apply checkpoints for identifying stressors in working life and mitigating their harmful effects. It also provides guidance on linking workplace risk assessment with the process of stress prevention”. The checkpoints have been developed to promote good practice within “enterprises and organizations in general, and they are especially useful for companies and</p>

		<p>organizations that wish to incorporate stress prevention into their overall occupational safety and health policy and management systems”.</p>
<p>Violence and Harassment</p>	<p>Guidance: WHO, 2003 Raising awareness to psychological harassment at work</p>	<p>“Psychological harassment is a form of employee abuse arising from unethical behaviour and leading to victimisation of the worker (...). It can produce serious negative consequences on the quality of life and on individuals’ health (...).” “This booklet aims at raising awareness (...) by providing information on its characteristics (...)”.</p>
	<p>Guidance: ILO, 2006 Violence at Work</p>	<p>Violence at Work (3rd Edition) examines aggressive acts that occur in workplaces (...) bullying, mobbing and verbal abuse. It provides information and evidence about the incidence and severity of workplace violence in countries around the world (...) evaluates various causal explanations and details some of the social and economic costs. It evaluates the effectiveness of workplace anti-violence measures and responses such as regulatory innovations, policy interventions, workplace design that may reduce risks, collective agreements and various “best practice” options worldwide.</p>
	<p>Guidance: EU-OSHA, 2011 Workplace Violence and Harassment: a European Picture</p>	<p>The aims of the report are to, “scrutinise differences in EU Member States in terms of the level of occurrence of different forms of violence and harassment at work (...), as well as examples of the use of preventive measures; review the methodology and data sources used in different countries to assess the risk, prevalence and consequences of both workplace violence and harassment”.</p>
	<p>Framework Agreement on Harassment and Violence at Work, 2007 European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP</p>	<p>“Harassment and violence are due to unacceptable behaviour by one or more individuals and can take many different forms, some of which may be more easily identified than others. The work environment can influence people’s exposure to harassment and violence”.</p> <p>“Raising awareness and appropriate training of managers and workers can reduce the likelihood of harassment and violence at work. Enterprises need to have a clear statement outlining that</p>

		<p>harassment and violence will not be tolerated. This statement will specify procedures to be followed where cases arise”.</p>
<p>Other relevant initiatives</p>	<p>WHO Action Plan, 2012 for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012–2016,</p> <p>Council of the European Union, 2000 Lisbon Strategy: to become the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion</p> <p>Council Resolution 2000/C218/02, on the balanced participation of women and men in family and working life</p>	<p>A key goal of the action plan is, “To improve health and well-being by making school and workplace settings more supportive of health”.</p> <p>“Workplaces also provide an important entry point for NCD prevention and health promotion programmes. Workplace health promotion (WHP), when designed and executed as a comprehensive initiative for healthy workplaces, is effective in reducing NCD risk factors by tackling physical inactivity, unhealthy dietary habits, smoke- and alcohol-free work environments, and psychosocial risk factors, with the participation of workers and managers”.</p> <p>In context of generating more and better jobs for Europe: developing an active employment policy, the Council and the Commission are invited to address, " improving employability and reducing skills gaps, in particular by providing employment services with a Europe-wide data base on jobs and learning opportunities; promoting special programmes to enable unemployed people to fill skill gaps; (...) by exploiting the complementarity between lifelong learning and adaptability through flexible management of working time and job rotation; (...) furthering all aspects of equal opportunities, including reducing occupational segregation, and making it easier to reconcile working life and family life, (...)”.</p> <p>The resolution called on employers in the public and private sectors, workers and the social partners at national and European level “to step up their efforts to ensure balanced participation of men and women in family and working life, notably through the organisation of working time and the abolition of conditions which lead to wage differentials between men and women”.</p>

	<p>Council Resolution 2000/C218/03, on action on health determinants</p>	<p>“Takes note of the results of the debates held at the European Conference on health determinants in the European Union held at Evora on 15 and 16 March 2000, which placed particular emphasis on mental health (...)and recommended a series of practical and targeted steps to address the challenges in these areas”.</p> <p>“Underlines the need for the Community to direct its action towards preventing disease and promoting health”.</p> <p>“Welcomes the Commission's commitment to developing a broad health strategy and the presentation of its proposal for a new health programme, containing a specific strand of action aimed at addressing health determinants by means of health promotion and disease prevention underpinned by inter-sectoral policy (...)”.</p>
	<p>Council of the European Union Conclusions, 2001 on a Community strategy to reduce alcohol-related harm</p>	<p>“Underlines the close link between alcohol abuse and reduced productivity at work, unemployment, social marginalisation (...) and mental illness”.</p> <p>“Considers that any Community action should focus on measures with a European added value, taking full account of possibilities offered by the future action programme in the field of public health, but also including measures in policy areas other than public health”.</p>
	<p>Framework Agreement on Telework, 2002 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP</p>	<p>“The agreement identifies the key areas requiring adaptation or particular attention when people work away from the employer’s premises, for instance data protection, privacy, health and safety, organisation of work, training, etc”.</p> <p>“Within the framework of applicable legislation, collective agreements and company rules, the teleworker manages the organisation of his/her working time. The workload and performance standards of the teleworker are equivalent to those of comparable workers at the employers’ premises. The employer ensures that measures are taken preventing the teleworker from being isolated from the rest of the working community in the company (...)”.</p>

	<p>Framework of Actions for the Lifelong Development of Competencies and Qualifications, 2002 European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP</p>	<p>“In the context of technological developments and of diversification of work relations and organisations, employees are confronted with greater mobility (...) and to the need to maintain and improve competencies and qualifications levels. Against this background of rapid pace of change, the social partners at European level affirm the development of competencies and the acquisition of qualifications as major challenges of lifelong learning”.</p>
	<p>Council Decision 2003/C 218/01, on setting up an Advisory Committee on Safety and Health at Work</p>	<p>The Advisory Committee for Safety and Health “shall have the task of assisting the Commission in the preparation, implementation and evaluation of activities in the fields of safety and health at work”.</p> <p>“Help to devise a common approach to problems in the fields of safety and health at work and identify Community priorities as well as the measures necessary for implementing them”.</p> <p>“Contribute, alongside the European Agency for Safety and Health at Work, to keeping national administrations, trades unions and employers' organisations informed of Community measures in order to facilitate cooperation and to encourage any initiatives on their part to exchange experience and establish codes of practice”.</p>
	<p>Opinion of the European Economic and Social Committee, 2005 on the Green Paper Improving the mental health of the population — Towards a strategy on mental health for the European Union (2006/C 195/11)</p>	<p>“In view of their impact on mental health, attention should be paid to improving conditions for those both in and out of employment. The issue of work and mental health touches on questions such as the value attributed to work and its personal cost, the impact of unemployment and invalidity”.</p>

	<p>Framework of Actions on Gender Equality, 2005 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP</p>	<p>“Traditional gender roles and stereotypes continue to have a strong influence on the division of labour between men and women at home, in the workplace and in society at large, and tend to continue a vicious circle of obstacles for achieving gender equality (...) social partners do have a role to play in addressing gender roles and stereotypes in employment and in the workplace”.</p> <p>“Evidence [indicates] that women continue to do the majority of work in the home or family, tend to have in interrupted patterns of employment, with all potential negative effects for career, wages and pensions, and are over-represented in part-time jobs”.</p>
	<p>Recommendations of the European Parliament and of the Council, 2006 on key competences for lifelong learning</p>	<p>“Social competence is linked to personal and social well-being which requires an understanding of how individuals can ensure optimum physical and mental health, including as a resource for oneself and one's family and one's immediate social environment, and knowledge of how a healthy lifestyle can contribute to this. For successful interpersonal and social participation it is essential to understand the codes of conduct and manners generally accepted in different societies and environments (e.g. at work). It is equally important to be aware of basic concepts relating to individuals, groups, work organisations, gender equality and non-discrimination, society and culture”.</p>
	<p>Opinion of the Committee of the Regions, 2006 on the Proposal for a Recommendation of the European Parliament and of the Council on key competences for lifelong learning</p>	<p>“This field of competence includes social aspects in the sense that the individual sees himself as a resource for himself, his family and his environment. It also includes medicinal aspects such as an insight into the importance of a healthy lifestyle, physical and mental health and an active lifestyle. As medicine advances, the health of children and young people is deteriorating in many societies, owing to poor dietary and exercise habits. This will become very serious unless something is done”.</p>

	<p>Communication from the Commission {SEC(2007) 214-216} Improving quality and productivity at work: Community strategy 2007-2012 on health and safety at work</p>	<p>The strategy for health and safety at work 2007-2012 calls for a more preventive culture with priority for mental health in the workplace.</p> <p>“The Commission encourages Member States to incorporate into their national strategies specific initiatives aimed at preventing mental health problems and promoting mental health more effectively, in combination with Community initiatives on the subject, including the employment of persons with a mental disability”.</p> <p>“The Commission stresses the importance of negotiations between the social partners on preventing violence and harassment at the workplace and encourages them to draw conclusions from the assessment of the implementation of the European framework agreement on work-related stress”.</p>
	<p>EC 2007 - White paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues</p>	<p>The white paper calls on Businesses to, “support the development of healthy lifestyles in the workplace. Together with employee organisations, they should also develop proposals/guidelines for ways in which companies of different sizes can introduce simple, cost-effective measures to promote healthy lifestyles of employees”.</p>
	<p>Commission Recommendation 2008/867/EC on the active inclusion of people excluded from the labour market</p>	<p>“People most excluded from work need more personalised pathways to employment”.</p> <p>“People lacking basic learning capacities or suffering from long periods of unemployment do not easily benefit from standard training or rehabilitation policies. Moreover, once they are in employment, they are still in a vulnerable position in the absence of a supportive environment”.</p> <p>“Health is an important requirement for participation in the labour market. People suffering from chronic health impediments cannot successfully participate in lasting employment or in training in preparation for employment”.</p>

	<p>Opinion of the Committee of the Regions 2008 on Flexicurity</p>	<p>“Believes that a lack of social protection can threaten labour market flexibility. To minimise this risk, the four principles of flexicurity should be established and upheld in equal measure;</p> <ul style="list-style-type: none"> – flexible contractual arrangements for the employer and employee – active labour market policies – reliable and responsive lifelong learning systems to ensure continual adaptability and employability of workers – modern social security systems should combine adequate income support with the need to facilitate labour market mobility”.
	<p>Guidance: European Commission, 2009 Report of Ad Hoc Expert Group on the Transition from Institutional to Community-based Care</p>	<p>“Issues concerning transition from institutional to community-based care must be addressed across all the relevant policy areas, such as employment, education, health, social policy and others”.</p> <p>“Promote improved working conditions of professional carers, aiming to make the jobs in the sector attractive. Require that bodies representing, training and accrediting the professional practice of staff working with elderly people, children, persons with mental health problems and persons with disabilities adopt a commitment to supporting the human dignity, inclusion and autonomy of service users in their work”.</p>
	<p>Framework Agreement on Inclusive Labour Markets, 2010 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP</p>	<p>“This Framework Agreement covers those persons who encounter difficulties in entering, returning to or integrating into the labour market and those who, although in employment, are at risk of losing their job due to [several] factors”.</p> <p>“Work-related factors include amongst others work organisation and work environment, recruitment processes, technological evolution and training policies”.</p> <p>“Individual factors are linked to aspects such as skills, qualification and education levels, motivation, language knowledge, health status and frequent or long unemployment periods”.</p>

	<p>Communication from the Commission COM(2010) 2020 EUROPE 2020: A strategy for smart, sustainable and inclusive growth</p>	<p>“Action under this priority[Inclusive growth – a high-employment economy delivering economic, social and territorial cohesion] will require modernising, strengthening our employment education and training policies and social protection systems by increasing labour participation and reducing structural unemployment, as well as raising corporate social responsibility among the business community. (...) Implementing flexicurity principles and enabling people to acquire new skills to adapt to new conditions and potential career shifts will be key. A major effort will be needed to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth (...)”.</p> <p>“Flagship Initiative: An Agenda for new skills and jobs. The aim is to create conditions for modernising labour markets with a view to raising employment levels and ensuring the sustainability of our social models. This means empowering people through the acquisition of new skills to enable our current and future workforce to adapt to new conditions and potential career shifts, reduce unemployment and raise labour productivity”.</p>
	<p>Communication from the Commission COM(2010) 682 An Agenda for new skills and jobs: A European contribution towards full employment</p>	<p>“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”.</p> <p>“Adopting targeted approaches for the more vulnerable workers, particularly the low skilled, unemployed, (...), people with mental disorders, (...)”.</p> <p>“In the area of occupational health and safety, priorities will include (...) the prevention of musculoskeletal disorders. (...) risks associated with nano-materials</p>

	<p>Council of the European Union Conclusions, 2011 on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours</p> <p>Communication from the Commission COM(2014) 332 on an EU Strategic Framework on Health and Safety at Work 2014-2020</p>	<p>and the causes of the growing incidence of mental illnesses in the work place will be investigated”.</p> <p>The Council expressed its commitment to, “accelerate progress on combating unhealthy lifestyle behaviours, such as tobacco use, alcohol related harm, unhealthy diet and lack of physical activity, leading to increased incidence of non-communicable chronic diseases, such as cancer, respiratory diseases, cardiovascular diseases, diabetes and mental illnesses, which are recognised to be important causes of premature mortality, morbidity and disability in the European Union”.</p> <p>“Specific attention should be given to addressing the impact of changes in work organisation in terms of physical and mental health”. The assessment of new emerging risks, based on scientific evidence, and dissemination of the results will be crucial parts of the ex post evaluation of current OSH legislation. Actions as from 2014 (... includes) identify and disseminate good practice on preventing mental health problems at work</p>
--	---	--

Apart from the EU level initiatives presented above, it should also be noted that in some EU member states efforts have been made to address mental health at work through similar national approaches. For example, in the UK the Health & Safety Executive has developed the Management Standards approach to help reduce the levels of work-related stress reported by British workers (Mackay et al., 2004). This approach has been adapted and is also used in Italy (Iavicoli et al., 2014). A detailed review and analysis of national level frameworks is presented in section 4.3.

Inclusivity, Sustainable Development and EU2020

A number of policies and supporting documents relevant to mental health at work are aimed at promoting inclusivity through policies aimed at strengthening social protection and social inclusion as well as solidarity in health by reducing health inequalities in the EU. The key policies are:

- Opinion of the European Economic and Social Committee on Health and Migrations (2007/C 256/22)
- Commission staff working document - Joint Report on Social Protection and Social Inclusion - Supporting document (SEC/2007/0329)
- European Parliament resolution of 6 May 2009 on the Renewed social agenda (2008/2330(INI))

- Commission staff working document - Joint Report on social protection and social inclusion - Accompanying document to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions - Proposal for the Joint Report on social protection and social inclusion 2008 [(COM(2008) 42 final)/ SEC/2008/0091]
- Opinion of the European Economic and Social Committee on the 'Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – Solidarity in health: reducing health inequalities in the EU' [COM(2009) 567]
- Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Solidarity in health: reducing health inequalities in the EU[{SEC(2009) 1396} {SEC(2009) 1397} / COM/2009/0567]
- European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU (2010/2089(INI))

In 2005 the European Council set out principles to guide Europe on a sustainable path of development. These principles include the on-going need to foster economic prosperity based on an innovative, competitive and eco-efficient economy, protecting and improving the quality of the environment; promoting equity and social cohesion in solidarity with the rest of the world. In 2006 the European Council adopted a renewed Sustainable Development Strategy (SDS) that sets out a single, coherent plan on how the EU will more effectively live up to these principles and the overarching objective of sustainable development enshrined in the Treaty. The plan consists of seven key challenges, one of which includes public health, which must be tackled if Europe is to move along a sustainable development path and maintain current levels of prosperity and welfare. It recognised that SDS goals can only be met in close partnership with the Member States and hence set in motion a new process of review and reporting involving the Commission and the Member States.

The Communication from the Commission on the - Progress Report on the Sustainable Development Strategy 2007 [{SEC(2007)1416}/ COM/2007/0642] is the first stocktaking based on this new way of working. It reviews results in moving towards the seven core objectives and identifies policy initiatives at both EU and member state level that have contributed to these results. A Commission staff working document is an accompanying document to the Communication from the Commission to the Council and the European Parliament Progress Report on the European Union Sustainable Development Strategy 2007 [{COM(2007)642} /SEC/2007/1416]. In the area of Public Health, the progress report indicates that Europeans are not only living longer, but they are living a greater part of their lives unaffected by serious health problems. Fewer people are dying from chronic diseases. There is a continuous reduction in the incidence of serious accidents at work. However, at the same time, life style illnesses such as obesity and mental illness are becoming an increasing problem. Concerning mental health, while the suicide rate is decreasing overall, 60,000 suicides occur annually. Some 11.5% of Europeans suffer from a mental disorder. Mental health problems currently cost the EU at least 3-4% of GDP. Whilst most policy action is taken at Member State or local level, the EU has taken a number of initiatives of direct relevance to public health - a review as reviewed in the sections above.

Europe faces a moment of transformation. The 2008 financial crisis has wiped out years of economic and social progress and exposed structural weaknesses in Europe's economy (EC, 2010b). To help Europe come out stronger from the crisis and turn the

EU into a smart, sustainable and inclusive economy delivering high levels of employment, productivity and social cohesion, the Europe 2020 strategy was launched which sets out a vision of Europe's social market economy for the 21st century. Europe 2020 puts forward three mutually reinforcing priorities:

- Smart growth: developing an economy based on knowledge and innovation.
- Sustainable growth: promoting a more resource efficient, greener and more competitive economy.
- Inclusive growth: fostering a high-employment economy delivering social and territorial cohesion.

The targets are representative of the three priorities of smart, sustainable and inclusive growth but they are not exhaustive: a wide range of actions at national, EU and international levels will be necessary to underpin them. The Commission is putting forward seven flagship initiatives to catalyse progress under each priority theme: one of which is titled the "An agenda for new skills and jobs" to modernise labour markets and empower people by developing their skills throughout the lifecycle with a view to increase labour participation and better match labour supply and demand, including through labour mobility (COM/2010/0682).

A skilled workforce is an essential asset to develop a competitive, sustainable and innovative economy in line with Europe 2020 goals. In times of budgetary constraints and unprecedented global competitive pressures, EU employment and skills policies that help shape the transition to a green, smart and innovative economy must be a matter of priority. The EU can meet all these challenges and raise employment rates substantially, particularly for women and young and older workers, but only with resolute action focussing on four key priorities:

- First, better functioning labour markets. Flexicurity policies are the best instrument to modernise labour markets: they must be revisited and adapted to the post-crisis context, in order to accelerate the pace of reform, reduce labour market segmentation, support gender equality and make transitions pay.
- Second, a more skilled workforce, capable of contributing and adjusting to technological change with new patterns of work organisation.
- Third, better job quality and working conditions. 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.
- Fourth, stronger policies to promote job creation and demand for labour. It is not enough to ensure that people.

This 'Agenda for new skills and jobs' flagship initiative sets out, in 13 key actions with accompanying and preparatory measures, the possible EU contribution to this joint effort as part of the Europe 2020 strategy.

4.1.3 The effectiveness of existing policy initiatives for promoting mental health and psychosocial risk management in the workplace

This section focuses primarily on the evaluation of the OSH Framework Directive as well as the two framework agreements completed by the social partners. This evaluation is based on reports by the European Commission (EC, 2004; 2011). The evaluation report of the Framework Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work and associated directives (89/654/EEC, 89/655/EEC, 89/656/EEC, 90/269/EEC and 90/270/EEC) is the response by the Commission to the request laid down in the final provisions of each of these directives which state that “the Commission shall submit periodically to the European Parliament (EP), the Council and the Economic and Social Committee a report on the implementation of this Directive” (EC, 2004). The evaluation report was based on the national reports provided by the Member States to the European Commission in accordance with the directives which state that “Member States shall report to the Commission every five years (every four years for Directives 90/269 and 90/270) on the practical implementation of the provisions of this Directive, indicating the points of view of employers and workers” (EC, 2004). It also builds on an independent experts’ report, analysing the implementation of the directives in all sectors, including the public sector. The analysis concerns the transposition and application of the framework directive 89/391 on the introduction of measures to encourage improvements in the safety and health of workers at work as well as of the first five individual directives, addressing particular workplace environments or risks (EC, 2004).

The implementation of both the framework agreement on work-related stress and the framework agreement on harassment and violence at work was monitored by the European Social Partners for three years. The aim of these reports is to highlight how the European agreements are implemented, not to provide information on or an assessment of the concrete impact it has had. The monitoring is carried out by the social partners and reported to the European Commission who compile and present the final report which examines how an Agreement is implemented by national social partners in Member States, and what affect this has on national responses to specific issues. It examines policy developments and social partners’ initiatives in each Member State, and highlights the value-added of such an Agreement (European Social Partners, 2011).

Evaluation of the implementation of the Framework Directive 89/391/EEC

Following the introduction of the 1989 EC Council Framework Directive 89/391/EEC, EU Member States have transposed the Directive into their national legal structures as a result of which employers in these countries have an obligation to assess all health and safety risks for employees, including psychosocial risks (Leka et al., 2010). The first report from the European Commission on the practical implementation of the provisions of the Health and Safety at Work Directives (EC, 2004) indicates that the EU legislation has had a positive influence on the national policies for occupational health and safety. At the same time, the health and safety measures at the workplace are reported to have widely contributed towards improved working conditions, boosting productivity, competitiveness and employment. The increased use of health and safety measures and reported improvements in working conditions in turn resulted from the impact of the Directive on national legislation. In Greece, Ireland, Portugal, Spain, Italy, and Luxembourg, the Framework Directive had considerable legal consequences due to the fact that they had antiquated or inadequate legislation on the subject when the Directive was adopted. In Austria, France, Germany, the UK, the Netherlands and Belgium the Directive served to complete or refine existing national legislation and finally, in the opinion of Denmark, Finland and Sweden, transposition did not require major adjustments since they had already rules in place

which were in line with the Directives concerned (EC, 2004). Table 6 summarises the European Commission's evaluation of the implementation of the main Framework Directive in the EU15 and also its impact in relation to psychosocial risks according to the report.

Table 6: Evaluation of the impact of Framework Directive 89/391 in 15 EU member states (pre-2004)

Area of impact	Effect of Implementation
<i>Legal impact in member states</i>	<ul style="list-style-type: none"> – In Greece, Ireland, Portugal, Spain, Italy and Luxembourg, the Framework Directive had considerable legal consequences since these countries had antiquated or inadequate national legislation on health and safety when the Directive was adopted – In Austria, France, Germany, United Kingdom, the Netherlands and Belgium, the Directive served to complete or refine existing national legislation – In Denmark, Finland and Sweden, transposition of the Directive did not require major adjustments since they already had national legislation in place which was in line with the Directive
<i>Positive effects of implementation</i>	<ul style="list-style-type: none"> – Decrease in the number of accidents at work – Increase in employers' awareness of health and safety concerns – Emphasis on a prevention philosophy – Broadness of scope, characterised by the shift from a technology-driven approach, towards a policy of occupational safety and health which focused on the individuals' behaviour and organisational structures – Obligation for the employer to perform risk assessments and provide documentation – Obligation for the employer to inform and train workers – Increased emphasis on rights and obligations of workers – Consolidation and simplification of exiting national regulations
<i>Main difficulties of implementation</i>	<ul style="list-style-type: none"> – Increased administrative obligations and formalities, financial burden and the time needed to prepare appropriate measures – Lack of participation by workers in operational processes – Absence of evaluation criteria for national labour inspectorates – Lack of harmonised European statistical information system on occupational accidents and diseases; although this has been addressed to an extent – Problems in implementing certain provisions in SMEs
<i>Impact on psychosocial risks</i>	<ul style="list-style-type: none"> – Most existing risk assessment practices characterised as superficial, schematic procedures where the focus is put on obvious risks. Long-term effects (e.g. mental factors) as well as risks that are not easily observed were reported to be neglected – Concerning the practical implementation of the provisions related to risk assessment, there is hardly any consideration

-
- of psychosocial risk factors and work organisational factors
 - Significant deficits in ensuring a broad coverage of preventive services relating to psychological aspects were identified
-

Source: Adapted from Leka et al. (2010)

The evaluation of the Framework Directive indicated that the tasks of risk assessment, documentation and supervision are not universally spread, even in member states with a tradition based on prevention (EC, 2004). The report also highlighted that where schematic procedures were in place in organisations, they generally focused on obvious risks where long-term effects (e.g. mental health) as well as risks that are not easily observed were being neglected. There was also hardly any consideration of psychosocial risk factors and work organisational factors and risk assessments were often being considered to be a one-time obligation lacking continuity where the efficiency of the measures was not sufficiently supervised by employers. Furthermore, it was also reported that at the national level risks were not being analysed and evaluated globally as a consequence of which separate measures were being set in place without an integrative approach for the analysis of the conditions at the workplace (EC, 2004). The findings of the evaluation indicated that much still needed to be done as regards psychosocial risks such as work control and work organisation, preventing unreasonably intense work pace and repetitive work. This suggested an insufficient application of some of the general principles of prevention foreseen in the Framework Directive 89/391 (Leka et al., 2010).

The accession of the new member states to the European Union has represented a major step towards change for the European Union (EU), not least for those involved in occupational safety and health (OSH). Since 2004, 13 new countries have joined the European Union. In these cases the framework directive was part of the negotiation for joining the EU and *acquis communautaire* (EU *acquis*), which meant the approximation of national laws to EU law before membership (Hämäläinen, 2006). The 2004 report from the Commission did not examine the implementation of the Directive in the new member states, and even though the new member states would have adapted or modified their national legislations prior to accession, the disparities between older EU member states and new member states in health, social, and industrial relations issues are significant (Hämäläinen, 2008).

The Commission as well as agencies such as the European Agency for Safety and Health at Work worked with these countries since 2000 to ensure that they were able to act as full members of the network and that their needs and priorities were taken into account when work programs were prepared. Some of these particular needs related to the characteristics of workplaces in these countries, for example, being less client-oriented and relying less on computer technology, with lower job control, higher demands, longer work hours, and stronger hierarchical structures (Konkolewsky, 2005).

It is therefore important to take into consideration different national situations, ascribable to the time available to acknowledge and implement European Directives (in the case of new member states) and related policies to political and administrative capacities of each member country that can have a direct impact on implementation of good practice and preventive measures at the workplace level. Furthermore, since the Directive places the responsibility of monitoring the health of workers on national agencies through the application of measures introduced in accordance with national laws and practices, it is also important to consider the relations between the national welfare state systems, healthcare systems and industrial relations. The administrative

capacities, implementation and delivery, and decentralisation of the government vary among countries. Industrial relations also affect individual policy areas, depending on their independence from state interventions, self-regulations, and involvement of social partners in the management of welfare programmes (Hemerijck, 2002).

Evaluation of the framework agreement on work-related stress

Having identified the need for specific joint action on the issue of work-related stress and anticipating a Commission consultation on stress, the European social partners included this issue in the work programme of social dialogue 2003-2005 (European Social Partners, 2004). This consultation led to the signing of a non-binding agreement on work-related stress reached at European level by employer and employee organisations as part of the Social Dialogue process, the 'Framework Agreement on Work-related Stress' in 2004. In summary, the aims of the voluntary agreement are:

- To increase the awareness and understanding of employers, workers and their representatives of work-related stress, and
- To draw their attention to signs that could indicate problems of work-related stress.

The objective is to provide employers and employees with a framework of measures which will identify and prevent problems of work-related stress and help to manage them when they do arise. Under the agreement, the responsibility for determining the appropriate measures rests with the employer. These measures are carried out with the participation and collaboration of workers and/or their representatives. These measures can be collective, individual or both. They can be introduced in the form of specific measures targeted at identified stress factors or as part of an integrated stress policy encompassing both preventive and responsive measures (European Social Partners, 2004).

The final joint report of the implementation of the work-related stress agreement was adopted by the European social dialogue committee on 18 June 2008 and transmitted to the European Commission in October 2008 (European Social Partners, 2008). The aim of this report was to highlight how the European agreement has been implemented, not to provide information on or an assessment of the concrete impact it has had. The European Commission published its report on the implementation of the European social partners' Framework Agreement on Work-related Stress in February 2011 (European Commission, 2011). The report examines how this Agreement was implemented by national social partners in Member States, and what effect this had on national responses to work-related stress. It also reviews the current level of protection employees have from work-related stress. It examines policy developments and social partners' initiatives in each Member State, and highlights the value-added of the Agreement. It also identifies shortcomings in implementation, and limitations in workers' protection. Table 7 presents a summary of key milestones achieved in member states in relation to the implementation of the work-related stress agreement.

Table 7: Results of the implementation of the European Framework Agreement on Work-related Stress

Social partners' Involvement Instrument	Substantial joint efforts of social partners	Moderate or unilateral efforts of social partners	Limited social partners initiatives	No social partners initiative so far
National collective agreement or social partner action based on explicit legal framework	NL, FI, SE BE, DK, UK ³ FR ⁴ ICE, NO	IT	EL, RO	
Non-binding instrument based on general legal provisions	ES (agreement) LU, AT (recommendations)	IE (recommendations) CZ, DE ²		
Mainly legislation	LV	HU ¹ , SK ¹ (SP initiated) PT ¹		LT ¹ BG, EE
No action reported or declaration with limited follow-up			CY ⁵ , PL SI	MT

Notes: Situation in early 2010. This overview necessarily simplifies differences within categories.
 1 Regulation following European Framework Agreement
 2 Joint action indirectly through statutory self-governed accident insurance bodies that have a preventive mission
 3 Recognised as occupational health risk in common law
 4 National agreement, persistent problems at company level led to government intervention
 5 Formal, joint recognition of pertinence of the general legal framework

Source: Adapted from EC (2011)

As can be concluded from the above Table, the main activities that followed the signing of the agreement were its use as an awareness raising tool and as a means of promoting social dialogue in the area. It is also interesting to note that substantial joint efforts of social partners took place mostly in EU member states where there is already high awareness in relation to the issue of work-related stress, such as Finland, Netherlands, Sweden, Denmark, France and the UK. The implementation of the agreement was reported to be a significant step forward and added real value in most Member States while some shortcomings in coverage, impact of measures, and the provision of a comprehensive action-oriented framework were identified. It must be also noted that social partners in Bulgaria, Estonia, Greece, Italy, Lithuania, and Malta have not reported on the implementation of the agreement (European Social Partners, 2011).

Evaluation of the framework agreement on harassment and violence at work

The European social partners maintain that mutual respect for the dignity of others at all levels within the workplace is one of the key characteristics of successful organisations. That is why they consider harassment and violence unacceptable and condemn them in all their forms. They consider it is a mutual concern of employers and workers to deal with these issues, which can have serious social and economic consequences (European Social Partners, 2007). Various EU directives and national laws define the employers' duty to protect workers against harassment and violence in the workplace.

The social partners included the issue of harassment and violence in the work programme of social dialogue 2006-2008 (European Social Partners, 2006). This consultation led to the signing of a non-binding agreement on harassment and violence at work, reached at European level by employer and employee organisations as part of the Social Dialogue process, the 'Framework Agreement on Harassment and Violence at Work' (European Social Partners, 2007).

It is important to note that the agreement relates both to bullying and third party violence. The aims of the agreement are to increase awareness and understanding of employees, workers and their representatives of workplace harassment and violence, and to provide employers, workers and their representatives at all levels with an action-oriented framework to identify, manage and prevent problems of harassment and violence at work. According to the agreement, enterprises need to have a clear statement outlining that harassment and violence will not be tolerated. The procedures to be followed where cases arise should be included. The agreement will be implemented and monitored for three years at the national level.

According to Maria Helena André, Deputy General Secretary of the ETUC (Grégoire, 2007), the biggest net benefit of the agreement on harassment and violence at work is having it. She further elaborates that the European social partner agreements can help improve working conditions and protection of workers at work. Some European countries already have specific legislation and collective agreements on psychosocial risks, work-related stress and harassment and violence at work, but most have little beyond the general legal basis of the 1989 EC Council Framework Directive. She expects that the agreement on harassment and violence at work will force the national social partners to get around the table, admit that the risk exists within organisations, and work out joint solutions to roll out systems for preventing and dealing with them when they arise in the workplace. The implementation of the framework agreement on harassment and violence at work has been being monitored for three years from 2008 to 2010. Table 8 presents a summary of key milestones achieved in member states in relation to the implementation of the harassment and violence at work agreement.

Table 8: Summary of key milestones achieved in EU member states, Iceland, Norway, and Turkey in relation to the implementation of the framework agreement on harassment and violence at work in 2008-2010

Member State	Translation of Agreement	Awareness raising	Further Social Dialogue Initiatives	Sectoral Initiatives	Development of new/revised policy/legislation
Portugal, Spain, Slovenia, Norway	Yes	Yes	Yes	Yes	Yes
Czech Republic, Denmark, Finland, Latvia, Netherlands, Sweden	Yes	Yes	Yes	Yes	No
Austria, Poland	Yes	Yes	Yes	No	No
Italy	Yes	Yes	No	Yes	No
Hungary, Luxemburg	Yes	Yes	No	No	No
Cyprus	Yes	No	No	No	No
Germany, Iceland	Yes	No [#]	No [#]	No [#]	No [#]
Bulgaria, Estonia, France, Greece, Lithuania, Malta, Romania, Slovakia, Croatia	Yes	No report	No report	No report	No report
Belgium	No [#]	No [#]	No [#]	No [#]	No [#]
Ireland, United Kingdom, Turkey	No report	No report	No report	No report	No report

[#] The framework agreement was not implemented due to existing legislation

As can be concluded from Table 6, the main activities that followed the signing of the agreement were its translation in national languages. The translation was carried out by the European Commission; however, in some countries the translations were made jointly and were accepted by the social partner organisations. Legislation in certain countries (specific to health and safety at work as well as general laws) adequately covered issues in relation to harassment and violence at work and as such the agreement was not implemented. In most cases the agreement was used as an awareness raising tool and to further existing initiatives as in the case for example of Sweden and Czech Republic.

A comprehensive review of research and case studies to examine the impact of social dialogue on working conditions in 28 European countries indicated that a number of quantitative studies as well as quantitative studies show that social dialogue is extremely active at national, sectoral and company level, and in all areas of working conditions – particularly in the field of occupational health and safety. Several studies have attempted to show a link between the presence of social dialogue and

improvements in a range of working conditions. Such improvements include reduced working time, increased working time flexibility to suit employees' needs, access to and participation in training, the existence of equal opportunities policies, and job security measures. Even though it is often difficult to determine the exact contribution that social dialogue has made to improvements in working conditions the findings highlight the relevance and value of social dialogue (Broughton, 2008).

We find a rather mixed picture regarding the state of European social dialogue in the area of psychosocial risks at work. Serious questions have been raised in the literature as to the appropriateness and effectiveness of new modes of governance ('autonomous agreements') (Branch, 2005). These challenges are accentuated by the diversity of national industrial relations systems and weak social dialogue structures and capacities, particularly in the new member states. A related and even more important challenge for effective social dialogue on work-related stress results from differences (in terms of perspectives, priorities and interests) between social actors, particularly between employers' organizations and trade unions.

Ertel and colleagues (2010) call for focused activities at European level to harmonize stakeholder perspectives on the issue of psychosocial risk factors and work-related stress. Active communication between all parties concerned is needed, including a proactive approach of government (Larsen & Andersen, 2007).

It is beyond doubt that the social partners, employers as well as employees, perceive an added value in the framework of European social dialogue, particularly because European social dialogue enables the social partners to voice their opinion on all legislative proposals at the EU level which in turn also strengthens the legitimacy of the policy outputs (De Boer et al., 2005). The importance European of social dialogue in the policy process, especially relating to occupational safety and health, including mental health and psychosocial risk management in the workplace has been highlighted by all stakeholders. The framework agreements have often been reported to be the most significant contribution of social dialogue at the European level (Ertel et al., 2010).

Nevertheless, while there have been a number of reported and measureable benefits, it is not always possible to determine the exact contribution that social dialogue has made to improvements in working conditions. For example, in some studies, improvements have been made following social dialogue intervention, but it is difficult to establish causal links between these improvements and the intervention measures (Broughton, 2008). Also, the viability of the use of European social dialogue as means of regulating social Europe, particularly when collective agreements are implemented via 'soft' means rather than legally binding directives has also been challenged in some studies. For example, an evaluation of the autonomous framework agreements on telework and work-related stress indicated that their implementation and substantive effects were in practice piecemeal (Prosser, 2011). Keller (2008) noted, the available evidence over more than a decade demonstrates that they [the social partners] have not managed to exploit their increased opportunities of common action and to achieve a higher quality of negotiated legislation.'

The challenge of implementing social dialogue initiatives are accentuated by the diversity of national industrial relations systems and weak social dialogue structures and capacities, particularly in the new member states (Branch, 2005; Mailand & Due, 2004) related and even more important challenge for effective social dialogue particularly in the case of new and emerging risks, such as psychosocial risks, arises from differences (in terms of perspectives, priorities and interests) between social

actors, particularly between employers' organizations and trade unions (EU-OSHA, 2010; Iavicoli et al., 2011). To implement non-legally binding autonomous agreements, social partners must commit to discuss and implement them at national level through their member organisations, and to monitor the process (Martin & Visser, 2008).

4.2 Identification and description of policy gaps

The next step in the study included a gap analysis that considered the extent to which the current EU policy framework on mental health in the workplace is sufficient on the basis of a set of defined criteria in the form of a Policy Scorecard (see Table 9). The Policy Scorecard was developed after review of Policy Analysis Templates (Annex 9.1), filled in for each policy. Each policy (regulatory as well as non-binding) was scored on a scale of '0-5 stars' on the basis of their relevance/applicability to, and/or coverage of facets relating to, mental health at work. Policies which did not cover or refer to mental health at work were given a score of 0 stars while policies which were directly relevant and comprehensively covered each facet were given a score of 5 stars. The five facets were: reference to mental health in the objectives and scope of the policy; coverage of exposure factors; coverage of mental health problems/disorders at work and related outcomes; risk assessment aspects; and preventive actions in relation to mental health in the workplace.

Table 9: Policy scorecard – key facets and scoring criteria




















Key Facets	0 	1 	2 	3 	4 	5 
<i>Mental health in the workplace referred to in the objectives and scope of the policy</i>	Not covered by the general objectives or scope of the policy	Covered in principle but not effectively addressed	Only implicitly covered by the objectives/scope of the policy	Partially covered by the objectives/scope of the policy	Sufficient coverage but lack definitions of key terms within the policy	Comprehensively covered by the general objective or scope of the policy
<i>Coverage of exposure factors in relation to mental health in the workplace</i>	No reference to or acknowledgement/ coverage of exposure factors in relation to mental health in the workplace	Covered in principle but not effectively addressed	Only implicit acknowledgement/ coverage of some exposure factors in relation to mental health in the workplace	Partial acknowledgement/ coverage of exposure factors in relation to mental health in the workplace	Sufficient coverage but lack of specificity on exposure factors in relation to mental health in the workplace	Comprehensive coverage of exposure factors in relation to mental health in the workplace
<i>Coverage of mental health problems/ disorders at work and related outcomes</i>	No reference to or acknowledgement/ coverage of mental health problems/ disorders at work and related outcomes	Covered in principle but not effectively addressed	Only implicit acknowledgement/ coverage of mental health problems/ disorders at work and related outcomes	Partial acknowledgement/ coverage of mental health problems/ disorders at work and related outcomes	Sufficient coverage but lack of specificity on mental health problems/ disorders at work and related outcomes	Comprehensive coverage of mental health problems/ disorders at work and related outcomes
<i>Coverage of risk assessment aspects in relation to mental health in the workplace</i>	No reference to or acknowledgement/ coverage of risk assessment aspects in relation to mental health in the workplace	Covered in principle but not effectively addressed	Only implicit acknowledgement/ coverage of risk assessment aspects in relation to mental health in the workplace	Partial acknowledgement/ coverage of risk assessment aspects in relation to mental health in the workplace	Sufficient coverage but lack of specificity on risk assessment aspects in relation to mental health in the workplace	Comprehensive coverage of risk assessment aspects in relation to mental health in the workplace
<i>Coverage of preventive actions in relation to mental health in the workplace</i>	No reference to or acknowledgement/ coverage of preventive actions in relation to mental health in the workplace	Covered in principle but not effectively addressed	Only implicit acknowledgement/ coverage of preventive actions in relation to mental health in the workplace	Partial acknowledgement/ coverage of preventive actions in relation to mental health in the workplace	Sufficient coverage but lack of specificity on preventive actions in relation to mental health in the workplace	Comprehensive coverage of preventive actions in relation to mental health in the workplace




Table 10: Policy Scorecard – Regulatory instruments of relevance to mental health and psychosocial risks in the workplace at the European level




Instrument	Mental health in the workplace referred to in the objectives/ scope of the policy	Coverage of exposure factors in relation to mental health in the workplace	Coverage of mental health problems/ disorders at work and related outcomes	Coverage of risk assessment aspects in relation to mental health in the workplace	Coverage of preventive actions in relation to mental health in the workplace	Overall
1. Directive 89/391/EEC the European Framework Directive on Safety and Health at Work	2	3	0	4	4	
2. Directive 2003/88/EC concerning certain aspects of the organisation of working time (consolidates and repeals Directive 93/104/EC)	1	3	2	3	3	
3. Directive 2010/32/EU implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU	0	5	1	5	2	
4. Directive 90/270/EEC on the minimum safety and health requirements for work with display screen equipment (fifth individual Directive within the meaning of	3	3	0	3	2	




Article 16 (1) of Directive 89/391/EEC)						
5. Directive 92/85/EC on pregnant workers, women who have recently given birth or are breast-feeding	3	3	0	3	1	
6. C155 Occupational Safety and Health Convention (ILO), 1981	3	2	0	1	1	
7. Directive 94/33/EC on the protection of young people at work	3	2	0	2	1	
8. Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation	0	2	0	2	3	
9. C 183 Maternity Protection Convention (ILO), 2000	0	2	0	2	3	
10. Directive 2006/54/EC on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation	0	2	0	2	3	
11. Directive 2008/94/EC on the protection of employees in the event of the insolvency of	0	1	0	1	1	

their employer (repealing Directive 2002/74/EC and Council Directive 80/987/EEC)						
12. Directive 2010/18/EU implementing the revised Framework Agreement on parental leave (repealing Directive 96/34/EC)	0	1	0	0	3	
13. Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin	0	1	0	1	2	
14. Directive 2002/14/EC establishing a general framework for informing and consulting employees in the European Community	0	1	0	2	2	
15. Directive 2002/15/EC on the organisation of working time of persons performing mobile road transport activities	0	1	1	1	2	
16. C187 Promotional Framework for Occupational Safety and Health Convention (ILO), 2006	0	1	1	1	2	
17. Directive 2009/104/EC	0	1	1	1	1	

concerning the minimum safety and health requirements for the use of work equipment by workers at work (second individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC) [replacing Directive 89/655/EEC]						
18. Directive 89/654/EEC concerning the minimum safety and health requirements for the workplace (first individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC)	0	1	0	1	0	
19. Directive 89/656/EEC on the minimum health and safety requirements for the use by workers of personal protective equipment at the workplace (third individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC)	0	1	0	1	0	
20. Directive 90/269/EEC on the minimum health and safety requirements	0	1	0	1	0	

for the manual handling of loads where there is a risk particularly of back injury to workers (fourth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)						
21. C175 Part-time Work Convention (ILO), 1994	0	1	0	1	0	
22. Directive 97/81/EC concerning the framework agreement on part-time work	0	1	0	0	1	
23. Directive 98/59/EC on the approximation of the laws of the Member States relating to collective redundancies	0	1	0	1	1	
24. Directive 99/70/EC concerning the framework agreement on fixed-term work	0	1	0	1	0	
25. Directive 2000/79/EC concerning the European Agreement on the Organisation of Working Time of Mobile Workers in Civil Aviation.	0	1	0	0	1	
26. Council Directive 2001/23/EC on	0	1	0	0	1	

the approximation of the laws of the Member States relating to the safeguarding of employees' rights in the event of transfers of undertakings, businesses or parts of undertakings or businesses						
27. Directive 2002/73/EC on equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions (amending Directive 76/207/EEC)	0	1	0	0	1	
28. Directive 2009/38/EC on the establishment of a European Works Council or a procedure in Community-scale undertakings and Community-scale groups of undertakings for the purposes of informing and consulting employees (recast)	0	1	0	0	1	
29. Directive 93/103/EC concerning the minimum safety and health requirements for work on board	0	1	0	0	1	

fishing vessels (thirteenth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)						
30. Directive 92/91/EEC - concerning the minimum requirements for improving the safety and health protection of workers in the mineral-extracting industries through drilling (eleventh individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)	0	1	0	1	1	
31. Directive 92/104/EEC on the minimum requirements for improving the safety and health protection of workers in surface and underground mineral-extracting industries (twelfth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)	0	1	0	1	1	
32. Directive 92/57/EEC on the implementation of minimum safety and health	0	1	0	0	1	


requirements at temporary or mobile construction sites (eighth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)						
33. Directive 91/383/EEC supplementing the measures to encourage improvements in the safety and health at work of workers with a fixed-duration employment relationship or a temporary employment relationship	0	1	0	1	0	






Table 11: Policy Scorecard – Non-binding/voluntary policy initiatives of relevance to mental health and psychosocial risks in the workplace








Document	Mental health in the workplace referred to in the objectives and scope of the policy	Coverage of exposure factors in relation to mental health in the workplace	Coverage of mental health problems at work and related outcomes	Coverage of risk assessment aspects in relation to mental health in the workplace	Coverage of preventive actions in relation to mental health in the workplace	Overall
1. Guidance: ILO, 1986 Psychosocial factors at work: Recognition and control	4	5	5	5	5	
2. Guidance: EC, 1999 Guidance on work-related stress – Spice of life or kiss of death?	4	5	5	5	5	
3. Guidance: EU-OSHA, 2002 How to Tackle Psychosocial Issues and Reduce Work-Related Stress	4	5	5	5	5	
4. Guidance: WHO, 2008 PRIMA-EF: Guidance on the European Framework for Psychosocial Risk Management: A Resource for Employers and Worker Representatives	4	5	5	5	5	
5. Guidance: WHO, 2003 Work Organization and Stress	4	5	5	4	5	
6. WHO Healthy Workplaces Framework, 2010 Healthy workplaces: a model for action: for employers, workers, policymakers and practitioners	4	5	4	4	5	
7. WHO Mental health declaration for Europe, 2005 and Mental Health Action Plan for Europe	5	4	4	4	4	









8. R194 revised annex, ILO 2010 Recommendation concerning the List of Occupational Diseases and the Recording and Notification of Occupational Accidents and Diseases	4	4	4	3	N/A	
9. EU High-level Conference, Brussels, 2010 - Investing into wellbeing at work: Managing psychosocial risks in times of change	4	5	3	4	4	
10. Guidance: ILO, 2012 Stress Prevention at Work Checkpoints - Practical improvements for stress prevention in the workplace	4	5	4	4	4	
11. EN ISO 10075-1: 1991 Ergonomic principles related to work-load – General terms and definitions	2	4	3	3	4	
12. EN ISO 10075-2: 1996 Ergonomic principles related to work-load – Design principles	2	3	3	3	4	
13. Framework Agreement on Work-related Stress, 2004 European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP	3	4	3	3	4	
14. Communication from the Commission {SEC(2007) 214-216} Improving quality and productivity at work: Community strategy 2007-2012 on health and safety at work	4	3	3	3	4	
15. EU-Conference, Berlin, 2011 - Promoting mental health and well-being in workplaces	4	4	3	3	3	




16. Committee of Senior Labour Inspectors (SLIC), 2012 Campaign on psychosocial risks at work	4	4	3	4	3	
17. Communication from the Commission COM(2014) 332 on an EU Strategic Framework on Health and Safety at Work 2014-2020	4	4	3	3	4	
18. Council of the European Union Conclusions, 2002 on combating stress and depression-related problems	3	2	4	1	4	
19. European Pact for Mental Health and Wellbeing, 2008 Together for mental health and wellbeing	3	3	2	3	3	
20. European Parliament resolution T6-0063/2009 on Mental Health, Reference 2008/2209(INI), non-legislative resolution	3	3	2	3	3	
21. Opinion of the European Economic and Social Committee, 2013 on the European Year of Mental Health — Better work, better quality of life (2013/C 44/06)	4	4	1	3	3	
22. Green paper – EC, 2005 Improving the mental health of the population: Towards a strategy on mental health for the European Union	3	2	3	2	3	
23. European Parliament resolution (2006/2058(INI)) on improving the mental health of the population. Towards a strategy on mental health for the EU	3	3	2	2	3	

24. Guidance: WHO, 2007 Raising awareness of stress at work in developing countries: a modern hazard in a traditional working environment: advice to employers and worker representatives	3	3	2	2	2	
25. Guidance: EU-OSHA, 2011 Workplace Violence and Harassment: a European Picture	2	2	2	3	3	
26. Council of the European Union Conclusions, 2003 on Mental health – Conference on Mental Illness and Stigma in Europe: facing up the challenges of social inclusion and equity	3	2	2	1	2	
27. Guidance: WHO, 2003 Raising awareness to psychological harassment at work	2	2	2	2	3	
28. Council of the European Union Conclusions, 2005 on a Community Mental Health Action – Outcome of proceedings	3	2	1	1	3	
29. Guidance: ILO, 2006 Violence at Work	2	2	2	2	3	
30. Communication from the Commission COM(2010) 682 An Agenda for new skills and jobs: A European contribution towards full employment	4	3	1	2	1	
31. WHO Action Plan, 2012 for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012–2016	1	3	1	3	3	

32. Council Resolution 2000/C86/01 , on the promotion of mental health	3	0	2	0	2	
33. Opinion of the European Economic and Social Committee, 2005 on the Green Paper Improving the mental health of the population – Towards a strategy on mental health for the European Union (2006/C 195/11)	3	1	1	1	2	
34. EC 2007 - White paper - Together for health - A Strategic Approach for the EU 2008-2013	2	1	1	3	1	
35. Framework Agreement on Harassment and Violence at Work, 2007 European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP	1	3	1	1	2	
36. The Standing Committee of European Doctors (CPME) Position Paper, 2009 Mental Health in workplace settings "Fit and healthy at work"	3	2	1	0	2	
37. Recommendations of the European Parliament and of the Council, 2006 on key competences for lifelong learning	1	2	1	0	1	
38. Mental and Physical Health Platform (MPHP) 2009 the Mental and Physical Health Charter and Call for Action	3	1	1	0	1	
39. Recommendations from Mental Health Europe (MHE), 2009 Work Programme of the Spanish-Belgian-Hungarian Trio	3	1	1	0	1	

Presidency of the Council of the EU (2010 – 2011)						
40. Council of the European Union Conclusions, 2011 on 'The European Pact for Mental Health and Well-being- results and future action'	2	0	0	1	2	
41. Council Resolution 2000/C218/02 , on the balanced participation of women and men in family and working life	0	1	0	0	1	
42. Council Resolution 2000/C218/03 , on action on health determinants	1	1	0	0	1	
43. Council of the European Union, 2000 Lisbon Strategy: to become the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion	0	1	0	1	1	
44. Council of the European Union Conclusions, 2001 on a Community strategy to reduce alcohol-related harm	1	1	0	0	1	
45. Framework Agreement on Telework, 2002 European social partners - ETUC, UNICE (BUSINESSEUROPE), UEAPME and CEEP	0	1	0	1	1	
46. Framework of Actions for the Lifelong Development of Competencies and Qualifications, 2002 European social partners - ETUC, BUSINESSEUROPE,	0	1	0	0	1	

UEAPME and CEEP						
47. Council Decision 2003/C 218/01 , on setting up an Advisory Committee on Safety and Health at Work	1	1	0	1	1	
48. Framework of Actions on Gender Equality, 2005 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP	0	1	0	0	1	
49. Opinion of the Committee of the Regions, 2006 on the Proposal for a Recommendation of the European Parliament and of the Council on key competences for lifelong learning	0	2	0	0	1	
50. EC 2007 - White paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues	0	1	0	0	1	
51. Commission Recommendation 2008/867/EC on the active inclusion of people excluded from the labour market	0	1	1	0	1	
52. Opinion of the Committee of the Regions 2008 on Flexicurity	0	1	0	0	1	
53. Guidance: European Commission, 2009 Report of Ad Hoc Expert Group on the Transition from Institutional to Community-based Care	1	1	0	0	1	
54. Framework Agreement on Inclusive Labour Markets, 2010 European social partners - ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP	0	2	0	0	1	

55. Communication from the Commission COM(2010) 2020 EUROPE 2020: A strategy for smart, sustainable and inclusive growth	0	2	0	0	1	
56. WHO European Mental Health Strategy, 2011	1	0	0	1	0	
57. Council of the European Union Conclusions, 2011 on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours	1	1	0	0	1	

From the review and gap analysis presented here on regulatory and voluntary policy initiatives it is possible to make some observations. The first is that there is lack of clarity and specificity on the terminology used. The second is that although the different instruments/initiatives are based on related paradigms, very few of them provide specific guidance on managing risks in relation to mental health in the workplace to enable organisations (and especially small and medium-sized enterprises - SMEs) to implement a preventive framework of action. The third is whether existing policies have actually fulfilled expectations in practice in the area of mental health in the workplace. Recent findings suggest that although OSH legislation is seen by European employers as a key driver to address OSH issues, it has been less effective for the management of psychosocial risks and the promotion of mental health in the workplace (EU-OSHA, 2010; Natali, et al., 2008). In relation to voluntary policy instruments, there is the question of whether they have been effective in supporting the implementation of existing legislation and in guaranteeing quality with regard to the 'essential requirements' established by European policies.

The analysis at EU level was supplemented with the results of a case study analysis of national level policies in several Member States. This allowed the refinement of policy scenario options that formed the basis of a stakeholder consultation across EU-EFTA countries and informed recommendations to be considered by the Commission in this area.

4.3 The national policy context in relation to mental health in the workplace: A European review

Information on national policies and programmes on mental health in the workplace was collected in two ways. Firstly, a policy and literature review was conducted which reviewed not only scientific publications but also those from key institutions (such as EC, ILO), government bodies, research institutions and social partners. Some key references used include among others the following: European Commission, 2010, 2011, 2012, 2013; Lippel, 2010; Ocegüera, Aldrete & Ruíz, 2009; Pinkos Cobb, 2012;

SLIC, 2012; WHO, 2008. Secondly, a survey was conducted with experts to explore relevant legislative and policy frameworks for dealing with mental health in the workplace; relevant programmes and campaigns, available data and tools, and key stakeholders and networks. A network of national correspondents was established consisting of the National Contact Offices of the European Network for Workplace Health Promotion. In countries where it was not possible to collect data, the correspondents of Eurofound were contacted. All 31 EU/EEA/EFTA countries were collaborative. The Consortium developed a Mental Health Policy Survey for the national correspondents (Annex 9.2) including the following elements:

- Overall summary of situation in relation to the policy context for mental health at work, making reference to relevant legislation as well as other policies and initiatives
- Types of policies
- Dimensions of policies
- Criteria for case study selection
- Suggested list defining characteristics of key stakeholders
- Suggested data sources
- Reporting structure.

This data was used to analyse policies and programmes in 31 countries in Europe. The overall findings are presented for each country in Annex 9.3.

4.3.1 Case study analysis of national policy initiatives

The expert survey conducted across Europe also asked respondents to identify examples of good practice at policy level that could be further analysed as case studies. Several suggestions were offered that were reviewed on the basis of the following criteria:

- Clear targeting of mental health issues in the workplace
- Availability of sufficient information for description and analysis purposes
- Clear basis in legislation/regulation (though they may extend beyond the provisions of legislation or regulation)
- Sufficient scale to ensure that generic conclusions can be drawn from them
- Coverage of exposure factors in relation to mental health (for example exposure to psychosocial risks)
- Coverage of mental health problems in the workplace and related outcomes
- Coverage of preventive actions (at primary, secondary and tertiary level) in relation to mental health in the workplace
- Coverage of risk assessment aspects in relation to mental health
- Coverage of administrative infrastructure for risk assessment and prevention in relation to mental health in the workplace
- Availability of information on evaluation of the initiative and outcomes achieved.

The following policy approaches were selected in a variety of countries:

- Belgium - Royal Decree of 17 May 2007 concerning the prevention of psychosocial load caused by work, including violence, harassment and sexual harassment at work
- UK – Management Standards for Work-related Stress (2004) [& Italy – Adaptation of UK Management standards for Work-related Stress]
- UK – Mental Health Strategy for Scotland: 2012-2015 [& evaluation of Healthy Working Lives Strategy with respect to mental health]
- Norway - National Strategic Plan for Work and Mental Health 2007-2012
- Denmark – Labour Inspectorate Programme with focus on psychosocial risks
- The Netherlands – Work and Health Covenants & OSH Catalogues
- Finland – Tripartite framework agreement on active ageing in Finland (FI1110011I)
- Germany - psyGA "Mental Health in the World of Work"
- Italy - List of occupational diseases

Information was collected on the basis of available literature and consultation with key stakeholders on the above initiatives. In addition semi-structured interviews were conducted in relation to these initiatives in each country (see Annex 9.4 for interview schedule). The collected information was used to present an analysis of each initiative by filling a developed Policy Analysis Template (Annex 9.1).

The case studies were analysed in order to gain a better understanding of different policy options and scenarios, and were used for three main purposes:

- Scenario analysis, i.e. analysis of different approaches to dealing with mental health at work. The case studies were used for comparative analysis purposes so that conclusions could be drawn regarding the effectiveness, costs and cost effectiveness of ways to deal with mental health at work issues within the context of OSH.
- Illustration – the case studies were used for illustrative purposes in relation to the guidelines that were produced.
- Gathering of stakeholder views – used for feeding into the overall consultation process for the development of the guidelines.

The review identified several good practice examples across countries that have served to highlight the importance of mental health in the workplace and engage various stakeholders. It was especially encouraging to also explore the successful adaptation of one initiative in another country (the Management Standards for Work-related Stress in the UK and Italy). Important benefits were reported from these initiatives and it is important they are publicised across the EU. The type of initiative came with specific benefits but also challenges. However, stakeholders were overall satisfied with the impact of the initiative. It should be noted, though, that there was limited information both on cost-effectiveness and on robust evaluation in relation to these initiatives. This is an area that requires improvement to enable learning and assessment of impact. These issues are revisited later in this report in section 6.

5. Establishment of baseline scenario

The evaluation and gap analysis of the policy framework on mental health in the workplace allowed the development of a baseline scenario which included:

- a) An overview of the problem in both legal and practical terms at EU level, and in individual Member States and EFTA/EEA countries;
- b) A description of the current context and challenges, and the necessity and added value of EU action on this issue from an OSH perspective.

According to this baseline scenario, if the status quo as concerns the policy context to mental health in the workplace is maintained, it is likely that a number of activities will continue to take place across the EU/EFTA countries in this area given the impact of mental ill health on individuals, organisations and society. However, there is uncertainty as to whether they will achieve the desired outcomes, especially since preventive actions still seem to be lacking across countries. As it has been shown in this report, the prevalence of mental ill health in the workplace, including poor psychological well-being is widespread across all EU/EFTA countries and there are indications that this will only increase due to exposure to risk factors such as job insecurity, work intensification and organisational restructuring. In addition, the impact of mental ill health is profound on individuals, organisations and society as a whole. At the individual level, exposure to psychosocial risks can result not only to poor psychological health and well-being but also to physical problems such as cardiovascular disease. These problems challenge participation in the workforce and performance through absenteeism and presenteeism. Discrimination and social exclusion against those affected by mental health disorders still remain a problem exacerbating the situation. At the organisational level, evidence indicates that mental ill health and poor psychological well-being affects business performance through absenteeism, presenteeism, reduced job satisfaction and organisational commitment, a poor work climate and human error. Additional costs are incurred by businesses in terms of hiring and training costs as well as reduced productivity and innovation. At societal level, there are associated costs to national social security and benefit systems, national economies and challenges on healthcare systems. These trends are projected to continue in the future.

Efforts have been made both at policy and practice level to address mental ill health in the workplace. Employment, including OSH, legislation as well as public health legislation address the issue by placing emphasis on prevention through tackling risk factors and preventing discrimination. In addition, several other policy initiatives have been implemented both across the EU and within countries. Examples include strategies and campaigns, social dialogue initiatives including social partner agreements and frameworks of actions, and guidance. Although there have been a number of policy initiatives for more than ten years in the EU, awareness in relation to mental health in the workplace and the importance of preventive action still seems to be lacking. This is despite available data that map the prevalence and impact both of risk factors and mental ill health outcomes.

In addition, despite the fact that the Framework Directive 89/391/EEC covers all types of risk to workers' health and, as the framework agreement on work-related stress clarifies, this includes work-related stress, there still appears to be limited awareness of this provision both by employers and other key stakeholders such as policy makers and inspectors in different countries. Limited awareness and expertise on how to conduct inspections on psychosocial risks associated with mental ill health were among the key drivers for the 2012 SLIC campaign. However, with widespread budget cuts in the public sector, inspections in many countries are becoming more reactive in nature (e.g. in the UK). Within this climate it is important that employer responsibility is strengthened and awareness is further developed both in relation to the policy framework on mental health in the workplace and specific preventive measures that should be introduced to promote mental health. Currently, there is no comprehensive

guidance that will allow employers to be aware of their responsibilities in law (all relevant legislation at EU level) and clarify further how to fulfil their responsibilities by conducting risk assessments and putting in place preventive measures.

Examples of efforts to provide such guidance exist in selected countries and an analysis of these strategies will allow for conclusions to be drawn on their effectiveness. However, in other countries there is limited prioritisation in this area and further sharing of good practice and cross-fertilisation of activities can have positive results. In short, a more co-ordinated action plan is necessary at EU level, clarifying requirements and the case for mental health promotion in the workplace and drawing upon good practice efforts within specific countries. In addition, monitoring across the EU and between and within Member States should be further developed by refining existing systems. A specific issue to be considered is the inclusion of mental health disorders in lists of occupational diseases in EU countries. Without effective monitoring and dedicated reporting, knowledge at the Community level about the rate of progress would be weak.

Continuation of EU activities as currently set would not necessarily lead to an improvement of the situation nor would it necessarily lead to greater awareness in relation to the vital importance of mental health in the workplace. However, this option would not imply any additional administrative costs, or require re-orientation of funds from other policies.

6. Establishment of alternative scenarios

The main purpose of 'scenario building' was to identify "the best EU policy scenario for mental health at the workplace". Based on the results obtained in the previous stages of the project, potential future scenarios were described and put into perspective in relation to the baseline scenario or 'status quo'. We also placed them within the context of what is known about the benefits and costs of protecting and improving mental health in the workplace. The scenarios were based on the review of the EU-OSH legal framework and identification of best practices at the national level, but also on the consultation of relevant stakeholders (e.g. social partners, national, regional and local authorities in the member states, the scientific community and particularly mental health professionals such as psychologists and psychiatrists, health and social security providers and enterprises).

This 'best EU policy scenario' was identified using the Delphi-method, i.e. a structured communication technique by which opinions of (in this case) stakeholders were collected iteratively in different rounds. However, the assumption should be taken into account that what is seen as 'best' scenario is not necessarily the same for different countries or regions in Europe or for different stakeholders, reflecting their role or their interest. This includes consideration of the costs and benefits of different scenarios, within the context of what is currently known about the cost effectiveness of actions to promote and protect better mental health within workplaces.

Based on the literature and previous work done in the project, the following types of scenarios were identified:

1. The 'status quo', no new and specific or targeted actions.

2. Implementing non-binding initiatives, such as an EU action programme on mental health at work, stimulating national strategies, programmes or campaigns, stimulating initiatives of the inspectorate, of sectors, of trade unions or of other networks, stimulating the use of the management standards, initiate training or award competitions, etc.
3. Combining or consolidating EU-directives.
4. Providing a technical update of existing EU legislation.
5. New legislation on mental health in the workplace.

Scenario 1: Status quo, no action

Risks relevant to mental health and their management are among employers' responsibilities as stipulated in the Framework Directive 89/391/EEC. On the basis of this Directive, policies and guidance of relevance to mental health have been developed. These include legally binding instruments (such as EU regulations, directives and national pieces of legislation) and other 'hard' policies (such as ILO conventions), as well as nonbinding/voluntary policies (or 'soft' policies such as decisions, recommendations and conclusions of EU institutions), social partner agreements and various other actions. In this first possible scenario, the European Commission will not take any new initiatives in the field of mental health in the workplace. However, it is possible for implementation to be improved within the current package of legislative provisions.

Scenario 2: Non-binding initiatives

A number of non-binding initiatives of relevance to mental health and psychosocial risks in the workplace have been developed and implemented at EU level. The initiatives range from broad EU strategies and public health policies to social dialogue initiatives. In addition, other policy initiatives include the setting up of formalised stakeholder committees, EU level campaigns, policies on managing disability etc. In this scenario, new non-binding initiatives will be initiated at EU level.

Scenario 3: Consolidating legislation (directives)

The Framework Directive 89/391/EEC on Safety and Health of Workers at Work lays down employers' general obligations to ensure workers' health and safety in every aspect related to work, 'addressing all types of risk'. The Framework Directive with its general principles continues to apply in full to all areas covered by individual directives. However, where individual directives contain more stringent and/or specific provisions, these special provisions of individual directives prevail (EC, 2004). These include:

Directive 89/654/EEC concerning the minimum safety and health requirements for the workplace;

Directive 2009/104/EC concerning the minimum safety and health requirements for the use of work equipment by workers at work;

Directive 89/656/EEC on the minimum health and safety requirements for the use by workers of personal protective equipment at the workplace;

Directive 90/269/EEC on the minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers;

Directive 90/270/EEC on the minimum safety and health requirements for work with display screen equipment.

In addition to these, a number of other Directives introduced at EU level are also relevant to mental health in the workplace. Examples include:

Council Directive 92/85/EEC on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding;

Directive 93/104/EC concerning certain aspects of the organisation of working time;

Directive 2000/78/EC prohibiting direct or indirect discrimination on grounds of religion or belief, disability, age or sexual orientation;

Directive 76/207/EEC on equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions **Amended by Directive 2002/73/EC**;

Directive 2006/54/EC on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation.

In the third scenario suggested, there would be a review and consolidation of all relevant existing legislation into one comprehensive piece of legislation.

Scenario 4: Technical update of relevant legislation

A number of regulatory instruments of relevance to mental health and psychosocial risks are applicable to the EU member states. Even though each of these regulations addresses certain aspects of mental health and/or the psychosocial work environment, it should be noted that the terms 'mental health', 'stress' and 'psychosocial risks' are not mentioned explicitly in most pieces of legislation. The main example in this respect is the Framework Directive 89/391/EEC on Safety and Health of Workers at Work. Even though the Directive asks employers to ensure workers' health and safety in every aspect related to work, 'addressing all types of risk at source', it does not include the terms 'psychosocial risk' or 'work-related stress'. Therefore, a technical update of the Framework Directive including explicitly the protection of workers' mental health could be a possible scenario. Such an update would not need new primary legislation.

Scenario 5. New directive

In this policy option, a new EU directive would be established, explicitly addressing all significant work-related risk factors for mental health, work-related stress and the retention and employment of people with mental health problems. The Directive could define the psychosocial load caused by work (cf the Royal Decree of 17 May 2007 in Belgium: "any load of a psychosocial nature, caused by the execution of the work or arising as a result of the execution of the work, which has a detrimental effect upon the physical or mental health of the person"). It could define the roles and responsibilities of people in the organisation who are appointed to play a mediating role, and it could introduce procedures when addressing risks of relevance to mental health in the workplace. A new directive could also make reference to relatively new specific issues such as harassment and bullying, discrimination, and work-life balance.

The above scenarios were evaluated through a Delphi study. In the first round, in-depth interviews with key stakeholders were used. In the second round, a survey, developed on the basis of the first round results, was used.

6.1 Results of the Delphi study

As indicated, stakeholders were interviewed using the Delphi-method. Based on the good practices and scenario building, a semi-structured questionnaire was developed for interviewing relevant stakeholders (see Annex 9.5). In the first round, the questionnaire was developed and tested by in-depth interviews with 22 relevant stakeholders in a restricted number of countries. Based on the findings of this first round, the interview was restructured into a shortened online questionnaire and was sent to different stakeholders in each of the 28 EU countries who were asked to respond (see Annex 9.6).

6.1.1 The first Delphi round

This in-depth interviewing of stakeholders in the first Delphi was done with relevant key stakeholders in a restricted number of countries. The selection of 4 countries (the UK, Germany, Slovenia and the Netherlands) was guided by the results of the evaluation of the EU Framework Agreement on work-related stress (see also Table 7, results of the implementation of the European Framework Agreement on Work-related Stress, in this report). 22 interviews were held in countries that ranged from having implemented substantial efforts and either having implemented national collective agreements or non-binding initiatives, to countries where social partners were moderately active to not active at all.

The content of the questionnaire was guided by the scenarios identified. All five scenarios (from status quo to the development of new legislation) were presented and experts were invited to discuss each scenario along the line of (1) has that scenario been addressed in their country, and if yes, how, (2) its strengths and weaknesses, (3) the potential effectiveness and costs of this scenario, and (4) other contextual factors required to be in place for the implementation of this scenario (in their own country or potentially in other countries).

Scenarios 1, 2 and 5: Non-binding initiatives most used and debated against binding initiatives/(new) legislation

Results of this first round indicated that experts in general had a good understanding of the five scenarios identified up front. There was no specific indication to change a scenario substantially. The scenarios as explained led to good discussions on mental health at work policies and their potential relevance at EU-level in the different countries.

In the few countries that participated in this first round, it was clear that there is no specific legislation, but that non-binding initiatives are the status-quo. In the UK the Management Standards for Work-related Stress were often mentioned. In Germany the PsyGA project by BKK/BAuA was an example of a non-binding initiative provided. Some of the relevant stakeholders that were interviewed indicated that non-binding initiatives might be a more appropriate way to tackle this 'soft' problem although, particularly in Germany, there are different opinions and approaches on tackling 'mental health at work' with an ongoing debate for hard vs. soft law initiatives (note the recent introduction of specific legislation in this area in Germany in 2014). In Slovenia, it was reported that '...mental health problems represent an important problem; people are getting sick and others are vulnerable to risk exposure. There is a

big stigma, employers do not really know what to do, and they have no proper help from outside (counselors, occupational health institutes etc.). Also there are not many people inside the company who can assist (psychologists etc.). That is why employers cannot cope with vulnerable or sick people or even with the risks they are exposed to. Legislation is an important minimum basis, but is not enough to change the practices in the country. Also non-binding initiatives and promotion are needed’.

Stakeholders also indicated that: ‘the current problem with existing legislation is that it’s quite complex and doesn’t explicitly mention psychosocial risks.’ ‘..In case one would make an effort of making (new) legislation, mental health issues are multi-causal so it’s very difficult to pin it down to workplace issues. It’s (or part of it is) a relationship between the individual and the workplace... often the individual has an issue with line management...’.

Although the actors had different points of view on whether binding policy is needed or not, they agreed on the importance of promoting workplace health, and combating stress. They differed on the way and method they thought might be best to achieve this aim. ‘Trying to get something EU harmonised is going to be very difficult because the conditions in each country vary enormously, which is why we think the current situation is probably the best. We think at best the EU will come up with guidance...’. However, a major weakness of the non-binding policies was reported to be that they can be ignored. Particularly respondents from Slovenia supported new legislation in the area of mental health at work.

An interesting comment on psychosocial risk management in the UK was: ‘We don’t have the resources to maintain the status quo, we’re actually moving backwards. Measures being cut back because of austerity across the country. It’s worrying because if people develop conditions in the workplace, where is the support for them? The government launched talking therapies as a solution but the waiting list is 8-12 months, how is that helping the individual and the workplace?’.

In this first round, discussion focussed mostly on the possibility of new legislation and non-binding initiatives. There were only some minor comments on the other scenarios.

Scenario 3: Consolidating Directives in the area

On the option of ‘Consolidating Directives in the area’ respondents commented that it is important to consolidate when possible and practical. However, legislation needs to be transparent, easy to find and clear about its objectives, so it may not be possible to consolidate in every case. None of the countries had any experience with consolidating mental health policies. Some commented that psychosocial risks are narrowly related to problems of working time patterns where some consolidating may be possible. One of the comments was ‘This is the least offensive of the last three scenarios, because all you’re doing is not creating anything new, you’re bringing stuff that exists in one place. There might be an element of clarification. It might bring a bit more attention to the issue, but unless you can develop solutions which are workable, there are a lot of things out there but what effect do they have?’.

Scenario 4: Providing a technical update

A strong view by many respondents was that it is important that mental health and psychosocial risks are mentioned explicitly in law. One of the respondents indicated that this policy option would ‘depend on the extent to which countries interpret broad OSH goal-based legislation to cover psychosocial risks. In the UK we accept that and there’s very little argument about that, we have case law which backs that up

(national transposition of Directives is understood to include stress). In other places in the EU there might be resistance to interpret the Directive in that way, in those cases it would probably help to amend the law to be more explicit'. So the issue here seemed to be whether there will be enough leverage within the EU for something like a 'European strategy and policy for mental health at work'.

This first round provided rich qualitative information. It was then important to obtain the views on the different policy scenarios on mental health in the workplace by a more representative sample of EU representatives in all EU countries. This led to the development of a survey for the second round of the Delphi.

6.1.2 The second Delphi round

For the second Delphi round, a web-link to an online survey was sent to a large number of relevant stakeholders in all 28 EU countries. The members of the Advisory Committee on Safety and Health at Work (ACSHW) were invited to participate in the survey. Use was made of personal networks as well as contacts through PEROSH, EWCO and the European Networks for Workplace and Mental Health.

The descriptive analysis performed aimed to assess priorities in policy scenarios and identify strengths and weaknesses of these policies. The priorities and strengths and weaknesses were additionally considered by country and country cluster (using the Esping-Andersen classification) as well as the type of relevant stakeholder (i.e. policymaker/inspectorate, employer representative, employee representative, expert/professional, insurers). Responses in this second round of the Delphi on the costs of the different options were taken into account in our cost-benefit analysis of the different scenarios.

Response by country (cluster)

The responses to the second round are shown in Table 12. The net response rate was 58 respondents.

Table 12: Delphi responses by country – Round 2

Country	Response	Percentage
Austria	2	3.8
Belgium	1	1.9
Croatia	1	1.9
Czech Republic	1	1.9
Denmark	5	9.4
Estonia	2	3.8
Finland	2	3.8
Germany	4	7.5
Greece	2	3.8
Hungary	1	1.9
Ireland	1	1.9
Italy	3	5.7
Latvia	3	5.7
Lithuania	1	1.9
Portugal	1	1.9

Slovakia	2	3.8
Slovenia	3	5.7
Spain	8	15.1
Sweden	2	3.8
The Netherlands	4	7.5
United Kingdom	3	5.7
Bosnia	1	1.9
Total	53	100

Table 12 shows that 22 European countries in total were represented while the response per country ranges between 1 and 8 respondents.

When considering country clusters in order to make a more robust national differentiation and to consider differences between old and new member states, and between North, Central, South, West and East (also guided by social security systems), the Esping-Andersen country clusters can be identified (see Table 13). This clustering shows that the responses from the old and new member states, as well as from Northern, Middle and Southern European countries are quite well distributed. Only the response from the UK and Ireland cluster is limited.

Table 13: Response by country cluster

Country cluster	Response	Percentage
Northern Europe (inc. DK, FI, NL, SE)	13	24.5
Continental countries (inc. AT, BE, DE)	7	13.2
Southern Europe (inc. ES, HE, IT, PT)	14	26.4
United Kingdom and Ireland	4	7.5
New Member States (inc. BA, CZ, EE, HU, HR, LT, LV, SK, SL)	15	28.3
Total	53	100

Response by type of relevant stakeholder

The response is also presented by type of relevant stakeholder (see Table 14). Here, we can see that the largest group of respondents is experts/professionals, followed by policymakers (including the inspectorate). Employer representatives are also well represented (each about a quarter of all responses). The smallest group is 'insurers'.

Table 14: Response by type of relevant stakeholder

Type of representative	Response	Percentage
Policymaker (ministries; including inspectorate)	15	28.3
Employer representative	14	26.4
Employee representative	5	9.4
Expert/professional	16	30.2
Insurer	3	5.7
Total	53	100

When we consider the response of the different types of relevant stakeholders by country cluster (see Table 15), we see that on average the distribution of

representatives by country cluster is balanced. Only the response of employee representatives is 'incomplete': only employee representatives from Northern Europe and from the new member states have responded. Also the group of insurers is quite small and does not cover all country clusters.

Table 15: Response by relevant stakeholder by type and country cluster

Type of relevant stakeholder	Northern Europe	Continental countries	Southern Europe	United Kingdom and Ireland	New member states	Total (N)
Policymaker (ministries; including inspectorate)	28.6%	20.0%	13.3%	0.0%	40.0%	15
Employer representative	21.4%	14.3%	35.7%	14.3%	14.3%	14
Employee representative	60.0%	0.0%	0.0%	0.0%	40.0%	5
Expert/professional	21.4%	7.1%	42.9%	7.1%	21.4%	14
Insurer	0.0%	33.3%	0.0%	33.3%	33.3%	3
Total (N)	13	7	14	4	15	53

Priority scenarios

All stakeholders were presented with the scenarios and were asked to prioritise them. Consequently, all were asked to select their top two preferred scenarios and discuss the strengths and weaknesses of these.

In Table 16 below, these results are presented in two ways. First, the mean rating per scenario⁸ has been calculated. Taking into account this score, results in scenario 2: 'non-binding initiatives' rank highest. Scenario 4: 'developing a technical update' ranks second. Scenario 3 of 'combining or consolidating EU directives' ranks third. 'Developing new EU legislation' on mental health is rated lowest. Second, ratings have been calculated on the basis of percentages of 'best' or 'worst' choice. On the basis of this score, the scenario which, on average, ranks lowest (i.e. developing new EU legislation), has the highest rating as 'best choice'. When analysing this more in-depth, we see that the ratings on this scenario are, contrary to the other scenarios, quite extreme: 23% of stakeholders indicate that 'developing new EU-legislation' is 'the best' choice but as much as 48.2% rates this scenario as 'the worst'. Those who rated this option as 'best' are mainly employee representatives and representatives from the labour inspectorate. In this respect, the representatives from the labour inspectorate (N=7) rated these scenario a little different from (other) policymakers. The latter found this scenario much less preferable.

⁸ Here we consider these ordinal ratings as interval ratings, under the assumption that differences between the rating levels are about equal.

Table 16: Priorities in scenario ratings (N=55)

Scenario	Average rating (1-5)	Ranking from best to worst scenario (%)				
		Best choice Rating 5	2nd choice Rating 4	3rd choice Rating 3	4st choice Rating 2	5th choice Rating 1
1. Maintaining the status quo	2.45	21.8	12.7	3.6	12.7	49.1
2. Non-binding initiatives	3.29	16.4	40.0	10.9	21.8	2.7
3. Combining or consolidating EU-directives	2.65	5.5	16.4	36.4	21.8	20.0
4. Providing a technical update	2.89	14.5	21.8	14.5	36.4	3.1
5. Developing new EU-legislation	2.49	23.2	16.1	5.4	7.1	48.2

In considering regional differences in priorities for mental health policy scenarios, the most 'compact' indicator of the average score by country cluster was examined (see Table 17 below). Considering country clusters, we see quite diverse preferences. The scenario 'non-binding initiatives' is the most preferred scenario in Southern Europe as well as in the UK & Ireland, and it is a combined favourite (with 'developing new legislation') in the new member states. Although 'developing new legislation' is one of the least preferred scenarios, it is also a combined favourite in the new member states. In none of the country clusters, 'maintaining the status quo' and 'combining or consolidating EU-directives' are among the most preferred scenarios. The Northern European country cluster prefers 'developing new legislation' most, whereas the continental country cluster prefers 'a technical update' most. One could observe that some country clusters are much more outspoken about their preferences (e.g. Southern Europe and UK & Ireland) than others (e.g. new member states and the continental countries).

Table 17: Average rating of the scenarios by country cluster (N=55)

Scenario	Average Total	Northern Europe	Continental countries	Southern Europe	UK & Ireland	New member states
1. Maintaining the status quo	2.45	1.92	2.29	3.07	3.25	2.21
2. Non-binding initiatives	3.29	3.08	2.57	4.07	4.25	2.86
3. Combining or consolidating EU-directives	2.65	2.33	2.57	2.79	3.25	2.64
4. Providing a technical update	2.89	3.00	2.86	2.97	3.00	2.79
5. Developing new EU-legislation	2.49	3.33	2.29	2.43	1.00	2.86

Main comparisons should be made in the columns (range 5 - 1; best - worst)

The country cluster preferences may have been somewhat confounded by the fact that the types of relevant stakeholders (particularly the employee representatives) are not evenly distributed amongst the country clusters and the different stakeholders may well have different views on the preferred scenarios. Therefore, in Table 18 the preferred scenarios are also presented by type of relevant stakeholder and may best be read column wise.

As may have been expected, there are large differences in preferred scenarios between the different stakeholders. The overall most preferred scenario of 'non-binding initiatives' is also the preferred scenario by the experts and professionals, but all other stakeholders have other, very outspoken, preferences. Regarding this issue, policymakers in general appear to have a quite different opinion than representatives of the labour inspectorate, in that the latter group favours 'new legislation' while other policymakers do not. Other policymakers also prefer a technical update. The only other group of stakeholders that clearly prefers new EU-legislation are employee representatives. Employer representatives prefer the status quo most, although many also report preferring 'non-binding EU initiatives'. Finally, the small number of insurers that responded report a highest preference for a technical update of existing legislation.

Table 18: Average rating of the scenarios by type of relevant stakeholder (range 5-1; best –worst)

Scenario	Total	Policymakers (incl. inspectorate)	Employer representatives	Employee representatives	Experts / Professionals	Insurers
1. Maintaining the status quo	2.45	1.82	4.64	1.00	2.20	2.67
2. Non-binding EU initiatives	3.29	3.00	4.15	1.80	3.40	3.00
3. Combining or consolidating EU-directives	2.65	2.67	2.38	3.20	2.27	2.67
4. Providing a technical update	2.89	3.47	2.23	2.60	2.67	3.33
5. Developing new EU-legislation	2.49	3.60 (insp: 4.34; other policymakers : 2.78)	1.00	4.40	2.07	2.33

Several of the respondents took the opportunity to additionally comment on their choices. Many of these comments relate to the (apparent) discrepancy between either being in favour of new EU-legislation or being in favour of non-binding EU-initiatives.

One of the employee representatives commented that non-binding initiatives (like good practices, covenants, pledges etc.) will only be effective in a few companies. Especially those companies who are not interested in good practice can only be forced by regulation and control. However, an expert from Italy, a country with legislation in this specific area of mental health, comments that this legislative framework makes it very difficult to effectively promote mental health in the workplace. It is felt that there

is a strong need to set the work environment and work-relatedness as the key principles for prevention policies, incapacity compensation and employers' responsibility. This would allow for great simplification and delegation to social partners and OSH-guidelines. One of the employer representatives, however, does not think that there are easy solutions. This representative stated that mental health in the workplace is a very complicated issue since it is very complicated to determine whether the cause of the problem is work-related or not. Since there is already a comprehensive EU health and safety legislative framework, we should ensure a better implementation of this legislation, according to their view.

In dealing with this complex issue of mental health in the workplace, another employer representative also commented that an integrated approach is warranted, taking into account the job content, working conditions, working environment, career perspectives, work life balance and interventions of different fields of expertise. For these reasons, this employer representative argued that a legislation-based approach might even be counter-productive. Again another employer representative agreed and concluded that 'businesses should lead the way, enabled by their national governments, and should come up with holistic health and safety initiatives relevant to their organisation, which include mental health, but also have a broader approach to psychosocial illness and physical health. Awareness raising campaigns, best practice sharing and guidance at national level is however useful. An employee representative additionally commented that company external sources of psychosocial risks should be included in considerations since these are not just a health and safety issue, but also an economic and (international) market issue.

One of the Southern European experts commented that 'many improvements in working conditions come from legislative changes'. Their country '...is run through legislation. Implementing non-binding initiatives is an indirect route to the most appropriate long-term change. But its implementation (of the non-binding initiatives) in the current circumstances does not seem useful'. One of the policymakers additionally commented that the existing EU OSH legislative framework does not sufficiently cover mental health issues. A technical update of existing legislation could expand and strengthen the scope of OSH law in a more practical and direct manner in comparison with a new directive. However, an employer representative stated that 'clearly, previous proposals of 'psychosocial hazard' legislation demonstrate the lack of understanding and 'stigma' that surrounds these issues... just as you can't have a physical injuries directive' you can't group all mental health issues together in one piece of legislation'. However, the Framework Directive clearly includes physical and mental well-being - in short the legal structure exists - but given the complexities surrounding mental well-being, it is difficult for legislation to ever establish a 'safe' limit for employers to achieve. According to them, 'the practicalities of legislation for psychosocial hazards are such that it should really not be considered an option'.

Some of the comments are of a highly pragmatic nature. For example, an employer representative in one of the new member states indicated that mental health factors are not key in their country. Their priority is to first provide a safe work environment. One of the insurers stated that 'the absence of any recognised, generally successful treatment or help for a lot of mental issues negates any point in expanding legal responsibilities'. Finally, one of the policymakers commented that 'Scenario 1' (status quo) is not an option given the magnitude of the problem. Scenario 2 ('non-binding EU initiatives') will not provide effective solutions, considering that there already are a number of non-binding initiatives at EU-level'. This stakeholder therefore concluded that the answer lies in a combination of scenarios 3-5.

Overall, the scenario regarding maintenance of the status quo is considered to be quite effective by those who chose this scenario. Those who indicated that new legislation would be the preferred scenario, expected this to be moderately - and sometimes even - well effective. The effectiveness of non-binding EU-initiatives is mainly considered positive by those who chose it but sometimes views are mixed. A technical update of existing legislation is rated on effectiveness as moderate to bad. Finally, combining or consolidating directives is expected to be moderately effective.

Preference for non-binding EU-initiative types

Where 'non-binding EU initiatives' was selected by stakeholders as their preferred option, they were asked to indicate favourite types. Table 19 shows the ranking of these findings. The table does not show a lot of variation in average ranking across non-binding EU initiatives: average ratings range from 2.72 to 3.87 (on a rating scale of 5 - best - to 1 - least preferred). The non-binding EU initiative that was on average rated highest, is 'awareness raising campaign', but 'national strategies on mental health policies' also rate high. The distribution of ratings per non-binding EU initiative is not as skewed as found for the scenarios.

Table 19: A ranking of types of non-binding EU initiatives on mental health when selected as preferred choice (N=27-31)

Non-binding EU initiatives	Average (5-1)	Percentages (%)				
		Best choice Rating 5	2nd choice Rating 4	3rd choice Rating 3	4th choice Rating 2	5th choice Rating 1
National strategies	3.61	29.0	25.8	25.8	16.1	3.2
Awareness raising campaigns	3.87	35.5	35.3	12.9	12.9	3.1
Sectoral initiatives	3.32	12.9	35.5	25.8	22.6	3.2
Voluntary work-related management standards	3.03	17.2	27.6	13.8	24.1	17.2
Technical guidance for labour inspectors	3.00	13.8	24.1	20.7	31.0	10.3
Company policy on managing mental health	3.53	16.7	43.3	23.3	10.0	3.0
Recognising mental and stress-related illnesses on official list of occ. diseases	2.72	20.0	13.3	6.7	13.3	46.7

The overview of non-binding EU initiatives is also presented by country cluster and by type of stakeholder in Tables 20 and 21 respectively. Considering the preferences in non-binding initiatives by country cluster, we can see that on average there is considerable agreement: the most preferred non-binding initiative is awareness raising campaigns. Only the UK and Ireland consider 'company policy on managing mental health problems' most preferable, followed by implementing 'voluntary management standards' (developed, and with quite a history, in the UK as analysed in the case studies of this report).

Table 20: Non-binding EU initiatives by country cluster (ratings from 5 (most preferred) to 1 (5th in preference) (N=29-31)

Non-binding EU initiative	Total Average	Northern Europe	Continental countries	Southern Europe	UK & Ireland	New member states
National strategies	3.61	3.75	3.50	3.43	3.75	3.43
Awareness raising campaigns	3.87	3.87	4.00	4.14	3.25	3.71
Sectoral initiatives	3.32	3.25	2.50	3.86	3.25	3.14
Voluntary work-related management standards	3.03	2.57	3.50	3.33	4.00	2.14
Technical guidance for labour inspectors	3.00	3.14	2.67	2.57	2.75	3.29
Company policy on managing mental health	3.53	3.86	2.00	3.00	4.75	3.29
Recognising mental and stress-related illnesses on official list of occ. diseases	2.72	2.71	2.00	2.57	2.00	2.43

Stakeholders do show some more divergence in their rankings in comparison to country clusters, but their preferences are somewhat less outspoken as compared to those relating to the policy scenarios - although particularly experts and professionals appear to have little variation in preference regarding these initiatives. Also although 'insurers' were not so outspoken in their preferences of scenarios, they are more so regarding these non-binding EU initiatives.

Unlike the preferences of the scenarios, the 'on average' most preferred non-binding-initiative does not show a strong divide in the groups of stakeholders. The rating of 'awareness raising campaigns' is high for most groups, but when not rated highest, it is, at least, rated as 'moderate'. Awareness raising campaigns were rated as most preferred by policymakers (both general policymakers and inspectorate) and employer representatives. It should be pointed out that the 'technical guidance for labour inspectors' rated quite high for policymakers, especially for the representatives of the inspectorate who responded to the survey. Technical guidance for the labour inspectorate was also the most favourite EU-initiative of the employee representatives. The employee representatives, however, had equal preference for 'company policy on managing mental health problems'. Experts mostly preferred the implementation of the voluntary work-related management standards, but did not differentiate much among their preferences. Insurers preferred national strategies most, but it should be mentioned that their preferences for the awareness raising campaigns were also quite high (higher than the overall average).

Table 21: Non-binding EU initiatives by stakeholder type (ratings from 5 (most preferred) to 1 (5th in preference) (N=29-31)

Non-binding initiative	EU	Total Average	Policymakers (incl. inspectorate)	Employer representatives	Employee representatives	Experts / Professionals	Insurers
National strategies		3.61	3.83	3.20	3.00	3.50	4.67
Awareness raising campaigns		3.87	4.67	4.00	3.00	3.20	4.00
Sectoral initiatives		3.32	2.83	3.40	2.00	3.40	3.67
Voluntary work-related management standards		3.03	1.60	3.30	2.00	3.56	2.67
Technical guidance for labour inspectors		3.00	4.00 (general pm: 2.00; inspect: 4.5)	2.10	4.00	3.22	2.67
Company policy on managing mental health		3.53	3.67	3.40	4.00	3.44	3.67
Recognising mental and stress-related illnesses on official list of occupational diseases		2.72	3.80	1.00	2.00	3.10	2.67

The fact that there were only very few additional comments to these ratings is an additional argument that non-binding EU initiatives are much less controversial amongst stakeholders and countries.

6.2 The strengths and weaknesses for the main scenarios

In this section, we have documented a lot of the original comments from the respondents in order to shape a message of strengths and weaknesses using respondent arguments regarding the five types of scenarios. Most comments regarding strengths and weaknesses related to non-binding EU-initiatives and the introduction of new EU-legislation on mental health in the workplace.

6.2.1 Strengths and weaknesses of non-binding EU-initiatives

Strengths: The main arguments on strengths of non-binding EU initiatives relate to the fact that there already is European legislation (a European Framework Directive) on occupational safety and health which includes psychosocial risks and aims to prevent mental health problems at the workplace. Ensuring better implementation of this legislation is the most appropriate way to improve protection against all health

and safety risks at the workplace. In addition, the flexibility of 'non-binding initiatives' can be considered to be crucial in this respect, as it allows countries, national social partners or sector organisations to decide on the actions for implementation.

According to an employer representative: 'We need to take into consideration that there are many differences among countries and it is impossible to have only one legislation for all of them that takes care of all their specific details. Ensuring better implementation of the existing legislation is the most appropriate way to improve protection against all health and safety risks at the workplace'. An expert further stated that: 'Employers can choose freely what an appropriate option for their environment (company/sector/region/network) is. This scenario provides flexibility'. Indeed an insurer also supported that 'The empowerment of employers can result in the investment in mental health and can improve their motivation to act, build social cohesion in an organisation and as a result improve the results of the company'. Finally some respondents referred to recognised successful initiatives that could be more widely used. For example, an employer representative argued that 'When implemented effectively, the management standards [for work-related stress in the UK] can be extremely successful'.

Weaknesses: The strength of the non-binding initiatives may also be its weakness. As mentioned previously, it is likely that non-binding initiatives (like good practices, covenants, pledges etc.) will only be effective in a few companies. As an employee representative put it: 'Especially companies that are not interested in implementing good practice, can only be forced by regulation and control'.

6.2.2 Strengths and weaknesses of new EU-legislation

Strengths: A major strength of this scenario is that EU-legislation is binding. Many stakeholders argue that a binding measure is more likely to be implemented (employee representatives; insurers; policymakers, new member states). It defines clear rights and obligations for employers and employees. It also forces parties to take mental health issues seriously. A labour inspector argued that 'legal requirements are easier to communicate with society which is important for a topic which is not something specific and defined but rather abstract good will'. Particularly in several European countries where there is hardly a preventive culture in place, companies basically (should) respond to legislation. Some of the stakeholders think that 'only then – after the 'binding' part- the non-binding initiatives may arise' (expert/professional).

Weaknesses: One important argument for the weakness of 'new EU-legislation on psychosocial risk management and mental health at work' is that due to the complexity of mental (ill) health, the definition of rules for sanctioning companies is not 'hard' enough. Therefore, legislative initiatives are counter-productive and may mainly produce much administrative costs and burdens. As a policy maker states: 'Legislation means more comprehensive procedures, higher costs and new structures for employers'. Other arguments related to the amount of time it will take to develop such a legislation: 'It takes years and years to develop any piece of EU legislation' (policy maker). A final, but quite important argument stated by a policy maker is that 'there is lack of political willingness to address the problem adequately'.

6.2.3 Strengths and weaknesses of providing a technical update

Strengths: A major strength of this policy scenario is that it provides more guidance from the EU or at the national level, which will support the implementation of the policy. This may be especially warranted because of the complexity of the topic at hand. As an employer representative put it, 'If there is more guidance from the EU or at the national level, the present policies could be very effective. However, this would request clear principles on the assessment process as well as on how to act on specific (individual/organisational) cases in terms of absenteeism etc.'. For some of the respondents, 'The technical updating of the framework directive including explicitly the protection of workers' mental health in combination with non-binding guidelines could be the most reasonable scenario' (policy maker).

Weaknesses: Several respondents pointed out that the term 'work-stress' as the result of psychosocial risk factors must be written into the Framework Directive directly. Also, 'The Framework Directive does not specify which risk factors are likely to create work-related stress and should be included in a risk assessment, nor does it specify measures to combat stress' (policymaker).

6.2.4 Strengths and weaknesses of combining or consolidating EU directives

No clear strengths or weaknesses have been described by the respondents. One could interpret the lack of comments and arguments as an indicator that this is not an important or interesting enough policy option for respondents.

6.2.5 Strengths and weaknesses of maintaining the status quo

Strengths: For many respondents, due to the complexity of mental health, new legislative initiatives were not considered very useful or having any added value. Part of the strengths for non-binding initiatives also apply to this policy option. Because of the fact that there already is an existing legislative framework, ensuring better implementation of this framework is the most appropriate way to improve protection for all OSH risks, including those for mental health. According to an employer representative, 'The initiatives taken at sector and company level can be tailored to specific needs and integrated into business strategies'. Another argument related to the fact that specific legislation on mental health in the workplace would be too complex and difficult. As an employer representative put it: 'Do not waste time by developing legislation which won't really help the employee nor the employer'.

Weaknesses: A major weakness – but not only for this scenario – is the complexity of the mental health topic. However, for some of the employer representatives, this scenario has no weaknesses. Some others stated that at present there is a lack of awareness of best practice examples in the field of psychosocial risk initiatives and this should be promoted further. An insurer also argued that companies would benefit from external independent and authoritative evidence-based guidance.

6.3 Assessing the costs and benefits of the different policy scenarios

Our overarching aim was to better understand the economic costs and impacts of different policy options for better mental health in the workplace, focusing on the

impacts of the five different policy scenarios that were developed. The five scenarios were placed and considered within the broader context of the current state of knowledge both on the impact of poor mental health at work in Europe and via our review of the cost effectiveness of different interventions to improve mental health in the workplace (a summary of the costs and benefits of different interventions has already been discussed in this report). As this was a rapid review we focused on looking for new literature published since 2013 to build on previous reviews and studies that we were able to identify. This included looking at the results of different economic modelling studies conducted in the EU in particular. A focus was placed both on promoting a mentally healthy work environment for all workers, as well as looking at measures to support employees at high risk, or already living with mental health problems.

A mixed methods approach was undertaken to assess the magnitude of the costs and benefits of the different scenarios. In addition to the literature review described above, during the scenario building work participants in the four selected countries (Germany, the Netherlands, Slovenia and the UK) were asked to give their views on the potential impacts, strengths and weaknesses that these scenarios will have, for instance in terms of impact on staff turnover and sick leave, administration costs, and productivity and performance of a business or industry as a whole. Participants were also asked to provide any insights and information that they might have on the costs of poor mental health at work in their countries. In addition to obtaining information from experts on potential costs and benefits of these scenarios, we also undertook an additional rapid review of literature to identify any relevant work looking specifically at the costs of the implementation of the different policy scenarios, for instance looking for information on the costs of implementing directives, developing a technical update or relying on non-binding initiatives at the EU level. This included looking for information on implementation costs in Canada where workplace standards have recently been developed (BNQ-CSA Group Technical Committee on Psychological Health and Safety in the Workplace, 2013).

We also drew where we could on relevant material from the 10 case studies and EU initiative survey materials in respect of resource use and effectiveness of policies. Using this information we then aimed to construct logic models to highlight developmental costs for the different scenarios, the likely potential buy-in from stakeholders and the potential costs of implementation.

6.3.1 Results

We have noted that detailed interviews were conducted with different stakeholders in the UK, Slovenia, Germany and the Netherlands to look at the strengths and weaknesses of the different policy scenarios. As part of these interviews the stakeholders were asked: "Are you aware of any estimates that have been made on the effectiveness as well as the economic costs and/or benefits" of different policy scenarios. With a few exceptions, respondents found it difficult to give an opinion on the effectiveness, rather than the political practicalities, of alternative strategies to the status quo. They were more able to point to sources of information on the current costs of poor mental health in their countries, e.g. noting in the UK that productivity losses account for about £3.7 billion every year, with 13 million working days on average lost due to mental health problems, with an average length of absence for mental health of 31 days. One interviewee noted that some scenarios – the status quo and the technical update – would have little or no resource consequences, while a new

directive might have substantive resource implications, particularly if there had to be an investment in expanding monitoring and inspection resources to ensure enforcement of a new directive. Some experts were sceptical on the cost effectiveness of awareness raising strategies in making an impact; evidence on awareness raising campaigns in respect of public health issues such as healthy lifestyles, exercise and alcohol is certainly mixed and often unlikely to have much impact without other measures also being adopted. This was not inconsistent with the 10 detailed case studies undertaken; in most cases little formal evaluation of the impact of different actions had taken place. Where evaluation had been conducted this has largely been qualitative in nature rather than formally assessing whether the actions have statistically made a difference (in some cases evaluation is still underway).

It was also difficult for respondents to say much about the potential cost and resource impacts of the different scenarios. There was some concern that moving to a more legally binding approach would lead to increased costs of litigation for business – as one interviewee stated, ‘if you make it a legal duties issue you get lawyers involved and they have a different interest, which isn’t making people better, it’s about getting the money to cover their costs’. In the case of the Work and Health Covenants soft approach case study in the Netherlands, overall about one third of the costs of the scheme, €84 million, were covered by the government, with employers covering the remaining €166 million. Some insights can also be gained from the development of the non-mandatory Health and Safety Executive Management Standards for Work-related Stress in the UK. While there is no published estimate of the total costs of this initiative one interviewee felt that the whole process, including consultation and development and subsequent training of inspectors to scrutinise employers was in the region of £20 million: ‘we are looking at around 20 million pounds [...] You think about a national process where you have got to consult across a broad range of stakeholders, multiple stakeholders, engage over 20 staff at policy level, three scientists, and four HSL [Health and Safety Laboratory employees] [...] a commitment to several hundred workshops over the course of the first year. The training for a hundred inspectors, and going out to do individual assessments, when you take the cumulative cost of it, this is where the figure came about’.

In contrast, statutory funding to aid in the implementation of the Healthy Working Lives Strategy for Scotland was very modest indeed, essentially just covering the annual full time employment costs of one individual (£60,000), with a fundamental reliance on business to cover most of the costs. Looking at the non-legally binding social partner agreement case study in Finland to promote more inclusive employment, a trade union interviewee felt that the costs of the initiative were not the obstacle. Instead it was rather some of the attitudes in workplaces towards the inclusion of people who were known to have mental health problems. The interviewee noted that ‘[the requirements under the agreement] are not necessarily very expensive. It needs some working time, [...] maybe they need to buy [in] some expert services, but very often, the direct costs are not necessarily very high. But, what seems to be an obstacle in many cases is, the employer considers hiring a partially disabled person or for example, a person who is recovering from mental health problems [a risk]. The employer is afraid that this worker will go on sick leave again and maybe it is not a very stable investment’.

It was also noted that there may be a lack of financial incentives for employers to focus on helping employees who are absent to return to work, as in nearly all Member States some of the most visible costs of sickness absence are shifted quickly away from employers. One respondent noted that ‘the system does not stimulate to keep people in the workplace but is more likely to shift people to their pension. Employers

have to pay employees for the first 6 weeks. After this period the social security system takes over. There is a low incentive to keep them in'. There was also an acknowledgement that incentives for employers may be influenced by the background of the employee, with employees in more skilled jobs with higher replacement costs judged to have a stronger case for support: '[action] depends on the level of profitability and the level of expertise. It is very difficult to replace an aircraft safety critical systems officer compared with a cashier working in a supermarket'. The interviewee therefore suggested that some companies would be more willing than others to look at further action, with a focus on non-binding initiatives.

Few respondents were able to say much about any economic assessments for actions in the workplace, although awareness appeared to be higher in the UK, which has a long standing system of making use of economic evaluation in policy decision making. This is unsurprising given the limited economic literature that we have previously discussed in this report. Some respondents in the UK noted the economic analysis and impact assessment prepared to complement the 2011 national mental health strategy in England – No health without mental health. However another respondent was rather sceptical of their value, referring to the challenges in obtaining accurate data from economic analyses even where they have been conducted and noting that:

'Most cost benefit analyses (CBA) are very poor, with figures banded around which have no economic or scientific basis, most of the CBA are either deductive or modelling, and I'm not sure that I know of any well-developed CBA generally that I would bank on. I suspect there isn't for this either. Most of them are limited, they don't take into account hidden costs and focus on specific issues e.g. sickness absence. The weaknesses are not knowing what the key variables are, and when you have figured some out, you don't know how to measure them again so you're back to guessing. To do them properly is a major scientific undertaking. We do it to justify things and create the rationale for doing things. And there are places where you can say it costs this and the savings will be that. But normally that's so specific it doesn't really tell you anything about the overall problem'.

Conversely one of the interviewees for the Danish case study on their strategy to tackle problems in the psychosocial working environment felt that cost benefit analysis was useful but focused too much on the cost of regulation and not enough on capturing the benefits of a better working environment, stating that: 'in the last five years, also from the European side, it has been very much focused on burdensome regulations, how much does it cost to have a meeting to discuss risks etc. But you never discuss the gains from preventing accidents or violence or psychosocial issues. You never have the benefits in these calculations. I think it is a bad way to do things. It should be more balanced'.

There was also recognition that in countries without occupational health insurance schemes, i.e. most tax-funded health systems in Europe, it is difficult for small and medium-sized companies to invest in workplace health promotion initiatives because of the cost. It is easier for large companies to absorb these costs. In Germany there is an obligation on health insurers to provide workplace health promotion programmes: in 2012 health insurers invested €238 million for primary prevention and health promotion programmes at work, or €3.41 euros per insured person. These schemes reached 4.8 million people. In Slovenia it was noted that companies often do not have sufficient finance to implement workplace mental health promotion programmes unless they receive support from insurance companies, who might otherwise have to pick up some of the costs associated with sickness absence.

In summary, there was little information in either the grey or the scientific literature about the costs of developing different policy scenarios. Given the comparative lack of literature on the costs of policy development, rather than on the costs of policy implementation at the EU level in this area, we also sought to identify information on the costs of policy development and implementation at national level in different jurisdictions related to workplace health. Again the information available as we have seen was extremely limited both in Europe and also in Canada. We have therefore summarised magnitudes of cost drivers in Table 22 rather than attempting to provide complex estimates of cost. While the literature provides examples of the costs of individual company based schemes, as we have noted there is almost nothing available on the cost of developing and implementing the different policy options at a European level, so our analysis must be treated with great caution. This does not just cover monetary costs but also time costs and the potential challenge of bureaucratic barriers. Green cells indicate that the level of cost is likely to be negligible, yellow likely to be somewhat higher, and red where costs are most prohibitive.

Table 22: Potential costs associated with different policy scenarios

	Development Efforts	Potential Buy In	Implementation
Status Quo	Minimal cost	Already achieved; higher engagement needed	No change unless investment in fostering implementation
Non-binding Initiatives	Minimal cost	Voluntary	Variable uptake
Technical Update	Minimal cost	Voluntary	Variable uptake
Combining / Consolidating Directives	Minimal financial costs; time costs higher	Consolidating what was already agreed	Potentially better uptake than status quo
New Directive	Minimal financial costs; long time to realise development	Longer process; potential obstacles	Legal requirements should mean good uptake

6.3.2 Developmental costs

What is clear is that the overall costs of all of the scenarios depend very much on the extent to which an initiative is actually translated into action on the ground in Member States. Looking first at the development costs of each of the scenarios, it is clear from

interviews, case studies, the Delphi survey and from our analysis of literature, that there are minimal costs associated with the continuance of the status quo, where the groundwork has already been laid, and also for technical updates where the principal cost is the time for inputs needed to research and then iteratively draft the update document. Non-binding initiatives are also likely to have minimal developmental costs although they can take considerable time, e.g. if for instance there would be the development of a new set of workplace mental health promotion standards and guidelines. In reality, however, what might be more likely would be the adaptation of an approach such as the UK's existing Management Standards for Work-related Stress to different country contexts, as has happened in Italy. This should reduce developmental costs although there will still be costs required for adaptation to a different country context. In the case of a new consolidated Directive, while the developmental costs would again be minimal, the time costs could be substantive given the need for formal consultation and subsequent procedures needed by the EU to adopt any consolidated Directive.

The most expensive option would be the development of a new Directive; again most of the costs here would be the time costs associated with formal procedures and consultations to develop as draft and the legal processes at the EU level to ratify any new Directive, followed by actions at Member State level to transpose a new Directive into national law. There are few monetary estimates available on the costs of negotiating a Directive, preparing a consultative document and then undertaking the subsequent steps to implement a Directive. Insight can be gained from looking at experience in establishing a third list of indicative occupational exposure limit values in Directive 2009/161/EU. In the UK, the Health and Safety Executive estimated that the costs of negotiating the Directive, preparing the Consultative Document and undertaking the subsequent steps to implement the Directive were £290,000 (HSE, 2011). This included estimated full time staff costs over 4 years for two policy advisors and a scientist as well as work contracted to external agencies. Even if this is conservative, it suggests that costs for each Member State may be less than €0.5 million for a new Directive. It is also the case that in the absence of legislation being developed at a European level, member states would then focus on developing their own national approaches; this was a key conclusion of a recent review of health and safety legislation in the UK (Lofstedt, 2011). Where a new Directive is thought to bring in a series of measures that have mixed impacts, member states might also be able to draft the necessary legislation or instruments to transpose the advantageous provisions as soon as possible while holding back the burdensome or cost-neutral ones until the transposition deadline (HM Government, 2013).

6.3.3 Potential buy-in

In addition to developmental costs, the overall economic costs of each of the different policy scenarios will depend on the level of buy-in achieved from different stakeholders in each of the Member States. This is difficult to judge but in the case of the status quo to some extent buy-in will already have been achieved, thus minimising cost. However, as expert interviewees have indicated, in many cases the status quo has not been particularly successful in addressing mental health issues at work. The challenge with the status quo therefore, if it is at all to become better implemented, is that it will have to engage with stakeholders that it has failed to do to date. Financial and other resources (e.g. time and high profile endorsements/campaigns) may be needed to achieve this.

Looking at non-binding initiatives, it is simply impossible to determine what level of buy-in will be achieved. In some contexts, guidelines and campaigns have been successful in encouraging action in workplaces because they have managed to get buy-in previously from stakeholders. The extent to which this is achievable will vary across countries.

The same will apply with the technical update; the level of uptake is unclear, although one expert interviewee noted that it is perhaps less likely to have less immediate influence in the UK where legal precedent is more likely to have an impact on the way in which existing legal instruments are interpreted. Consolidation, in principle, should have already achieved buy-in, but, as with the status quo option, there may be opportunities during the consultation process to encourage further buy-in. Buy-in may take most time and be most difficult to achieve with a new Directive, as this process will require political will and overcoming resistance to organisational change. This will at least be the case in some Member States that perhaps may be less enthusiastic for further regulation.

6.3.4 Assessing the costs of implementation

In essence, none of the five scenarios examined imply substantial financial costs for development or stakeholder buy-in, although there may be substantive costs in the case of a new directive or consolidated directive. The costs of implementation will ultimately depend on several factors: the level of uptake, the level of existing resource capacity in each member state and the combination of interventions that each enterprise decides to adopt. Only a new directive is likely to guarantee uptake; it is difficult to assess the level of uptake of the other options and in all likelihood this is likely to be highly variable across member states. It will also depend on the extent to which small and medium-sized enterprises as well as large enterprises adopt additional measures.

For non-binding arrangements, some qualitative positive experiences on adoption from a business point of view can be identified. In our case study analysis, one interviewee from a retail organisation indicated that once initial training was complete, recurring costs would be modest. Commenting on the HSE Management Standards in the UK the interviewee said that 'we invested money and it was the right thing to do, the benefits absolutely outweigh the cost. Obviously there are costs because every leader is taken off the job for one full day. In the first six months we had something like 220 leaders go through the programme, we then just run a couple of days a year to catch new people or people who have been newly promoted'. Although there is little in the way of quantifiable information on costs and benefits of such standards, some recent data by the HSE paints a very interesting picture. A recent evaluation by the HSE revealed that between 2001/2002 and 2010/2011 the number of self-reported new cases of work-related illness fell by 43,000 and the total number of cases by 69,000 – an overall reduction of 8.5%. According to HSE data, the five sectors specifically targeted with a view to adopting the Management Standards have fared "significantly better" than others in addressing psychosocial risks. The economic benefits of the fall in cases of work-related stress have been considerable. HSE economists have estimated that on average the overall cost of a case of work-related ill health (to the individual, the NHS and the economy) is £16,000. On this basis, approximate cost savings of £1.1bn (for prevalence) and £688m (for incidence) between 2001/2002 and 2010/2011 are estimated which might be viewed as "conservative" (HSE, 2014).

Another example is the recent standards developed in Canada (Box 1) – even though some barriers linked to potential resource use – need to deal with complexity and an additional workload for employers – were highlighted in qualitative research.

Box 1. Benefits and barriers to implementation of the Canadian Psychosocial Health and Safety in the Workplace Standard

The national standard of Canada for Psychological Health and Safety in the Workplace was launched in January 2013 (BNQ-CSA Group Technical Committee on Psychological Health and Safety in the Workplace, 2013). The standard is a voluntary set of guidelines, tools and resources focused on promoting employees psychological health and preventing psychological harm due to workplace factors.

While there is quite a rich literature on the reasons for the introduction of a national non-binding set of standards on psychosocial health in the workplace in Canada, there appears to have been very little discussion on the costs of implementation and development of these standards. Instead the argument has been strongly made that there will be an economic return on investment as can be seen in the publicity drive for the scheme.



Recently some work has been undertaken to identify what some of the barriers to the implementation of these standards might be. A qualitative, exploratory study was undertaken to uncover employers' perceptions of, and receptivity to, a comprehensive policy approach for dealing with psychological health and safety in the workplace (Kunyk, Morris, & Reisdorfer, 2014). This was done through interviews with representatives of 17 different workplaces ranging from a business with less than 20 employees to another with more than 100,000 employees.

Interviewees did recognise benefits to employers including improved employee performance, corporate image, loyalty, recruitment and retention, approachability, and safety along with reduction in costs, conflict, and other issues. In terms of barriers although there was no explicit mention of the costs of implementation there were concerns about complexity. The standards document is 60 pages in length and there was a feeling that the companies that could benefit most from adopting the standards may be the companies that would be least likely to make use of them. Participants felt that its size prohibited their ability to describe it in a meaningful and concise manner and that this would preclude their ability to advocate to their senior managers and other decision makers. They also noted the challenge of implementation across multiple sites within a business and the potential increased workload placed on business. There were also concerns that the standards might lead to increased litigation.

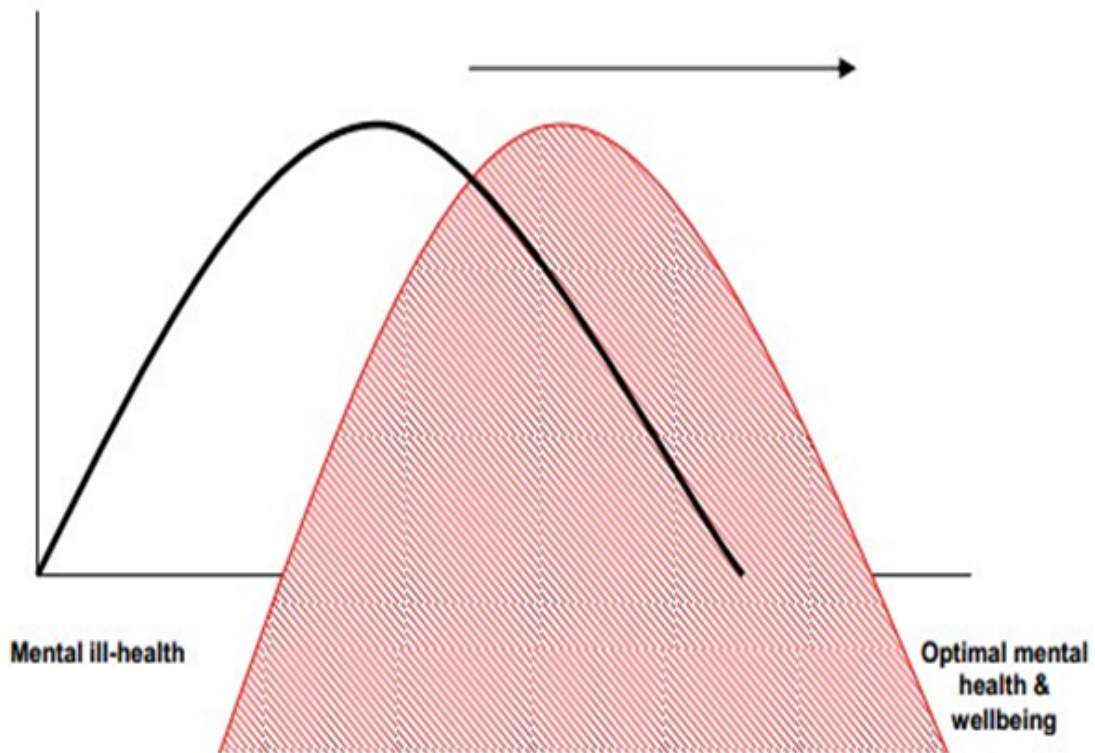
A second factor that will influence costs is the level of existing resource and infrastructure capacity in countries. For instance, one potential option that may be considered is to train labour inspectors to be better aware of mental health promotion issues. In countries with very limited labour inspectorates, implementing this measure would be much more costly than in countries that have substantive labour inspectorates. This lack of governmental resources to expand services and activities such as monitoring and inspection may be a key barrier to implementation. At a business level the availability of existing infrastructure and resources will also make a difference to the costs of awareness raising and internal business communication.

Box 2: Examples of actions that could be taken as part of implementation of different scenarios

Adoption of new procurement and contracting processes
Adoption of new measures on flexible working
Awareness campaigns on the importance of mental health at work
Enhanced collaboration between occupational and mainstream health systems
Development and adaptation of standards for mental health at work
Greater focus on mental health in risk assessment procedures
Monitoring implementation and enforcement sanctions
National adaptations of EU legislation
Recognised mentally healthy workplace award schemes
Support for active inclusion in work
Training of managers and other staff in enterprises
Training of health and safety inspectors

Implementation will differ depending on actions adopted. Some potential actions are listed in Box 2 – but many other actions may be possible. Many of these actions in turn could lead to very different initiatives taking place in different enterprises. For instance, a successful awareness campaign could mean that enterprises invest in different preventive measures such as minimising risks to mental health, training line managers, flexible working, and better career development support. While we cannot be sure of the costs of implementation, we can be relatively confident, as our discussion in Chapter 3 of both the costs of poor mental health and the cost effectiveness of workplace mental health promotion indicates, that many different activities have been shown to generate economic benefits that outweigh their costs. These are well documented and they provide a powerful case for considering actions to promote better mental health at work. The potential for gains is not surprising given that potentially modest shifts to improvement of mental health in the working population could realise significant gains (Figure 8).

Figure 8: Potential for health and economic gains through modest improvements towards better mental health and wellbeing at work



Source: Sutherland & Cooper (2002)

Moreover, there is increased recognition of the case for action in both some policy makers and employers. This recognises that there is a business case, but it is not just about the saving costs. As one of our expert interviewees stated: 'scientific evidence linking the stressful psychosocial work environment with [poor] mental health is overwhelming.....people who experience stressful working conditions have an 80% elevated risk for developing depression in the next 5 years compared to those who have the same age, sex, profession, and who are not exposed'.

Another interviewee commented that: 'it is very clear that the costs caused by the effects of mental illness and psychosocial burden at work are much higher than the possible costs of mental health promotion programmes. In terms of work performance, and work absence, in terms of lack of staff, in times of labour market changes where it is not very easy to find new staff, it becomes very important for a company to be able to deal with the issue of mental health'.

It is also increasingly recognised that the workplace is a potential location in which to identify risks to mental health from outside of the working environment. More and more companies, particularly large companies, are highlighting the business case as a reason for investing in mental health at work. Companies that have indicated this approach include Accelor-Mittal, a major steel and mining company, the retailer Marks and Spencer, the engineering firm, Siemens, and the telecoms company British Telecom.

Moreover, in a recent article in the Financial Times, Andy Buxton, health and wellbeing manager at National Grid, the company responsible for managing the UK's electricity supply network, says he used a detailed business case for health and wellbeing expenditure to the board, proving that: 'for every pound spent on psychological

rehabilitation processes we got back at least two in returning people to work early". He added however that 'but now they just see it as the right thing to do. To not do anything would be damaging to the individual and employer alike' (Smedley, 2014).

6.3.5 Conclusions on policy scenarios and economic impact

Our analysis indicates that non-binding EU initiatives were most often preferred, which may reflect the feeling from interviews that additional regulation and legislation may be difficult whilst well designed non-binding measures have been shown to help improve the focus on mental health in the workplace in some country contexts. The scenario on 'developing a technical update' ranks second, whereas 'combining or integrating EU directives' ranks third.

Opinions are mixed among stakeholders and across countries. While the scenario on 'developing a new EU legislation on mental health' ranks lowest when considering average ratings; the perspective of respondents is somewhat split, 48% indicated that it was the 'worst choice' while 23% felt it was the 'best choice'.

Non-binding EU initiatives as the 'overall favourite' are on average most preferred in Southern Europe and UK & Ireland. In the new member states this scenario shares first place with the scenario on 'developing new EU legislation'. In Northern countries, the latter is the most preferred scenario. Continental country respondents preferred a technical update of existing legislation.

The differences in preference are, however, much more pronounced for the different stakeholders as compared to the country clusters. Only experts and professionals also prefer non-binding EU-initiatives the most. Employee representatives and policy makers in some countries (particularly labour inspectorate) most strongly prefer developing new EU legislation, whereas employer representatives most often prefer the status quo. The above is to be explained by the fact that particularly the different stakeholders have quite different roles and thus different interests in the scenarios.

Regarding the preference for the non-binding EU scenario, the different stakeholders do not differ greatly in their preference for a specific initiative. The main preference is awareness raising campaigns, closely followed by developing and implementing a national strategy on mental health. The latter is somewhat remarkable considering that many European countries already have mental health strategies in place, while at European level the Pact on Mental Health and Wellbeing recognises the importance of mental health in the workplace.

Our economic analysis indicates that little information is available on the potential costs of the different scenarios, although it appears that none will incur substantial development costs, but some, e.g. a new directive, would take considerably longer to develop. Resourcing concerns did not appear as major concerns in most of our case studies and interviews. Nonetheless the costs of implementation are likely to vary considerably; crucially they will depend not only on uptake but on the existing infrastructure and resources that are available in different member states. In member states where resources are limited, the costs of some potential measures would be much higher as there would be a need to develop capacity which does not exist rather than adapt existing infrastructure or train existing personnel.

While it is difficult to determine the actual costs of implementation, it is clear from our review of the evidence on the cost effectiveness of workplace health promotion programmes that the economic returns overall will be greater than the costs of investment. Much of these benefits will be gained by enterprises but there are also benefits to health and social welfare systems and to the economy as a whole. While there is some uncertainty about the magnitude of benefits, and a recognition that the business case is less strong in enterprises where there are fewer costs associated with staff turnover, there are now numerous examples of cost effective schemes in different country contexts, albeit many of these are outside of Europe, such as in Canada, the US and Australia.

However, most of the schemes that have been evaluated have been implemented in large enterprises; regardless of any policy scenario chosen, it may also be important to put some emphasis on looking at measures to support small and medium-sized enterprises to actively implement measures in the workplace. More generally, the key challenges remain implementation and having sufficient incentives to encourage action. Generating further evidence base on the effectiveness of actions in the European context and learning from various actions implemented across Europe is one way forward while another would be to look at ways to assess the impact of different strategies on an ongoing basis to help inform future implementation practice.

7. Recommendations

This report detailed a series of steps in evaluating the policy context to the promotion of mental health in the workplace in EU/EFTA countries and minimizing relevant risks. The first step was a review of the magnitude of mental health concerns in the workplace in Europe and the impact of mental ill health on individuals, organisations and society overall. As it has been shown in this report, the prevalence of mental ill health in the workplace, including poor psychological well-being is widespread across all EU/EFTA countries and there are indications that this will only increase due to exposure to risk factors such as job insecurity, work intensification and organisational restructuring. In addition, the impact of mental ill health is profound on individuals, organisations and society as a whole. At the individual level, exposure to psychosocial risks can result not only to poor psychological health and well-being but also to physical problems such as cardiovascular disease. These problems challenge participation in the workforce and performance through absenteeism and presenteeism. Discrimination and social exclusion against those affected by mental health disorders still remain a problem exacerbating the situation. At the organisational level, evidence indicates that mental ill health and poor psychological well-being affects business performance through absenteeism, presenteeism, reduced job satisfaction and organisational commitment, a poor work climate and human error. Additional costs are incurred by businesses in terms of hiring and training costs as well as reduced productivity and innovation. At societal level, there are associated costs to national social security and benefit systems, national economies and challenges on healthcare systems. These trends are projected to continue in the future. The negative impact of poor mental health in the workplace is now undisputed. However, further awareness needs to be raised on the other half of the story, the positive impact of good mental health on sustainability at individual, organisational and societal level as a means of achieving the Europe 2020 goals.

The second step was a policy review at EU level with a focus on both regulatory and voluntary policy instruments, detailing the 'history' of policy evolution in this area in the EU. This was supplemented by a gap analysis. Employment, including OSH, legislation as well as public health legislation address the issue by placing emphasis on prevention through tackling risk factors and preventing discrimination. However some challenges have been identified. Although, for example, a common legal framework in the EU exists in relation to mental health in the workplace through the Framework Directive 89/391/EEC which covers all types of risk to workers' health, there still appears to be limited awareness of this provision both by employers and other key stakeholders (including, until recently at least, inspectors in different member states). Limited awareness and expertise on how to conduct inspections on psychosocial risks associated with mental ill health were among the key drivers for the 2012 SLIC campaign. However, with widespread budget cuts in the public sector, inspections in many countries are becoming more reactive in nature. The situation seems to be negatively exacerbated further by the fact that the Framework Directive does not include specific terminology in relation to mental health in the workplace (for example it only refers to broad areas from which risk factors can arise, such as work organisation, and does not include terms such as work-related stress or psychosocial risks). From the review and gap analysis presented on regulatory and voluntary policy initiatives it can be observed that: a. there is lack of clarity and specificity on the terminology used; and b. although the different instruments/initiatives are based on related paradigms, very few of them provide specific guidance on managing risks in relation to mental health in the workplace to enable organisations (and especially small and medium-sized enterprises - SMEs) to implement a preventive framework of action. A question then arises of whether existing policies have actually fulfilled expectations in practice in the area of mental health in the workplace. Several additional policy instruments of a non-binding nature have clarified the relevance and application of the Framework Directive in this area such as the framework agreements on work-related stress and on harassment and violence at work. The EC guidance on risk assessment also includes useful detail in this area.

The gap analysis conducted in this study concerned both regulation and non-binding policies. It showed that a number of non-binding policies have been developed at EU level which provide specific guidance in this area while several gaps are evident in legislation at EU level. In light of this, it would be advisable to revisit the content of the Framework Directive in relation to psychosocial risks and mental health in the workplace to provide further clarity and harmonise terminology across other key OSH legislation accordingly. The review also showed that there is more scope for better co-ordination at EU institutional level in this area since several policy initiatives and studies have been implemented in this area, for example from different Directorate Generals, the European Parliament, and the European Agency for Safety & Health at Work. There is scope for closer collaboration and co-ordination to achieve maximum impact in a cost-effective manner.

The third step in this study, the review of policies at national level in the EU/EFTA countries and a case study analysis of different types of policy instruments and initiatives, showcased several examples of good practice that have been implemented in individual or even across member states. These have helped tremendously in clarifying the legal framework and employer and employee responsibilities. An example is the Management Standards for work-related stress in the UK that have been adapted in Italy. Awareness raising of these initiatives and sharing of good practices across the EU has only recently started to materialise to some extent and there is far more scope in learning from these good practices and even exploring the

feasibility of promoting a more unified approach at EU level. To do so, existing monitoring systems in the EU (such as the European Working Conditions Survey by Eurofound and the European Survey of Enterprises on New & Emerging Risks by EU-OSHA) will have to be strengthened to allow better benchmarking across members states. In short, a more co-ordinated action plan is necessary at EU level, clarifying requirements (both in employment and public health policies) and the case for mental health promotion in the workplace and drawing upon good practice efforts within specific countries. In addition, monitoring across the EU and between and within Member States should be further developed by refining existing systems. A specific issue to be considered is the inclusion of mental health disorders in lists of occupational diseases in EU countries. Without effective monitoring and dedicated reporting, knowledge at the Community level about the rate of progress would be weak.

Although there have been a number of policy initiatives for many years in the EU, awareness in relation to mental health in the workplace and the importance of preventive action still seems to be lacking. This is despite available data that map the prevalence and impact both of risk factors and mental ill health outcomes. Findings suggest that although OSH legislation is seen by European employers as a key driver to address OSH issues, it has been less effective for the management of psychosocial risks and the promotion of mental health in the workplace (e.g. EU-OSHA, 2010). In relation to voluntary policy instruments, there is the question of whether they have been effective in supporting the implementation of existing legislation and in guaranteeing quality with regard to the 'essential requirements' established by European policies. It is important that employer responsibility is strengthened and awareness is further developed both in relation to the policy framework on mental health in the workplace and specific preventive measures that should be introduced to promote mental health. Currently, there is no guidance that specifically clarifies employer responsibilities in law in this area and how to fulfil their responsibilities by conducting risk assessments and putting in place preventive measures. It is hoped that this gap will be addressed to some extent by the interpretative document of the Framework Directive provisions in relation to mental health in the workplace that has been developed as part of this study.

The next step in the study included the development and evaluation of several scenarios on policy options in relation to mental health in the workplace in the EU on the basis of a Delphi study including interviews and an online survey. Our analysis showed that if the current status quo as concerns the policy context to mental health in the workplace is maintained, it is likely that a number of activities will continue to take place across the EU/EFTA countries in this area given the documented, and now undisputed, impact of mental ill health on individuals, organisations and society. However, there is uncertainty as to whether they will achieve the desired outcomes, especially since preventive actions still seem to be lacking across countries. Our analysis also indicates that the views of key stakeholders across countries on the various policy scenarios (maintaining the status quo; introducing non-binding EU initiatives; combining or consolidating EU directives; providing a technical update of existing EU legislation; developing EU legislation in this area) differ. Overall, non-binding EU initiatives were most often preferred, which may reflect the view from stakeholders that additional legislation may be difficult to develop whilst well designed non-binding measures have been shown to help improve the focus on mental health in the workplace in some country contexts. The scenario on 'developing a technical update of existing legislation' ranked overall second, whereas 'combining or consolidating EU directives' ranked third.

Economic analysis indicated the availability of very little information on the costs of implementing different scenarios, although qualitatively it appears that none would incur substantial development costs, but some, e.g. a new directive, would take considerably longer to develop. The costs of implementation are likely to vary considerably; and would depend on uptake and also on the existing infrastructure and resources in member states. While it is difficult to determine the actual costs of implementation, it is clear from our review and analysis that the economic returns overall are likely to be greater than the costs of investment. Much of these benefits will be gained by enterprises but there are also benefits to health and social welfare systems and to the economy as a whole. It should also be noted that many of these economic analyses are likely to be conservative as most only look at the benefits of a reduction in absenteeism and/or presenteeism and do not consider other benefits to business including better creativity and innovation, greater staff retention, and public image of the company. There are also additional wider benefits to society if workplace actions promote better mental health as this also helps protect against the risk of physical health problems. In addition, these scenarios do not normally take a human rights perspective to the promotion of mental health which would favour further action in this area. Leka, van Wassenhove and Jain (2015) note the limited interpretation of the concept of 'business case' and instead argue for a 'value case' to be considered for the promotion of mental health in the workplace. They also note challenges in policy and in practice, lack of co-ordination, and a lack of a long-term strategic approach in relation to addressing mental health in the workplace as a priority area.

Regardless of any policy scenario chosen, it would be important to put further emphasis on measures to support small and medium-sized enterprises to actively implement good practices in the workplace. There are also potential economic benefits to governments and insurers that can be realised if they support occupational health services and other workplace mental health promotion actions in companies that would not otherwise be able to provide these services. The evidence base on the effectiveness of actions taken in the European context should be strengthened to promote cross-fertilization of learning. In addition, assessing the impact of different strategies on an ongoing basis to help inform future implementation practice is important.

It is worth noting that similar conclusions have been reached by other recent studies in this area, such as the Milieu Consulting (2013) for the European Parliament which refers to the need for a clear and coherent framework at the EU level bringing together the occupational and public health dimensions, considering the inclusion of mental health disorders in the list of occupational diseases, and the need for further awareness raising campaigns. Similar conclusions can also be found in the scientific literature (e.g. Ertel et al., 2010; Iavicoli et al., 2014; Leka et al., 2011b) where the OSH EU policy context has been discussed in relation to psychosocial risks and work-related stress. Our analysis has built on previous work by a thorough consideration of the policy framework at EU and national level and investigating the views of key stakeholders in relation to various policy scenarios.

The final steps of this project focused on the development of two guidance documents. The first is an interpretative document of Framework Directive 89/391/EEC in relation to mental health in the workplace. This interpretative document aims to reiterate, in particular to employers and anyone with relevant responsibilities in organisations, the formal requirements of Council Directive 89/391/EEC as regards mental health in the workplace. The second is a guidance document on how to implement a comprehensive approach for the promotion of mental health in the workplace. It is hoped that these

two documents will clarify legal requirements and good practice in this area further for employers and other key stakeholders in Europe.

On the basis of our study the following recommendations can be made to the European Commission to achieve progress in the area of mental health in the workplace:

- Revisit the content (coverage and terminology) of Council Directive 89/391/EEC to include clear reference to psychosocial risks and mental health in the workplace.
- Promote the interpretative document of Council Directive 89/391/EEC to clarify legal requirements for employers and other key stakeholders in Europe.
- Promote the guidance document on how to implement a comprehensive approach for the promotion of mental health in the workplace.
- Harmonise coverage and terminology in relation to psychosocial risks and mental health in the workplace across all key pieces of OSH legislation.
- Consider the inclusion of mental health disorders in the list of occupational diseases at EU level.
- Continue to promote both regulatory and non-binding initiatives to raise awareness and promote good practice.
- Co-ordinate action at EU institutional level in this area to achieve maximum impact.
- Raise awareness on the positive impact of good mental health and its association with sustainability as a means of achieving the Europe 2020 goals.
- Strengthen existing monitoring systems in the EU (such as the European Working Conditions Survey by Eurofound and the European Survey of Enterprises on New & Emerging Risks by EU-OSHA) to allow better monitoring and benchmarking across members states.
- Publicise lessons learnt from good practices implemented in member states to motivate action across the EU.
- Place further emphasis on measures to support small and medium-sized enterprises to actively implement good practices in the workplace.

8. References

- Allebeck P, & Mastekaasa A. (2004). Risk factors for sick leave - general studies. *Scandinavian Journal of Public Health Supplement*, 63, 49-108
- Amabile, T. M., & Conti, R. (1999). Changes in the Work Environment for Creativity during Downsizing. *Academy of Management Journal*, 42(6), 630-640.
- Amabile, T. M., Conti, R., Coon, H., Lazenby, J., & Herron, M. (1996). Assessing the work environment for creativity. *Academy of Management Journal*, 39(5), 1154-1184.
- Amabile, T. M., Goldfarb, P., & Brackfield, S. C. (1990). Social influences on creativity: Evaluation, coaction, and surveillance. *Creativity Research Journal*, 3, 6-21.
- Anker, R. (1998). *Gender and Jobs, Sex Segregation of Occupations in the World*. Geneva: International Labour Office.
- Arnetz, B.B., Adble, E., Backman, L., Lynch, A., & Lublin, A. (2013). Assessment of a prevention program for work-related stress among urban police officers. *International Archives of Occupational and Environmental Health*, 86(1), 79-88.
- Aronsson, G., Gustafsson, K. & Dallner, M. (2000). Sick but yet at work. An empirical study of sickness presenteeism. *Journal of Epidemiology & Community Health*, 54, 502-509.
- Awa, W.L, Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education & Counselling*, 78(2), 184-190.
- Axtell, C.M., Holman, D.J., Unsworth, K.L., Wall, T.D., & Waterson, P.E. (2000). Shopfloor innovation: Facilitating the suggestion and implementation of ideas. *Journal of Occupational and Organizational Psychology*, 73, 265-285.
- Barling, J., Kelloway, E. K., & Iverson, R.D. (2003). High-quality work, job satisfaction, and occupational injuries. *Journal of Applied Psychology*, 88, 276-283.
- Barling, J., Loughlin, C., Kelloway, K.E. (2002). Development and Test of a Model Linking Safety- Specific Transformational Leadership and Occupational Safety. *Journal of Applied Psychology*, 87(3), 488-496.
- Beck, A., Crain, A.L., Solberg, L.I., Unutzer, J., Glasgow, R.E., Maciosek, M.V. & Whitebird, R. (2011). Severity of depression and magnitude of productivity loss. *Annals of Family Medicine*, 9, 305-11.
- Beddington, J., Cooper, C.L., Field, J., Goswami, U., Huppert, F.A., Jenkins, R., Thomas, S.M. (2008). The mental wealth of nations. *Nature*, 455, 1057-60.
- Benach, J., & Mutaner, C. (2007). Precarious employment and health: Developing a research agenda. *Journal of Epidemiology & Community Health*, 61, 276-277.
- Bhui, K.S., Dinos, S., Stansfeld, S.A. & White, P.D. (2012). A synthesis of the evidence for managing stress at work: A review of the reviews reporting on anxiety, depression, and absenteeism. *Journal of Environmental & Public Health*, 515874.

Bjerkan, A.M. (2010). Health, environment, safety culture and climate- analysing the relationships to occupational accidents. *Journal of Risk Research*, 13(4), 445-477.

Blatter, B., Heuvel, S., van den, Kraker, H. den, Treutlein, D., Hollander, A., OpdeBeeck, R., Eeckelaert, L., Muylaert, K., Pawlowska, Z., Borowska, M. & Roman-Liu, D. (2009). Impact study of community initiative for WRMSDS in Europe. Hoofddorp: TNO.

BNQ-CSA Group Technical Committee on Psychological Health and Safety in the Workplace (2013). Psychological health and safety in the workplace — Prevention, promotion, and guidance to staged implementation. Montreal: Bureau de normalisation du Quebec.

Bond F.W., & Bunce D. (2000) Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *Journal of Occupational Health Psychology*, 5(1), 156-63.

Bond, F. W., Flaxman, P.E., & Bunce, D. (2008). The influence of psychological flexibility on work redesign: Mediated moderation of a work reorganization intervention. *Journal of Applied Psychology*, 93(3), 645-654.

Bonde J.P.E. (2008). Psychosocial factors at work and risk of depression: A systematic review of the epidemiological evidence. *Occupational & Environmental Medicine*, 65, 438-445.

Bondy, K., Matten, D., & Moon, J. (2004). The Adoption of Voluntary Codes of Conduct in MNCs: A Three-Country Comparative Study. *Business & Society Review*, 109 (4), 449-477.

Branch, A. (2005). The Evolution of the European social dialogue towards Greater Autonomy: Challenges and Potential Benefits. *International Journal of Comparative Law and Industrial Relations*, 21(2), 321-46.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Briggs, A.M., Bragge, P., Smith, A., Govil, D. & Straker, L.M. (2009). Prevalence and Associated Factors for Thoracic Spine Pain in the Adult Working Population: A Literature Review. *Journal of Occupational Health*, 51, 177-192.

Broughton, A. (2008). Working Conditions and Social Dialogue. European Foundation for the Improvement of Living and Working Conditions. Available at: <http://www.eurofound.europa.eu/docs/comparative/tn0710019s/tn0710019s.pdf>

Burchell, B., Fagan, C., O'Brien, C., & Smith, M J. (2007). Working conditions in the European Union: The gender perspective. Luxembourg: Office for Official Publications of the European Communities.

Campbell, F., Worrall, L. & Cooper, C. (2000). The psychological effects of downsizing and privatisation. *Wolverhampton Business School Working Paper Series*, 1-20.

Cancelliere, C., Cassidy, J.D., Ammendolia, C. & Cote, P. (2011). Are workplace health promotion programs effective at improving presenteeism in workers? A systematic review and best evidence synthesis of the literature. *BMC Public Health*, 11, 395.

- Cheng, Y., Chen, C.W., Chen, C.J. & Chiang, T. L. 2005. Job insecurity and its association with health among employees in the Taiwanese general population. *Social Science & Medicine*, 61, 41-52.
- Chui, W., Chan, A., Snape, E. & Redman, T. (2001). Age stereotypes and discriminatory attitudes towards older workers: An East-West comparison. *Human Relations*, 54(5), 629-61.
- Corbiere, M., Shen, J., Rouleau, M. & Dewa, C.S. 2009. A systematic review of preventive interventions regarding mental health issues in organizations. *Work*, 33, 81-116.
- Cox, T., Leka, S., Ivanov, I., & Kortum, E. (2004). Work, employment and mental health in Europe. *Work & Stress*, 18(2), 179-185.
- Cox, T. (1993). *Stress research and stress management: Putting theory to work*. HSE Contract Research Report No 61/1993). Sudbury: HSE Books.
- Cooper, C.L., & Cartwright, S. (1997). An intervention strategy for workplace stress. *Journal of Psychosomatic Research*, 43(1), 7-16.
- CMH – Centre for Mental Health. (2010). *The Economic and Social Costs of Mental Health problems in 2009/10*. London: CMH.
- Da Costa, B.E. & Vieira, E.R. (2009). Risk factors for work-related musculoskeletal disorders: A systematic review of recent longitudinal studies. *American Journal of Industrial Medicine*, 48,1-39.
- De Boer, R., Benedictus, H., & van der Meer, M. (2005). Broadening without intensification: The added value of the European social and sectoral dialogue. *European Journal of Industrial Relations*, 11(1), 51–70.
- De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., ...Leucht, S. (2011). Physical illness in patients with severe mental disorders. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 52-77.
- Deacon, A. (1997). *From welfare to work: Lessons from America*. Institute of Economic Affairs.
- Dekkers-Sánchez, P.M., Hoving, J.L., Sluiter, J.K. & Frings-Dresen, M.H.W. (2008). Factors associated with long-term sick leave in sicklisted employees: A systematic review. *Occupational & Environmental Medicine*, 65, 153-157.
- Department for Business Innovation and Skills (2008). *Foresight Mental Capital and Wellbeing Project. Final Project Report*. London: The Government Office for Science.
- Department of Work and Pensions (2013). *DWP Statistics*. Available at <http://statistics.dwp.gov.uk/asd/>, London, DWP.
- Dewa, C., & Hoch, J. (2014). Estimating the Net Benefit of a Specialized Return-to-Work Program for Workers on Short-Term Disability Related to a Mental Disorder: An Example Exploring Investment in Collaborative Care. *Journal of Occupational & Environmental Medicine*. 56(6), 628-31.

Dewa, C. S., McDaid, D., & Ettner, S.L. (2007). An International Perspective on Worker Mental Health Problems: Who Bears The Burden and How Are Costs Addressed? *Canadian Journal of Psychiatry*, 52(6), 346-356.

Dewa, C.S., & McDaid, D. (2010). Investing in the Mental Health of the Labour Force: Epidemiological and Economic Impact of Mental Disorders in the Workplace. In I. Schultz and S. Rogers (eds.) *Handbook of Work Accommodation and Retention in Mental Health*. Boston: Springer.

de Zeeuw, E.L.E.J., Tak, E.C.P.M., Dusseldorp, E., & Hendriksen, I.J.M.(2010). Workplace exercise intervention to prevent depression: A pilot randomized controlled trial. *Mental Health & Physical Activity* 3(2), 72-77.

Dornan, A., & Jane-Llopis, E. (2010). *The Wellness Imperative: creating more effective organisations*. Geneva: World Economic Forum.

Duijts, S.F.A., Kant, I.J., Swaen, G.M.H., Brandt, P.A., & Zeegers, P.A. (2007). A meta-analysis of observational studies identifies predictors of sickness absence. *Journal of Clinical Epidemiology*, 60, 1105-15.

EC - European Commission (2007). Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Towards Common Principles of Flexicurity: More and better jobs through flexibility and security. Retrieved 25 June, 2013, from <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52007DC0359:EN:NOT>

EC - European Commission (2013). Report on the current situation in relation to occupational diseases' systems in EU Member States and EFTA/EEA countries, in particular relative to Commission Recommendation 2003/670/EC concerning the European Schedule of Occupational Diseases and gathering of data on relevant related aspects. Retrieved 25 June, 2013, from <http://ec.europa.eu/social/BlobServlet?docId=9982&langId=en>

EC - European Commission (2002). *Guidance on work-related stress – Spice of life or kiss of death?* Luxembourg: Office for Official Publications of the European Communities. Available at: <http://osha.europa.eu/data/links/guidance-on-work-related-stress>

EC -European Commission (2004). Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions on the practical implementation of the provisions of the Health and Safety at Work Directives 89/391 (Framework), 89/654 (Workplaces), 89/655 (Work Equipment), 89/656 (Personal Protective Equipment), 90/269 (Manual Handling of Loads) and 90/270 (Display Screen Equipment). Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52004DC0062:EN:HTML>

EC – European Commission (2006). Commission Staff Working Document - Industrial relations in Europe 2006. Available at: <http://register.consilium.europa.eu/pdf/en/06/st15/st15670.en06.pdf>

EC – European Commission (2010a). Eurobarometer on mental health. Available at: http://ec.europa.eu/health/mental_health/eurobarometers/index_en.htm

EC – European Commission (2010b). Europe 2020: A strategy for smart, sustainable and inclusive growth. COM(2010) 2020. Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:2020:FIN:EN:PDF>

EC – European Commission (2010c). Commission staff working document on the functioning and potential of European sectoral social dialogue. SEC(2010) 964 final. Available at: <http://ec.europa.eu/social/BlobServlet?docId=5591&langId=en>

Eller, N.H., Netterstrøm, B., Gyntelberg, F. et al. Work-related psychosocial factors and the development of ischemic heart disease. *Cardiology in Review*, 2009, 17, 83-97.

Ertel, E., Stilianow, U., Iavicoli, S., Natali, E., Jain, A., & Leka, S. (2010). European social dialogue on psychosocial risks at work: Benefits and challenges. *European Journal of Industrial Relations*, 16(2), 169-183.

EU-OSHA – European Agency for Safety and Health at Work (2007). Expert forecast on emerging psychosocial risks related to occupational safety and health. Luxembourg: Office for Official Publications of the European Communities.

EU-OSHA – European Agency for Safety and Health at Work (2009). OSH in figures: Stress at work - facts and figures. Luxembourg: Office for Official Publications of the European Communities.

EU-OSHA – European Agency for Safety and Health at Work (2010). European Survey of Enterprises on New and Emerging Risks: Managing safety and health at work. European Risk Observatory Report. Luxembourg: Office for Official Publications of the European Communities.

EU-OSHA – European Agency for Safety and Health at Work (2011). Mental health promotion in the workplace – A good practice report. Luxembourg: Office for Official Publications of the European Communities.

EU-OSHA – European Agency for Safety and Health at Work (2002). New forms of contractual relationships and the implications for occupational safety and health. Luxembourg: Office for Official Publications of the European Communities. Available at: <http://osha.europa.eu/en/publications/reports/206>

EU-OSHA – European Agency for Safety and Health at Work (2000). Research on work-related stress. Luxembourg: Office for Official Publications of the European Communities. Available at: <http://osha.europa.eu/en/publications/reports/203>

Eurofound - European Foundation for the Improvement of Living and Working Conditions (2011). Autonomous agreement – an explanation. European Foundation for the improvement of living and working conditions. Available at: <http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/autonomousagreement.htm>

Eurofound - European Foundation for the Improvement of Living and Working Conditions (2007). Fourth European survey on working conditions 2005. Luxembourg: Office for Official Publications of the European Communities. Available at: <http://www.eurofound.europa.eu/publications/htmlfiles/ef0698.htm>

European Social Partners (ETUC, BUSINESSEUROPE, UEAPME, CEEP) (2002). Framework of actions for the lifelong development of competencies and qualifications. Available at: <http://www.etuc.org/a/580>

European Social Partners (ETUC, BUSINESSEUROPE, UEAPME, CEEP) (2005). Framework of actions on gender equality. Available at: http://www.etuc.org/IMG/pdf/framework_of_actions_gender_equality_010305-2.pdf
European Social Partners (2004). Framework Agreement on Work-related Stress. European social partners -ETUC, UNICE(BUSINESSEUROPE), UEAPME and CEEP, Brussels, 2004. Available at: http://ec.europa.eu/employment_social/news/2004/oct/stress_agreement_en.pdf

European Social Partners (2006). Work Programme of the European Social Partners 2006 – 2008. Brussels: European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP.

European Social Partners (2007). Framework Agreement on Harassment and Violence at Work. Brussels: Social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP. Available at: http://ec.europa.eu/employment_social/news/2007/apr/harassment_violence_at_work_en.pdf

European Social Partners (2008). Implementation of the European autonomous framework agreement on work-related stress. Report adopted by the European Social Partners – Adopted at the Social Dialogue Committee on 18 June 2008. Brussels: European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP.

European Social Partners (2011). Implementation of the European autonomous framework agreement on harassment and violence at work. Report adopted by the European Social Partners – Adopted at the Social Dialogue Committee on 24 October 2011. Brussels: European social partners - ETUC, BUSINESSEUROPE, UEAPME and CEEP.

Eurostat (1999). Work-related health problems and accidental injuries (ad hoc module of the 1999 Labour Force Survey): Eurostat Metadata in SDDS format: Eurostat.

Evans-Lacko, S., Knapp, M., McCrone, P., Thornicroft, G., & Mojtabai, R. (2013). The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries. *PLoS ONE*, 8(7).

Fagan, C., & Burchell, B.J. (2002). *Gender, Jobs and Working Conditions in the European Union*. Dublin: European Foundation for the Improvement of Living and Working Conditions.

Ferrie, J.E., Martikainen, P., Shipley, M.J., Marmot, M.G., Stansfeld, S.A., & Smith, G.D. (2001). Employment status and health after privatisation in white collar civil servants: prospective cohort study. *British Medical Journal*, 322 (7287), 647-651.
Flanagan, R.J. (2006). *Globalisation and Labour Conditions*. Oxford: Oxford University Press.

Greenan, N., Kalugina, E. & Walkowiak, E. (2013). Has the quality of working life improved in the EU-15 between 1995-2005. *Industrial and Corporate Change Advance*, June 10, 1-30.

Grégoire, D. (2007). European framework agreements: "The best option as the politics stand" (Interview with deputy general secretary of the ETUC, Maria Helena André) - Psychosocial Factors. HESA Newsletter, 33, 6-7.

Griffiths, A. (1997). Ageing, health and productivity: A challenge for the new millennium. *Work & Stress*, 11, 197-214.

Hamberg-van Reenen, H.H., Proper, K.I., & van den Berg, M. (2012). Worksite mental health interventions: A systematic review of economic evaluations. *Occupational & Environmental Medicine*, 69, 837-45.

Hämäläinen, R-M. (2008). The Europeanisation of occupational health services: A study of the impact of EU policies. Research Report 82. Helsinki: Finnish Institute of Occupational Health.

Hämäläinen, R-M. (2006). Workplace Health Promotion in Europe – the role of national health policies and strategies. Helsinki: Finnish Institute of Occupational Health.

Hemerijck, A. (2002). The Self-transformation of the European social model(s). In D. Gallie, A. Hemerijck, J. Myles, J. Myers, G. Esping-Andersen (eds). *Why we need a new welfare state*. Oxford: Oxford University Press.

H M Government (2013). Transposition guidance. How to implement European Directives effectively. London: Department for Business, Innovation and Skills.

Hoel, H., Sparks, K., & Cooper, C. (2001). The Cost of Violence/Stress At Work and the Benefits of a Violence/Stress-Free Working Environment. Report commissioned by the International Labour Organization, University of Manchester.

Hoffmann, S.G., Asnaani, A., Vonk, I.J.J., Sawyer, A.T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive Therapy & Research*, 35(5), 427-440.

Houtman, I. & Bossche, S. van den (2010). Trends in arbeidsomstandigheden in Nederland en Europa. *Tijdschrift voor Arbeidsvraagstukken*, 26(4), 432-450.

Houtman, I., Douwes, M., de Jong, T., Meeuwssen, J.M., Jongen, M., Brekelmans, F., Nieboer-Op de Weegh, M., Brouwer, D., Van den Bossche, S., Zwetsloot, G., Reinert, D., Neizsner, I., Hauke, A., Flaspolder, E., Zieschang, H., Kolk, A., Niers, E., Bruggemann-Prieshoff, H., Rotman, D., Karpowicz, J., Perista, H., Cabrita, J., Corral, A. (2008). New Forms of Physical and Psychosocial Health Risks at Work. Study request by the European Parliament's Committee on Employment and Social Affairs (EMPL).IP/A/E<PL/FWC/2006-205/C1-SC1, European Parliament. Available at: <http://www.europarl.europa.eu/document/activities/cont/201107/20110718ATT24294/20110718ATT24294EN.pdf>

HSE – Health and Safety Executive (2011). 3rd European Commission Directive on Indicative Occupational Exposure Limit Values (IOELVs) – draft consultative document. London: HSE

HSE – Health and Safety Executive (2010). Self-reported work-related illness and workplace injuries in 2008/09: Results from the Labour Force Survey. Sudbury: HSE Books. Available at: <http://www.hse.gov.uk/statistics/lfs/lfs0809.pdf>

HSE – Health and Safety Executive (2006). A Business Case for the Management Standards for Stress. Sudbury: HSE Books.

HSE – Health and Safety Executive (2005). Case Study: Establishing the Business Case for Investing in Stress Prevention Activities and Evaluating their Impact on Sickness Absence Levels. Sudbury: HSE Books.

Hsieh, H.F., & Shannon, S.E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, 15(9), 1277-1288.

Iavicoli, S., Leka, S., Jain, A., Persechino, B., Rondinone, B.M., Ronchetti, M., & Valenti, A. (2014). Hard and soft law approaches to addressing psychosocial risks in Europe: Lessons learned in the development of the Italian approach. *Journal of Risk Research*, 17(7), 855-869.

Iavicoli, S., Natali, E., Deitinger, P., Rondinone, B., Ertel, M., Jain, A., & Leka, S. (2011). Occupational health and safety policy and psychosocial risks in Europe: The role of stakeholders' perceptions. *Health Policy*, 101(1), 87-94.

Iavicoli, S., Deitinger, P., Grandi, C., Lupoli, M., Pera, A., & Rondinone, B. (2004). Fact-finding survey on the perception of work-related stress in EU candidate countries. In S. Iavicoli, P. Deitinger, C. Grandi, M. Lupoli, A. Pera, & M. Petyx (Eds.). *Stress at Work in Enlarging Europe* (pp.81-97). Rome: ISPESL.

Ilmarinen, J. (1999). Ageing worker in the European Union: Status and promotion of work ability, employability and employment. Helsinki, Finland: Finnish Institute of Occupational Health.

Ilmarinen, J. (2006). The ageing workforce - challenges for occupational health. *Occupational Medicine*, 56(6), 361-364.

ILO - International Labour Office (2012). *Stress Prevention at Work Checkpoints*. Geneva: ILO.

ILO - International Labour Office (2010a). *Emerging risks and new patterns of prevention in a changing world of work*. Geneva: International Labour Office. Available at:

http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@safework/documents/publication/wcms_123653.pdf

ILO - International Labour Office (2010b). *Recommendation concerning the List of Occupational Diseases and the Recording and Notification of Occupational Accidents and Diseases ILO recommendation R194 revised annex*. Geneva: International Labour Office. Available at: <http://www.ilo.org/ilolex/cgi-lex/convde.pl?R194>

ILO - International Labour Office (2006). *Occupational Safety and Health: Synergies between security and productivity*. Geneva: International Labour Office.

ILO - International Labour Office (1986). *Psychosocial factors at work: Recognition and control*. Report of the Joint International Labour Office and World Health Organization on Occupational Health, Ninth Session, Geneva, 18-24 September 1984. Occupational Safety and Health Series No. 56. Geneva: International Labour Office.

ILO - International Labour Office (2009). Health and life at work - a basic human right. International Labour Organization, Geneva.

Jain. A., Leka. S., & Zwetsloot. G. (2011). Corporate Social Responsibility and Psychosocial Risk Management in Europe. *Journal of Business Ethics*, 101, 619-633.

Jain, A., Ripa, D., & Herrero (2014). An analysis of the coverage of psychosocial hazards at work in corporate social responsibility instruments and standards. In S. Leka & R. Sinclair (Eds.) *Contemporary Occupational Health Psychology: Global perspectives on research and practice* (Vol. 3). Chichester, England: Wiley-Blackwell.

Jenny, G.J., Brauchli, R., Inauen, A., Füllermann, Fridrich, A., & Bauer, G.F. (2014). Process and outcome evaluation of an organizational-level stress management intervention in Switzerland. *Health Promotion International*, 29 (1).

Joling, C., & Kraan, K. (2008). Use of technology and working conditions in the European Union. European Foundation for the Improvement of Working and Living Conditions (EUROFOUND). Luxembourg: Office for Official Publications of the European Communities.

Kauppinen, K., & Kandolin, I. (1998). Gender and working in the European Union. Dublin: European Foundation for the Improvement of Living and Working Conditions.

Kawachi, I. (2008). Globalisation and workers' health. *Industrial Health*, 46(5), 421-423.

Keller, B. (2008). Social Dialogue: The Specific Case of the European Union. *International Journal of Comparative Labour Law and Industrial Relations*, 24, 201-226.

Kieselbach, T., Armgarth, E., Bagnara, S., Elo, A-L., Jefferys, S., Joling, C., Kuhn, K., Nielsen, K., Popma, J., Rogovsky, N., Sahler, B., Thomson, G., Triomphe, C. E. & Widerszal-Bazyl, M. (2009) Health in Restructuring. Innovative Approaches and Policy Recommendations. European Expert Group on Health in Restructuring. München: Hampp Verlag.

Kim, S., Suh, C., Park, M., Kim, K., Lee, C.K., Son, B.C., et al. & Jung, H. (2014). Effectiveness of a Comprehensive Stress Management Program to Reduce Work-Related Stress in a Medium-Sized Enterprise. *Annals of Occupational & Environmental Medicine*, 26(4).

King D, Wickam-Jones M. (1999). From Clinton to Blair: the Democratic (Party) origins of welfare to work. *Political Quarterly*, 70, 62-74.

Kivimäki, M., Head, J., Ferrie, J.E., Shipley, M.J., Vahtera, J., & Marmot, M.G. (2003). Sickness absence as a global measure of health: Evidence from mortality in the Whitehall II prospective cohort study. *British Medical Journal*, 327(7411), 364-368.

Kivimäki, M., Nyberg, S.T., Batty, G.D. et al. (2012). Job strain as a risk factor for future coronary heart disease: collaborative meta-analysis of 2358 events in 197,473 men and women. *The Lancet*, 380, 1491-97.

Kivimäki, M., Vahtera, J., Elovainio, M., Virtanen, M., & Siegrist, J. (2007). Effort-reward imbalance, procedural injustice and relational injustice as psychosocial

predictors of health: Complementary or redundant models? *Occupational & Environmental Medicine*, 64 (10), 659-665.

Kleinschmidt C. (2013). *A guide for managers. Taking the stress out of stress*. Essen: BKK Bundersverband.

Knapp, M., McDaid, D. & Parsonage, M. (2011). *Mental health promotion and prevention: the economic case*. Department of Health: London. Available at: https://www.gov.uk/government/uploads/system/.../dh_126386.pdf

Kompier, M.A.J., 'New systems of work organisation and workers' health', *Scandinavian Journal of Work, Environment and Health*, 32(6), 2006, 421-430.

Konkolewsky, H-H. (2005). Needs and priorities in occupational health and safety for the enlarged European Union. *Scandinavian Journal of Work, Environment & Health, Supp, 1*, 68-71.

Koningsveld, E.A.P., Zwinkels, W.S. Mossink, J.C.M., Thie, X.M., & Abspoel, M. (2003). *Societal costs of working conditions (in Dutch)*. The Hague: Ministry of Social Affairs and Employment (no 324).

Koukoulaki, T. (2004). Stress prevention in Europe: trade union activities. In: S. Iavicoli, P. Deitinger, C. Grandi, M. Lupoli, A. Pera, & M. Petyx (eds), *Stress at work in Enlarging Europe*, Rome: ISPESL (pp. 17-27).

Kunyk, D., Morris, H., & Reisdorfer, E. (2014). *Organisational Receptivity to a Voluntary Psychological Health & Safety Workplace Standard*. Calgary: University of Alberta.

Kuoppala, J., Lamminpää, A, Liira, J. & Vaino, H. (2008). Leadership, Job Well-Being, and Health Effects – A Systematic Review and a Meta- Analysis. *Journal of Occupational & Environmental Medicine*, 50, 904-915.

Kuper, H., Singh-Manoux, A., Siegrist, J., & Marmot, M. (2002). When reciprocity fails: Effort-reward imbalance in relation to coronary heart disease and health functioning within the Whitehall II study. *Occupational & Environmental Medicine*, 59 (11), 777-784.

LaMontagne, A., Keegel, T., Louie, A., Ostry, A. & Landsbergis, P. (2007). A systematic review of the job-stress intervention evaluation literature, 1990-2005. *International Journal of Occupational and Environmental Health*, 13, 268-280.

Langenhan, M.K., Leka, S., & Jain, A. (2013). Psychosocial risks: Is risk management strategic enough in business and policy making? *Safety & Health at Work*, 4, 87-94.

Larsen T., & Andersen, S. (2007). A new mode of European regulation?. *European Journal of Industrial Relations*, 13(2), 181-198.

Leineweber, C., Westerlund, H., Hagberg, J., Svedberg, P. & Alexanderson, K. (2012). Sickness presenteeism is more than an alternative to sickness absence: results from the population-based SLOSH study. *International Archives of Occupational & Environmental Health*, 85, 905-914.

Leka, S. & Cox, T. (2008). *The European Framework for Psychosocial Risk Management: Prima-EF*. Nottingham: I-WHO Publications.

Leka, S., Hassard, J., Jain, A., Makrinov, N., Cox, T., Kortum, E., Ertel, M., Hallsten, L., Iavicoli, S., Lindstrom, K., & Zwetsloot, G. (2008). *Towards the development of a psychosocial risk management framework, SALTSA*. Nottingham: I-WHO publications.
Leka, S., Jain, A., Iavicoli, S., Vartia, M., & Ertel, M. (2011a). The role of policy for the management of psychosocial risks at the workplace in the European Union. *Safety Science*, 49(4), 558-564.

Leka, S., Jain, A., Widerszal-Bazyl, M., Żołnierczyk-Zreda, D., & Zwetsloot, G. (2011b). Developing a standard for psychosocial risk management: PAS1010. *Safety Science*, 49(7), 1047-1057.

Leka, S., Van Wassenhove, W., & Jain, A. (2015). Is psychosocial risk prevention possible? Deconstructing common presumptions. *Safety Science*, 71 (1), 61–67.

Lexis, M.A., Jansen, N.W., Huibers, M.J., van Amelsvoort, L.G., Berkouwer, A., Tjin, A., Ton, G., van den Brandt, P.A., & Kant, I. (2011) Prevention of long-term sickness absence and major depression in high-risk employees: A randomised controlled trial. *Occupational & Environmental Medicine*, 68(6), 400-7.

Levi, L. (2002). Spice of life or kiss of death. In *Working on Stress, Magazine of the European Agency of Safety and Health at Work No.5*. Luxembourg: Office for Official Publications of the European Communities. Available at: <http://osha.europa.eu/en/publications/magazine/5>

Levi, L. (2005). Working life and mental health - A challenge to psychiatry? *World Psychiatry*, 4(1), 53-57.

Lippel, K. (2010). The Law of Workplace Bullying: An International Overview. *Comparative Labor Law and Policy Journal*, 32 (1), 1-13.

Lofstedt, R.E. (2011). *Reclaiming health and safety for all: An independent review of health and safety legislation*. London: Department of Work and Pensions.

MacKay, C.J., Cousins, R., Kelly, P.J., Lee, S., McCaig, R.H. (2004). Management standards and work related stress in the UK: policy background and science. *Work and Stress*, 18, 91–112.

Magana, C.G., & Hovey, J.D. (2003). Psychosocial stressors associated with Mexican migrant farm workers in the Midwest United States. *Journal of Immigrant Health*, 5(2), 75-86.

Mailand, M., & Due, J. (2004). Social Dialogue in Central and Eastern Europe: Present State and Future Development. *European Journal of Industrial Relations*, 10(2), 179–197.

Marine, A., Ruotsalainen, J., Serra, C., & Verbeek, J. (2006). Preventing occupational stress in healthcare workers. *Cochrane Database of Systematic Reviews* (4).

Marmot, M., Siegrist, J., & Theorell, T. (2006). Health and the psychosocial environment at work, in Marmot, M.; Wilkinson, R.G. (eds): *Social determinants of health*. Oxford: Oxford University Press), pp. 97-130.

Martin, A., Sanderson, K., & Cocker, F. (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scandinavian Journal of Work Environment & Health*, 35(1), 7-18.

Martín, N.R., & Visser, J. (2008). A More "Autonomous" European Social Dialogue: The Implementation of the Framework Agreement on Telework. *International Journal of Comparative Labour Law and Industrial Relations*, 24, 511-548.

Matrix Insight (2013). Economic analysis of workplace mental health promotion and mental disorder prevention programmes and of their potential contribution to EU health, social and economic policy objectives, Matrix Insight, Research commissioned by the European Agency for Health and Consumers. Available at: http://ec.europa.eu/health/mental_health/docs/matrix_economic_analysis_mh_promotion_en.pdf

Maurer, T. (2001). Career-relevant learning and development, worker age, and beliefs about self-efficacy for development. *Journal of Management*, 27, 123-140.

McDaid, D. (2007). The economics of mental health in the workplace: what do we know and where do we go? *Epidemiologia e Psichiatria Sociale*, 16, 294-8.

McDaid, D. (2008). Mental health in workplace settings. Consensus paper. Luxembourg: European Communities.

McDaid, D. (2011). Background document for the Thematic Conference on Promotion of Mental Health and Well-being in Workplaces. Luxembourg: Office for Official Publications of the European Communities.

McDaid, D., & Park, A.L. (2011). Investing in mental health and well-being: Findings from the DataPrev project. *Health Promotion International*, 26(1), 108-139.

McDaid, D & Park, A-L. (2014). Investing in wellbeing in the workplace: more than just a business case. In McDaid, D. & Cooper, C. (eds). *Economics of Wellbeing: Wellbeing: A Complete Reference Guide, Volume V*. Oxford: John Wiley & Sons Ltd.

McDaid, D., King, D., Park, A. & Parsonage, M. (2011). Promoting wellbeing in the workplace. In: Knapp, M., McDaid, D. & Parsonage, M. (eds.) *Mental health promotion and mental illness prevention: the economic case*. London: Department of Health.

McIntyre, R.S., Liauw, S., Taylor, V.H. (2011). Depression in the workplace: the intermediary effect of medical comorbidity. *Journal of Affective Disorders*, 128(1), S29-36.

Mead, L.M. (1997). *The new paternalism: supervisory approaches to poverty*. Brookings Institute.

Mental Health Foundation (2007). The fundamental facts. Available at: <http://www.mentalhealth.org.uk/publications/fundamental-facts/>

MHE - Mental Health Europe (2006). *MHE Position on the EC Green Paper on Mental Health*

An EU Strategy on Mental Health and Well Being. Brussels: Mental Health Europe.

Michaels, C.N., & Greene, A.M. (2013). Worksite Wellness: Increasing Adoption of Workplace Health Promotion Programs. *Health Promotion Practice*, 14(4), 473-479.

Michie, S. (2002). Causes and management of stress at work. *Occupational & Environmental Medicine*, 59, 67-72.

Milieu Consulting (2013). Occupational health concerns: Stress-related and psychological problems associated with work. European Parliament: Directorate-General for Internal Policies.

Mills, P.R., Kessler, R.C., Cooper, J., & Sullivan, S. (2007). Impact of a health promotion program on employee health risks and work productivity. *American Journal of Health Promotion*, 22, 45-53.

Milner, A., Page, A., & LaMontagne, A.D. (2013). Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis. *PLoS ONE*, 8(1), e51333.

Mino, Y., Babazono, A., Tsuda, T., & Yasuda, N. (2006). Can stress management at the workplace prevent depression? A randomized controlled trial. *Psychotherapy & Psychosomatics*, 75(3), 177-82.

Mladovsky, P., Allin, S., Masseria, C., Hernandez-Quevedo C., McDaid, D., & Mossialos, E. (2009). Health in the European Union. European Observatory on Health Systems and Policies. Observatory Studies No.19. Available at: ec.europa.eu/social/BlobServlet?docId=4742&langId=en

Molinie, A.F. (2003). Age and working conditions in the European Union. Dublin: European Foundation for the Improvement of Living and Working Conditions.

Montano, D., Hoven, H., & Siegrist, J. (2014). Effects of organisational-level interventions at work on employees' health: a systematic review. *BMC Public Health*, 14 (135).

Montero, M. J., Araque, R. A., & Rey, J. M. (2009). Occupational Health and Safety in the Framework of Corporate Social Responsibility. *Safety Science* 47(10), 1440-1445.

Nahrgang, J.D., Morgeson, F.P., & Hofmann, D.A. (2011). Safety at work: A meta-analytic investigation of the link between job demands, job resources, burnout, engagement, and safety outcomes. *Journal of Applied Psychology*, 96(1), 71-94.

Natali, E., Deitingner, P., Rondinone, B., & Iavicoli, I. (2008). Exploring Stakeholders' Perceptions on Social Policies, Infrastructures and Social Dialogue in relation to Psychosocial Risks. In: S. Leka, T. Cox, (eds). *The European framework for psychosocial risk management: PRIMA-EF* (pp. 79-95). Nottingham: I-WHO Publications.

National Institute for Health and Care Excellence (2008). Workplace interventions that are effective for promoting mental wellbeing. Synopsis of the evidence of effectiveness and cost-effectiveness. London: NICE.

Ndjaboué, R., Brisson, C., & Vézina, M. (2012). Organisational justice and mental health: a systematic review of prospective studies. *Occupational and Environmental Medicine*, 69, 694-700.

- Niederle, M., & Versterlund, L. (2007). Do women shy away from competition? Do men compete too much? *Quarterly Journal of Economics* 122(3), 1067-1101.
- Nielsen, K., Randall, R., & Christensen, K.B. (2010). Developing new ways of evaluating organizational-level interventions. In J. Houdmont & S. Leka (Eds.) *Contemporary Occupational Health Psychology: Global perspectives on research and practice* (Vol. 1). Chichester, England: Wiley-Blackwell.
- NICE - National Institute for Health and Care Excellence (2009). *Promoting Mental Wellbeing at Work: Business Case*. London: NICE.
- Netterstrom, B., Conrad, N., Bech, P., Fink, P., Olsen, O., Rugulies, R., et al. (2008). The relation between work-related psychosocial factors and the development of depression. *Epidemiological Review*, 30, 118-132.
- NIOSH – National Institute of Occupational Safety and Health (2002). *The changing organisation of work and the safety and health of working people: Knowledge gaps and research directions*. Cincinnati: DHHS (NIOSH).
- Oceguera, A., Aldrete, G. & Ruiz-Moreno, A. (2009). Estudio comparado de la legislación del mobbing en Latinoamérica. *Política y Sociedad*, 8, 83-94.
- OECD - Organisation for Economic Co-operation and Development (2012). *Sick on the Job? Myths and Realities about Mental Health and Work*. Paris: OECD Publishing.
- Olesen, J., Gustavsson, A., Svensson, M., Wittchen, H.U., & Jonsson, B. (2012). The economic cost of brain disorders in Europe. *European Journal of Neurology*, 19 (1), 155-62.
- Packham, C., & Webster, S. (2009). *Psychosocial Working Conditions in Britain in 2009*. Norwich: HSE. Available at: <http://www.hse.gov.uk/statistics/pdf/pwc2009.pdf>
- Peña-Casas, R., & Pochet, P. (2009). *Fifteen years of working conditions in Europe. Convergence and divergence over time and within Europe*. European Foundation for the Improvement of Working and Living Conditions (EUROFOUND). Luxembourg: Office for Official Publications of the European Communities.
- Perkins, R., Farmer, P., & Litchfield, P. (2009). *Realising ambitions: better employment support for people with a mental health condition*. London: Department of Work and Pensions.
- Pinkos Cobb, E. (2012). *Bullying, Violence, Harassment, Discrimination and Stress: Emerging Workplace Health and Safety Issues*. The Isosceles Group.
- Pochet, P., Peeters, A., Léonard, E., & Perin, E. (2009). *Dynamics of the European sectoral social dialogue*. European Foundation for the Improvement of Living and Working Conditions. Luxembourg: Office for Official Publications of the European Communities. Available at: <http://www.eurofound.europa.eu/pubdocs/2008/98/en/2/EF0898EN.pdf>
- Prosser, T. (2011). The implementation of the Telerwork and Work-related Stress Agreements: European social dialogue through 'soft' law?. *European Journal of Industrial Relations*, 17(3), 245-260.

- Quinlan, M. (2004). Workers' compensation and the challenges posed by changing patterns of work. *Policy & Practice in Safety & Health*, 2(1), 25-52.
- Randall, R., & Nielsen, K. (2010). Interventions to promote well-being at work. In S. Leka, & J. Houdmont (Eds.), *Occupational Health Psychology*, Chichester: Wiley-Blackwell.
- Randall, R., Cox, T., & Griffiths, A. (2007). Participants' accounts of a stress management intervention. *Human Relations*, 60(8), 1181-1209.
- Randall, R., Griffiths, A. & Cox, T. (2005). Evaluating organizational stress management interventions using adapted study designs. *European Journal of Work and Organizational Psychology*, 14, 23-41.
- Richardson, K. M. & Rothstein, H. R. (2008). Effects of occupational stress management intervention programs: a meta-analysis. *Journal of Occupational Health Psychology*, 13, 69-93.
- Robertson, I. & Cooper, C. (2011). *Wellbeing: Productivity and Happiness at Work*. Basingstoke: Palgrave MacMillan.
- Roelfs, D.J., Shor, E., Davidson, K.W., & Schwartz, J.E. (2011). Losing life and livelihood: a systematic review and meta-analysis of unemployment and all-cause mortality. *Social Science & Medicine*, 72, 840-54.
- Rosengren, A., Hawken, S., Ôunpuu, S., Sliwa, K., Zubaid, M., Almahmeed, W. A., Blackett, K. N., Sittiamorn, C., Sato, H., Yusuf, S. (2004). Association of psychosocial risk factors with risk of acute myocardial infarction in 11 119 cases and 13 648 controls from 52 countries (the INTERHEART study): case-control study. *Lancet*, 364, 953-962.
- Rubery, J., & Fagan, C. (1993). Occupational segregation of women and men in the European Community. In: *Social Europe Supplement*, No. 3./93. Luxembourg: Office for Official Publications of the European Communities.
- Rubery, J., Smith, M., & Fagan, C. (1999). *Women's Employment in Europe: Trends and Prospects*. London: Routledge.
- Rundmo, T. (1992). Risk perception and safety on offshore petroleum platforms – Part II: Perceived risk, job stress and accidents. *Safety Science*, 15(1), 53-68.
- Rundmo, T. (1995). Perceived risk, safety status, and job stress among injured and noninjured employees on offshore petroleum installations. *Safety Science*, 26(1), 87-97.
- Ruwaard, J., Lange, A., Bouwman, M., Broeksteeg, J., & Schrieken, B. (2007). E-mailed standardized cognitive behavioural treatment of work-related stress: A randomized controlled trial. *Cognitive Behavioral Therapy*, 36(3), 179-92.
- Sanderson, K., & Andrews, G. (2006). Common mental disorders in the workforce: recent findings from descriptive and social epidemiology. *Canadian Journal of Psychiatry*, 51, 63-75.

- Semmer, N. (2006). Job stress interventions and the organization of work. *Scandinavian Journal of Work Environment and Health*, 32, 515–27.
- Shields, M.A., & Price, S.W. (2003). The labour market outcomes and psychological well-being of ethnic minority migrants in Britain. UK, Home Office. Retrieved November 3rd, 2003 from National Coalition of Anti-Deportation Campaigns.
- SLIC - The Committee of Senior Labour Inspectors (2012). Psychosocial risk assessments - SLIC Inspection Campaign 2012. Available from: http://www.av.se/dokument/inenglish/European_Work/Slic_2012/SLIC2012_Final_report.pdf
- Smedley, T. (2014) High cost of mental health problems forces employers to act. *Financial Times*, July 7.
- Spurgeon, A., Harrington, J. M., & Cooper, C. L. (1997). Health and safety problems associated with long working hours: A review of the current position. *Occupational & Environmental Medicine*, 54(6), 1997, 367-375.
- Stansfeld, S.A., Bosma, H., Hemingway, H., & Marmot, M.G. (1998). Psychosocial work characteristics and social support as predictors of SF-36 health functioning: The Whitehall II study. *Psychosomatic Medicine*, 60, 247–255.
- Stansfeld, S.A., Fuhrer, R., Shipley, M.J., & Marmot, M. G. (1999). Work characteristics predict psychiatric disorder: Prospective results from the Whitehall II study. *Occupational & Environmental Medicine*, 56, 302–307.
- Stier, H., & Yaish, M. (2014). Occupational segregation and gender inequality in job quality: a multi-level approach. *Work, Employment and Society*, 28(2), 225-246.
- Suter, R., Scott-Parker, & Zadek, S. (2007). *Realising potential: disability confidence builds better business*. London: Employers' Forum on Disability.
- Sutherland, V. J., & Cooper, C. L. (2002). Models of job stress. In J. C. Thomas & M. Hersen (Eds.), *Handbook of mental health in the workplace* (pp. 33–59).
- Sverke, M., Hellgren, J., & Näswall, K. (2002). No security: A meta-analysis and review of job insecurity and its consequences. *Journal of Occupational Health Psychology*, 7(3), 242-264.
- Taloyan, M., Aronsson, G., Leineweber, C., Magnusson Hanson, L., Alexanderson, K. & Westerlund, H. (2012). Sick leave predicts suboptimal self-rated health and sickness absence: a nationally representative study of the Swedish working population. *PLoS One*, 7, e44721.
- Taris, T., Kompier, M., Geurts, S., Schreurs, P., Schaufeli, W., de Boer, Sepmeijer, K, & Watez, C. (2003). Stress management interventions in the Dutch domiciliary care sector: Findings from 81 organisations. *International Journal of Stress Management*, 10, 297-325.
- Theeboom, T., Beersma, B., & Annelies, E.M. Van. (2014). Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context. *Journal of Positive Psychology*, 9(1), 1-18.

- Trontin, C., Lassagne, M., Boini, S. & Rinal, S. (2007). Le coût du stress professionnel en France en 2007. INRS, Paris Tech.
- Tsutsumi, A., & Kawakami, N. (2004). A review of empirical studies on the model of effort-reward imbalance at work: Reducing occupational stress by implementing a new theory. *Social Science & Medicine*, 59, 2335-2359.
- Tsutsumi, A., Nagami, M., Yoshikawa, T., & Kawakami, N. (2009). Participatory intervention for workplace improvements on mental health and job performance among blue-collar workers: A cluster randomized controlled study. *Journal of Occupational & Environmental Medicine / American College of Occupational and Environmental Medicine*, 51 (5), 554-63.
- Vahtera, J., Pentti, J., Kivimäki, M. (2004). Sick absence as a predictor of mortality among male and female employees'. *Journal of Epidemiology and Community Health*, 58(4), 321-326.
- van den Berg, T.I.J., Elders, L.A.M., de Zwart, B.C.H., & Burdorf, A. (2009). The effects of work-related and individual factors on the Work Ability Index: a systematic review. *Occupational & Environmental Medicine*, 66, 211-220.
- van der Beek, A.J., Dresen-Frings, M.H.W., van Dijk, F.J.H., et al. (1997). Priorities in occupational health research: a Delphi study in the Netherlands. *Occupational & Environmental Medicine*, 54, 504-510.
- van der Klink, J. J. L., Blonk, R. W. B., Schene, A. H., & van Dijk, F. J. H. (2001). The benefits of interventions for work-related stress. *American Journal of Public Health*, 91(2), 270-276.
- Vaughan-Whitehead, D. (2003). *EU Enlargement versus Social Europe? The Uncertain Future of the European Social Model*. Cheltenham, UK: Edward Elgar.
- Vinnem, J.E., Hestad, J.A., Kvaløy, J.T., & Skogdalen, J.E. (2010). Analysis of root causes of major hazard precursors (hydrocarbon leaks) in the Norwegian offshore petroleum industry. *Reliability Engineering and System Safety*, 95/11, 1142-1153.
- Vogel, L. (2003). *The gender workplace health gap in Europe*. Brussels: European Trade Union Institute.
- Waddell, G., & Burton, A.K. (2006). *Is work good for your health and well-being?* London: The Stationary Office.
- Wang, H., & Samson, K. 2009. *Wellness and productivity management: a new approach to increasing performance*. Philadelphia: Right Management Inc.
- Weiler, A. (2004). *Quality in industrial relations: Comparative indicators*. Luxembourg: Office for Official Publications of the European Communities. (Report prepared for the European Foundation for the Improvement of Living and Working Conditions).
- Westerlund, H., Vahtera, J., Ferrie, J.E., Singh-Manoux, A., Pentti, J., Melchior, M., Leineweber, C., Jokela, M., Siegrist, J., Goldberg, M., Zins, M., & Kivimäki, M. (2010). Effect of retirement on major chronic conditions and fatigue: French GAZEL occupational cohort study. *British Medical Journal*, 341, c6149.

Westgaard, R.H., & Winkel, J. (2011). Occupational musculoskeletal and mental health: Significance of rationalization and opportunities to create sustainable production systems – a systematic review. *Applied ergonomics*, 42, 261-296.

Wittchen, H.U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jonsson, B., Olesen, J., Allgulander, C., Alonso, J., Faravelli, C., Fratiglioni, L., Jennum, P., Lieb, R., Maercker, A., Os, J. van, Salvador-Carulla, L., Simon, R. & Steinhausen, H.-C. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European Neuropsychopharmacology*, 21, 655-679.

WHO – World Health Organisation (2014). Data and Statistics. Available at: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>

WHO - World Health Organisation. (2010). Health impact of psychosocial hazards at work: An overview. Geneva: World Health Organisation. Available at: http://www.who.int/occupational_health/publications/hazardpsychosocial/en/index.html

WHO - World Health Organisation (2008). PRIMA-EF: Guidance on the European Framework for Psychosocial Risk Management: A Resource for Employers and Worker Representatives. Protecting workers' health series, no. 9. Geneva: World Health Organisation. Available at: http://www.who.int/occupational_health/publications/Protecting_Workers_Health_Series_No_9/en/index.html

WHO - World Health Organisation (2003a). Work Organisation and Stress. Protecting workers' health series', no. 3. Geneva: World Health Organisation. Available at: http://www.who.int/occupational_health/publications/stress/en/index.html

World Health Organization (WHO), (2003b). Raising awareness to psychological harassment at work. Protecting workers' health series; no. 4. Geneva: World Health Organization.

World Health Organization (WHO), (2007). Raising awareness of stress at work in developing countries: a modern hazard in a traditional working environment: advice to employers and worker representatives. Protecting workers' health series; no. 6. Geneva: World Health Organization.

Yin, R.K. (2009). *Case Study Research: Design and Methods (Applied Social Research Methods)* 4th Edition. London: Sage.

Yoshimura, K., Kawakami, N., Tsusumi, A., Inoue, A., Kobayashi, Y., Takeuchi, A., & Fukuda, T. (2013). Cost-benefit analysis of primary prevention programs for mental health at the workplace in Japan. *Sangyo Eiseigaku Zasshi*, 55(1), 11-24.

Zahm, S.H., (2000). Women at work. In M.B. Goldman & M.C. Hatch (Eds.) *Women and Health*. San Diego, CA: Academic Press (pp. 441-445).

Zapf, D., & Einarsen, S. (2010). Individual antecedents of bullying: Victims and perpetrators. In S. Einarsen, H. Hoel, D. Zapf, and C. L. Cooper (Eds.), *Bullying and emotional abuse in the workplace: International perspectives in research and practice*. London: Taylor & Francis, (pp. 177-20).

