Mental Health Policy and Service Guidance Package

MENTAL HEALTH POLICIES AND PROGRAMMES IN THE WORKPLACE

"The development and implementation of a workplace mental health policy and programme will benefit the health of employees, increase productivity for the company and will contribute to the wellbeing of the community at large."

World Health Organization

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Service Guidance Package

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Preface

This module is part of the WHO Mental Health Policy and Service Guidance Package, which provides practical information aimed at helping countries to improve the mental health of their populations.

What is the purpose of the guidance package?

The package provides guidance for policy-makers and planners on:

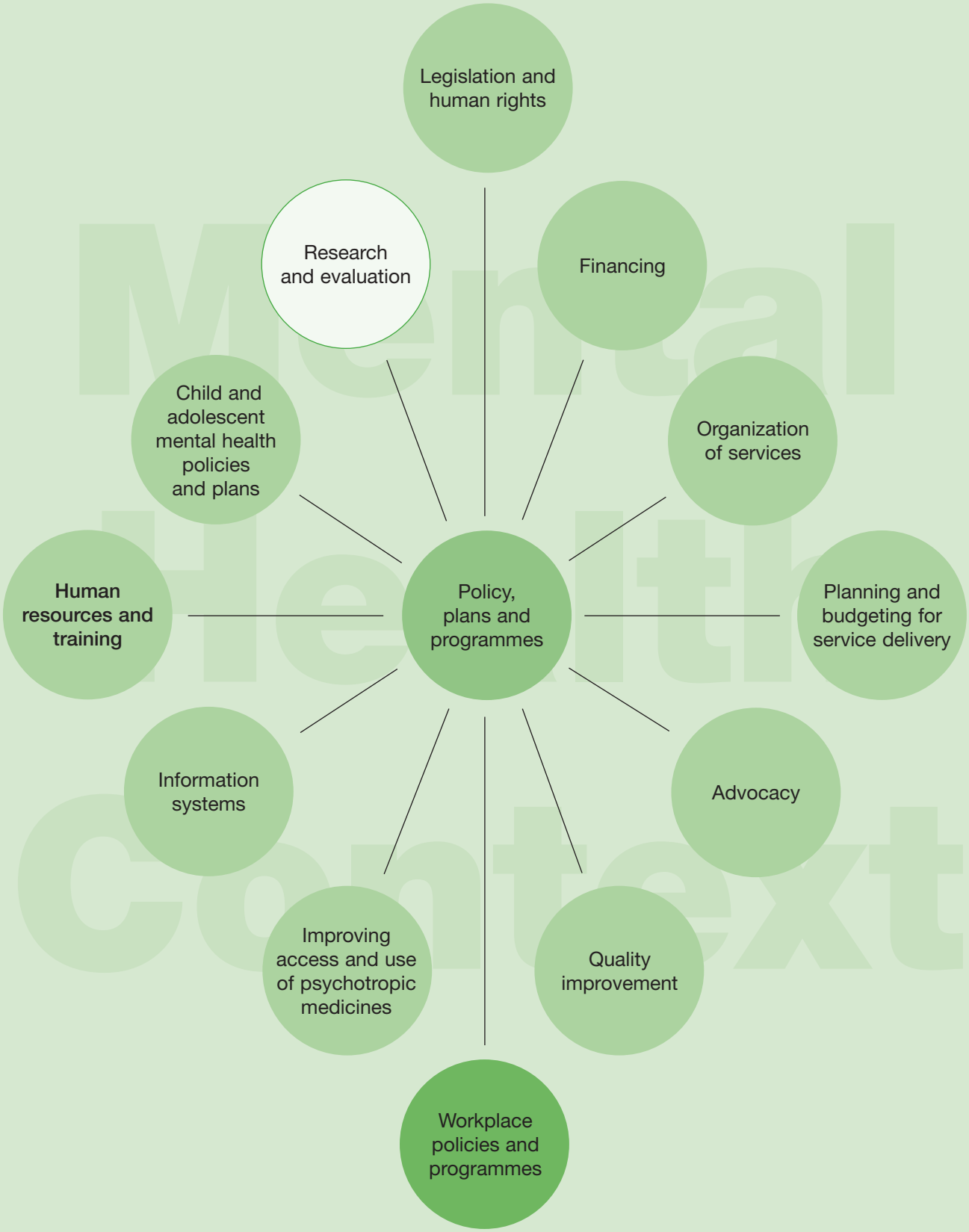
- developing policies and comprehensive strategies for improving the mental health of populations;
- using existing resources to achieve the greatest possible benefits;
- providing effective services to persons in need;
- helping people with mental disorders to reintegrate into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The guidance package consists of a number of interrelated user-friendly modules, designed to address a wide variety of needs and priorities in policy development and service planning. Each module deals with a core aspect of mental health.

The guidance package comprises the following modules:

> The Mental Health Context
> Mental Health Policy, Plans and Programmes
> Mental Health Financing
> Mental Health Legislation and Human Rights
> Advocacy for Mental Health
> Organization of Services for Mental Health
> Quality Improvement for Mental Health
> Improving Access and Use of Psychotropic Medicines
> Planning and Budgeting to Deliver Services for Mental Health
> Child and Adolescent Mental Health Policies and Plans
> Mental Health Information Systems
> Human Resources and Training for Mental Health
> Research and Evaluation of Mental Health Policy and Services
> Workplace Mental Health Policies and Programmes


Legislation and human rights
Research and evaluation
Financing
Child and adolescent mental health policies and plans
Organization of services
Human resources and training
Policy, plans and programmes
Planning and budgeting for service delivery
Information systems
Advocacy
Improving access and use of psychotropic medicines
Quality improvement
Workplace policies and programmes
still to be developed

Who is the guidance package for?

The modules should be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders, and their families;
- nongovernmental organizations involved or interested in the provision of mental health services.

The present module will be of particular interest to:

- employers;
- employees;
- human resources professionals;
- occupational health professionals;
- mental health professionals;
- trade unions and other employee organizations.

How to use the modules

The modules can be used **individually or as a package.** They are cross-referenced with each other for ease of use. Users may go through the modules consecutively, or may select the specific module appropriate to their particular interest; for example, mental health legislation is dealt with primarily in the module *Mental health legislation and human rights.*

The modules can serve a number of different purposes:

- as a **training package** for all those involved in organizing, delivering and funding mental health services;
- as educational materials in university or college courses;
- as a framework for **technical consultancy** by international and national organizations providing support to countries that wish to reform their mental health policies and/or services;
- as **advocacy tools** for use by consumer, family and advocacy organizations, to increase awareness among politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

Format of the modules

The aims and the target audience of each module are clearly outlined. Guidance is presented in a step-by-step format to make it easier to use. The guidance is not intended to be prescriptive; users are encouraged to adapt the material according to their own needs and circumstances. Practical examples from different countries are used throughout the modules.

All the modules should be read in the light of WHO's policy of providing most mental health care through general health services and in community settings. Mental health is necessarily an intersectoral issue, requiring the involvement of the health, education, employment, housing and social services sectors, and in some cases the criminal justice system. It is also important to engage in serious consultations with consumer and family organizations in the development of policies and the delivery of services.

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MENTAL HEALTH POLICIES AND PROGRAMMES IN THE WORKPLACE

Executive summary

Mental health problems, such as depression, anxiety, substance abuse and stress, are common, affecting individuals, their families and co-workers, and the broader community. In addition, they have a direct impact on workplaces through increased absenteeism, reduced productivity, and increased costs.

Mental health problems are the result of a complex interplay between biological, psychological, social and environmental factors. There is increasing evidence that both the content and context of work can play a role in the development of mental health problems in the workplace.

Key factors include:

- workload (both excessive and insufficient work);
- lack of participation and control in the workplace;
- monotonous or unpleasant tasks;
- role ambiguity or conflict;
- lack of recognition at work;
- inequity;
- poor interpersonal relationships;
- poor working conditions;
- poor leadership and communication;
- conflicting home and work demands.

The role of government

Governments have a crucial role in promoting mental health, including the mental health of workers, and in ensuring that mental health problems are recognized early and treated effectively. Governments are also usually employers themselves, often employing thousands of people.

Some of the crucial roles of government are:

- to identify vulnerable populations, such as women, children, the elderly and people with disabilities, promote their access to work, and ensure that they are able to enjoy the same conditions as other groups in the work environment.

- to establish policy and legislation in key areas, such as prevention of discrimination, income protection, safety and health at work, mental health policy and services, and reduction of unemployment.

Employer, employee and nongovernmental organizations, also have an important role in working with governments to improve the mental health of employees. These partners should advocate for the development of policies and strategies that promote the mental health of employees and prevent and treat mental health problems.

Putting in place a workplace mental health policy

For many businesses, addressing mental health problems at the workplace will begin with the development of a policy. A mental health policy for the workplace helps to define the vision for improving the mental health of the workforce and to establish a model for action. When well formulated, such a policy will also identify and facilitate the agreements needed among the different stakeholders in the workplace. Without policy direction, lack of coordination and fragmentation will reduce the impact of any workplace mental health strategy.

A mental health policy for the workplace can be developed separately, or as part of a broader health and safety policy. Putting the policy in place involves the following steps:

- Step I. Analysing the mental health issues.
- Step II. Developing the policy.
- Step III. Developing strategies to implement the policy.
- Step IV. Implementing and evaluating the policy.

Step I. Analysing the mental health issues

It is important to make the case for developing a mental health policy in the workplace in order to gain the explicit endorsement and commitment of the employer and other key stakeholders. The employer is more likely to support the development of a policy if its potential cost impact can be demonstrated.

In making the business case, general data showing the link between mental ill-health and reduced productivity and increased costs should be presented. In addition, any readily available data from the workplace itself should be analysed and presented in order to make the business case. A detailed assessment of mental health issues in the workplace, however, may not be possible until the commitment of management has been secured.

A coordinating body, such as a steering committee or working group, should be established to guide the assessment of the workforce, facilitate consultation with the various stakeholders and coordinate the development of the workplace mental health policy. This body should ensure that all key stakeholders are involved in developing the policy.

The workplace mental health policy needs to be based on a comprehensive understanding of the issues, derived from a detailed assessment of the situation. All available relevant information should be assembled. Such information might include: human resources data (e.g. absenteeism records or number of resignations); occupational health and safety data (e.g. accidents or risk assessments), financial data (e.g. the cost of replacing employees who are on long-term disability leave) and health data (e.g. common health problems among the workforce).

It may be necessary to collect new information through, for example, surveys on the incidence and prevalence of mental health problems in the workplace; risk assessments to identify occupational health and safety issues in the work environment; interviews or focus group discussions with key informants, such as employees, their families, managers, and medical personnel within the organization.

Step II. Developing the policy

A workplace mental health policy usually comprises a vision statement, a statement of the values and principles on which the policy will be based, and a set of objectives. These components need not be dealt with sequentially; often they are developed simultaneously.

The vision statement presents a general image of the future of mental health in the workplace. It should set high expectations as to what can be achieved, while at the same time being realistic.

It is often difficult to achieve a common vision among stakeholders who may have diverse interests and perspectives. It is essential that all stakeholders have input to the vision. An active compromise among the majority of stakeholders may be necessary if the policy is to be successfully implemented.

Values and principles form the basis for the development of objectives and strategies. Values refer to judgements or beliefs about what is considered worth while or desirable, and principles refer to the standards or rules that guide actions, and should ultimately emanate from the values.

Workplaces have their own values and culture, which should be reflected in a policy. The values and principles underlying the workplace mental health policy should strike a balance between the various interests of the different stakeholders.

Objectives translate the policy vision into concrete statements of what is to be achieved. Objectives should respond to the identified issues and aim to improve the mental health of the workforce. They should be specific and achievable within a specified timeframe of the policy.

During the process of formulating the vision, values, principles and objectives, it is essential to consult with all stakeholders. Key stakeholders should be identified early and involved in the analysis and assessment of the mental health needs in the workplace. Consultations should continue throughout the process of developing the policy.

Step III. Developing strategies to implement the policy

Once the mental health policy has been developed, strategies are needed to implement it. The strategies are the core of any mental health plan.

The first task is to review the options for strategies, which can be divided into five main categories

- increasing employee awareness of mental health issues;
- supporting employees at risk;
- providing treatment for employees with a mental health problem;
- changing the organization of work;
- reintegrating employees with a mental health problem into the workplace.

The specific strategies chosen will depend on the needs of the business and its employees and the resources available.

Next, it is important to ensure that sufficient resources are available to implement the strategies. This requires a clear understanding of both the strategies to be implemented and the associated costs. The resources needed might include additional financing (for example, to establish an employee assistance programme) or the redirection of funds that are currently used elsewhere (for example, negotiating with health clinic staff to conduct a mental health awareness campaign).

Finally, the plan to implement the policy has to be formulated. The plan should outline the objectives, specific strategies to be used, targets to be achieved and activities to be carried out. The timeframe, responsible people, outputs and potential obstacles should be clearly identified.

Step IV. Implementing and evaluating the policy

The main actions in implementing and evaluating a mental health policy in the workplace include:

- generating support and collaboration;
- coordinating implementation;
- training;
- establishing a demonstration project; and
- evaluating the outcomes.

The mental health policy needs to be disseminated and communicated to all stakeholders. Many policies fail because they are poorly communicated. Some approaches to communication are listed below.

- Organize an event to launch the policy.
- Distribute posters and leaflets outlining the policy.
- Hold meetings with different groups of employees to explain the policy.
- Publish the policy on the company's Website.

The implementation process needs to be carefully coordinated and monitored. The plan should be reviewed and updated as necessary.

A process for implementation should be established. An individual, a department or a committee might be given responsibility for the implementation of the plan. Regular reporting to the employer, employees, and funders of the policy should be part of the implementation plan.

It is important to ensure that the people who will be leading the implementation process are properly trained to understand the issues associated with mental health in the workplace. A range of stakeholders may benefit from training at this stage, including:

- health workers,
- human resource personnel,
- managers and supervisors,
- union delegates,
- occupational health and safety representatives.

It is often useful to set up a demonstration project to implement a strategy in one part of the company. Such a project can often be implemented rapidly and thoroughly evaluated. The demonstration project may target a particular group of employees (for example, administrative staff) or a specific department.

The demonstration project may also be used as an advocacy tool, to illustrate the value of specific strategies; as a training area for the implementation of the plan; and to provide detailed guidance for other parts of the workplace on implementing specific strategies.

It is important to evaluate the effect of the policy and strategies on individual workers and on the organization. This will also assist in building an evidence base of effective mental health interventions in the workplace. Ideally, the evaluation should be planned when the policy is being developed, and should contain both quantitative and qualitative elements.

Aims of the module

The aim of this module is to provide guidance on developing and implementing a mental health policy in the workplace. It is intended as a resource to help employers protect and improve the mental health of their workforce.

Target audience

The primary audience for this module comprises employers, employees, human resources professionals, occupational health professionals, mental health professionals, trade unions and other employee organizations.

However, the focus of the module is on policies and plans within individual workplaces, rather than the broader policy and regulatory context of the country. Other modules in WHO's Mental Health Policy and Service Guidance Package contain guidance on the development of mental health policies, plans and programmes at national level.

How to use this module

The introductory chapters provide the conceptual foundations for the module. Productive employment is important in achieving a decent living standard, social and economic development, and personal fulfilment. Mental health problems in the workplace carry a heavy toll for the individual and his or her family, for the workplace, and for society as a whole.

Practical guidance is provided on formulating a mental health policy for the workplace, and developing a plan and related strategies for its implementation.

The guidance is not intended to be prescriptive, and should be adapted to reflect the context of individual workplaces and the needs of employees and employers. In some workplaces, particularly large ones, the development of a workplace mental health policy will often be a formal activity, led by experts in occupational health and involving a wide range of stakeholders. Smaller workplaces might collaborate to develop a single policy that is relevant to the different businesses.

1. Work and mental health

Work is an essential feature of most people's adult life, and has personal, economic and social value. Work substantially contributes to a person's identity; it provides income for an individual and his or her family, and can make a person feel that he or she is playing a useful role in society. It is also an important source of social support. Participation in work also contributes to the economic and social development of communities.

Work substantially contributes to a person's identity; it provides income for an individual and his or her family and can make a person feel that he or she is playing a useful role in society.

This module outlines the types of mental health problems that may be encountered in the workplace, together with their consequences and costs, and proposes systematic strategies to prevent and reduce their impact on the person concerned and on the workplace. It does not address in detail the important role of work in maintaining mental health or in rehabilitating workers who have developed mental health problems.

The module makes the case for the development of a mental health policy and strategies within the workplace to promote the mental health of all employees and ensure the early recognition and treatment of mental health problems.

The term *workplace* is used here to refer to any environment where economic activity occurs. It includes large workplaces, employing thousands of people, small and medium-sized workplaces, and homes where individuals or families may work. Workplaces include public, private and nongovernmental organizations; for-profit and not-for-profit undertakings; small and family-based businesses. Mental health issues associated with unpaid work, such as domestic tasks, are not addressed.

The term *employer* refers to the owner of the business or the senior manager, such as a chief executive officer, who is responsible for achieving the objectives of the business. In many countries governments are one of the largest employers, and have the same responsibilities to employees as private for-profit businesses.

The term *employee* refers to a person working for a business. While in some workplaces there is a clear distinction between employer and employee, in small or family businesses a person may be both an employer and an employee. Similarly, in large workplaces, an individual may be both an employee of the business and a manager responsible for achieving organizational objectives and managing other employees.

Mental health can be defined in a number of ways. It is more than the absence of a mental disorder (World Health Organization, 2001). It includes concepts such as subjective well-being, perceived self-efficacy, autonomy, competence, and the achievement of one's intellectual and emotional potential.

Mental health is more than the absence of a mental disorder.

People who are mentally healthy may occasionally have symptoms of emotional distress, but they are appropriate and in proportion to the situation. Mental health involves a wide range of emotions, thoughts and behaviours. With good mental health, people feel well, and can tolerate reasonable amounts of pressure, adapt to changing circumstances, enjoy rewarding personal relationships and work according to their abilities. A person's mental health is affected by individual factors and experience, social interactions, the environment, and societal and cultural norms and expectations (World Health Organization, 2004b). A key component of an individual's mental health is the ability to adequately fulfil his or her roles, including capacity to work.

Work is important for mental health and indeed the right to work in just and favourable conditions and with protection from unemployment is enshrined in the United Nations Universal Declaration of Human Rights (Article 23). Work produces personal and health benefits, while the absence or loss of work can potentially damage a person's mental health (Huxley, 2001).

Work is important for mental health.

Work affects a person's mental health, while in turn an employee's mental health affects the workplace.

The changing world of work

The nature of work is changing rapidly. Factors such as the globalization of markets, urbanization and migration, and advances in information technology have an impact on the nature of work and on the health – including mental health – of employees.

The nature of work is changing rapidly.

Most working people are found in low- and middle-income countries, where workplaces are often smaller, working conditions more stressful and occupational health protection weaker than in high-income countries. Unfortunately, most of the evidence on mental health problems in the workplace has been derived from high-income countries. Nevertheless, some of this evidence is also applicable to developing countries and can be used to inform the development of workplace mental health policies in low- and middle-income countries.

Globalization

Total world economic activity has increased with the liberalization of trade and the elimination of barriers to the transfer of capital and goods between countries (Rantanen, 1999). Globalization refers to the progressive integration of economies and societies. Globalization is not a new phenomenon. Indeed the International Labour Organization was formed in 1919 in recognition of the need to ensure that the integration of national economies is based on social justice.

Gobalization affects individuals, families and the society generally. It has the potential to promote development and increase the wealth of the community by improving the national economy. In some developing countries, large multinational companies have introduced occupational health services (Lehtinen, 2001). Changes in the workplace that increase the income of employees, facilitate access to education and training, and improve working conditions will have a positive effect on the mental health of employees.

In some developing countries, large multinational companies have introduced occupational health services.

However, globalization may also have a negative impact on employment and working conditions. For example, the growth of large multinational companies has been accompanied by greater decentralization, outsourcing and flexible work environments, with wide variations in the conditions of work and in exposure to occupational hazards (Rantanen, 1999).

Globalization has also led to the emergence of new industries. In Central America, for example, “maquiladora” or the assembly industry has emerged. In this industry, 90% of employees are women or children, and workplaces are often characterized by unstable jobs, low wages, long working hours, sexual harassment, temporary contracts and subcontracting (Gutierrez, 2000). While these new industries make an important contribution to the national economy, such working conditions are likely to have a negative impact on the mental health of employees and their families.

Urbanization and migration

The need to find work has also resulted in many workers moving to other countries with a stronger employment sector or better working conditions. The International Labour Organization estimates that there are about 120 million workers living outside their country of origin, representing 3% of the global labour force. While migration can have a positive effect on the mental well-being of an employee, it can also cause stress through an increased risk of exposure to poverty and exploitation, difficulties in integrating into a new community, and the loss of family and other social support networks.

ILO estimates that there are approximately 120 million workers living outside their country of origin, representing 3% of the global labour force.

Information technology

Advances in information and communication technology affect the traditional relationship between workers and the workplace. Information and communication technology can allow work to be performed in different physical locations. Workers may therefore be located geographically distant from the traditional workplace. Such developments create new challenges for employees. While some may enjoy the freedom associated with working at home, for many the isolation and loss of social support associated with working alone causes stress and increases the risk of developing a mental health problem.

Advances in information and communication technology affect the traditional relationship between workers and the workplace.

Moreover, contrary to expectations raised 15–20 years ago, improvements in technology have not resulted in shorter working weeks, reduced stress and increased leisure activities. Instead, an increasing number of employees are working more than ever. Boundaries between home and work can become unclear, compromising the conventional separation between work and the private sphere (Kanter, 1977). A landmark study of 31 500 workers in Canada (Duxbury & Higgins, 2001) found that technology was one of the key reasons that one in four Canadians were working more than 50 hours a week, and accounted for nearly all the unpaid overtime worked at home.

Small and medium-sized workplaces

Small and medium-sized workplaces remain common. In the European Union, for example, 100 million of the estimated 140 million employees work in small or medium-sized workplaces or are self-employed (Rantanen, 1999). In Kenya, small workplaces (less than 50 employees) employ over 4.2 million people (Karanja et al., 2003).

In the European Union, 100 million of the estimated 140 million employees work in small or medium-sized workplaces or are self-employed.

Working conditions in small and medium-sized businesses vary considerably. Many such businesses are family-based and frequently operate outside regulatory frameworks increasing the likelihood of psychosocial hazards. In a study in Kenya of 100 employees working in small workplaces, 60% reported exposure to psychosocial hazards such as long working hours and wages not paid on time (Karanja et al., 2003). Exposure to physical, biological, mechanical and chemical hazards is likely to have consequences for employees' mental, as well as physical, health.

Box 1. The Tokyo Declaration

The Tokyo Declaration (1998) was adopted as a consensus statement by occupational health experts from Europe, Japan and the USA at a conference sponsored by Tokyo Medical University and attended by 29 experts. The Declaration acknowledged the economic and technological changes in the workplace that are contributing to stress among employees.

It noted that changes to workplaces include: *"…restructuring, mergers, acquisitions and downsizing, the frantic pace of work and life, the erosion of leisure time, and/or the blending of work and home time. Most of these developments are driven by economic and technological changes aiming at short-term productivity and profit gain… Production practices are increasingly 'leaner'. New employment practices such as use of contingent workers are increasingly adopted. Concurrently, job stability and tenure is decreasing… New management models are introduced … This rapid change, combined with both over- and under-employment, is likely to be highly stress provoking."*

Specific proposals for healthy work environments were made, including:

- implementation of strategies to prevent stress-related injury and illness;
- surveillance at individual workplaces and monitoring at regional and national levels in order to identify the extent of work-related stress health problems and to provide baselines against which to evaluate efforts to improve the situation;
- education and training of occupational and other key professional groups to facilitate their participation in testing and developing programmes to reduce the impact of work-related stress and to evaluate the outcome of such approaches;
- development of valid and reliable methodologies for research;
- creation of a clearing house for relevant information;
- addressing the stress-related consequences of unemployment on the individuals concerned and on their families and the communities in which they live, by minimizing unemployment and underemployment, minimizing overemployment, promoting "the healthy job" concept, and humanizing organizational restructuring.

(Tokyo Declaration, 1998)

Understanding mental health problems

The term *mental health* problem is used to describe symptoms associated with a mental disorder, but which are not of sufficient severity to be diagnosed as a mental disorder. For example, stress results in a number of symptoms associated with mental disorders, including distress and feelings of not coping. However, these are not usually of such severity that a mental disorder can be diagnosed. While mental health problems can cause significant suffering for individuals and their family, and have a negative impact on work performance, they do not necessarily lead to the development of a mental disorder.

While mental health problems can cause significant suffering for individuals and their family, and have a negative impact on work performance, they do not necessarily lead to the development of a mental disorder.

Mental disorders are clinically significant conditions characterized by altered thoughts, emotions or behaviour with associated distress or impaired functioning (World Health Organization, 2001). The *ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (World Health Organization, 1992) provides a comprehensive list of mental and behavioural disorders, categorized as follows:

Mental disorders are clinically significant conditions characterized by altered thoughts, emotions or behaviour with associated distress or impaired functioning.

- organic mental disorders (e.g. dementia);
- psychoactive substance use (e.g. harmful use of alcohol);
- schizophrenia and associated disorders (e.g. delusional disorders);

- mood disorders (e.g. depression, bipolar affective disorder);
- neurotic, stress-related and somataform disorders (e.g. anxiety disorders);
- behavioural syndromes (e.g. eating disorders);
- disorders of adult personality (e.g. paranoid personality disorder);
- mental retardation;
- disorders of psychological development (e.g. autism);
- child and adolescent disorders (e.g. conduct disorders).

In this module, the term mental disorder is used to refer to clinical syndromes, as classified by ICD-10. However much of the text uses the broader term mental health problem, to include not only diagnosable clinical syndromes, but also symptoms of emotional distress, which may not be of sufficient severity to warrant a diagnosis of a mental disorder, but nevertheless result in substantial personal suffering and distress and reduce productivity.

Prevalence and burden

At any given time, 450 million people are suffering from some form of mental or brain disorder. In order of prevalence, 121 million people suffer from depression, 70 million from alcohol-related problems, 50 million from epilepsy, 37 million from Alzheimer disease and 24 million from schizophrenia (World Health Organization, 2001). Between 10 and 20 million people around the world have attempted suicide, with an estimated 815 000 people committing suicide each year (World Health Organization, 2002).

At any given time, 450 million people are suffering from some form of mental or brain disorder.

A number of international reports have raised awareness of the global burden of mental disorders (World Bank, 1993; Murray & Lopez, 1996a, 1996b, 2000; World Health Organization, 2001). According to estimates for the year 2000, mental and neurological disorders accounted for 12.3% of disability-adjusted life years (DALYs) (the sum total of years of healthy life lost from a combination of premature death and disability). In addition, mental disorders accounted for 6 of the 20 leading causes of disability worldwide for the age group 15-44 years, the most productive section of the population (World Health Organization, 2001).

In 2000, mental and neurological disorders accounted for 12.3% of disability-adjusted life-years and 31% of years lived with disability

While proportionally the burden is greater in developed countries (21.4%), including those with formerly socialist economies (16.4%), developing countries are greatly affected and are likely to see a disproportionately large increase in the burden attributable to mental disorders in the coming decades because of aging populations, social problems and civil unrest (World Health Organization, 2001).

People with mental disorders are commonly seen in primary care settings; almost a quarter of people attending primary care services have a mental disorder (World Health Organization, 2001). The most common mental disorders in primary care are depression, anxiety and substance abuse, either alone or in combination with a physical disorder.

Stigma

In addition to the obvious suffering caused by mental disorders there is a hidden burden of stigma, discrimination and human rights violations. Many people have misconceptions about mental health problems; for example, they may believe that there is no treatment for mental health problems, that mental health problems are caused by personal weaknesses, or that people with mental disorders are incapable of making decisions for themselves and of running their own lives. These stigmatizing attitudes can result in discrimination in the workplace, such as the unfair denial of employment opportunities, as well as restricted access to services, health insurance or housing.

In addition to the obvious suffering caused by mental disorders there is a hidden burden of stigma, discrimination and human rights violations.

In countries that have comprehensive income assistance programmes for people with disabilities, many people with a mental health problem receive income in lieu of employment. To qualify for these programmes, people need to demonstrate that they are unable to work. While income protection against the financial consequences of ill health is important, many more people with mental health problems would be able to participate in the workforce if effective treatment and support were available and appropriate accommodations were made at the workplace.

Families also incur social costs, such as the emotional strain of looking after a disabled family member, diminished quality of life, social exclusion, stigmatization, loss of future opportunities for self-improvement, and loss of leisure and personal time. Carers are often at increased risk of developing a mental health problem.

Mental health problems in the workplace

While it is difficult to know exactly how many employees have a mental health problem, the figure is likely to be significant. In the United States, for example, 18.2% of employed people had evidence of a mental disorder which had impaired their work performance within the previous 30 days (Kessler & Frank, 1997). In a study in Germany, incapacity for work due to mental health problems accounted for 5.9% of lost workdays and appeared to be increasing (Liimatainen & Gabriel, 2000).

In the United States 18.2% of employed people had evidence of a mental disorder which had impaired their work performance within the previous 30 days.

The disabling effects of mental health problems vary according to the type and severity of the problem, and also to other factors such as the availability of social support. The following section briefly describes some of the mental disorders and mental health problems that may be found in the workplace.

Depressive disorders

Depression is one of the most common mental disorders found in the general community and in the workplace. Depression is characterized by sadness, fatigue, a loss of interest in most activities, and lack of energy. Other features, such as insomnia (or hypersomnia), loss (or gain) of appetite, a tendency to blame oneself, and difficulty concentrating are often present. In its most serious forms, it can lead to suicidal thoughts and eventually to suicide (World Health Organization, 2001). Depression can be difficult to diagnose and can manifest as physical symptoms, such as headache, back pain, stomach problems, or angina.

Depression is one of the most common mental disorders found in the general community and in the workplace.

Box 2. What is depression?

Depression is a mood disorder that is typically characterized by a lowered mood and a loss of interest or pleasure in usually enjoyable activities. While occasionally lowered mood is normal, depression is distinguished by its severity, persistence, duration and the presence of particular symptoms, such as sleep disturbances. Common emotional, behavioural and physical symptoms include:

- markedly depressed mood,
- loss of interest and enjoyment,
- reduced self-esteem,
- pessimistic view of the future,
- ideas or acts of self-harm or suicide,
- disturbed sleep,
- disturbed appetite,
- decreased libido,
- reduced energy,
- reduced concentration and attention.

Depression varies in its severity and the pattern of symptoms. For many, individual symptoms will be of short duration and disappear spontaneously. For others, symptoms persist, with an increasing sense of hopelessness and despair and sometimes suicidal thoughts. With proper treatment, most people recover.

Source: Hunt et al., 1995

It has been estimated that 5.8% of men and 9.5% of women will have a depressive episode in any 12-month period (WHO, 2001).

It has been estimated that 5.8% of men and 9.5% of women will have a depressive episode in any 12-month period. If current trends are maintained, depression will be the second most important cause of disability by the year 2020. In the 15–44 year age bracket, depression is already the second highest cause of morbidity, accounting for 8.3% of the global burden of disease in that age group (World Health Organization, 2001).

In the United States, it has been estimated that between 1.8% and 3.6% of workers suffer from depression (Goldberg & Steury, 2001). Studies also suggest that the average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those for an average employee who receives health benefits (Birnbaum et al., 1999).

Bipolar affective disorder is a disorder in which a depressive illness exists together with episodes of mania, characterized by elated mood, increased activity, overconfidence and poor concentration. It is much less common than depression alone (the point prevalence is estimated at 0.4%) (World Health Organization, 2001), but is associated with significant impairment of work performance and disability.

Substance use

The use of psychoactive substances is a major problem for the workplace. Substances include alcohol, opioids such as heroin, cannabinoids such as marijuana, sedatives and hypnotics, cocaine, other stimulants, hallucinogens, tobacco and volatile solvents. Substance misuse can lead to intoxication, dependence and psychosis (World Health Organization, 2001).

Alcohol is the most commonly used substance in most regions of the world, although prevalence varies. Alcohol is a major contributor to disease burden, accounting for 1.5% of all deaths and 3.5% of the total disability-adjusted life years (World Health Organization, 2001).

Inappropriate use of alcohol and drugs is manifested by increased absenteeism, decreased productivity, a marked increase in accidents, thefts, and an increased propensity towards aggressive behaviour, including violence at work and at home.

The use of alcohol and drugs in the workplace is manifested by increased absenteeism, decrease in productivity, a marked increase in accidents, thefts, drug trafficking, and an increased propensity towards aggressive behaviour, including family violence.

It is difficult to obtain reliable statistics on the use of alcohol and drugs in the workplace. The statistics vary according to the definition used, and the "acceptability" or "tolerance" of alcohol use in different workplaces and communities. It is generally believed that the figures used are underestimates.

In the United States, 23% of employees in a manufacturing plant admitted to drinking alcohol during working hours at least once (Grube et al., 1994). In Thailand, substance abuse is viewed as the primary issue in 18% of problems in the workplace (EAP Seminar, 2002). In Chile, 30% of employees who had experienced a severe work-related accident had used either alcohol or drugs in the 48 hours prior to the accident (Trucco et al., 1998).

Anxiety disorders

While some anxiety is normal, and moderate levels can even improve a person's performance, people with anxiety disorders have specific and recurring fears that they recognize as irrational, unrealistic and debilitating. Severe anxiety can impair a person's ability to understand new information, plan activities or undertake complex tasks (Treatment Protocol Project, 2000).

Severe anxiety can impair a person's ability to understand new information, plan activities or undertake complex tasks.

Box 3 gives some examples of common anxiety disorders and their symptoms.

Box 3. Examples of common anxiety disorders

Panic disorder	Recurrent attacks of severe anxiety (panic) which are not restricted to any particular situation or set of circumstances, and which are therefore unpredictable. Dominant symptoms vary from person to person, but sudden onset of palpitation, chest pain, choking sensation, dizziness and feelings of unreality are common. There is also invariably, a secondary fear of dying, losing control, or going mad.
Agoraphobia	Interrelated and often overlapping cluster of phobias embracing fears of open spaces, leaving home, entering shops, crowds and public places, of traveling in trains, buses or planes. Agoraphobia is extremely incapacitating, with some sufferers becoming completely housebound.
Social phobia	Social phobias are centered around a fear of scrutiny by other people in comparatively small groups (as opposed to crowds), leading to avoidance of social situations. They may be discrete (ie. restricted to eating in public, to public speaking, or to encounters with the opposite sex) or diffuse, involving almost all social situations outside the family circle. Social phobias are usually associated with low self-esteem and fear of criticism.

Generalized anxiety disorder	The essential feature of this disorder is anxiety, which is generalized and persistent but not restricted to any particular environment. Dominant symptoms are highly variable and include continuous feelings of nervousness, trembling, muscular tension, sweating, lightheadedness, palpitations, dizziness, and epigastric discomfort. Fears that the sufferer or a relative will shortly become ill or have an accident are often expressed, together with a variety of other worries and forebodings.
Obsessive-compulsive disorder	This disorder is characterized by recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images or impulses that enter the individuals mind again and again. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are often viewed by the individual as a means of preventing some objectively unlikely event, often involving harm to or caused by himself or herself.

(WHO, 1992)

Anxiety disorders are common. In Australia, for example, 9.7% of the population reported symptoms of an anxiety disorder. Anxiety disorders were more common in women and in people aged 18-55 years (Henderson et al., 2000).

The indirect costs of generalized anxiety disorder, in terms of factors such as labour turnover, substance abuse and loss of efficiency, exceed the direct costs of treatment (Federal Institute for Occupational Health and Safety, 2003).

Work-related stress

Stress is a pattern of emotional (e.g. anxiety, depression), cognitive (e.g. poor concentration), behavioural (e.g. increased alchohol use) and physical (e.g. increased blood pressure, headaches) reactions to adverse conditions and is characterized by high levels of arousal, distress and feelings of not coping (European Commission, Employment & Social Affairs, 1999). Stress is not usually classified as a mental disorder, although it can precipitate both physical and emotional problems.

Stress is a pattern of emotional, cognitive, behavioural and physical reactions to adverse conditions and is characterized by high levels of arousal, distress and feelings of not coping.

Pressure at work can be positive for employees; a lot depends on the nature, intensity and length of the pressure, the degree of control of the situation that an individual feels he or she has, the individual's response, and the existence or absence of protective factors. For example, a worker who is exposed to continued pressure over a long period (excessive workload for a number of months), who feels unable to control the situation (fears losing the job) and has minimal support at work and at home is at risk of the negative consequences of stress.

It has been estimated that work-related stress negatively affects at least 40 million workers in 15 countries of the European Union, costing 20 billion euros annually (European Commission, Employment & Social Affairs, 1999). This survey revealed that 45% of workers had monotonous tasks; 44% did not rotate tasks; 50% had short, repetitive tasks; 35% had no influence on task order; 28% had no influence on work rhythm; 54% reported working at very high speed, and 56% worked to tight deadlines.

It has been estimated that work-related stress affects at least 40 million workers in 15 countries of the European Union, costing 20 billion euros annually

In the United States, the percentage of workers who describe themselves as "never having the time to complete one's task" has increased from 40% in 1977 to 60% in 1997 (Theorell, 1999) and the average working time lost due to stress has risen by 36% since 1995. Elkin and Rosch (1990) estimated that in 1990, 54% of the 550 million working days lost annually, could be attributed to stress.

One major source of stress for employees is exposure to critical incidents, such as assaults, sexual or psychological harassment, and accidents. Acute stress disorders and post-traumatic stress disorder are potential consequences of critical incidents that need to be managed. Post-traumatic stress disorder, in particular, can lead to personal distress, significant disability and reduced work performance.

There is an increasing awareness of the impact of bullying or psychological harassment in the workplace. Psychological harassment can include daily humiliations, subtle criticisms, inappropriate remarks concerning a person's physical or psychological attributes, sexual advances, and inappropriate and unrealistic demands that undermine a person's dignity; it can affect physical and mental health.

One consequence of long-term exposure to stress may be burnout. The use of the expression burnout has become increasingly popular around the world to describe the result of a long-term exposure to a work situation that is beyond the person's capacity to cope. The term was coined by Freudenberger (1974) to refer to exhaustion of aid workers; the notion has now been broadened to include all types of workers.

Burnout is characterized by feelings of intense fatigue, a sense of isolation and loss of control, as well as a feeling of accomplishing nothing at work. It is often accompanied by insomnia, headaches, gastrointestinal symptoms, a variety of muscular and joint pains, and lapses in memory.

Burnout is characterized by feelings of intense fatigue, a sense of isolation and loss of control, as well as a feeling of accomplishing nothing at work.

There have been few studies on the prevalence of burnout in the workplace; however those that have been conducted suggest that it is common. For example, in Finland 7% of the population experienced severe burnout, while 50% reported some burnout symptoms (Liimatainen, 2000).

Psychotic disorders

Psychotic disorders are associated with marked behavioural problems and abnormal thinking. Schizophrenia is a severe psychotic disorder characterized by distortions in thinking and perception with associated inappropriate emotions. Symptoms can include disturbed behaviour, strong false beliefs (delusions), hallucinations and disturbed thought processes. Typically it commences in late adolescence or early adulthood. The course is variable; for some people it will be chronic or recurrent with residual disability (World Health Organization, 2001).

Schizophrenia is a severe psychotic disorder, characterized by distortions in thinking and perception with associated inappropriate emotions.

The point prevalence for schizophrenia is estimated to be 0.4%, i.e. at any point in time, 0.4% of the world's population have schizophrenia (World Health Organization, 2001).

Lack of employment is a major problem for many people with psychotic disorders (World Health Organization, 2001). In the United Kingdom, for example, more than 50% of people with schizophrenia were classed (although not necessarily correctly) as permanently unable to work and only 1 in 8 was employed (Patel & Knapp, 1997). The lack of access to employment can exacerbate a vicious cycle of poverty and worsening mental health.

Lack of employment is a major problem for many people with schizophrenia.

Mental retardation

Mental retardation is defined in the International Classification of Diseases as "*a condition of arrested or incomplete development of the mind characterized by impairment of skills … which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities*" (World Health Organization, 1992). Increasingly the term intellectual difficulties or disabilities is used instead of mental retardation. Mental retardation can occur with or without another mental or physical disorder. It has multiple causes, including genetic factors, brain injury and infection.

People with mental retardation may be especially vulnerable in the workplace. Only a small proportion of people with mental retardation who are able to work are employed. The employment opportunities that do occur tend to be in low-paid jobs, in small workplaces, where they may be vulnerable to exploitation, with an increased risk of developing other mental health problems.

Only a small proportion of people with mental retardation who are able to work are employed.

While some countries have legislation that protects the rights of people with mental retardation, individuals may experience difficulties in asserting these rights because of their limited cognitive abilities.

Co-morbidity

Mental and physical health problems are inter-related. For example, people with certain physical disorders, such as hypertension, epilepsy, diabetes, cancer, human immunodeficiency virus (HIV) infection, and tuberculosis, or who have had a myocardial infarction or stroke, have a high prevalence of depression (World Health Organization, 2003a). Such depression not only worsens the individual's suffering, but also results in lower adherence to medical treatment.

People with certain physical disorders, such as hypertension, epilepsy, stroke, diabetes, cancer, HIV infection and tuberculosis, or who have had a myocardial infarction or stroke, have a high prevalence of depression.

There has been growing evidence over the past 20 years of the impact of stress on physical health. For example, acute emotional or physical stress activates the sympathetic nervous system and results in increased heart rate and blood pressure. Chronic stress may result in long-term circulatory changes.

There is also a strong association between chronic pain and mental disorders (Dersh et al., 2002a) and chronic work-related musculoskeletal pain and mental disorders (Dersh et al., 2002b).

Different mental health problems themselves often occur together. For example, people with anxiety are frequently also depressed. Similarly, many people with substance use problems also have depression or anxiety.

Impact of mental health problems

Epidemiological surveys and clinical studies in Europe and elsewhere indicate that work and employment play an important role in relation to mental health (Liimatainen & Gabriel, 2000; World Health Organization, 2003a, 2004a). However, this role is not fully understood and, as a result, not properly managed in relation to the protection and promotion of good mental health (Cox et al., 2004).

The workplace can contribute positively to a person's mental health, may exacerbate an existing problem, or may contribute to the development of a mental health problem. The failure to prevent, recognize and treat mental health problems in the workplace has an impact on employers, employees and their families, and the community generally.

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Employers

Mental health problems have an impact on employers and businesses directly through increased absenteeism, reduced production, increased costs, and reduced profits. They also affect employers indirectly through factors such as reduced morale of staff.

> Increased absenteeism

In many developed countries, 35–45% of absenteeism from work is due to mental health problems.

In many developed countries, 35–45% of absenteeism from work is due to mental health problems (World Health Organization, 2003a). In the United Kingdom, for example, mental health problems are the second most important reason for absence from work, accounting for between 5 and 6 million lost working days annually (Liimatainen & Gabriel, 2000). A study in the United States found that an average of 6 working days per month per 100 workers were lost as result of mental disorders (Kessler & Frank, 1997). A Canadian university has reported that absences for psychological reasons increased 400% between 1993 and 1999 (Université Laval, 2002).

> Decreased productivity

Even if an employee is not absent from work, mental health problems can cause a substantial reduction in productivity. For example, in the United States, the number of "cutback" days (on which less work is done than usual) attributable to a mental disorder averaged 31 per month per 100 workers (Kessler & Frank, 1997). In annual terms, this represents 20 million working days on which employees are not fully productive because of a mental health problem (World Health Organization, 2003a).

In a large financial services company in the USA, depression resulted in an average of 44 working days for each employee with depression lost because of short-term disability compared with 42 days for heart disease, 39 days for lower back pain, and 21 days for asthma (Conti & Burton, 1994).

> Increased costs

In the USA, each worker with depression costs his or her employers approximately US$3000.

In the United States, each worker with depression costs his or her employers approximately US$3000. The majority of costs for employers are related to absenteeism and loss of productivity rather than treatment (Harnois & Gabriel, 2000).

The Association of Canadian Insurance Companies estimates that 30–50% of disability allowances are paid for mental health problems and that such problems are the leading cause of long-term absence from work. The experience of many employers is that, once an employee has been absent for three months for mental health reasons, it is very likely that the absence will last more than one year (Harnois & Gabriel, 2000).

The cost of mental disorders at a Canadian University, including the salary insurance and replacement of staff, amounted to C$3 million for the year 2001 (Université Laval, 2002).

It is estimated that stress-related absences cost between 4 and 5 billion pounds each year in the United Kingdom (Mentality, 2003).

> Indirect costs

There are many indirect costs of mental disorders in the workplace, related to poor work performance, reduced morale, high staff turnover, early retirement and work complaints and litigation (see Box 4). These indirect costs can be difficult to quantify.

Box 4. Indirect costs of mental health problems in the workplace:

Indirect costs may be a result of:

- poor performance at work;
- staff illness and shortages that can threaten the quality of service or product supplied;
- reduced morale among staff;
- high staff turnover (costs of recruitment, induction and training);
- early retirement;
- management time to deal with issues associated with mental health problems;
- providing temporary cover for colleagues;
- complaints and possibly litigation associated with mental health problems;
- cost to governments of health care and rehabilitation

Source: Mentality (2003)

Employees and their families

For individuals, mental health problems can lead to a reduced quality of life, as well as having significant economic and social effects. Absence from work is likely to affect the person's income. In combination with the costs of health care, this may cause significant financial hardship for employees with mental health problems. Many workers, particularly those in low-paid employment or small workplaces, do not have insurance that covers the cost of ill-health or absence from work. These employees are often not able to access the health services they need to treat their mental health problem, and may not be able to afford the time off work required for recovery.

Many workers, particularly those in low-paid employment or small workplaces, do not have insurance that covers the cost of ill-health or absence from work.

In addition, individuals with mental health problems often experience stigma and discrimination (World Health Organization, 2001). The financial and personal burden of having a mental health problem can create a negative cycle that, without effective treatment, may lead to a worsening of the mental health problem.

Families also experience the impact of mental health problems. They may have economic difficulties related to the reduced income and increased health care costs, the stress of coping with altered behaviour, disruption to the household routine, and restricted social activities (World Health Organization, 2001).

The community

The cost of mental health problems to the overall community includes the cost of treatment, particularly when this includes hospitalization. The most important component of the cost of treating depression is hospitalization, accounting for around half of the total in the United Kingdom and three-quarters in the United States (Berto et al., 2000). In addition, other costs to the community include those related to the loss of productivity, loss of lives, consequences of untreated illnesses (for example, increased numbers of people in prison), social exclusion and human rights abuses.

Mental health problems in the workplace adversely affect the national economy. In the European Union, for example, it is estimated that the cost of mental health problems in the workplace may amount to 3-4% of the gross national product (GNP) (Liimatainen & Gabriel, 2000).

Mental health problems in the workplace adversely affect the national economy.

Risk and protective factors for mental health problems

Risk factors increase the likelihood that a mental disorder will develop or that an existing disorder will become worse. In contrast, protective factors reduce the risk of mental health problems or reduce the effect of risk factors (Commonwealth Department of Health and Aged Care, 2000). While protective factors are associated with better mental health, there is not always clear evidence of a causal relationship.

Risk factors increase the likelihood that a mental disorder will develop.

Examples of protective factors for mental health are:

- good social skills,
- secure and stable family life,
- supportive relationship with another adult,
- sense of belonging,
- positive work climate,
- opportunities for success and recognition of achievement,
- economic security,
- good physical health,
- attachments and networks within the community,
- access to support services.

Individual risk factors

Mental health problems are the result of a complex interplay between biological, psychological and social factors (World Health Organization, 2001). An understanding of these factors has influenced the development of effective treatments.

Mental health problems are the result of a complex interplay between biological, psychological and social factors.

- *Biological factors*. Mental health problems are associated with biological factors, such as genetic characteristics and disturbance in neural communications (WHO, 2001).

- *Psychological factors*. Individual psychological factors are associated with the development of mental health problems. For example, children who are separated from their primary caregiver or deprived of nurturing for extended periods of time have a greater risk of developing a mental or behavioural disorder either in childhood or later in life. Similarly, mental or behavioural problems can occur as a result of failing to adapt to a stressful life event.

- *Social factors*. Social factors, such as urbanization, poverty and technological change, have been associated with the development of mental health problems. The costs of treatment and lost productivity associated with a mental health problem contribute significantly to poverty, while features associated with poverty, for example inadequate housing and malnutrition, also contribute to the development of mental health problems.

Social support, such as from colleagues, joint problem-solving and assistance from superiors play an important role in both the perception of stressors and the impact of stress on mental health outcomes (Kortum & Ertel, 2003).

Organizational risk factors

There is evidence that the poor organization of work plays a significant role in the development of mental health problems. The factors most frequently associated with mental health problems in the workplace include the following.

> Content of work

Workload. Excessive workload has been associated with mental health problems. The workload for an individual may be more than he or she can reasonably manage (too many things to do in too little time without enough resources) or it may be qualitatively excessive, in terms of its difficulty or complexity (Pérusse, 1984). Similarly, too little work or the underuse of a person's skills can also cause stress.

Excessive workload has been associated with mental health problems.

Participation and control. Employees who are unable to influence or adjust their work are likely to experience stress (European Commission, Employment and Social Affairs, 1999). For example, employees may be unable to participate in decisions that affect how they carry out their work, or to choose how to accomplish it (Comité de la Santé mentale du Québec, 1988). Insufficient participation in decisions related to work can lead to depression, poor physical and mental health, alcohol abuse, and low self-esteem (Karasek & Theorell, 1990).

Insufficient participation in decisions related to work can lead to depression, poor physical and mental health, alcohol abuse, and low self-esteem.

Job content. The content of the employee's tasks is also important to his or her mental health. Monotonous, understimulating or meaningless tasks, lack of variety, and unpleasant tasks increase the risk of mental health problems (World Health Organization, 2004a).

The content of the employee's tasks is also important to his or her mental health.

> Context of work

Role in organization. Both role conflict and role ambiguity increase the risk of mental health problems. Role conflict occurs when an individual faces what appear to be incompatible demands from employers or colleagues. Role ambiguity arises when an employee feels unsure of what is expected, either because of lack of information or because of a breakdown in communication with employers (Maslach et al. 2001).

Both role conflict and role ambiguity increase the risk of mental health problems.

Reward. Reward is the "status" (perception of worth) that the individual feels at work. While reward may be linked to salary, it more broadly refers to the respect and esteem in which the person is held in the workplace. This also includes the presence of adequate social support at work (Karasek & Theorell 1990). Lack of recognition at work is associated with reduced motivation, psychological distress and increased incidence of cardiovascular disease (Siegrist 1996).

Lack of recognition at work is associated with reduced motivation, psychological distress and increased incidence of cardiovascular disease.

Equity (fairness). Employees may feel that they are not being justly or equitably treated. Workload, salary and promotions often affect the perception of equity. The manner in which decisions are made (including downsizing) will also affect employees' sense of justice or equity. Employees may not have been consulted or informed about changes made in the workplace. Positive feelings of equity and fairness lead to increased satisfaction and motivation as well as commitment to work (Brockner & Greenberg, 1990).

Positive feelings of equity and fairness lead to increased satisfaction and motivation as well as commitment to work.

Interpersonal relationships. The quality of interpersonal relationships is important to mental health. Inadequate, inconsiderate or unsupportive supervision, poor relationships with co-workers, bullying, harassment and isolation increase the risk of a mental health problem (World Health Organization, 2004a). There is also some evidence of a relationship between supervisory style (e.g. authoritarian,

The quality of interpersonal relationships is important to mental health.

laissez-faire) and employee satisfaction (Blais, 2003).

Working environment. The physical working environment includes: (a) physical factors such as noise, pollution, and light, and (b) working hours. Irregular and excessive working hours can affect the circadian rhythms, and may lead to physical (insomnia, gastrointestinal problems) and behavioural (overeating, excessive alcohol use) problems. Excessive working hours often lead to decreased efficiency (Université Laval, 2002).

Workplace culture. The organizational culture of the workplace – communication, leadership and clarity of role and structure of the workplace – can affect mental health (World Health Organization, 2004a).

Home-work interface. Tensions between home and work have consequences for a person's mental health. Conflicting demands of work and home, a lack of support in the workplace for personal commitments, or a lack of support at home for work commitments can increase the risk of developing a mental health problem. (World Health Organization, 2004a)

Tensions between home and work have consequences for a person's mental health.

These factors are summarized in Table 1.

Box 5. Improving the motivation of employees

Improving the content and context of work is likely both to have an impact on the mental health of employees and to improve their motivation. A recent review of factors affecting attitudes and motivation (Maslach et al., 2001) found that achievement, recognition, work itself, responsibility, advancement and growth were the most important factors leading to job satisfaction, whereas difficulties related to company policy, supervision, relationships with supervisors, work conditions, salary, and relationships with peers were among the most significant factors leading to job dissatisfaction.

The impact of risk factors varies across different workplaces, occupational groups and cultures. Table 2 summarizes the results of a study of the risk factors for mental health problems among a total of 3142 managers, nurses and paramedical staff, and professionals in four organizations. While overwork was a factor contributing to stress among all three occupational groups, the pressure associated with decision making was a factor for nurses and paramedical staff, while professionals and managers identified poor relationships with superiors.

The impact of risk factors varies across different workplaces, occupational groups and cultures.

Table 2. Risk factors by category of employment

Managers	Nurses and paramedical staff	Professionals
Overwork	Overwork	Overwork
Low recognition	Low recognition	Low recognition
Poor relationships with superiors	Sustained mental effort	Poor relationship with superiors
Sustained mental effort	Pressure re impact of decisions	Sustained mental effort
Low participation in decisions	Role conflict	Low participation in decision making
Role conflict	Non-secure environment	Competitive climate
Low advancement possibilities	Requirements of working with patients	Information not clear
Competitive climate	Work/family conflict	Insufficient information to do work

Table 1. Factors associated with the development of mental health problems in the workplace

Work content	
Workload	Excessive workload Insufficient work
Lack of participation and control	Inability to participate in decision-making Inability to choose how to complete work
Job content	Monotonous tasks Unpleasant tasks Aversive tasks
Work context	
Role in organization	Role conflict Role ambiguity
Lack of reward (recognition)	Lack of recognition of work (e.g. through salary) Low status Inadequate social support in the workplace
Inequity (lack of fairness)	Perception that workplace is not just or equitable (e.g. in terms of workload, salary, or promotion) Poor management of organizational change (e.g. downsizing)
Poor interpersonal relationships	Unsupportive supervision Poor relationships with colleagues Bullying, harassment or violence Isolated or solitary work
Working environment and conditions	Inadequate physical environment (e.g. noise, pollution, light, danger) Irregular working hours (e.g. shift work or excessive working hours)
Workplace culture	Poor communication Poor leadership Lack of clarity about workplace objectives and structure
Home–work interface	Conflicting demands at home and at work Lack of support for home at work Lack of support for work at home

Key points: Work and mental health

- Mental health problems in the workplace are common.
- They affect individuals and their families, businesses and communities.
- An understanding of the protective and risk factors for mental health problems in the workplace is essential.

2. The role of government

Governments have a critical role in promoting mental health, preventing mental health problems in the community, and ensuring that mental health problems are recognized early and treated effectively.[1] Workplaces are important targets for government promotion and prevention activities. In addition, governments are usually employers themselves, often employing thousands of people.

Governments have a critical role in promoting mental health, preventing mental health problems in the community, and ensuring that mental health problems are recognized early and treated effectively.

At the national level, there is considerable variability in the administrative structures that oversee mental health issues in the workplace. However, in most countries the ministries of health and of labour will play a key role.

The ministry of health is usually responsible for formulating the country's mental health policy, proposing a framework for promoting the mental health of the population, and organizing and delivering mental health services. Ideally, the mental health policy should refer specifically to the interface between work and health, including mental health (World Health Organization, 2005).

Usually, the ministry of labour will have responsibility for issues associated with health and safety in the workplace. This may include not only regulation and monitoring of health and safety in the workplace, but also income protection for injured or disabled workers. In some countries, there may be a specific unit or programme dealing with several aspects of employment and disabilities.

In many countries, traditional healers are an important part of the health system. Where appropriate, labour laws and regulations should acknowledge their role and promote communication and collaboration between them and the workplace.

Vulnerable populations

The burden of mental health problems does not affect all sections of society uniformly. In the workplace, particular population groups may be at increased risk of developing a mental health problem. At the same time, these groups may experience additional barriers in accessing the required services.

The burden of mental health problems does not affect all sections of society uniformly.

Women

Women comprise over 40% of the global labour force. They also represent 70% of the world's poor, earn on average two-thirds of the income of men, and spend twice as much time as them on unpaid work (International Labour Organization, undated). In addition, in some countries women's access to education is restricted, which can result in their being employed in hazardous, low-paid jobs. This, in turn, can increase the risk of their developing a mental health problem. Exposure to sexism, racism and poverty is linked to mental health vulnerability (Harrell, 2000; Diaz et al., 2001), and this should be considered when mental health policies are being developed for the workplace.

Besides being paid proportionately less and having poorer working conditions than their male counterparts, women remain largely responsible for raising children and managing the household. Dual role burdens disproportionately affect women, who still take on the majority of unpaid caregiving (Luxton & Corman, 2001; Rao & Kelleher, 2003). Attempting to juggle these multiple responsibilities can create stress and contribute to the development of a mental health problem.

Besides being paid proportionately less and having poorer working conditions than their male counterparts, women remain largely responsible for raising children and managing the household.

[1] The key issues associated with mental health promotion and prevention are discussed in two recent WHO publications (World Health Organization, 2004b; 2004c).

Women frequently manage the financial and emotional burden of looking after an elderly parent. This contributes significantly to absenteeism in the workplace. For example, it has been estimated that, in the United States, one in five employees takes leave of absence (or even leaves work completely) in order to deal with responsibilities for parents. The aggregate cost of such caregiving, as measured in lost productivity, is estimated at more than US$11 billion a year (Lewis & Cooper, 1999).

Children

Children represent a significant proportion of the workforce. There are an estimated 211 million children aged between 5 and 14 years engaged in economic activity globally. Of these, 8.4 million are involved in the worst forms of child labour – trafficking, forced and bonded labour, armed conflict, prostitution, pornography and illicit activities (International Labour Office, 2002a).

There are an estimated 211 million children aged between 5 and 14 years engaged in economic activity globally.

Children are especially vulnerable in the workplace. Between 15% and 20% of all children and adolescents are likely to have a mental health problem (Bird, 1996; Verhulst, 1995). The stresses associated with working may increase a child's risk of developing a mental health problem, in both the short and the long term.

The needs of children at work are discussed in more detail elsewhere. Further information can be obtained from the International Labour Organization (www.ilo.org) or UNICEF (www.unicef.org).

People with disabilities

People with disabilities, including mental disabilities, are often denied opportunities for meaningful employment, and so remain trapped in a cycle of marginalization, social exclusion and poverty.

People with disabilities, including mental disabilities, are often denied opportunities for meaningful employment and so remain trapped in a cycle of marginalization, social exclusion and poverty.

Unemployment among people who are disabled is far higher than among other individuals of working age, and many disabled people who want to work are unable to do so (International Labour Office, 2002b). For example, in the European Union, 52% of people with disabilities are economically inactive compared with 28% of non-disabled people. Disabled people also work fewer hours and earn lower wages than non-disabled people (European Commission, Employment and Social Affairs, 2001).

Disabled people work fewer hours and earn lower wages than non-disabled people.

People with mental disorders have the lowest rate of employment of any group with disabilities (The President's New Freedom Commission on Mental Health, 2003). This is despite evidence that the majority want to work and could work, if assistance was provided. People with mental disabilities are frequently discouraged because of limited opportunities to obtain work, insufficient incentives for employers to employ people with mental disabilities, financial penalties of employment, stigma and discrimination, such as beliefs that people with mental health problems are not productive (World Health Organization, 2001).

People with mental disorders have the lowest rate of employment of any group with disabilities.

In some countries, people with mental disabilities have benefited from the development of labour cooperatives that have provided opportunities for employment and training. For example, in Côte d'Ivoire a chicken farm was established to provide employment for people with mental disabilities. Despite early resistance from the local community, the farm grew to become important economically for the region and to provide employment opportunities for other members of the community (World Health Organization, 2001).

Policy and legislation

Many improvements in the management of mental health problems in the workplace have resulted from legislative changes, often accompanied by relevant policy initiatives. Governments have a crucial role in providing a policy and regulatory framework that promotes the mental health of workers and ensures that workers with mental health problems have access to effective treatments.

Many improvements in the management of mental health problems in the workplace have resulted from legislative changes.

Antidiscrimination legislation

Activities of the United Nations have emphasized the right of disabled people to have the same opportunities as other citizens, including participation in economic activities such as work. The introduction of antidiscrimination legislation in some countries has been one of the most important legislative approaches to improving mental health in the workplace.

In 1993, the United Nations General Assembly adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (United Nations, 1993). The resolution identified a number of issues that need to be addressed to attain equal opportunities for disabled people, including: awareness-raising; medical care; rehabilitation; support services; employment; income maintenance and social security; family life and personal integrity; culture; recreation and sports; and religion.

The International Labour Organization's Declaration on Fundamental Principles and Rights at Work, adopted in 1998, commits governments, employers and workers' organizations to uphold principles and rights in four areas, including the elimination of discrimination in the workplace.

Many countries have legislation that prohibits discrimination against people with mental health problems. The effectiveness of these laws depends on (1) the underlying model of disability and whether it is inclusive of mental health problems; (2) the concept of equality, for example whether the law relates only to employment or also promotes access to education and training; and (3) the location of the legal provisions (i.e. whether provisions appear in criminal, constitutional, civil, labour or social welfare law) (International Labour Office, 2002a).

Many countries have legislation that prohibits discrimination against people with mental health problems.

Some countries have broadened their antidiscrimination laws to include people with mental health problems. In the United States, for example, the Americans with Disabilities Act of 1990 prohibits employers from discriminating in any aspect of employment because of a job applicant's or employee's disability, including one caused by a mental disorder.

In the United Kingdom, the Disability Discrimination Act of 1995 makes it unlawful for employers to discriminate against people with a mental disorder and requires employers to make reasonable adjustments to the workplace to ensure that people with disabilities have the opportunity to work (Mentality, 2003).

National laws can use a variety of mechanisms to promote the employment of people with disabilities, including the following (International Labour Office, 2002b):

National laws can use a variety of mechanisms to promote the employment of people with disabilities

- quota schemes, which require businesses of a certain size to employ a specified proportion of people with a disability;
- equity or nondiscrimination laws, which make it unlawful for people to discriminate on the basis of mental health problems;
- job retention laws, which require employers to retain people who become disabled while employed.

Income protection

Employees need to be protected against the cost of illness or disability. This should include protection against both the cost of treatment and the loss of wages when the person is unable to work. Many countries do not provide such protection.

Employees need to be protected against the cost of illness or disability.

Financing for mental health care should be based on three principles:

- People should be protected from catastrophic financial expenditure by minimizing their out-of pocket expenses for mental health care.
- The healthy should subsidize the sick, through strategies such as prepayment schemes that include mental health problems.
- The well off should subsidize the poor.

See the module on *Mental health financing* (WHO, 2003b) for more details.

Many employees, particularly those in small businesses, the self-employed, migrant workers, and casual and part-time workers, do not have access to income protection for absences from work due to ill health. Such people are at risk of extreme financial hardship if mental health problems impair their ability to work. Governments and employers need to work together to ensure that all workers are sufficiently protected against the risk of mental health problems.

Safety and health at work

Other legislative and policy provisions have focused on the obligations of the employer to provide a safe working environment. A range of international standards and guidelines commit countries to develop safe workplaces.

A range of international standards and guidelines commit countries to develop safe workplaces.

The International Labour Organization's SafeWork programme promotes safe working environments. Its primary objectives are to (1) increase the worldwide awareness of the scope and impact of work-related accidents, injuries and diseases; (2) promote the protection of all workers; and (3) enhance the capacity of its Member States and industry to design and implement effective prevention policies and programmes.

Worker safety has also been addressed through national laws. For example, in the United Kingdom, the Health and Safety Act (1974) and the Management of Health and Safety at Work Regulations (1999) require employers to provide a safe environment and to assess and control risks to worker safety (Mentality, 2003). The Occupational Safety Act (1958) and the Occupational Health Care Act (1987) in Finland make employers responsible for providing a safe workplace, as well as support and assistance for people with disabilities (Liimatainen, 2000).

Mental health policy and services

Many employees with mental health problems rely on the mental health services provided by government, nongovernmental organizations, or the private sector for the treatment of mental health problems. It is important that the services provided are accessible and that they provide high quality care. The 2001 *World Health Report* (World Health Organization, 2001) contained ten recommendations for action, which are summarized in Box 6.

Many workers with mental health problems, particularly low paid workers, those working in small workplaces and those working in the informal sector rely on the mental health services provided by government, non-governmental organizations or the private sector for the treatment of mental health problems.

Box 6. Recommendations for mental health care from *The World Health Report 2001*

- Provide treatment in primary care.
- Make psychotropic medicines available at all levels of health care.
- Give care in the community.
- Educate the public about mental health.
- Involve communities, families and consumers in developing policies, programmes and services.
- Establish national policies, programmes and legislation on mental health.
- Develop human resources to provide specialist care.
- Link with other sectors to improve mental health.
- Monitor community mental health.
- Support more research into the biological and psychosocial aspects of mental health.

WHO's Mental Health Policy and Service Guidance Package provides guidance to governments, policy-makers, mental health professionals, advocacy organizations and other stakeholders on improving the mental health of populations, using existing resources to achieve the greatest benefits, providing effective services to those in need, and assisting the reintegration of those with mental health problems into all aspects of community life, including employment.

Unemployment

Unemployment and associated factors, such as poverty and low education, are associated with a higher prevalence of mental disorders (World Health Organization, 2001) Unemployed people have more symptoms of depression than employed people, and people who have lost a job are twice as likely to be depressed as people in employment (World Health Organization, 2003a) In one study, people who were unemployed had twice the risk of depression of people who were employed (Dooley et al., 1994).

Unemployment has well known and significant effects on health and psychological well being.

While unemployment has well known and significant effects on health and psychological well-being, insecure jobs also appear to have health consequences. Even if the effects on individuals are not as serious as unemployment – and this is yet to be demonstrated – the overall effect of precarious employment appears to be negative (Quinlan, 2001/2002). Temporary workers (employees with short-term and insecure contracts) report more difficult work situations than permanent employees. The insecurity of their working conditions creates feelings of insecurity concerning their future.

Government policies that promote employment and reduce unemployment are likely to have a positive effect on mental health.

Government policies that promote employment and reduce unemployment are likely to have a positive effect on mental health in the community.

Box 7. Governmental approaches to enhancing mental health in the workplace: Thailand

In Thailand, a memorandum of understanding has been developed by the Ministry of Labour and Social Welfare and the Ministry of Public Health to promote mental health and well-being in the workplace. Both ministries have recognized the importance of multidisciplinary cooperation in enhancing current practices and standards of prevention, promotion, treatment and recovery programmes.

The Thai Health Promotion Association, a state agency with the goal of promoting health among the Thai population, was founded in 2001 and funded with 2% of tobacco and alcohol taxes. The agency is working on several projects related to mental health in the workplace.

Source: Dominique Norz, personal communication, 2004

Government partners

Employer, employee and nongovernmental organizations have an important role in working with governments to improve the mental health of employees. For example, the Central Organization of Finnish Trade Unions (SAK) has argued for preventative measures to reduce burnout and for a reduction in working hours (Liimatainen, 2000). Union activities to help address these issues have included training, legal support and negotiations with employers (Vezina & Cousineau, 1998).

Employer, employee and nongovernmental organizations have an important role in working with governments to improve the mental health of employees.

Employer, employee and nongovernmental organizations should advocate for the development of policies and strategies that promote the mental health of employees and prevent and treat mental health problems.

Box 8. Finnish National Workplace Programme

In Finland, the National Workplace Programme, made up of representatives from the Central Labour Market Organization, the Confederation of Employers, and the Health Division of the Ministry of Social Affairs and Health, has an overall goal to boost productivity and the quality of working life. As of 2000, the programme was involved in some 300 projects and 500 workplaces (Liimatainen & Gabriel, 2000).

Further information

More detailed guidance for countries on the development and implementation of policies and legislation for mental health is available in other modules of the Mental Health Policy and Service Guidance Package (World Health Organization, 2005).

Key points: The role of government

- Governments have a crucial role in promoting the mental health of employees and in ensuring that mental health problems are treated effectively.
- In the workplace, women, children and people with disabilities require special consideration.
- Policy and legislation can contribute positively to the mental health of the workforce.
- Government, employer, employee and nongovernmental agencies are important partners in the promotion of employees' mental health and the prevention and treatment of mental health problems.

3. Putting in place a workplace mental health policy

A mental health policy for the workplace defines the vision for improving the mental health of the workforce and establishes a model for action.

For many businesses, addressing mental health problems at the workplace will begin with the development of a policy. A mental health policy for the workplace defines the vision for improving the mental health of the workforce and establishes a model for action. When well formulated, such a policy will also identify and facilitate the agreements needed among the different stakeholders in the workplace. Without policy direction, lack of coordination and fragmentation will reduce the impact of any workplace mental health strategy.

A mental health policy for the workplace can be developed separately, or as part of a broader health and safety policy. Developing a mental health policy within such a wider policy framework will ensure that the broader determinants of mental health are considered. However, in practice, the decision about where mental health policy should be located will depend on the context of the workplace.

The decision to develop a workplace mental health policy may be a result of many different factors, including evidence of the impact of mental health strategies on productivity, an understanding of the importance of addressing mental health issues in the workplace, and the need to comply with regulations.

Chapters 4–7 provide guidance on developing a workplace policy on mental health. The first step is to analyse the mental health issues in the workplace. Key activities include: making the case to employers about the importance of mental health; establishing a coordinating process; and assessing the needs to be addressed in the policy.

The second step is to develop the policy. This involves formulating a vision statement; identifying the values and principles that will underlie the policy; defining the objectives of the policy; and consulting with key stakeholders.

The third step is to develop prevention and intervention strategies for the workplace. This involves reviewing the options for strategies; finding resources to implement the strategies; and developing an implementation plan.

The final step is to implement and evaluate the policy. For this, it is necessary to generate support and collaboration; coordinate implementation; train key personnel; establish demonstration projects; and evaluate the outcomes.

While these steps are presented in a sequential manner, the practice is often more complex. The guidance should be adapted to meet the needs of specific workplaces.

4. Step I: Analysing mental health issues

The first step in developing a workplace mental health policy is to analyse the mental health issues in the workplace. This requires a number of actions including developing a business case, establishing a coordinating process, and systematically assessing workplace needs.

Making the case

It is important to make the case for developing a mental health policy in the workplace in order to gain the explicit endorsement and commitment of the employer and other key stakeholders. This is vital for the actual development and acceptance of a workplace mental health policy. The employer is more likely to support the introduction of a policy if you can demonstrate that it will have a positive impact on the workplace, will be financially viable, and will be beneficial to work outcomes, that is, increase profits, efficiency or improve the product. Employers are often motivated to address mental health issues in the workplace when they understand the link with productivity. Other stakeholders may be more interested in improving the health of employees or in creating better working conditions.

The employer is more likely to support the introduction of a policy if you can demonstrate that it will have a positive impact on the workplace, will be financially viable, and will be beneficial to work outcomes.

In making the business case, general data showing the link between mental ill-health and reduced productivity and increased costs should be presented. In addition, any readily available data from the workplace itself should be analysed and presented. It is useful to outline the major mental health issues in the workplace, though a detailed assessment may not be possible until the commitment of management has been secured. The purpose of a workplace mental health policy and the anticipated benefits should also be outlined.

While the strategy used to communicate the benefits of a workplace mental health policy will depend on the workplace and the audience, it will often be useful to do so in writing. A brief report may be an effective way of communicating with an employer, while a pamphlet could be given to employees.

It is essential to generate and demonstrate broad support for the policy from all stakeholders.

It is essential to generate and demonstrate broad support for the policy from all stakeholders. Employers are unlikely to be convinced of the benefits of the project if there is opposition from employees.

Box 9 illustrates and provides examples of arguments for a mental health policy in the workplace.

Box 9. Arguments for improving mental health in the workplace

Example 1: "Good health equals good business"

There are too few employers who act on the maxim that "good health equals good business" – and even fewer who recognize the importance of mental health. But there are compelling business arguments for a positive, inclusive approach to mental health issues in the workplace:

- gaining important skills;
- reducing absence;
- creating better work relations;
- enhancing productivity and motivation;
- employing the best person for the job;
- retaining knowledge and skills;
- fostering acceptance and diversity;
- making your workplace more efficient.

Adapted from: *Mind out for mental health promotion campaign*. (National Institute for Mental Health, undated)

Example 2: Retention, retention, retention

Inadequate management of mental illnesses can result in a myriad of business costs, including absenteeism, disability payments, medication costs, accidents, and recruitment expenses. In addition, there are indirect expenses such as lost productivity, replacement payroll, training expenses, and time spent administering disability claims.

If an employee experiencing symptoms of mental illness does not get timely managerial support and medical attention, the outcome is likely to be negative and costly. Consider the following scenarios:

- An employee returns to full-time work after a "breakdown"; unable to make the transition, he has a relapse, and goes on to long-term disability status.
- An employee's performance slips; thinking that she is no longer up to the job, the manager demotes her.
- Unable to concentrate because of intrusive thoughts, and too fearful to talk to the employer, an employee quits without explanation.
- An employee acts inappropriately, e.g. accusing someone of spying or handling company funds recklessly. Although this behaviour is out of character, no one recognizes the signs of illness, and the person is fired.

Each of the situations above could have had a positive outcome, rather than a negative one, if management had recognized, and addressed, the underlying mental health issue.

Adapted from Canadian Mental Health Association, 2002.

Example 3: Treating depression increases productivity

A recent study undertaken in the USA has demonstrated that high quality care for depression can improve productivity at work and lower rates of absenteeism.

A two-year programme to treat employees suffering from depression at 12 primary care practices nationwide resulted in an average 6% improvement in productivity at work, or an estimated annual value of US$1491 per depressed full-time employee. The programme also reduced absenteeism by 22% over two years, saving the companies an estimated US$539 for each full-time employee with depression.

Source: Rost K. et al. (2004)

Establishing a coordinating process

It is important to establish a coordinating body, such as a steering committee or working group, to guide the assessment of the workforce, facilitate consultation with the various stakeholders, and coordinate the development of the workplace mental health policy. The coordinating body can also educate key stakeholders about workplace mental health issues, ensure their support, and obtain practical assistance for the assessment of workplace needs. For example, the medical service may provide information on health service use; the human resources department may agree to review sick leave trends; a trade union representative may have information on what is happening in other workplaces. The coordinating body should ensure that all stakeholders have a clear understanding of their roles and responsibilities. It is important to include worker representatives in such a committee.

The coordinating body can educate key stakeholders about workplace mental health issues, ensure their support, and obtain practical assistance for the assessment of workplace needs.

What form the coordinating body will take will depend on the workplace. In some places there may be an existing committee, such as an Occupational Health and Safety Committee, that could coordinate the development of a workplace mental health policy. In other workplaces, a new committee or working group may need to be established.

Whatever the form of the coordinating body, it should ensure that key stakeholders are involved, possess the necessary mandate to develop and implement a workplace mental health policy, and include the key agents who will be required to implement the strategies.

The coordinating body should ensure that key stakeholders are involved, possess the necessary mandate to develop and implement a workplace mental health policy, and include the key agents who will be required to implement the strategies.

Box 10. Developing a wellness committee

The National Managers Council in Canada has developed a number of tools to assist federal public service managers. One of these tools – *My millennium: my well-being: a managers' guide* – provides guidance on promoting wellness among employees.

The guide encourages the creation of wellness committees. The purpose of the committees is "to promote and support strategies related to the physical and social environment, help practices and personal resources that lead to improved physical, social, emotional, mental and spiritual well-being of employees, both in the workplace and in their private lives."

The committee usually consists of a coordinator, who acts as chair, and representatives of each department in the organization.

Adapted from Human Resources Development, Canada, 2000

Assessing mental health issues

The workplace mental health policy needs to be based on a comprehensive understanding of the issues. For example, it is important to understand what factors may be contributing to employee stress (or satisfaction), and what effects are being seen in the workplace, e.g. increasing levels of absenteeism or an excessive number of early retirements.

The workplace mental health policy needs to be based on a comprehensive understanding of the issues.

In assessing the issues, it is important to use information that is already available to the workplace. This can then be supplemented by collecting new information.

Assemble available information

Many workplaces routinely collect a range of data that may be useful for assessing mental health issues. The data available may include:

- human resources data, e.g. absenteeism records and resignations;
- occupational health and safety data, e.g. accidents or risk assessments;
- financial data, e.g. the cost of replacing employees who are on long-term disability leave;
- health data, e.g. common health problems among the workforce.

Many workplaces routinely collect a range of data that may be useful for assessing mental health issues.

In some workplaces, claims for mental health problems are managed by insurance companies. These companies probably routinely collect information that could contribute to the assessment. For example, they may be able to provide anonymous information on the number and types of claims for mental health issues, as well as on the cost of claims.

Using available information is an efficient method of assessing mental health issues. It is important to ensure that all the available data are identified before deciding what new information should be collected. The type and range of data available will vary between workplaces. In some workplaces, detailed information will be available from a number of different sources, while in others only limited or incomplete data may be available.

Using available information is an efficient method of assessing mental health issues.

- **Evidence from other workplaces**

Evidence may also be available from other workplaces involved in similar work. In addition, government departments, industry organizations or trade unions may have information from similar workplaces. A review of the literature may also provide relevant information.

Evidence may be available from other workplaces involved in similar work. In addition, government departments, industry organizations or trade unions may have information from similar workplaces.

Collect new information

Once the available information has been gathered, it might be necessary to collect new information. Possible approaches include conducting a survey, undertaking a risk assessment, and interviewing key stakeholders.

Additional information can be gathered through surveys, risk assessments and interviews with key stakeholders.

- **Surveys**

Surveys on the incidence and prevalence of mental health problems in the workplace often produce useful information. For example the National Workplace Survey, conducted in Canada in 1992, covered 3500 workplaces and a range of issues, including psychosocial concerns and stress (Craig et al., 1994). In this study, 22% of the companies reported having policies to deal with harassment while only 6% reported programmes to deal with the issue.

Surveys are carried out using a tool or questionnaire to identify the issues or measure the symptoms of a mental disorder. A questionnaire may be developed specifically for a particular workplace or a standard one may be used, depending on the type of information required. The approach will depend on what is being measured and the characteristics of the workplace. Technical advice from an expert in psychological assessment may be required. There are also textbooks that provide a useful overview of measures suitable for use in the workplace (Fields, 2002; Cook et al., 1981).

Surveys are carried out using a tool or questionnaire to identify the issues or measure the symptoms of a mental disorder.

The approach will depend on what is being measured and the characteristics of the workplace.

Box 11. Examples of organizational and psychological assessment scales

The Job Content Questionnaire, developed by Karasek (1985), assesses motivation and job satisfaction, and measures the difference between the psychological demands placed on the individual and the decisional latitude available.

Many organizations use the Index of Psychological Stress, developed by Cooper et al. (1988). This index measures organizational issues such as job content, interpersonal relations, conflict resolution, etc. It also addresses personal characteristics that may affect the development of stress reactions, such as personality type and extent to which available support is used.

The General Health Questionaire (GHQ) (Goldberg, 1978) has been used in many workplaces to measure psychiatric symptoms among employees. For example, a Swedish study used the GHQ to investigate whether employees who were psychologically distressed over-reported their work demands or under-reported the level of control they had at work (Waldenström et al., 2003).

The Occupational Stress Index (OSI) (Osipow & Spokane, 1987) can be tailored to specific occupations, and allows comparisons between occupations regarding the level of stress experienced by workers. This measure comprises 65 items rated on five scales: role overload, role insufficiency, role ambiguity, role boundary, responsibility and physical environment (Spokane & Ferrara, 2000).

The Motivational Supervisory Style Questionnaire (Blais, 2003) assesses different supervisory styles. It consists of 24 items on six scales: competence, control, *laissez-faire*, incompetence, autonomy, and involvement. Participants assess each item by indicating how frequently they think their immediate supervisor acts with them.

This is not an exhaustive list of assessment scales. The scales listed are not specifically endorsed by WHO.

> Risk assessment

Workplaces often use risk assessments to identify occupational health and safety issues in the workplace.

Risk assessments are often used to identify occupational health and safety issues in the workplace. A risk assessment is *"…a careful examination of what, in your work, could cause harm to people"* (Health and Safety Executive, 1998). While risk assessments were developed to identify physical hazards in the work environment, they can also be used to identify mental health hazards. Table 3 outlines a five-step approach to risk assessment.

Table 3. Risk assessment

Step 1	**Identify the hazard**. Explore the work environment. Use information from research or rapid assessment to identify particular hazards, such as a stressful working environment or high levels of drug or alcohol use.
Step 2	**Decide who might be harmed and how**. Is the hazard general for all workers or are workers undertaking specific activities (for example, administrative staff who interact frequently with the public) or certain categories of workers (for example inexperienced or young workers) at particular risk?
Step 3	**Evaluate the risks and decide whether existing precautions are adequate**. Is it possible to eliminate the risk or does the risk need to be managed? Can work be reorganized to reduce the risk (for example, improving the waiting procedure for the public to reduce the amount of verbal and physical abuse towards front-line staff) or support services made available (such as training or counselling)?
Step 4	**Record the findings**. It is important to record the findings, in order to evaluate the interventions later.
Step 5	**Review the assessment** and revise if necessary.

Source: Health and Safety Executive, 1998

> Interviews

Conducting interviews or focus groups discussions with key informants can provide a lot of information about the workplace. Information can be sought from employees, their families, managers, medical personnel within the organization, human resources officers, etc. Such interviews will also assist in understanding the cultural context for mental health within the organization.

Conducting interviews or focus group discussions with key informants can provide a lot of information about the workplace.

Interviews with employees can determine the expectations of staff and their satisfaction with current services. For example, a study on employee perspectives of the role of supervisors in preventing workplace disability after accidents interviewed 305 employees. The study found that interpersonal factors, such as empathy and support, were as important as physical accommodations in facilitating the return of workers after injury (Shaw et al., 2003).

Depending on the nature of the workplace and the culture of the employees, it may be appropriate to interview families. Family members are often in a unique position to identify the impact of work on the mental health of the employee and can often suggest creative and innovative strategies to address the issues.

Depending on the nature of the workplace and the culture of the employees, it may be appropriate to interview families.

When deciding whether to interview employees and their families, it is important to consider issues of confidentiality. Employees should be told how the information they provide will be used. Information about a person's mental health should not be disclosed to anyone, including the employer. Similarly, interviews with families should be conducted with close attention to ethical issues, such as obtaining the consent of the employee and the family and ensuring confidentiality.

Employees should be told how the information they provide will be used. Information about a person's mental health should not be disclosed to anyone.

Mental health issues can also affect employers. It is important to interview them regarding their own mental health needs as well as those of employees.

Box 12. Assessing mental health issues in the workplace

The following hypothetical case study demonstrates how a combination of assessment techniques can be used to understand mental health issues in the workplace.

In a business employing 10 000 workers, the Occupational Health and Safety Committee explored the issues to be addressed in a mental health policy. Existing data indicated that over the past five years there had been a significant increase in both absenteeism and staff turnover rates compared with rates found in similar industries.

Interviews were conducted with staff and managers. Changes in the production process that had been introduced a few years previously were identified as a significant cause of stress in the workplace. In addition there were communication difficulties between management and staff. A workplace risk assessment was conducted. Again production processes and communication issues were identified as risks to the psychological welfare of staff.

Randomly selected staff were then asked to complete a survey to assess symptoms of stress: 73% of staff reported some symptoms of stress, while 34% were very stressed. Managers had higher stress levels than employees working in the production area.

This information was used in the development of the mental health policy and selected strategies.

Box 13. Assessing and managing stress in a department store

A department store in the United Kingdom has adopted an innovative approach to the management of stress. This approach provides practical help and guidance to staff and management through a combination of interactive workshops led by occupational health advisers, and a comprehensive assessment of the sources and effects of pressure facing people in business.

The programme has evolved over the past 10 years to reflect the changing needs of the staff and the business. The emphasis has moved from training staff to manage pressure, to the broader issues of individual well-being and motivation.

The cornerstone of the strategy is a flexible half-day workshop on well-being and motivation, which uses the pressure management indicator (PMI) to identify key issues facing staff in different parts of the business. This information is used to shape interventions for the individual, the store, and the business. Employees attending the workshop receive an individual pressure profile, which enables them to make personal changes in their lives and, for the few people who report clinical levels of ill-health, prompts them to seek professional help.

The results for the PMI are aggregated to ensure confidentiality and analysed to show the key issues facing staff and the effects on their well-being. This analysis provides a clear assessment of training and development needs, as well as identifying where the sources of pressure should be addressed. The occupational health team combines the data collected from workshops with the qualitative information from the occupational health advisers to build a picture of the key issues facing the business, and links this to ongoing organizational development.

Adapted from: *Mind out for mental health promotion campaign*. (National Institute for Mental Health)

Key points: Analysing mental health issues

- It is important to identify the mental health issues within the workplace, their impact and cost, and the potential benefits of a workplace mental health policy, to mobilize broad stakeholder support when making the case for developing a workplace mental health policy.
- Information can be extracted from existing data, and surveys or interviews can be used to collect new information.

5. Step II: Developing the policy

A workplace mental health policy usually comprises a vision statement, a statement of the values and principles on which the policy will be based, and a set of objectives. These components need not be dealt with sequentially; often they will be developed simultaneously.

The policy should be developed only after comprehensive consultations with employees. In some workplaces, a committee or working group may be made responsible for developing the policy. Elsewhere, a health professional might be given responsibility for coordinating the development of the policy. Whichever mechanism is used, it is essential that all stakeholders are involved in the process.

The policy should be developed only after comprehensive consultations with employees.

Formulating a vision statement

The vision statement presents a general image of the future of mental health in the workplace. It should set high expectations as to what can be achieved while at the same time being realistic. In its final formulation, the vision statement should incorporate the main elements of a workplace mental health policy, and indicate the intended outcome of the policy within a few years. The vision statement should make clear the overall orientation of the policy (World Health Organization, 2005).

The vision statement presents a general image of the future of mental health in the workplace.

For example, the vision may be: "to promote a positive working environment where employers and employees collaborate to achieve the goals of the business; promote the physical and mental health of all employees; and welcome diversity by providing opportunities for people with mental disabilities to participate in the workplace".

It is often difficult to achieve a common vision among stakeholders who may have diverse interests and perspectives. Different stakeholders may interpret the mental health needs in the workplace differently or be seeking different outcomes. For example, employers may be aiming for improved productivity, while unions may be interested in improved working conditions. It is essential that all stakeholders have input to the vision. An active compromise among the majority of stakeholders may be necessary if the policy is to be successfully implemented. Even if a common vision is achieved, stakeholders may disagree on the actions needed to attain it (Castra, 2003).

An active compromise among the majority of stakeholders may be necessary if the policy is to be successfully implemented.

Identifying the values and principles

Values and principles form the basis for the development of objectives and strategies. Values refer to judgements or beliefs about what is considered worth while or desirable, and principles refer to the standards or rules that guide actions, and should emanate from values (World Health Organization, 2005).

Values and principles form the basis for the development of objectives and strategies.

Countries, regions and social groups all have their own values regarding mental health (World Health Organization, 2003b). Workplaces have their own values and culture, which should also be reflected in the policy. The values and principles underlying the workplace mental health policy should strike a balance between the various interests of the different stakeholders. For example, while employers may value productivity and increased profits, workers are more likely to value improved health. Discussion is needed on which values and guiding principles should inform the policy.

Defining the objectives

Objectives translate the policy vision into concrete statements of what is to be achieved.

Objectives translate the policy vision into concrete statements of what is to be achieved. Objectives should respond to the identified issues and aim to improve the mental health of the workforce. They should be specific and achievable within a specified timeframe.

Possible objectives may be: to educate all staff about mental health issues; to reorient the workplace to minimize the negative impact of stress on the mental health of employees; or to provide treatment for people with a mental disorder. Objectives can also respond to the needs of the business: e.g. to improve productivity by reducing absenteeism related to mental disorders; or to comply with safety regulations by conducting regular mental health risk assessments.

Box 14 contains a mental health charter that was developed in Canada. The charter identifies four principles and four objectives to promote mental health in the workplace.

Box 14. The Charter on Mental Health in the Knowledge Economy

Clear and present danger

- Depression and heart disease are on a course to become the leading causes of work years lost in the global economy by 2020 through human disability and premature death.

Principles of action

- The mental health of the working population and their families [is] important to the successful workings of the 21st century economy.
- Mental illness and addictions, therefore, are a business issue with a direct link to the capacity of people at every level of every organization to do what employers need them to do in an information or knowledge economy.
- The capacity of the work force to think, to be creative, to have productive relationships and to be innovative is vital to any corporation's competitive success.
- Economic and social investments will help contain the rise of mental disorders and their impact on economic performance.

Corporate objectives

Four objectives constitute a pathway to promote and protect mental health of the work force of the knowledge economy:

1. To prevent mental disability by promoting the earlier detection and treatment of mental health problems at work.
2. To reduce absenteeism and downtime costs by neutralizing or eliminating the known top 10 sources of workplace stress.
3. To improve substantially the awareness, knowledge and understanding of addiction and mental health issues among executives, managers, employees and co-workers.
4. To support public and corporate education to eliminate stigma, a significant barrier to the identification and treatment of these conditions and therefore the costs which they generate.

Reproduced from *Global Business and Economic Roundtable on Addiction and Mental Health*, November 2002 (www.mentalhealthroundtable.ca/jan_2003/charter_discuss_roundtable.pdf).)

Box 15. Workplace policies

Example 1

Policy statement

The business recognizes that stress can be brought about by excess pressure at work or from domestic situations, and can result in poor work performance and deteriorating physical and mental condition. It is committed to working towards a healthy organization, which places high value on both physical and mental health and therefore seeks to eliminate stress by:

- ensuring that managers regularly carry out a risk assessment of employee workloads, job design, etc., so as to ensure that pressure is at a level that stimulates and challenges rather than overloading and demoralizing;
- training staff to recognize indicators of occupational stress in both themselves and their colleagues;
- allowing all staff easy access to available staff support services;
- communicating clearly with staff, particularly on issues such as organizational change;
- providing services in the least stressful way possible.

Adapted from: *Mind out for mental health promotion campaign*. (National Institute for Mental Health)

Example 2

Vision

The business will improve its efficiency by promoting the mental health of all employees and responding rapidly to the needs of employees who develop a mental health problem.

Values and principles

- Employees are the most important asset of the organization: the business should provide support services for employees.
- The efficiency of the business will be improved if employees have good emotional health. Programmes should address the mental health of all employees.
- People should have access to treatment for mental health problems. It is cost-effective for a business to ensure the early treatment of employees with depression.

Objectives

- To decrease absenteeism as far as possible, by eliminating organizational factors that contribute to poor mental health.
- To improve the productivity of the business by providing better emotional support to employees after critical incidents.
- To minimize the disability of workers by ensuring that depression is recognized early and effective treatment made available.

This is a hypothetical example of a workplace mental health policy

Consulting key stakeholders

Key stakeholders should be identified early and involved in the analysis and assessment of the mental health needs in the workplace. Consultations should continue throughout the process of developing the policy.

Consultation should continue throughout the process of developing the policy.

The people to be consulted, and the approach, are likely to change as the process continues. For example, in the early stages you may choose to consult with a few representatives of the different stakeholders, to gain their support and obtain an initial impression of the issues. However, as the assessment goes into more detail, or when you are distributing information, it is likely to be important to involve a larger number of stakeholders.

In the workplace, the key stakeholders include employees and their families, the employer, trade unions and insurance companies.

Box 16. Developing a quality circle

The Association Interrégionale de Guidance et de Santé (AIGS) has 650 employees. In each department of the organization, quality circles have been created to monitor and improve mental health at the workplace. A quality circle involves groups of employees who meet regularly to discuss and monitor the welfare of employees, and who encourage organizational processes that promote mental health. The quality circle is a dynamic system that allows the workplace to adapt according to feedback from employees. While quality circles deal with many topics, they are particularly concerned with the quality of services, quality of life at work, communication and participation, working relationships, team spirit and motivation.

Source: Bernard Jacob, personal communication, 2004.

Employees and their families

Employees are the consumers of mental health programmes, and it is essential that they are actively engaged at the beginning of the process. Lack of control and influence are independent risk factors for stress (Department of Health, 2001) and the participation and inclusion of employees should be a fundamental principle of any mental health programme in the workplace.

Employees are the consumers of mental health programmes, and it is essential that they are actively engaged at the beginning of the process

Employees can be consulted formally or informally, individually, in groups, or through a collective organization, such as a union or staff association. Where they are well developed, employee assistance programmes (EAPs) could take on this role. The method and type of consultation will depend on its purpose and the organizational culture.

An extra effort may be needed to reach some types of employees, such as those who work irregular hours, part-time or casual employees, those who speak a different language from the majority, and those who work in isolated locations. It is essential that the consultation involves all employees and it is often necessary to develop specific strategies for groups that are difficult to reach.

It is often necessary to develop specific strategies for groups that are difficult to reach.

Examples of consultation approaches are:

- holding meetings with groups of employees;
- disseminating information and inviting feedback;
- circulating a questionnaire to employees;
- arranging face-to-face interviews with randomly selected employees;

- attaching information to employees' salary advice;
- establishing an information hotline;
- creating an information booth in a public area of the business (such as near a cafeteria).

Usually more than one consultation strategy will have to be used to ensure that all employees are involved.

Some employees may be afraid that the information they disclose will affect their employment. For example, they may fear that, if they disclose that they are feeling stressed, they will be demoted or sacked. Indeed, in some workplaces the disclosure of a mental health problem may result in discrimination against the employee. It is important to ensure that information disclosed by employees is kept confidential, and that employees are able to provide information anonymously.

Some employees may be afraid that the information they disclose will affect their employment.

Box 17. Assessing burnout among employees in Denmark

An assessment of the workplace needs for mental health can be done at the same time as consultation with employees to development an appropriate programme to address needs.

A Danish programme is undertaking an empirical study of the prevalence of burnout among 2000 employees from different human service occupations. The study includes both a survey and meetings with employees to discuss psychosocial aspects of their work environment. The programme is also consulting with employees and developing interventions with the participating businesses to increase the well-being of employees, reduce absenteeism, and cut the number of resignations.

Source: Federal Institute for Occupational Safety and Health, 2003

Employers

There will often be existing formal processes for consultation with employers and managers; for example, there may be an occupational health and safety committee that has representatives of the employers. Alternatively, a discussion paper could be developed for the board of directors, or individual interviews conducted with the employers. Again the strategy used should reflect the structure of the business and the purpose of the consultation.

Employee organizations

Many workplaces will have trade unions or other employee organizations (such as staff associations). Employee organizations can be powerful supporters (or opponents) of workplace mental health policies. They often have substantial influence within an organization and may have resources that can be used to fund specific strategies. Consultation with such groups is essential not only in gathering information about the mental health needs of the workers, but in gaining support for the development and implementation of the mental health policy.

Insurance companies

The employers may have mandated an insurance company to cover financial claims related to disability arising in the workplace, including those related to mental health issues. This may include income replacement for the disabled employee in the short or long term.

Insurance companies may be interested in contributing to the development of a workplace mental health policy to help reduce the costs of claims for mental health problems.

Key points: Developing a mental health policy for the workplace

- A workplace mental health policy comprises a vision statement, values and principles and a set of objectives.
- The vision statement represents a general image of the future of mental health in the workplace.
- Values are judgements or beliefs about what is worth while or valuable while principles refer to the standards or rules that guide actions.
- Objectives translate the policy into concrete statements of what is to be achieved.
- All stakeholders should be consulted when a workplace mental health policy is being developed.

6. Step III: Developing strategies to implement the policy

Once the mental health policy has been developed, strategies to implement the policy are needed. These are the core of any mental health plan. This step has three key tasks: reviewing the options for strategies; finding resources to implement the strategies; and developing an implementation plan.

Reviewing the options for strategies

To maximize the effectiveness of the policy, a number of different strategies should be developed. Strategies can be divided into five main categories: (1) increasing employee awareness of mental health issues; (2) supporting employees at risk; (3) providing treatment for employees with a mental health problem; (4) changing the organization of work; and (5) reintegrating employees with a mental health problem into the workplace. The specific strategies adopted will depend on the needs of the business and its employees and the resources available.

The specific strategies adopted will depend on the needs of the business and its employees and the resources available.

Increasing awareness of mental health

Mental health strategies in the workplace can focus on increasing managers and employees' awareness of mental health issues. For example, Health Canada has developed an information pamphlet on balancing work and home. This pamphlet provides practical ideas, such as: allowing flexible working hours; exploring alternative working arrangements, e.g. working from home or job-sharing; reassessing employee workloads to reduce job demands; and building social support in the workplace. The pamphlet can be accessed at:
http://www.hc-sc.gc.ca/hecs-sesc/workplace/pdf/workplaceJug_en.pdf

Mental health strategies in the workplace can focus on increasing the employees' awareness of mental health issues.

Other examples of employee awareness and education strategies include:

- distributing leaflets challenging the myths associated with mental illness;
- running workshops on looking after emotional well-being;
- putting up posters in the workplace on mental health issues;
- training supervisors to understand mental health issues in the workplace;
- sponsoring a staff social group to encourage the development of supportive environment in the workplace;
- establishing a library of resources with books, videos, etc. on mental health issues that employees can borrow;
- running team-building workshops.

Box 18 provides some examples of strategies that aim to increase employees' awareness of mental health issues in the workplace.

Box 18. Strategies to increase employee awareness of mental health issues in the workplace

Example 1: "My millennium: my well-being"

"My millennium: my well-being" is a millennium project organized by a national human resources working group in Canada.

The goal of the project is to provide employees with tools and opportunities to improve their individual well-being in five aspects: physical, emotional, spiritual, intellectual and social.

The project consists of a toolkit focusing on individual well-being and opportunities for group activities. The kit is made available as pamphlets, through intranet or local work sites, and via Internet.

The kit includes a wide range of material on each dimension and is very user-friendly. Each section contains questionnaires, tests, quizzes, tips, definitions, activities and proposals. Some of the subjects are as follows:

- **Physical**: improving your physical well-being, e.g. exercise, nutrition, sleeping habits, releasing stress from the body.
- **Emotional**: developing positive emotions, e.g. humour, assertiveness, forgiveness, dealing with anger.
- **Spiritual**: having a sense of connection to something larger than oneself, e.g. a sense of meaning and purpose, inner reflection and personal values.
- **Intellectual**: keeping one's mind active, alert, open, curious, and creative; continuous learning activities.
- **Social**: spending time with family and friends, recreational activities, activities with work colleagues; balancing the demands of life is one of the challenges to maintaining a good sense of social well-being.

The kit provides guidance not only for employees but also for managers. The guide underscores the reason for the existence of the project, i.e. to deal with an "unprecedented number of stress-related maladies", and points to the fact that we need a "healthy, productive and sustainable workforce to deliver quality service and maintain a competitive advantage". It defines the programme as an essential element of a recruitment and retention strategy.

A **manager's guide** shows how managers can support their employees' development and a workplace well-being initiative. The project includes a checklist of concrete ways to achieve this and encourages and helps managers to establish a wellness committee in the workplace.

Source: Human Resources Development, Canada, 2002

Example 2: SOLVE

SOLVE is an interactive educational programme designed to assist in the development of policy and action to address psychosocial issues in the workplace.

Stress, alcohol and drug use, violence (both physical and psychological), HIV/AIDS and tobacco use can all lead to health-related problems for the worker and lower productivity for the enterprise or organization. Taken together they represent a major cause of accidents, fatal injuries, disease and absenteeism at work in both industrialized and developing countries. SOLVE focuses on prevention by translating concepts into policies and policies into action at the national and enterprise levels.

There are numerous interrelationships between stress, alcohol and drug use, violence, and HIV/AIDS. Any one of these psychosocial problems may be a causal factor for the others. Psychosocial problems linked to these factors can initiate or exacerbate an increasingly damaging cycle that affects the individual, the organization or enterprise, and society as a whole.

Through educational courses, SOLVE encourages senior executives, directors of human resources, occupational safety and occupational health professionals, employers' and workers' representatives and others to develop a comprehensive policy for their respective workplace. This policy should incorporate issues such as prevention, non-discrimination, social support, worker involvement, the provision of training and information and the provision of treatment and rehabilitation. The policy should call for an occupational safety and health management system to assure smooth development, implementation and evaluation. For workers and supervisors, SOLVE provides for action through education and training translating policy into action at the shop-floor level.

In summary, SOLVE combines economic and social objectives by stressing win-win, low cost, practical solutions that meet the needs of both industry and workers.

For more information see: www.ilo.org/safework/solve

Source: International Labour Office, 2004

Providing support to employees at risk

Some employees are more vulnerable to mental health problems than others.

Some employees are more vulnerable to mental health problems than others. This vulnerability may be due to individual factors (for example they may be nearing retirement, have a physical health problem or be using alcohol in problematic ways), or organizational factors (for example, their work may be particularly stressful).

Workplace support strategies can target specific workers or groups of workers

Workplace support strategies can target specific workers or groups of workers. Some examples are:

- establishing a support group for working mothers;
- improving the recognition of depression among employees with physical health problems;
- providing support for employees who are nearing retirement to make the transition easier;
- providing counselling for employees who have been exposed to a stressful event;
- introducing brief interventions for employees with hazardous drinking patterns;
- enhancing social support networks for isolated workers.

Support can also include the use of screening tools for mental disorders, such as depression. In this way, employees who have a mental disorder can be identified early and referred for treatment. Inclusion in screening programmes for mental disorders should be voluntary, and due consideration should be given to the privacy of the employee and the need to ensure that screening does not result in discrimination. Screening programmes should be undertaken under the supervision of qualified mental health professionals.

Box 19 describes two different strategies that were developed to assist specific groups of employees at risk: older employees in a Finnish company and employees with substance abuse problems in the mining industry in the USA.

Box 19. Examples of strategies for supporting employees at risk

Example 1. Health checks for older employees

A company in Finland is a supplier of fibre and paper technologies in the forestry industry. It has a workplace mental health programme that places particular emphasis on the needs of workers over the age of 45, by providing medical checks and monitoring work stress. This special attention to the needs of older workers has resulted in fewer early retirements and improved operating results.

Source: Liimatainen, 2000

Example 2: Substance use and the mining industry

The United States Department of Labor, Mine Safety and Health Administration and the National Mine Health and Safety Academy have developed a safety manual on coping with substance use in the mining industry. The manual provides useful information for employers on the scope of substance abuse in the workplace and strategies to deal with the problem. These strategies include training supervisors and employees in the issues and providing individual support for workers with substance abuse problems.

Source: US Department of Labor, 1991

Providing treatment for employees with mental health problems

Treatment services should be available for employees with mental health problems. Large companies may have their own health service. The capacity of such health services to respond to mental health problems in the workplace should be assessed, and if necessary additional training and education provided. Information about mental health training programmes for health professionals can be obtained from ministries of health, professional organizations or local mental health services.

Treatment services should be available for employees with mental health problems.

Smaller workplaces may need to rely on health services in the community to provide treatment for employees with mental health problems. Generally primary health care professionals will provide these services.

The availability and cost of health services for mental health problems vary considerably. Where possible, employers should help employees obtain treatment by, for example, posting a list of health providers on a notice board, providing health insurance that includes coverage for mental health problems, or negotiating special rates for employees with local health services. Employers may also need to advocate with health providers and governments, for example, to ensure that treatment for mental health problems is available at primary care level (World Health Organization, 2003b).

Confidentiality is an important consideration in the treatment of mental health problems in the workplace. Many employees do not seek treatment for a mental health problem because they fear that it will affect their employment. Health providers treating employees must adhere to the usual principles of confidentiality: information should be disclosed only with the consent of the employee and any obligatory exceptions to this (for example, legal obligations to disclose information) should be explained to the person before treatment begins.

Many employees do not seek treatment for a mental health problem because they fear that it will effect their employment.

Box 20. Providing treatment for employees with mental health problems

Example 1. Improving recognition and treatment of psychosocial disorders in France

A French company improved the recognition and treatment of psychosocial disorders by providing training for the in-house medical service in mental health and the Mini International Neuropsychiatric Interview. A conference was held for employees on psychosocial issues and individual follow-up appointments with physicians were arranged. The service is available to more than 140 000 employees within the business, as well as employees from smaller, associated businesses.

Source: Federal Institute for Occupational Safety and Health, 2003.

Example 2. Treatment for sick physicians and nurses in Spain

A project in Spain is providing treatment and support for physicians and nurses with mental health problems and addictive behaviours. The project aims to raise awareness of mental health problems among physicians and nurses, provide treatment, and support return to work. In four years, 415 people have been treated and almost three-quarters have returned to work.

Source: Federal Institute for Occupational Safety and Health, 2003

In many large workplaces, employee assistance programmes (EAPs) provide treatment and referral for employees with mental health problems. An EAP is:

In many large workplaces, employee assistance programmes provide treatment and referral for employees with mental health problems.

> "…a work-based intervention programme aimed at the early identification and/or resolution of both work and personal problems that may adversely affect performance. These problems may include, but are not limited to, health, marital relationships, family, financial, substance abuse, or emotional concerns. The specific core activities of EAPs include: (1) expert consultation and training in the identification and resolution of job performance issues related to the aforementioned employee's personal concerns; (2) confidential and timely problem assessment, diagnosis, treatment, or referral to an appropriate community resource; (3) the formation of internal and external relationships between the workplace and community resources not available within the scope of the EAP." (Employee Assistance Professional Association, 1996).

In the United States, EAPs are available in 25% of large companies (with more than 5000 employees) and cover approximately 12% of the workforce. In the United Kingdom, the number of EAPs have grown by 40% since 1995 and by 2000 covered approximately two million employees in more than 775 organizations (Arthur, 2000).

There are three models for EAPs: internal programmes, external programmes, and programmes that use both internal and external resources (Beaudoin 1986). While external programmes offer greater confidentiality to employees, they have been criticised for their lack of integration with an organization's broader occupational health and safety processes (Kirk & Brown, 2001). Internal programmes tend to have closer connections to employers and organizational processes. While most EAPs involve the traditional face-to-face counselling relationship, a small but increasing number of companies (mostly in the United States) are using the Internet as part of their EAP programme (Raber, 1999).

The establishment of a successful EAP requires the following (Raber 1999):

- a coordinating committee with representatives of all stakeholders;
- support from the management of the organization;
- close involvement and participation of union representatives;
- training of supervisors in problem detection and management, as well as in how to make referrals;
- confidentiality for employees;
- promotion of the existence of the EAP and information on how to access it;
- written policies and procedures; and
- free (or affordable) access to the EAP for employees.

There is some evidence that EAPs are effective, although research has tended to focus on comparing different characteristics of EAPs – for example, the impact of offering follow-up (Foote & Erfurt, 1991) – or comparing the effects of an EAP intervention with other forms of support or treatment (Walsh et al., 1991).

The cost of EAP programmes varies depending on the general labour costs in the country and the scope of activities provided by the programme. In the United States, for example, EAP programmes cost on average US$27.69 per employee per year for internal programmes and US$22.19 for external programmes (French et al., 1999).

Box 21. Supporting health workers

A large hospital in the USA has established a support team for health workers that includes four psychiatrists. The services are offered to any hospital employee who provides direct clinical care to patients. The programme combines important elements of an employee assistance programme with those of an ombudsman's office, and provides a safe, confidential environment for communication and problem solving. Issues addressed may be work-related, personal, or both. A forum is provided in which the employee can voice concerns, evaluate situations, thoughts, and feelings, receive feedback, and make decisions accordingly.

The support team is also actively working to prevent distress in health care workers, by giving talks and facilitating group meetings on such topics as dealing with difficult patients, compassion fatigue (caregiver burnout), professional boundaries, and self-care.

Source: Dr Jason Andrus, Office of Clinician Support, Children's Hospital of Boston, personal communication.

Changing the organization of work

Mental health strategies in the workplace can also address organizational factors.

Mental health strategies in the workplace can also address organizational factors. Examples of such strategies are given below (Department of Health, 2001; Mentality, 2003):

- **Redress the effort/reward balance**: e.g. ensure that staff feel valued, promote positive messages related to work performance, ensure equity in remuneration, and involve staff in discussing what sort of rewards they would value.

- **Improve communications and staff involvement**: e.g. ensure effective communication strategies particularly during times of change and consult regularly with staff in planning and decision-making.

- **Enhance social support**: e.g. promote supportive management practices, develop peer support programmes, ensure appraisal processes are positive, provide opportunities for social networks to develop in the workplace, develop effective policies to deal with harassment and bullying.

- **Increase job control and latitude for decision-making**: ensure task variety, provide opportunities for people to have some choice in how they perform their work, and encourage staff input into policies and procedures.

- **Assess job demands**: e.g. review staff workloads regularly, encourage staff not to work long hours, implement flexible working hours, and ensure people take regular breaks.

- **Clarify job role**: e.g. ensure workers have a clear understanding of their role, and reduce role ambiguity and role conflict.

- **Review the work environment**: e.g. create a productive work environment by reducing excessive noise, ensuring adequate lighting, etc.

- **Clarify organizational structure and practices**: e.g. provide clear information about the structure, purpose and practices of the organization, ensure that selection, training and staff development activities are appropriate, and match employees skills, knowledge and abilities to the needs and nature of their job.

Box 22. Changing the organization of work to improve mental health

Example 1. Improving organizational climate

In July 2003, a large psychiatric hospital in Canada undertook to measure its organizational climate. A committee consisting of representatives of senior management, human resources, line managers, employees and union representatives developed questionnaires with the help of an outside company. Over a period of 15 days, self-administered questionnaires were sent out to 1246 employees. Replies were anonymous and confidential. Almost half of the employees completed the questionnaire, which covered the following themes:

- motivation and satisfaction at work;
- work conditions;
- interpersonal and professional relations between colleagues;
- interpersonal and professional relations with the immediate superior;
- training and development of personnel;
- performance evaluation;
- information and internal communications;
- quality of services and satisfaction;
- values and feelings of belonging;
- impact of computers at work.

The average reported level of satisfaction with the organizational climate was 6.0 (out of a possible 10), while the degree of satisfaction with work was 6.8. Generally managers tended to be more satisfied (8.1/10) than people working in auxiliary services (5.7) or those assigned to patient care (6.7).

These findings were presented to discussion groups, which met 4 months after the questionnaires were returned, and an action plan was developed to respond to priority areas.

Source: Douglas Hospital, Montreal, 2003.

Example 2. Identifying and addressing organizational hotspots for stress

In 2002, a leading telecommunications company developed a three-tiered approach to stress in the workplace, combining elements of prevention, treatment and rehabilitation. The strategy included:

- Primary level: minimizing workplace stress through effective job and workplace design.
- Secondary level: identifying organizational "hotspots" for stress and providing individuals with personalized assessment and advice.
- Tertiary level: providing remedial support to those suffering from stress and helping them to get back into the workplace.

In addition, an online assessment tool was made available to all staff, which identified health issues and likely sources of stress.

The strategy has significantly reduced the number of employees experiencing mental health problems, as well as the number of absences and early retirements.

Source: Incomes Data Service, 2004.

Reintegrating employees with mental health problems into the workplace

Returning to work is often an important component of an individual's recovery from a mental health problem. The workplace can play an important role in ensuring a successful return. In addition, people with mental health problems are an important part of the human capital needed for a successful business. Facilitating their return to work will ensure that their knowledge and skills are not lost to the workplace.

Returning to work is often an important component of an individual's recovery from a mental health problem.

People with disabilities, including disabilities associated with mental health problems, may also require special accommodations in the workplace in order to function effectively (Bond & Meyer, 1999; Fabian et al., 1993; McDonald-Wilson et al., 2002). Employers and people with disabilities need support to ensure that feasible workplace accommodations are provided when the demand is reasonable (McDonald-Wilson et al., 2002). Fabian et al. (1993) suggest a number of accommodations, in which the most important strategies for helping people on the job are: (1) providing orientation and training to supervisors to provide necessary assistance; (2) modifying work schedules and time; and (3) providing orientation and training to co-workers. Other accommodations may include flexibility in working hours so that people can keep medical appointments, or allowing workers who have a dry mouth (caused by medication) to drink water in their workspace (Bond & Meyer, 1999).

People with disabilities, including disabilities associated with mental health problems, may require special accommodations in the workplace in order to function effectively.

In many countries, employers have a legal obligation to facilitate the return to work of people with a mental health problem. Training for employers (including managers) can improve their understanding of mental health problems and help them provide appropriate accommodations.

In many countries, employers have a legal obligation to facilitate the return to work of people with a mental health problem.

Some accommodations or adjustments that might be considered are listed below.

Flexible working hours

Many people with mental health problems would benefit from a policy that allows them to work flexible hours when required. This would allow the worker, for example, to communicate more easily with a helping professional by telephone or to attend an appointment.

The medication used to treat some mental disorders may occasionally affect concentration or punctuality. For example, some medications may make it more difficult for a person to get up early in the morning. This effect is often worse when the person first takes the medication or when the dosage is increased. Workplaces can support employees by allowing some flexibility in their working hours.

It may also be useful to develop a policy to handle predictable and unpredictable absences of people with a mental health problem. In all instances the best results are obtained when employees are given a sense of overall control over the way they manage time and do their job.

Box 23. Working time experiments

The European Social Fund financed a research and development project called "Flexibility through six-hour shift". The model was based on work done by Professor Paavo Seppänen in 1967. Seppänen suggested that, to promote both effectiveness and human considerations, productive organizations should operate for 12 hours, in two six-hour shifts, rather than the usual eight hours. In the project the model was applied in eight small private firms and carried out on a shop floor for machine-bound work. Arrangements were agreed between the employer and the employees and, in most cases, wages remained the same. Every firm in the study benefited in some way: production costs and absenteeism decreased, and productivity and flexibility increased.

Between 1996 and 1998, 20 municipalities participated in an experiment on shorter working time; 1300 permanent employees reduced their working hours by an average of 20%, resulting in an average work week of 30 hours. The average wage loss was 7%. Some 600 new part-time employees were hired at the normal part-time wage to compensate for the loss of hours. The experiment was carried out primarily in female-dominated health and social services such as child-care, home care, dental care and physiotherapy. Working time was reduced either daily or weekly. Some services benefited from the new working time arrangements: the availability of services improved and the hours that services were available was extended. However, the research showed that the benefits of shorter hours were most visible in the improved quality of life and wellbeing of employees and in reduced stress.

Source: Liimatainen, 2000.

Education

It is important that employers and employees understand mental health problems, and that opportunities are available to discuss common myths and stereotypes. Information and education should generally be provided to all employees. Special attention should be paid to ensuring the confidentiality of an employee who has had a mental health problem and is returning to work. Some may not want to disclose their mental health problems to their colleagues, and the timing of education and information sessions on mental health issues should not inadvertently reveal health information about an employee without consent.

It is important that employers and employees understand mental health problems, and that opportunities are available to discuss common myths and stereotypes

Box 24. Educating managers in Sweden

A programme in Sweden had aimed to improve mental health by educating managers, focusing on demand and control at work, improving social climate, making goals clear, and slowing down the pace of work. The evaluation demonstrated improvements in the health of employees, reduced tension and better decision making.

Source: Federal Institute for Occupational Safety and Health, 2003

Using selected co-workers as mentors

Employees with a mental health problem may require additional support in the workplace. The designation of a suitable co-worker who is appropriately informed and trained may give better results than support offered by a supervisor or an outside person (Banks et al., 2000).

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The role of a mentor includes listening, providing information, enhancing motivation, and offering advice that may lead to improved work performance (Cullen & Barlow, 1998). It is important that the mentor fosters autonomy and respects the lifestyle, viewpoints and values of the person being assisted (Houde, 1995).

Confidentiality

It is useful for workplaces to have a policy on confidentiality, and to ensure that it is well publicized and understood by employees. While employers and co-workers may be required to assist a colleague who is returning to work, they do not need to know the details of the person's problems. Information about an employee's mental health problems should only be released with his or her consent.

Information about an employee's mental health problems should only be released with his or her consent.

Job content

Clear communication with employees regarding the content of their job is essential. Rearranging responsibilities within the group may be beneficial.

Clear communication with the employee regarding the content of their job is essential.

It may be useful for the company to establish formal links with organizations that provide information, advice and help for people with mental health problems. For example, there may be a local community health or community mental health service through which links can be established. It may also be appropriate to invite representatives from the health service to participate in implementing the strategies.

Box 25. Examples of reasonable accommodations for people with mental health problems

Changes in communication

- Arrange for all work requests to be put in writing for a library assistant who becomes anxious and confused when given verbal instructions.
- Train a supervisor to provide positive feedback along with criticisms of performance, for an employee re-entering the work force who needs to be reassured of his or her abilities after a long psychiatric hospitalization.
- Allow a worker who personalizes negative comments about his or her work performance to provide a self-appraisal before receiving feedback from a supervisor.
- Schedule daily planning sessions with a co-worker at the start of each day to develop hourly goals for someone who functions best with a clear time structure.

Modifications to the physical environment

- Provide room dividers for a data entry operator who has difficulty maintaining concentration (and thus accuracy) in an open work area.

Job modifications

- Arrange for someone who cannot drive or use public transport to work at home.
- Restructure a receptionist job by eliminating lunchtime switchboard duty.
- Exchange problematic secondary tasks for part of another employee's job description.

Schedule modification

- Allow a worker with poor physical stamina to extend his or her schedule to allow for additional breaks or rest periods during the day.
- Allow a worker to shift his or her schedule to attend psychotherapy appointments.

Source: Mancuso, 1990.

Selecting strategies

The strategies to be implemented in the workplace will depend on the nature of the workplace, the mental health issues identified and the resources available. Issues such as the acceptability of the strategy to employees and the sustainability of the intervention are also important.

While some workplaces may invest in many different strategies simultaneously, many will need to begin more slowly, with only one or two strategies. The decision about whether to focus on education, employees at risk, treatment services, the organization of work, or the reintegration of employees with mental health problems needs careful consideration of the evidence and consultation with all stakeholders.

Box 26 describes some hypothetical workplace strategies, based on the vision and objectives of the mental health policy described in Box 15.

Box 26. Developing strategies

Vision
The business will improve its efficiency by promoting the mental health of all employees and responding rapidly to the needs of employees who develop a mental health problem.

Objective 1: To decrease absenteeism as far as possible by eliminating organizational factors that contribute to poor mental health.

Strategies
- Develop a process to measure workload and review the workload of all employees.
- Implement procedures to review employee performance.
- Develop a staff recognition programme to reward employees who perform well.

Objective 2: To improve the productivity of the business by providing better emotional support to employees after critical incidents.

Strategies
- Introduce an employee assistance programme.
- Provide training for employees on the psychosocial issues associated with critical incidents.

- Develop an aggression prevention programme (incidents of aggression from customers were the most common critical incidents identified in the assessment of employee needs).

Objective 3: To minimize the disability of employees by ensuring that depression is recognized early and effective treatment made available.

Strategies
- Develop information leaflets for employees.
- Ensure that health clinic staff attend a seminar to help them recognize the signs of depression.

This is a hypothetical example to illustrate strategies that can contribute to achieving the objectives of a mental health policy in the workplace

Finding resources to implement the strategies

It is important to ensure that sufficient resources are available to implement the strategies. This requires a clear understanding of both the strategies to be implemented and the associated costs.

It is important to ensure that sufficient resources are available to implement the strategies.

The resources needed might include additional financing (for example, to establish an EAP) or the redirection of funds that are currently used elsewhere (for example, negotiating with health clinic staff to conduct a mental health awareness campaign).

Financing for mental health strategies in the workplace can come from a variety of sources:

- A proportion of an existing budget for employee health services can be dedicated to mental health strategies

- A proportion of the savings associated with improvements in workplace efficiency resulting from a mental health programme can be used to fund that programme.
- Savings in insurance costs as a result of improved employee health can be redirected to the mental health programme.
- Grants may be available from employer or employee organizations to implement a mental health programme.
- Assistance may be available from the government, a nongovernmental organization, or an external donor to implement a programme.

In some situations, it may be appropriate to require employees to make a small contribution towards the cost of the strategies.

Developing an implementation plan

The final task is to formulate a plan to implement the policy. The plan should outline the objectives, specific strategies to be used, targets to be achieved, and activities to be carried out. The time frame, responsible people, expected outputs and potential obstacles should be clearly identified.

The following questions should be considered in putting together the plan:

- What specific activities are needed to implement each strategy?
- Who will take responsibility for each activity?
- How long will each strategy and activity take?
- Which activities can be done simultaneously and which depend on the completion of another activity?
- What outputs are expected from each activity?
- What are the potential delays or obstacles?

While this may seem a complex list of issues, the process allows the objectives and the strategies to be brought together within a single planning framework.

Table 4 sets out a hypothetical example of an implementation plan for a mental health awareness campaign in a workplace.

Table 4. A hypothetical component of an implementation plan

Objective: To reduce employee sick leave by increasing awareness of mental health issues in the workplace and improving self-care

Strategy 1: Implement a mental health awareness campaign for all employees

Target: 50% of employees will have attended an mental health awareness workshop within one year

Work content	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Review mental health awareness campaigns in similar businesses	X	X									
Develop a proposal for a mental health awareness campaign, including required resources and expected costs		X	X	X							
Appoint a coordinator for the workshop					X						
Develop material for workshops						X	X	X			
Market workshops to all employees									X		
Commence workshops										X	
Evaluate effectiveness of workshops										X	

	Nov	Dec	Responsible person	Output	Potential obstacles
			Occupational health and safety officer	Recommended model for workshops	Unable to obtain information from other businesses
			Occupational health and safety officer	Proposal developed	No agreement from employer as resources are not available
			Human resources	Coordinator recruited	Difficulties in recruiting appropriate person
			Coordinator	Information developed	Difficulty in obtaining required information
			Coordinator	Information distributed	Difficulties in circulating information to some employees
	X	X	Coordinator	Service available	Employees do not attend workshops
	X	X	Coordinator	Evaluation report	Evaluation data not available. Participants do not complete evaluation forms

Key points: Developing strategies to implement the policy

- To maximize the effectiveness of a policy, a number of different strategies should be used.
- Information about mental health issues should be provided to all employees.
- Strategies should be developed to reduce the likelihood that employees at risk develop a mental health problem.
- Treatment services should be available for people who have a mental health problem.
- Changes to the organization of work can improve the mental health of employees.
- Strategies can be developed to help people with mental health problems to reintegrate the workplace.

7. Step IV: Implementing and evaluating the policy

The main actions in implementing and evaluating a mental health policy include: generating support and collaboration; coordinating implementation; training; establishing demonstration projects; and evaluating the outcomes.

Generating support and collaboration

The mental health policy needs to be disseminated and communicated to all stakeholders. Many policies fail because they are poorly communicated (World Health Organization, 2005). Some approaches to communication are listed below:

The mental health policy needs to be disseminated and communicated to all stakeholders.

- Organize an event to launch the policy.
- Distribute posters and leaflets on the policy.
- Hold meetings with different groups of employees to explain the policy.
- Publish the policy on the company's Website.

These activities can also be used to generate support and funding for the strategies. It is essential to have the support of key people within the company to advocate for the policy and ensure sufficient funding for its implementation.

It is essential to have the support of key people within the company to advocate for the policy and ensure sufficient funding for its implementation.

If the consultation process has been effective, then there should already be a number of opinion leaders within the business who are ready to publicly support the policy. Such expressions of support can help to reduce the stigma associated with mental health problems. If respected people in the business speak openly about mental health, employees may be encouraged also to openly acknowledge the issues.

Coordinating implementation

The implementation process needs to be carefully coordinated and monitored. The plan should be reviewed and updated as necessary.

The implementation process needs to be carefully coordinated and monitored.

A process for implementation needs to be established. An individual, a department or a committee might be given responsibility for the implementation of the plan. Regular reporting to the employer, employees, and funders of the policy should be part of the implementation plan. For example, requiring a report 12 months after the start of activities provides an opportunity to document the achievements, monitor implementation, and review the plan.

Training

It is important to ensure that the people who will be leading the implementation process are properly trained to understand the issues associated with mental health in the workplace. Training requirements should be outlined in the implementation plan.

A range of stakeholders may benefit from training at this stage, including:

- health workers,
- human resources personnel,
- managers and supervisors,
- union delegates,
- occupational health and safety representatives.

Training can often be provided by external organizations or (if the workplace is large)

Training can often be provided by external organizations or (if the workplace is large) might be conducted within the company.

might be conducted within the company. The content of the training programme will depend on the type of business and the priorities identified in the mental health policy. However, it should include an overview of mental health issues in the workplace, an outline of the major mental health issues faced by employees, and the key initiatives that have been included in the mental health policy and plan.

Training will often need to be carried out regularly, to ensure that new employees receive information about mental health issues and to update all employees' knowledge. These training needs should be documented in the implementation plan.

Setting up a demonstration project

It is often useful to set up a demonstration project to implement a strategy in one part of the workplace.

It is often useful to set up a demonstration project to implement a strategy in one part of the workplace. Such a project can often be implemented rapidly and the outcomes thoroughly evaluated (World Health Organization, 2005). The demonstration project may target a particular group of employees (for example, administrative staff) or a specific department.

The demonstration project may also be used: as an advocacy tool, to illustrate the value of specific strategies; as a training area for the implementation of the plan; and to provide detailed guidance for other parts of the workplace on implementing specific strategies. For example, it may be easier to develop and test a workload assessment process in only one area of the workplace, rather than in multiple areas simultaneously. As the process is refined, it can be expanded to include the whole organization. Managers may be more easily convinced of the benefits of measuring staff workload once they observe the effects in another area of the workplace.

Evaluating the policy

It is important to evaluate the effect of the policy and strategies on both individual workers and on the organization.

It is important to evaluate the effect of the policy and strategies on both individual workers and on the organization. This will also assist in building an evidence base of effective mental health interventions in the workplace.

Ideally, the evaluation should be planned when the policy is being developed, and key baseline information collected before implementation starts. In this way, it will be possible to measure changes that occur following implementation. However, sometimes an evaluation is requested after the strategies have been implemented. This has implications for the design of the evaluation.

The evaluation should contain both quantitative and qualitative elements.

The evaluation should contain both quantitative and qualitative elements. For example, information may be collected about the rates of absenteeism in a department as well as about the context of the workplace, reasons for absenteeism, and how the policy has been implemented. Both types of information are needed to understand whether strategies have been successful.

Given the complexity of programme evaluation, technical assistance may be required for its design and conduct. Generally, an evaluation will incorporate one or more of the following approaches (Atkins & Weiss, 2002).

- A **needs-based evaluation** addresses the relevance of the policy. Selected strategies for the target population are evaluated by assessing the underlying theory or model on which the policy is based. Much of the information collected in these early stages will be useful in describing the relationship between the needs of the employees and the organization and the strategies developed.

- **Formative or process evaluation** is usually done in the implementation phase and generates feedback that will be useful in guiding policy development. Key information includes what activities have occurred, where, with whom and how frequently. For example, how many leaflets on workplace stress have been distributed? How many staff have attended a mental illness awareness education programme? How many departments have reviewed their performance appraisal process?

A formative evaluation generates feedback that will be useful in guiding policy development.

- **Summative evaluation** assesses whether specific goals and objectives have been achieved. Depending on the goals of the policy, factors such as absenteeism, employee satisfaction, and productivity could be measured.

There are different ways of measuring policy outcomes. The most powerful is an experimental design, in which two groups are compared – one to which the policy has been applied and one to which it has not (see Box 27). Quasi-experimental designs, in which one group is assessed before and after implementation of the policy, is frequently used in real situations. In this approach, the evaluator can control only some of the dependent variables.

Box 27. Evaluating change: a hypothetical example

Before implementation (pre-test)
A survey of 400 workers at a large manufacturing plant found that 56% of the workforce reported at least two symptoms of stress.

Implementation
The results were discussed at a senior executive meeting. The occupational health and safety committee was given the task of developing a mental health policy. Following extensive consultation, three strategies were implemented to reduce employee stress in one section of the manufacturing plant, representing 200 workers (intervention group): (1) an employee stress awareness programme; (2) a system to measure employee workload; and (3) a strategy to improve communication between management and employees.

After implementation (post–test)
Twelve months after the policy was implemented, the survey was repeated. This time, only 22% of employees in the intervention group reported at least two symptoms of stress, while 60% of employees in the control group reported at least two symptoms. It thus appeared that the strategies had been effective.

The main goal of the summative evaluation is to inform decision-makers about the effectiveness of the programme. The report will need to be written in a language that is easily understood by the various decision-makers in the organization.

Further information on evaluation is given in the module *Research and evaluation for mental health* (World Health Organization, forthcoming).

Key points: Implementing and evaluating the programme

- It is necessary to generate support and collaboration to ensure the successful implementation of the programme.
- Implementation needs to be coordinated.
- Key staff may need to be trained to facilitate the implementation process.
- Setting up a demonstration project, which can be rapidly implemented and evaluated is often useful.
- The evaluation should begin at the commencement of the programme.
- The evaluation can include needs-based evaluation, formative evaluation and summative evaluation.

8. Barriers and solutions

In trying to introduce mental health policies and plans to a workplace, a number of barriers may be encountered. However, solutions can usually be found. Some examples are given below.

> *Employers believe that profits are higher when employees work excessive hours, and that responding to mental health issues will cost too much money.*

One of the principal barriers to the development of a mental health policy and plan for the workplace is the belief that it will negatively affect the profitability of the business. Employers may not understand the relationship between their employees' mental health and productivity.

There are a number of ways of overcoming this barrier. Demonstrating to employers that addressing mental health issues that can improve productivity is often helpful. Employer organizations can play a key role in educating employers about mental health. For example, they can include a speaker on mental health issues at an employers' forum. Linking mental health issues to employers' legal obligations may also help; for example, mental health issues could be included in health and safety risk assessments.

> *The workplace is too small*.

Employers with only a few employees may see the value of addressing mental health issues in large workplaces, but not understand that it is also important for small businesses. Often small workplaces do not employ occupational health experts or health professionals, and do not have anyone with the expertise to respond to mental health issues.

Small workplaces are likely to rely on existing health services within the country. Employers with small businesses can develop links with mental health services in the community in order to, for example, obtain information on mental health issues or refer employees with mental health problems for treatment. If available services are inadequate, employers can be powerful advocates for the development of mental health services. Collective employer organizations may also be able to assist, by making available expertise to different workplaces.

> *There is resistance among stakeholders*.

Many stakeholders may be resistant to the development of a mental health policy and associated strategies. They may be unaware of the impact of mental health issues in the workplace or unwilling to make changes in the workplace. Effective information and consultation with all stakeholders throughout the process is essential. Key opinion leaders can also be useful. For example, a respected person within the workplace could discuss mental health issues at an open forum. In addition, demonstration projects within the workplace can illustrate the impact of strategies.

> *Stakeholders do not believe that interventions will be effective*.

Some stakeholders may not believe that interventions for mental health problems in the workplace will be effective. Key opinion leaders, such as medical staff, may be able to convince them of the importance of addressing mental health issues. External experts may also be useful. The module Mental health advocacy (World Health Organization 2003c) provides more detailed guidance on sensitizing stakeholders in mental health issues.

> *Insufficient resources*.
Resources available to implement mental health strategies may be very limited. It may therefore be necessary initially to consider strategies that require few resources, while working to sensitize all concerned to mental health issues. It may be possible to redirect some resources from other areas, or to find funding from external donors. Many governments have funds available for occupational health and safety initiatives, particularly for small workplaces. Nongovernmental organizations may also be able to assist.

> *Employers may be afraid of the consequences of addressing mental health issues*.
They may be concerned about unforeseeable consequences that could have a negative impact on the business. For example, they may believe that talking about mental health will cause mental health problems among employees, or that raising awareness will result in an increase in absenteeism or claims for compensation.

One approach to overcoming this obstacle is to provide relevant up-to-date information to employers. In some workplaces, addressing mental health might reduce the cost of worker insurance. Using other workplaces that have addressed mental health issues as examples can be useful. It is also important to emphasize that mental health issues can be addressed over time, providing an opportunity to sensitize employees and monitor the impact of change.

> *Stigma*.
The impact of the stigma associated with mental health issues is substantial and should not be underestimated. Employers and employees may not want to explore the issues because of myths and stereotypes. They may believe, for example, that mental health problems are caused by personal weaknesses or that people with mental health problems never recover.

It is important to educate the workforce about mental health. Few strategies will be successful unless the workforce understands mental health problems, their impact on the workplace, and the fact that they can be treated.

> *Employers do not want to employ people with mental health problems*.
Some employers may resist employing people with mental health problems. Employers need to be aware of any legislation that prevents them from dismissing employees because of a mental health problem or discriminating against people with disabilities when recruiting. It is also important that employers understand the important contribution that people with mental health problems can make to the workplace.

> *Employees do not attend activities*.
In some workplaces, employees may not attend the activities offered as part of a mental health plan. This may be because they feel the activities are not appropriate or because of the stigma associated with mental health problems. Potential solutions include an analysis of the workplace need for mental health activities and consultation with employees. It is also important to educate employees about mental health issues so that they feel comfortable participating in the activities.

Table 5 summarizes the main obstacles and some solutions.

Table 5. Obstacles to the introduction of a mental health policy in the workplace and some solutions

Obstacles	Possible solutions
Concern that mental health policy will reduce profits	> Provide information to employers on mental health and productivity > Encourage employer organizations to become involved in mental health activities
Belief that the workplace is too small for a mental health policy	> Encourage employer organizations to provide assistance to small workplaces > Encourage links between small workplaces and primary health care services
Resistance from stakeholders	> Provide information to stakeholders > Use influential people in the workplace to champion mental health > Arrange demonstration project
Insufficient resources	> Develop low-resource strategies > Explore opportunities for redirecting resources from other activities > Explore opportunities for external funding
Employers are afraid that focusing on mental health problems will have unforeseeable consequences	> Provide relevant information on the impact of mental health issues in the workplace. > Provide evidence of effective mental health interventions > Show how other businesses have successfully implemented mental health programmes > Introduce activities slowly
Stigma: some employers and employees may feel that employees with mental health problems are weak, unreliable, potentially dangerous and less productive than other employees.	> Show evidence that challenges the myths of mental illness. > Invite a speaker who has had experience of a mental illness to speak with staff to educate the workforce
Employers do not want to employ people with mental health problem	> Provide information to employers on mental health problems > Make sure that employers know about their legal responsibilities > Use experiences from other businesses to illustrate positive impact of employing people with mental health problems
Employees do not attend activities	> Make sure that the activities reflect employees' concerns > Involve employees in the planning of activities > Ensure that information about the programmes is distributed to employees > Ensure that employees are given the time to attend the programme

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders, 4th ed*. Washington, DC: American Psychiatric Association.

Arthur RA (2000). Employee assistance programmes: the emperor's new clothes of stress management? *British Journal of Guidance and Counselling*, **28**(4): 549-559.

Atkins JA, Weiss HM (2002). Program evaluation: the bottom line in organizational health. In: Quick JC, Tetrick LC, eds., *Handbook of occupational health psychology*, Washington, DC: American Psychological Association.

Banks D et al. (2000). Indiana University, Natural Supports Research Projects. Presented at the VII World Association for Psychosocial Rehabilitation Congress, Paris, May 2000.

Beaudoin O (1986). *Le counselling en milieu de travail: les programmes d'aide aux employés*. Montreal, Editions Agence d'Arc Inc.

Berto P et al. (2000). Depression: cost-of-illness studies in the international literature: A review. *Journal of Mental Health Policy and Economics*, **3**: 3-10.

Bird H (1996). Epidemiology of childhood disorders in a cross-cultural context. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, **37**: 35-49.

Birnbaum HD et al.(1999). Workplace burden of depression: a case study in social functioning using employer claims data. *Drug Benefits Trends*, **11**:6BH-12BH

Blais MR (2003). *A professional autonomy model of healthy leadership and organizational well-being* (presented at Symposium on Challenges in a changing workplace - *The Fifth Interdisciplinary Conference on Occupational Stress and Health)*, Toronto, 20-22 March.

Blais, M. R., (1991). *The Motivational Supervisory Style Questionnaire*. Unpublished Manuscript. Research and Training Laboratory on Motivation and Authentic Leadership, University of Quebec at Montreal.

Bond GR, Meyer PS (1999). The role of medications in the employment of people with schizophrenia. *Journal of Rehabilitation*, Oct-Nov-Dec: 9-16.

Brockner J, Greenberg J (1990). The impact of layoffs on survivors : An organizational perspective. In: Carroll J, ed., *Applied social psychology and organizational settings*, Hillsdale, NJ, Erlbaum:45.

Canadian Mental Health Association (2002). *Working well: an employer's guide to hiring and retaining people with mental illness*. Ontario: Canadian Mental Health Association.

Castra D (2003). *L'insertion professionnelle des publics précaires. Le travail humain*. Paris, PUF.

Center for Mental Health in Schools at UCLA. (2004). *An introductory packet on understanding and minimizing staff burnout*. Los Angeles, CA.

Comité de la Santé mentale du Québec (1988). *Pour donner un sens au travail*. Montéal, Québec: Gaétan Morin: 24.

Commonwealth Department of Health and Aged Care (2000). *Promotion, prevention and early intervention for mental health – a monograph*. Canberra, Mental Health and Special Programs Branch.

Conti DJ, Burton WN (1994). The economic impact of depression in a workplace. *Journal of Occupational Medicine*, **36**: 988.

Cook J et al. (1981). *The experience of work: a compendium of 249 measures and their use*. London, Academic Press.

Cooper CL et al. (1988). *Occupational stress indicator data supplement*. Windsor, NFER-Nelson.

Cox T et al. (2004). Work, employment and mental health in Europe. *Work & Stress*, 18(2):1-7.

Craig C et al. (1994). *Health promotion at work. Results of the 1992 National Workplace Survey*. Ottawa, Canadian Fitness and Lifestyle Research Institute.

Cullen LA, Barlow JH (1998). Mentoring in the context of a training programme for young unemployed adults with physical disability. *International Journal of Rehabilitation Research*, **21**: 389-391.

Department of Health (2001). *Making it happen: a guide to developing mental health promotion*. London, The Stationery Office.

Dersh J et al. (2002a) Chronic pain and psychopathology: research findings and theoretical considerations. *Psychosomatic Medicine*, 64(5):773-86.

Dersh J et al. (2002b) Prevalence of psychiatric disorders in patients with chronic work-related musculoskeletal pain disability. *Journal of Occupational and Environmental Medicine*, 44(5):459-468.

Diaz R et al. (2001). The impact on homophobia, poverty and racism on the mental health of gay and bisexual latino men: findings from 3 US cities. *American Journal of Public Health*, 91(6): 927-933.

Dooley D et al. (1994) Depression and unemployment: panel findings from the epidemiologic catchment area study. *American Journal of Community Psychology*, 22(6): 745-765.

Douglas Hospital, Montreal (2003). *Rapport final: Diagnostic de l'état actuel du climat organisationnel de l'Hôpital Douglas*. Douglas Hospital, Montreal.

Duxbury L, Higgins C (2001). *The 2001 National Work Life Conflict Study Report 1*. Ottawa, Health Canada.

EAP Seminar (2002). *Mental Health Promotion and Drug Prevention in the Workplace*. Organized by the Department of Mental Health, Thailand, Bangkok.

Elkin AJ, Rosch PJ (1990). Promoting mental health at the workplace: the prevention side of stress management. *Occupational Medicine: State of Art Review*, **5**(4): 739–754.

Employee Assistance Professional Association (1996). *International programme guidelines for international EAPs*.

European Commission, Employment and Social Affairs (1999). *Guidance on work related stress: spice of life or kiss of death*? Luxembourg.

European Commission, Employment and Social Affairs (2001). *The employment situation of people with disabilities in the European Union*. Brussels.

Fabian ES et al. (1993). Reasonable accommodations for workers with serious mental illness: type, frequency, and associated outcomes. *Psychosocial Rehabilitation Journal*, 17: 163-172.

Federal Institute for Occupational Safety and Health (2003). *Final report. Sector: Working adults*. Dortmund, Federal Institute for Occupational Safety and Health.

Fields D (2002). *Taking the measure of work: a guide to validated scales for organizational research and diagnosis*. Thousand Oaks, Sage Publications.

Foote A, Erfurt JC (1991). Effects of EAP follow-up on prevention of relapse among substance abuse clients. *Journal of Studies on Alcohol*, 52(3): 241-248.

French M et al. (1999). Cost of employee assistance programs: comparison of the national estimates from 1993 and 1995. *Journal of Behavioural Health Services & Research*, **26**(1): 95-103.

Freudenberger HJ (1974). Staff burnout. *Journal of Social Issues*, 30: 159-165.

Goldberg D (1978). *Manual to the general health questionnaire*. Windsor, National Foundation for Educational Research.

Goldberg RJ, Steury S (2001). Depression in the workplace: Costs and barriers to treatment. *Psychiatric Service*, **52**(12): 1639.

Grube JW et al. (1994). Alcohol expectancies and workplace drinking. *Journal of Applied Social Psychology*, **24**(7): 646-660.

Gutierrez E (2000). Workers' health in Latin America and the Caribbean: looking to the future. *Perspectives in Health*, 5(2) available at www.paho.org.

Harrell S (2000). A multidimensional conceptualization of racism-related stress: implications for the well-being of people of color. *American Journal of Orthopsychiatry*, 70: 42-57.

Harnois GP, Gabriel P (2000). *Mental health and work: issues and good practices*. Geneva, World Health Organization and International Labour Office.

Health Behavior New Service (2004). *Depression treatment boosts employee productivity*. Washington, DC: Center for the Advancement of Health.

Health and Safety Executive (1998). *Five steps to risk assessment*. London, Her Majesty's Stationery Office.

Henderson S et al. (2000). Australia's mental health: an overview of the general population survey. *Australian and New Zealand Journal of Psychiatry*, **34**(197): 197-205.

Holkeri H (1999). Globalization and its effects on occupational health and safety. *Asian Pacific Newsletter on Occupational Health and Safety*, 88: 51.

Homedes N (1995). *The disability-adjusted life year (DALY) definition, measurement and potential use*. Washington, DC, World Bank (Human Capital Development and Operations Policy Working Paper).

Houde R (1995). *Des mentors pour la relève*. Montreal, Méridien: 253.

Human Resources Development Canada (2000). *My millennium, my well-being: guide for work place well-being activities*. Ottawa, Government of Canada.

Hunt C et al. (1995). *The management of mental disorders*. Sydney, World Health Organization Training and Reference Centre for CIDI, Clinical Research Unit for Anxiety Disorders.

Huxley P (2001). Work and mental health: An introduction to the special section. *Journal of Mental Health*, 10(4): 367-372.

Incomes Data Services, UK (2004). Stress management, BT. *IDS HR Study* 775 13-16.

International Labour Office (2002a). *Every child counts: new global estimates on child labour*. Geneva.

International Labour Office (2002b). *Employment of people with disabilities: the impact of legislation*. Report of a technical consultation, Addis Ababa, 20-22 May. Geneva.

International Labour Office (2002c). *Framework guidelines for addressing workplace violence in the health sector*. Geneva.

International Labour Office (2002d). *Managing disabilities in the workplace*. Geneva.

International Labour Office (2004). *Addressing psychosocial problems at work*. Geneva (www.ilo.org/safework/solve).

International Labour Organization (undated). *ILO activities on the social dimension of globalization: synthesis report*. Geneva (http://www.ilo.org/public/english/wcsdg/globali/documents.htm).

International Labour Organization (undated) *Facts on women at work*. Geneva, International Labour Office.

Kanter RM (1977). *World and family in the US: a critical review and agenda for research and policy*. New York, Russell Sage Foundation.

Karanja I et al. (2003). Safety and health in the informal sector. *African newsletter on Occupational Health and Safety*, 13(6): 4-6.

Karasek R (1985). Job content questionnaire and user's guide. Lowell, MA, University of Massachusetts.

Karasek R, Theorell T (1990). *Healthy work: stress, productivity and the reconstruction of working life*. New York, Basic Books: 381.

Kessler RC, Frank RG (1997). The impact of psychiatric disorders on work loss days *Psychological medicine*, **27**(4): 861-873.

Kirk A, Brown B (2001). A comparison of internal and external providers of EAPs in Australia. *Journal of Occupational Health and Safety Australia and New Zealand*, **17**(6): 579-585.

Kortum E, Ertel M (2003). Occupational stress and well-being at work - An overview of our current understanding and future directions. *African Newsletter on Occupational Health and Safety*, 13(2) August.

Lajoie F (2003). Gestion du stress: Apprendre à ne rien faire, une idée angoissante!. *L'Actualité Médicale*, 25 June.

Leger (2004) *Depression and anxiety among Canadian women in the workplace*. (Study conducted on behalf of Wyeth Canada;
www.legermarketing.com/documents/spclm/041115eng.pdf).

Lehtinen L (2001). Work in the global village. *Asian Pacific Newsletter on Occupational Health and Safety*, 8(2): 74.

Lewis S, Cooper CL (1999). The work-family research agenda in changing contexts. *Journal of Occupational Health Psychology*, 4(4): 382-393.

Liimatainen M, Gabriel P (2000). *Mental health in the workplace. Situation analysis: United Kingdom*. Geneva, International Labour Office.

Liimatainen M (2000). *Mental health in the workplace. Situation analysis: Finland*. Geneva, International Labour Office.

Luxton M, Corman J (2001). *Getting by in hard times: gendered labour at home and on the job*. Toronto, University of Toronto Press.

Mancuso LL (1990). Reasonable accommodation for workers with psychiatric disabilities. *Psychosocial Rehabilitation Journal*, 14(2):3-19.

Maslach C et al. (2001). Job burnout. *Annual Review of Psychology*, 52:397-422.

McDonald-Wilson KL et al. (2002). An investigation of reasonable workplace accommodations for people with psychiatric disabilities: quantitative findings from a multi-site study. *Community Mental Health Journal*, 38(1): 35-50.

Rost K. et al. (2004). The Effect of Improving Primary Care Depression Management on Employee Absenteeism and Productivity: A Randomized Trial. *Medical Care*. 42(12):1202-1210.

Mentality (2003). *Making it effective: a guide to evidence based mental health promotion*. London (Radical mentalities – Briefing Paper 1; www.mentality.org.uk).

Mentality (undated). *Toolkit for mental health promotion in the workplace*. London.

Murray CJL, Lopez AD, eds (1996a). *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA, Harvard School of Public Health on behalf of the World Health Organization and the World Bank (Global Burden of Disease and Injury Series, Vol. I).

Murray CJL, Lopez AD (1996b). *Global health statistics*. Cambridge, MA, Harvard School of Public Health on behalf of the World Health Organization and the World Bank

(Global Burden of Disease and Injury Series, Vol. II).

Murray CJL, Lopez AD (2000). Progress and directions in refining the global burden of disease approach: a response to Williams. *Health Economics*, **9**: 69-82.

National Institute for Mental Health *(undated) Mindout for mental health*. (http://www.nimhe.org.uk/downloads/LineMngrPack-FINAL.pdf).

Osipow SH, Spokane AR (1987). *Manual of the occupational stress inventory: research version*. Odessa, Psychological Assessment Resources.

Patel A, Knapp M (1997). *The cost of mental health: report to the Health Education Authority*. London, Centre for Economics of Mental Health, Institute of Psychiatry (Working Paper).

Pérusse M (1984). *La psychologie industrielle*. Quebec, Laval University (course notes, Notions de base : santé et sécurité au travail, Médecine sociale et préventive).

Quick J, Tetrick L (2003). *Handbook of occupational health psychology*. Washington, DC: American Psychological Association.

Quinlan M (2001/2002). Workplace health and safety effects of precarious employment. *Global Occupational Health Network (GOHNET) Newsletter*, No. 2, winter.

Raber R (1999). The internet and EAP. *Behavioral Health Management*, 9(5): 34-39.

Rantanen J (1999). Research challenges arising from changes in worklife. *Scandinavian Journal of Work and Environmental Health*, 25(6) (special issue): 473-483.

Rao A, Kelleher D (2003). Institutions, organizations and gender equality in an era of globalization. *Gender and Development*, 11: 142-150.

Savoie A (1989). La relation éducative en milieu de travail. *Revue québécoise de psychologie*, 10(1): 112.

Shaw WS et al. (2003). Employee perspectives on the role of supervisors to prevent workplace disability after injuries. *Journal of Occupational Rehabilitation*, 13(3): 129-142.

Siegrist J (1996). Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology*, 1:27–41.

Spokane AR, Ferrara D (2000). Samuel H. Osipow's contributions to occupational mental health and the assessment of stress: the occupational stress inventory. In: Leong FTL, Barak A, eds., *Contemporary models in vocational psychology. A volume in honor of Samuel H. Osipow*, Mahwah, Lawrence Erlbaum Associates: 79-96.

Substance Abuse and Mental Health Services Administration (1993). *National household survey on drug abuse: main findings*, 1991. Rockville, MD (DHHS Publication No. SMA 93-1980).

The President's New Freedom Commission on Mental Health (2003). *Achieving the promise: transforming health care in America: final report*. Rockville, MD (DHHS Pub. No. SMA-03-3832).

Theorell T (1999). How to deal with stress in organizations? - a health perspective on theory and practice. *Scandinavian Journal of Work, Environment and Health*, 25 (Special Issue): 616-624.

Tokyo Declaration (1998). *Journal of Tokyo Medical University*, 56:760-767.

Treatment Protocol Project (2000). *Management of mental disorders*, 3rd ed. Sydney, World Health Organization Collaborating Centre for Mental Health and Substance Abuse.

Trucco M et al. (1998). Consumo reciente de alcohol y drogas en accidentes del trabajo. *Revista Médica de Chile*, 126: 1262-1267.

Tziner A (2002). Human *resource management and organization behaviour*. Aldershot: Ashgate Publishing Limited.

United Nations (1993). *The Standard Rules on the Equalization of Opportunities for People with Disabilities*. UN General Assembly Resolution 48/96.

United Nations (1948). *Universal Declaration of Human Rights*. Adopted and proclaimed by UN General Assembly Resolution 217 A (III).

Université Laval (2002). *La santé mentale au travail*. Quebec.

US Department of Labour (1991). *Coping with substance abuse in mining*. Beckley, National Mine Health and Safety Academy (Safety manual No. 25).

Verhulst FC (1995). A review of community studies. In: Verhulst FC, Koot HM, eds., *The epidemiology of child and adolescent psychopathology*. Oxford, Oxford University Press.

Vezina M et al. (1988). *Pour donner un sens au travail*. Comité de la Santé mentale du Québec, Montréal: Gaétan Morin.

Waldenström K et al. (2003). Does psychological distress influence reporting of demands and control at work? *Occupational and Environmental Medicine*, 60: 887-891.

Walsh DC et al. (1991). A randomized trial of treatment options for alcohol-abusing workers. *New England Journal of Medicine*, 325(11): 775-782.

World Bank (1993). *World development report 1993: investing in health*. New York, Oxford University Press.

World Health Organization (1992) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Geneva.

World Health Organization (2001). *The World Health Report 2001*. Geneva.

World Health Organization (2002). *World report on violence and health*. Geneva.

World Health Organization (2003a). *Investing in mental health*. Geneva.

World Health Organization (2003b). *Mental health financing, WHO Mental Health Policy and Service Guidance Package*: Geneva.

World Health Organization (2003c). *Advocacy for Mental Health. WHO Mental Health Policy and Service Guidance Package*. Geneva. World Health Organization.

World Health Organization (2004a). *Work organization and stress*. Geneva.

World Health Organization (2004b). *Promoting mental health: concepts, emerging evidence, practice*. Geneva.

World Health Organization (2004c). *Prevention of mental disorders: effective interventions and policy options*. Geneva.

World Health Organization (2005). *Mental health policy, plans and programmes (WHO Mental Health Policy and Service Guidance Package)*. Geneva.

World Health Organization (forthcoming). *Research and evaluation for mental health (WHO Mental Health Policy and Service Guidance Package)* Geneva.

Further reading

Gabriel P, Liimatainen MR. *Mental health in the workplace*. Geneva, International Labour Office, 2000.

Harnois GP, Gabriel P. *Mental health and work: impact, issues and good practices*. Geneva, World Health Organization, 2000.

International Labour Office. *Framework guidelines for addressing workplace violence in the health sector*. Geneva, 2002.

International Labour Office. *Guidelines on occupational safety and health management systems*. Geneva, International Labour Office, 2001.

Pratt D. *The healthy scorecard: delivering breakthrough results that employees and investors will love*. Victoria, B.C.: Trafford, 2001.

Quick JC, Tetrick LE, eds. *Handbook of occupational health psychology*. Washington, D.C. American Psychological Association, 2003.

Solutions at work: practical guides to managing disability. London: Employers' Forum on Disability, 2002.

Stress, santé et intervention au travail. Sherbrooke: University of Sherbrooke, 1998. (Collection Gestion des Paradoxes dans les Organisations, Volume 7).

Tziner A. *Human resource management and organization behavior: selected perspectives*. Aldershot: Ashgate Publishing Ltd, 2002.

Vézina M et al., *Pour donner un sens au travail: bilan et orientations du Québec en santé mentale au travail.* Montréal, Québec: Gaétan Morin, 1992.

National Institute for Occupational Safety and Health. *Working with stress*. Washington, D C: Department of Health and Human Resources, 2002 (DVD, 17 minutes).

Organizations

Association Interrégionale de Guidance et de Santé, rue Vert-Vinâve 60, 4041 Vottem, Belgium; www.aigs.be

Center for Psychiatric Rehabilitation, Boston University; 940 Commonwealth Avenue West, Boston, MA 02215, USA http://www.bu.edu/cpr/; email: psyrehab@bu.edu

Chair in Corporate Occupational Health and Safety Management, Laval University, Quebec, Canada; Pavillon Palasis-Prince, local 2326, Québec, Canada, G1K 7P4 http://cgsst.fsa.ulaval.ca/

European Agency for Safety and Health at Work; Gran Via 33, E-48009 Bilbao, Spain http://osha.eu.int

European Foundation for the Improvement of Living and Working Conditions; Loughlinstown House, Shankill, Co. Dublin, Ireland.
http://ideas.repec.org/s/fth/eurofo.html

Global Applied Disability Research and Information Network on Employment and Training (GLADNET); Cornell University, Ithaca, NY 14853, USA http://www.gladnet.org/; email: info@gladnet.org

International Association for Psychosocial Rehabilitation Services (IAPSRS), 601 North Hammonds Ferry Road, Suite 3, Linthicum, Maryland 21090, USA; Rose Hill Center, 5130 Rose Hill Blvd, Holly, MI 48442, USA www.iapsrs.org

International Labour Office, 4, route des Morillons, CH-1211 Geneva 22, Switzerland; http://www.ilo.org/

National Partnership for Workplace Mental Health; American Psychiatric Foundation 1000 Wilson Blvd. Suite 1825, Arlington, VA 22209-3901, USA
http://www.workplacementalhealth.org

Virginia Commonwealth University; VCU- Rehabilitation Research and Training Center on Workplace Supports and Job Retention, 1314 West Main Street, P.O. Box 842011, Richmond, VA 23284-2011 http://www.worksupport.com/topics/employment.asp

World Federation for Mental Health; 2001 N Beauregard Street, Suite 950, Alexandria, Virginia 22302-0810, USA http://www.wfmh.org/

World Psychiatric Association; Dept. of Psychiatry & Behavioral Sciences, Metropolitan Hospital Center, New York Medical College, 1901 First Avenue, Suite 4M-3, New York, NY 10029, USA http://www.wpanet.org/

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