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Promoting mental well-being in the workplace: A European policy perspective

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Summary
The nature of the workplace continues to change as Europe adapts to the challenges of competing in a global marketplace. Across the European Union there is a trend of increasing absenteeism and early retirement due to mental health problems, particularly stress and depression. The social and economic costs of lost productivity in Europe are substantial. Moreover, the sustainability of social protection systems may be challenged further by increases in the levels of disability benefits paid to people who have left work on grounds of poor mental health. Yet despite these significant consequences, at both national and pan-European levels, decision-makers have been slow to recognise the importance of promoting mental health within the workplace, although recently there have been some positive developments. This paper outlines some of the socio-economic arguments for the promotion of good mental well-being in the labour force and identifies how they link with different national and European policy agendas around four key issues: economic growth and development, the promotion of a high level of public health, sustainability of social welfare systems and social inclusion. The role and activities to promote mental well-being in the workplace undertaken by both national and international organizations in Europe are outlined along with important gaps and challenges that need to be addressed.

Introduction

Work plays a vital part in all our lives. For the individual it provides an opportunity to earn wages, which in turn provides greater financial security, and increases the opportunities to acquire material wealth. It also provides social status and identity, a sense of achievement and a means of structuring one's time (Jahoda, 1981). For employers there are productivity gains, while society more generally benefits from potential economic growth and thus more revenue through taxation. By contrast unemployment is associated with poor health status, and in particular an increased chance of poor mental health (Kessler, House, & Turner, 1987; Nordenmark & Strandh, 1999; Warr, 1987). Moreover social exclusion can also be exacerbated by long-term unemployment.

Work, particularly that involving stressful tasks, can however be the cause of mental ill health or a contributing factor to such illness (Gabriel & Liimatainen, 2000; Michie & Williams, 2003). There are many factors which contribute to the manifestation of work-related stress. For instance this may be related to functions of job, organization and management, workload and hours of work, and the level of empowerment in the decision-making process (Karasek, 1979; Karasek & Theorell, 1990). A lack of appropriate reward commensurate with the level of effort in employment may also lead to work-related stress (Siegrist, 1996; Siegrist, J., Siegrist, K., & Weber, 1986). Rewards can include levels of pay, esteem and standing in the workplace and opportunities for career progression. The balance between work, social and family life can also be a major factor, as can lack of job security (Godin & Kittel, 2004; Leka, 2003; Virtanen, Vahtera, Kivimaki, Pentti, & Ferrie, 2002).

The nature of the workplace continues to change as Europe adapts to the challenges of competing in a global marketplace. In recent decades we have also been moving away from an industrial to an information economy. The structure of the workforce in Europe is also changing: it is ageing and now has greater female and immigrant participation (Cox & Rial-Gonzalez, 2002). Companies must respond quickly to these changing circumstances, facing a constant drive to maintain or increase market share and profits, while also forcing down costs. This highly competitive atmosphere has implications both for the security of employment and the demands

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made on today's employees. It is also increasingly true that 'there is a deepening dependence of global corporations on the minds rather than the backs and muscles of those that work for them. Mental capacity will do the heavy lifting in the information economy' (De Vries & Wilkerson, 2003).

This changing work situation should be seen in the context of an increased level of poor mental well-being in the workplace. In the European Union (EU) overall work-related stress is now thought to affect one-third of the workforce (Ivanov, 2005). Data elsewhere in the developed world confirms the significant impact of stress. For instance one study from Ontario estimated that in one 30-day period 8.4% of the working population experience a mental health disorder (Dewa & Lin, 2000). The US National Co-morbidity Survey estimates that on average 18% of the workforce have some form of clinical psychiatric disorder at any one point in time (Kessler et al., 1994). There is though great variation by type of job. This can be illustrated by one study of medical general practices in England, which reported that 23% of all staff responding could be classified using the 12-item General Health Questionnaire as having mental distress, with the highest levels reported in practice managers and the lowest in clerical and administrative staff (Calnan, Wainwright, Forsythe, Wall, & Almond, 2001).

Across the European Union for both men and women there is also evidence of a trend of increasing absenteeism and early retirement due to mental health problems. The social and economic costs of lost productivity through absenteeism, sickness and retirement in Europe are substantial and have knock-on implications in terms of hiring and training costs, reduced economic growth, lost taxation revenue and higher social security payments. Indeed the sustainability of social protection systems may be challenged by substantial increases in disability benefits paid to people who have left work on grounds of poor mental health. Yet at both a national and pan-European level, institutions have been slow to recognise the importance of promoting mental health within the workplace. Very recent developments that we discuss later in the paper do, however, suggest a move in the right direction.

In this paper we set out some of the socio-economic consequences of poor mental well-being in the labour force drawing on data from a recent report prepared by the EC-supported Mental Health Economics European Network (MHEEN), and augmented by a brief review of relevant literature. We then identify how these consequences link in with different national and international policy agendas around four key issues: economic growth and development, the promotion of a high level of public health, the sustainability of social welfare systems, and social inclusion in the workforce. The role and activities undertaken at both a national and international level in Europe for the promotion of mental well-being in the workplace are then outlined along with important gaps and challenges that need to be addressed.

Trends in workplace mental health across Europe

It is well known that a major contributor to the economic costs of mental health problems is lost productivity, far exceeding direct health and social care costs, typically accounting for between 60–80% of all estimated costs of poor mental health (Knapp, Mangalore, & Simon, 2004; Thomas & Morris, 2003). Productivity losses arise in a number of ways: short- and long-term absenteeism; reduced performance at the workplace (presenteeism); early retirement other work cutback; reduced opportunities for career development; days out-of-role; and reduced lifetime productivity due to premature mortality. Workplace difficulties can obviously impact on the income of the individual, and family members may also face employment difficulties if their care and support responsibilities prevent them from participating fully in the labour market. Out-of-pocket expenses are another potentially large burden. Any consistent increase in the prevalence of mental health problems in the workplace would therefore be not only extremely unfortunate for the individuals concerned, but also of concern to employers, governments and social and private health insurance organizations that have to carry these growing social and economic costs.

Absenteeism and early retirement

Data collected by MHEEN confirm a trend of increasing absenteeism and early retirement due to mental illness (and particularly depression) across Europe for both men and women. Mental health problems are also beginning to overtake musculo-skeletal problems as the leading cause of days of absence from work in a number of European countries (Wynne & MacAnaney, 2004). Some countries have reported increases in both the number of days of absence and the number of cases reported due to mental health problems. In Sweden, mental health problems account for approximately 27% of all cases of long-term sick leave (RFV, 2003). In the Netherlands, between 1970 and 2003, although the overall level of health in the working population did not change there was a steady increase in the risk of workers being registered as disabled because of a psychological disorder; by 2003, 35% of those leaving work

became disabled because of these disorders (Statistics Netherlands, 2004). In Austria, while total days of absenteeism for all causes decreased by 13% between 1993 and 2002, days of absenteeism due to mental health problems increased by 56% (Zechmeister, 2004).

These findings are consistent with those reported elsewhere. One report commissioned by the International Labour Organization reported 'an alarming increase' in the incidence of mental health problems in the workplace, particularly depression in the UK, Finland, Germany, Poland and the USA between 1990 and 2000. Links between long-term absenteeism, disability status and the onset of work-related stress have also been reported by the European Working Conditions Observatory (Houtman, 2004). They reported that in Germany the number of long-term sick due to mental health problems increased by 74% between 1995 and 2002, compared with just a 10% increase in sickness absence due to musculoskeletal or respiratory problems for example. In Spain, the General Workers Union estimated that between 50–60% of sick leave and disability claims are due to stress at work.

The economic costs of lost productivity

The high economic costs associated with productivity losses are apparent from a number of national studies. Some examples can be given. One study in Sweden estimated that 66% of total mental health care costs were due to lost productivity (Institute of Health Economics, 1997), while 80% of the economic burden of depression in Portugal has been attributed to lost productivity (Ramos & Sennfelt, 1996). In the Netherlands, the total costs of employee drop-out and disability due to mental health problems have been estimated to be approximately 0.5% of GDP or €1.44 billion per annum (Jarvisalo, Andersson, Boedeker, & Houtman, 2005).

Other significant estimates of the costs due to depression in the workplace can be found in Germany where it has been estimated that in 2002, 18 million working days were lost costing employers some €1.59 billion. In the UK, the Health and Safety Executive has estimated that between five and six million days are lost per annum because of depression. A recent study from England estimated total costs of adult depression in 2002 to be €15.46 billion or €309.2 per head of population. Treatment costs accounted for only €636 million of this total; the vast majority of costs were due to lost employment because of absenteeism and premature mortality (Thomas & Morris, 2003). These estimates may well underestimate the true economic costs as research undertaken in the USA suggests that the cost of reduced work performance by those remaining at work but suffering from depression (sometimes called presenteesim) may be as much as five times as great as for those who are absent from the workplace (Kessler & Frank, 1997). Moreover recent analysis of data from the UK Quarterly Labour Force Survey indicates that employees with mental health problems may be absent around five times more often than those with other health problems (Almond & Healy, 2003).

Economists often do not consider social welfare benefits in estimates of the costs of mental health problems, as they are merely resource transfers across the population. Paying sickness and disability benefits does however mean that these resources are no longer available for other purposes, so from a distributional perspective there are certainly costs for a social welfare system. For instance in France in 2000 between 14 and 24% of total social security spending on occupational illness was due to work-related stress (Bejean & Sultan-Taieb, 2005). In England mental health problems now account for more disability benefit claims than musculoskeletal disorders; in response new guidelines have been drawn up by the Health and Safety Executive on the management of stress at work (Henderson, Glozier, & Holland, 2005). Indeed one English study suggests that if included these could account for one-third of the total costs of mental health problems (Patel & Knapp, 1998). Finally in Finland between 1990 and 2003 the number of paid sickness absences for formally diagnosed mental health problems increased by 93%. Twenty percent of all sickness benefits and 42% of all disability pensions were paid out for people with mental health problems; overall around 50% of all people recorded as suffering from depression are on long-term disability pensions (Jarvisalo et al., 2005).

Relevance to the European policy agenda

How do these profound personal, social and economic consequences fit into both national and supranational policy agenda across Europe? There could be impacts in many areas of national and international policy, but here we focus on four key policy areas.

Economic development

Firstly there is the macroeconomic dimension. Governments have long put economic development at the heart of their policy programmes. Historically, the promotion of good mental well-being has been a national (or sub-national) responsibility. There is however little evidence until recently to suggest

that protecting mental health in the workplace has been seen as an element of this policy. At an EU level the situation is now somewhat different. Employment issues are of particular concern as they form part of the EU's twin 10-year objectives, set out in the Lisbon Agenda in 2000, for economic development, including a 70% employment rate of the population, and social inclusion in the workforce so as to raise the level of employment of vulnerable groups including people with disabilities (Commission of the European Communities, 2005a). There is, however, growing disquiet over the lack of progress towards meeting the targets of this agenda, attributed in part to an over optimistic assessment of economic performance, and secondly because too many targets were set in too many areas (BBC, 2005). Indeed it has now been re-launched, focusing on a smaller number of areas. One negative consequence is that the new approach places less emphasis on social inclusion, although it is still present in the strategy document (Commission of the European Communities, 2005b). Nonetheless the agenda, coupled with greater awareness of the economic costs of poor workplace mental health, has stimulated interest in workplace mental health promotion as one means of facilitating economic growth.

Promotion and protection of public health

A second key issue at both national and international level is the promotion and protection of good mental health. At a national level policies have been put in place in most countries to promote occupational safety and health in the workplace. This being said, the focus appears to have been very much on physical rather than mental health. Moreover in many European countries the promotion of workplace mental health has been seen as separate from public health, and often co-ordinated outside the Ministry of Health, making it more difficult to have a joined-up approach to public mental health (Cox, Leha, Ivanov, & Kortums, 2004).

At a European level, mental health remained very much an issue for national governments alone until the 1993 Maastricht Treaty stated that in achieving harmonization of the internal market, 'a high level of human health should be guaranteed' (Article 95, paragraph 3), and that 'a high level of human health protection must be ensured in the definition and implementation of all Community policies and activities on the protection of a high level of public health' (Article 152).

Thus while health care *per se* remains an issue to be dealt with at national level, promoting good mental health in the workplace has for more than a decade been within the competence of the EU. This is not only on grounds of the promotion of a high level of public health, but also through other directives and legislation on the promotion of health and safety in the workplace.

Of course, pan-European approaches to workplace mental health promotion did not begin with the Maastricht Treaty. Organizations such as the World Health Organization, International Labour Organization and World Bank have also been active in this field for some time. Nevertheless, greater EU involvement from not just a competition but also a health perspective has been a key recent driver in the exchange of information at a European level on workplace mental health promotion.

Ensuring the sustainability of social welfare systems

The functioning and sustainability of the social welfare systems is also of key concern given the ageing of most European populations. As we have noted already the number of people taking both early retirement or in receipt of disability benefits has risen rapidly. There is evidence now that a number of European governments consider this a serious enough issue to consider radical reform of access to such benefits. They are also considering the possibility that social welfare and disability benefits intended to act as a safety net for the vulnerable may in fact contain perverse incentives for individuals to leave employment or remain economically inactive.

Promoting social inclusion

Employment strategy in Europe as set out in the Lisbon Process also places social inclusion at the heart of economic policy. The EU is working to strengthen national equal opportunity regimes to help address issues such as the work/life balance, gender discrimination and the return to work of disadvantaged groups such as those with mental health problems. This focus allows scope for the EU to look at barriers to reemployment and reintegration into the labour force.

Current actions in Europe

While many of the actions to address risk factors at the workplace and potential disincentives within the benefit system can only be addressed at national or sub-national levels, there are a number of ongoing activities at a pan-national level.

Perhaps the most important of these, at least symbolically because it demonstrates political commitment to mental health, was the January 2005 Helsinki intergovernmental conference on mental health organized by the WHO Regional

Office for Europe, European Commission, Council of Europe and Government of Finland. Workplace health promotion was one of many important issues discussed at the conference. The end result was a political commitment and action plan for mental health. The governments of all 52 European countries signed a declaration calling for action to 'promote the mental well-being of the population as a whole by measures that aim to create awareness and positive change for individuals and families, communities and civil society, educational and working environments...' (World Health Organization, 2005). A detailed action plan was also endorsed by ministers, which called specifically for action to 'create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles' and also to 'include mental health in programmes dealing with occupational health and safety' (World Health Organization, 2005). Welcome though these commitments are, the onus is on individual countries to implement these actions over the next 5–10 years, according to their own needs and resources. It will thus be some time before we can assess whether changes in national plans and strategies have the potential to be effective; one catalyst for change might be a report on progress towards achievement of the Helsinki declaration, but no firm plans for such an assessment are as yet in place.

The EU and its agencies are playing an increasingly important role, in response to the policy agenda outlined earlier. Through Directorate General (DG) Employment and Social Affairs, the Commission asked the European Social Partners (European associations of trades unions and employers organizations) to formulate a plan to combat stress in the workplace. Subsequently in October 2004, the European social partners signed a framework agreement on work-related stress (Monks, Strube, Reckinger, & Plassman, 2004). The principle objective of the agreement was 'to increase awareness and understanding of employers, workers and their representatives of work-related stress, and draw their attention to signs that could indicate problems of work-related stress'. The agreement provides a general framework for analyzing and dealing with work-related stress. It points out that European directives covering occupational safety and health also cover work-related stress in so far as this is a threat to health and safety. Problems may be addressed through risk assessments, a stress policy or specific measures targeted at specific stress factors.

Much EU activity focuses on research and information exchange, with an intention of strengthening the evidence base both on the scope of the problem and potential solutions. Within DG Employment and Social Affairs the European Foundation for the Improvement of Living and Working Conditions conducts and commissions research on a range of social policy issues. One of these areas looks at maintaining well-being within the workplace, while another explores how to promote the social inclusion of people with disabilities (including mental health problems) within the workforce. Another agency, the European Agency for Safety and Health at Work also provides information on a range of occupational health and safety issues, including work-related stress.

Within DG Health and Consumer Protection, the Public Health Programme has funded a number of projects looking at mental health in the workplace. These have included support for the European Network for Workplace Health Promotion, a group linking occupational safety and health groups across the EU, and the work of the International Mental Health Promotion Action Group (IMPHA). One outcome of this EU work has been the production of a report by the German Federal Institute of Occupational Safety and Health looking at existing strategies to cope with anxiety, stress and depression in workplaces across the EU (Berkels, 2004).

National actions

Of course, national governments across much of Europe may have been involved in a range of measures to improve occupational safety and health. What is most distinctive, however, is the extent to which they are involved in a process of welfare system reform intended to help facilitate and encourage those who have become unemployed return to work. In some countries this has involved reform of social welfare benefits so as to act as a further incentive to return to work (Teague, 1999). The extent to which this is intended to impact on those claiming disability benefits is less clear, although politically this is now an issue for concern in many European countries (Jarvisalo et al., 2005). Some countries have launched or announced reform of disability benefit systems so as to target them more effectively at those who are least capable of work. For instance in England there are ongoing attempts to reform access to disability benefits and encourage individuals towards vocational rehabilitation (Henderson, Glozier, & Holland, 2005), while in the Netherlands a target of a 75% reduction in those claiming long-term disability benefits has been set. While such reforms may act as an incentive for individuals to seek employment, changes to the social welfare system alone will be insufficient to promote long-term job retention. Welfare reform needs to be a part of a package of measures that may include enforcement of anti-discrimination

legislation, participation in vocational rehabilitation courses, availability of support and adaptations in the workplace, flexible working arrangements, disability awareness training for the rest of the workforce and help with the costs of transportation (Organisation for Economic Cooperation and Development, 2003; Wynne & MacAnaney, 2004).

Gaps to be addressed

Limited availability of occupational health services

Although the importance of employment to mental health has been known for some time, it has been argued that there remains a lack of understanding of, and a lack of focus on the protection and promotion of good mental health in the workplace in Europe, with occupational mental health seen somewhat a 'Cinderella' subject (Cox et al., 2004). Perhaps this should not be surprising given that mental health generally has remained a low priority: only four of the old EU countries spend more than 10% of their budgets on mental health, despite its overall contribution of more than 20% to the burden of disease in Europe (McDaid, Knapp, & Curran, 2005).

This neglect may also reflect the distinction between a public mental health agenda, and the approach taken in the field of occupational safety and health. The public health agenda is firmly focused on alleviating clinically diagnosable mental health problems, where work is seen as a protective factor against poor mental health. This is a very different from the field of occupational safety and health, where there is a concentration on identifying risk factors in the workplace that contribute to (non-clinical) work-related stress. At an international level there evidence of co-ordination between occupational health and public health institutions is limited, while at national level occupational health is often placed in ministries of labour rather than health, where the culture may be very different.

The provision of occupational health services is highly variable across Europe; in some countries compulsory, often state provided, schemes may be in place whereas in others these issues are left to the market, but overall fewer than 15% of European workers are thought to have access to such services (Ivanov, 2005). Even where these are available it is argued that they have inevitably focused on physical rather than mental health problems (Cox et al., 2004). At a national level there is a need for legislation and action programmes to ensure that mental health is included within occupational safety and health. Improved co-ordination is also clearly required with public mental health programmes and strategies, where work is seen as a benefit to mental health, at national, regional and indeed European level is also required.

Limited evidence on effectiveness and cost effectiveness of interventions

There is still much action that can be taken at a European level to build up the knowledge base. It seems clear that rigorous evaluations of workplace interventions remain rare, despite concerns having been raised over this lack of evidence for a considerable period of time (Jenkins, 1993). It is also remarkable that despite the potentially enormous economic benefits to be gained by preventing mental health problems in the workplace, we still know little about interventions that are cost effective. It is an undeniable fact that resources are scarce, but we ignore resource consequences at our peril. In this area the potential case seems strong and it is acknowledged that cost effectiveness evidence could strengthen the case for investment (Schaufeli, 2004). One recent systematic review of workplace interventions however could only find six studies that were evaluated using rigorous methods, not one of which presented information on cost effectiveness (Michie & Williams, 2003). Moreover few studies in the review were longitudinal, thus it was very difficult to determine any causality between potential risk factors in the workplace and the prevalence of work related stress. The review was also highly critical of the lack of attention paid to primary prevention strategies and the absence of high quality evaluation standards in most studies.

Where data is available this seems to be largely from North America. European data is needed to help build the case for investment in such mental health promoting interventions. The EU and its constituent elements can provide a mechanism for the exchange of information on what works, in what context and at what cost. While it may not always be possible to transfer solutions say between a workplace in London and one in Athens or Bratislava, by making transparent the process, mechanisms and resource requirements involved it may be possible to adapt interventions to consider their cost effectiveness in local settings. The Commission is however now funding further work of the MHEEN network to look at both the effective strategies and interventions to encourage workplace health promotion, as well as looking further at some of the issues around potential perverse incentives associated with disability benefits.

Another step forward would be to ensure that data on productivity losses are readily collected across countries, as significant gaps still exist which can make it difficult to fully estimate the economic consequences of poor mental. More can also be done

to build a case for action not only for policy makers, but also for companies and other stakeholders who ultimately share in the benefits of having a healthier workforce. One of the possible reasons for the higher rate of long-term sickness leave and premature retirement is the stigma and prejudice that are still associated with mental health problems; tackling these issues can only be done through a process of education and awareness raising within the workplace, although it should of course be backed up by both national and EU-wide legislation governing discrimination in the workplace. The effectiveness of such legislation also needs to be monitored at an EU-wide level.

Relationship between work status and social welfare systems

The functioning of the social welfare systems is of key concern given the ageing of populations, raising questions about their future sustainability. Incentives to encourage those who can work actually to maintain or return to work have not been very extensively examined in European contexts. While there is evidence of an increased uptake of disability benefits, much more can be done to determine whether this represents a genuine increase or rather an improved detection of mental health problems in the workplace. Benefits might also be received for other reasons. They may provide a financial safeguard allowing early retirement or other lifestyle change (Burchardt, 2003), or they may be a political way of disguising unemployment within society as incapacity. Indeed in England there are more people claiming sickness and disability benefits for mental health conditions than the total number of unemployed people registered as seeking work. The rates of claims for incapacity benefit in England also increase with age which might also signify the greater difficulty older workers have in finding employment (Office of the Deputy Prime Minister, 2004).

We also need to know more about whether benefits can create barriers to employment, for instance in some countries the receipt of a disability pension can actually disqualify an individual from receiving help with job seeking. Alternatively should there be more focus on the stigma and social exclusion faced by individuals receiving disability benefits which may severely curtail their opportunities for a return to employment? (Trades Union Congress, 2004).

Comparative in depth analysis of the impact of disability benefits on the willingness to return to work across Europe have not as yet been fully considered, as social welfare systems differ in many respects including diagnosis procedures, levels and duration of mandatory payments and other responsibilities placed on employers. While the operation of social welfare systems is an issue for national governments there are clearly opportunities for comparative research and exchange of information at a European level. It is not clear across Europe what processes are in place and how effective they are in encouraging a person back into the economically active population. Some work is now underway to address this gap (Wynne & MacAnaney, 2004).

Another area where little analysis has been conducted in Europe is on access to employer or private insurance-related disability benefits. While access to such benefits in Europe has been limited, it appears to be growing. Evidence from Canada indicates that these may either facilitate or act as a barrier to maintenance or return to employment, and require further investigation (Dewa, Lesage, Goering, & Caveen, 2004). For instance one pertinent question is the extent to which such schemes might, in addition to protecting incomes, also provide access to counselling and support not funded by health and social welfare systems. One insurance company in the UK has reported having around 1000 new claims for income protection per year, of which 300 (particularly teachers) are related to mental illness including stress. They also report that this number has been increasing over the last 10 years (Aviva Plc, 2005).

Strengthening action within public and private sector enterprises

Of course much action needs to take place at workplace level. The public sector remains a major employer in many countries in Europe and is in a key position to be a driving force in implementing actions both to tackle risk factors that can contribute to poor mental health in the workplace, and also put in place policies for reintegration into the workplace. Their size and less commercial ethos may make them best placed to pilot and evaluate innovative actions. Trade unions, which traditionally have a stronger influence in the public sector, could also act as a catalyst for change. There is however no comprehensive account of actions taken by public sector employers *per se* so it is difficult to know to what extent actions are being taken and whether these differ from the private sector. Anecdotal actions can be identified, for instance in the UK one recent government report called on public sector institutions to take a more proactive approach to the social inclusion of people with mental health problems in the workplace (Office of the Deputy Prime Minister, 2004), while in Sweden promoting good mental health forms a critical element of ongoing research to improve health and work capacity within the public sector (Heijbel, Josephson, Jensen, & Vingard, 2005).

In both the public and private sectors the cost of lost productivity, as well as legal action for work-sustained injuries including stress may act as drivers to encourage employers to improve the general workplace environment, and to introduce (further) mental health-promoting initiatives. As noted above the social partners have signed up to a framework on stress in the workplace and some large private companies in Europe have already responded to increasing absenteeism with the introduction of processes aimed at preventing mental health problems and supporting those who develop them. However such initiatives seem to remain the exception rather than the rule (Ozamiz & Gumplmaier, 2001). One recent survey of 950 companies in western Europe reported that 52% of respondents believed that staff absenteeism and turnover were significant risks to their business, but did not know how to deal with work-related stress (Marsh, 2004). Schemes need to be extended to cover small and medium sized enterprises as well as larger firms, and their success or otherwise could be monitored at both national and European levels.

Conclusions

It might be thought remarkable, given the strong evidence of the profound socio-economic impact of poor mental health, that there has (until recently at least) only been a muted response to the promotion of mental health in the workplace. In many respects this is unsurprising. In many countries funding for mental health is low relative to its contribution to disease burden. This is in part a consequence of public ignorance and stigma. Moreover the responsibility for delivering and co-ordinating promotion, treatment and rehabilitation services is often fragmented, resting with multiple agencies funded through different sectors. This fragmented system can make it difficult for decision makers to invest scarce resources in mental health promoting strategies, when the benefits (e.g., reduced need for social welfare payments) may accrue to different budget holders.

Workplace mental health has largely been the remit of occupational health and safety programmes, but as we have noted these have tended historically to focus largely on physical health issues, while mental health programmes in the health sector, until recently have not seen the workplace as a setting for intervention. It is also almost certainly the case that mental health problems in the workplace were under reported, with employees reluctant to disclose this information for fear of losing their job. From an employers' perspective, the continuing lack of robust evidence on the cost effectiveness of potential interventions may also have been a contributing factor to a reluctance to invest in mental health promotion.

The situation appears to be changing. Awareness of the personal, social and economic costs of poor mental health has grown, and social security systems cannot fail to notice the increase in mental health related long-term disability. There now appears to be a concerted commitment for action. While some issues such as the operation of social welfare benefit systems are clearly matters to be decided within individual countries, increasingly there is a role for international organizations such as the EU, WHO and ILO in promoting well-being in the workplace. Such bodies can encourage governments to take action, help develop capacity in both the understanding of the issues and also in evaluating and monitoring the implementation of policies and interventions.

The recent Helsinki Declaration is of particular importance as it gives symbolic recognition to mental health issues (including workplace health), but it will be several years before it will be possible to judge its impact. Similarly it is also too early to make a judgement on the impact of the Social Partners Framework agreement, as this requires engagement with social partners at European and national levels and, critically, also with staff within individual companies. The outlook however is encouraging; both events in Helsinki and a proposed European Commission Green Paper on the promotion of mental well-being to be published in late 2005 may offer significant opportunities for a greater focus on workplace mental health. As ever the challenge remains to translate aspirations and political statements in policy and practice.

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