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Healthy Employees in Healthy Organisations – the European Network for Workplace Health Promotion (ENWHP)

Dr. Gregor Breucker and Dr. Reinhold Sochert

Networks committed to a healthy world of work in Europe

The European Network for Workplace Health Promotion (ENWHP) was established in 1995 under a joint initiative by the European Commission and the Federal Institute for Occupational Safety and Health in Germany. ENWHP brings together the knowledge and experience of a group of networks which themselves were set up as part of a European action programme aimed at bringing about improvements in the field of public health.

ENWHP member organisations represent both the statutory occupational safety and health sector and the public health sector. In each member state of the European Union, as well as in the countries of the European Economic Area (Norway, Iceland and Liechtenstein), plus Switzerland, one member organisation performs the function of a national contact office for the ENWHP.

ENWHP members do not act under a direct state mandate. The Network has an informal status and its resolutions take the form of recommendations. The principal focus of the Network's activities is the exchange of experience.

Strategy and mission

The primary role of the Network – and the reason it was established - is to disseminate good practice in workplace health promotion in member countries. It has two long-term objectives:

- To contribute towards the establishment and further development of public health-supporting infrastructures at both European and individual state level.
- To increase substantially the number of companies and public administrations in Europe which are committed to the principles of health promotion in their HR and corporate policies.

In order to achieve these aims, the Network runs three campaigns simultaneously as part of its overall strategy:

- a) Each member organisation supports, in its own country, the establishment and further development of networks and exchange forums which can act as contact points for interested companies and public administrations and can facilitate the exchange of experience.
Good examples of this are the national and regional networks in Austria and Germany (www.netzwerk-bgf.at for Austria and www.dnbgf.de for Germany). This ensures that as many stakeholders as possible in each country - institutional players as well as companies and public administrations - are directly involved. The European Network thus provides an informal – and invaluable - umbrella of independent initiatives.
- b) Through numerous projects and initiatives, the ENWHP supports the development and transfer of know-how relating to all questions and issues of workplace health promotion. This includes the identification of effective and efficient processes, policies and methods of WHP as well as the collation of arguments – social, commercial and financial – to convince employers and opinion-formers of the vital role of taking better care of ourselves.

- c) Finally, the Network is involved in the development and dissemination of vocational and further training programmes in order to promote the establishment and development of competencies in the various groups of stakeholders.

Workplace health promotion – on the road to a healthy world of work

Core elements of a common understanding in this field were developed and established in the Luxembourg declaration on workplace health promotion in Europe (BKK Bundesverband 1997, <http://www.enwhp.org/publications.html>).

WHP is a cross-sectional task both in companies and public administrations as well as at supra-company level. At company level, it is ideally an integral part of company management, a function of managerial staff and occupational safety and health stakeholders. At the same time, it should also be a priority topic for workers' representatives and a vital subject for every individual employee. At supra-company level, WHP reflects labour, social and health policies and is a function of the social security institutions responsible for the relevant political sectors (statutory social insurance funds, institutions of occupational safety and health and public health, health services etc.)

Workplace health promotion brings together the above to improve working conditions through initiatives which promote a healthier lifestyle for employees. Moreover, it supplements preventive activities which are aimed at reducing inappropriate workplace demands and which strengthen or extend the positive resources available to employees and companies.

Workplace health promotion highlights the principle of direct participation of all groups and the need for jointly agreed actions, taking account of different interests. Both state action and local agreements – at company and supra-company levels – can create supporting framework conditions for the dissemination of good practice.

This European understanding embraces different approaches to WHP in line with national framework conditions and traditions. Reflecting this, the Network has developed a set of criteria for good practice against which initiatives in individual countries can be documented and assessed.

In order to achieve the second strategic objective - an increase in the number of health-promoting companies and administrations in Europe - the ENWHP, with its links to national networks, is in a position to identify key priorities and processes and is able to facilitate the transference of knowledge and experience across international and sector boundaries.

The main initiatives the ENWHP has conducted since the end of 2002 include:

- The establishment of a European Toolbox for workplace health promotion. The Toolbox is offered on the Network's website and contains different tools for company practice.
(*ENWHP Toolbox. A European collection of methods and practices for promoting health at the workplace.* <http://www.enwhp.org>).
- The development of the business and social case for investment in workplace health promotion.
(*ENWHP 2004. Making the case for Workplace Health Promotion. Analysis of the effects of WHP.* <http://www.enwhp.org>).
- The collection of practical examples of WHP in the context of demographic change.
(*BKK Bundesverband 2007. Maintain employability! Strategies and tools for a long healthy working life.*)
- The implementation of the *Move Europe* campaign to promote a healthy lifestyle in the world of work (from 2006).

Mental health at the workplace – the contribution of workplace health promotion

Workplace health promotion is a holistic approach aimed at the continuous improvement of health. Among its concerns is that ‘inappropriate’ physical and psychosocial demands on workers should be reduced and the relevant support resources (personal and organisational) strengthened. Mental health continues to be one of the key challenges of WHP.

In this area, WHP supports companies and public administrations in three fields of action:

- Measures to reduce, limit or prevent inappropriate mental loads (prevention);
- Measures to strengthen the resources for mental health (health promotion);
- Measures to support workers who are ill or are subject to inappropriate mental loads (reintegration into the company, assistance and health care).

In tandem with this, WHP supports a health-promoting corporate culture and a company health policy geared to it.

Work in tune with life. ‘Move Europe’

Effective interventions already exist for promoting mental health and wellbeing and combating mental ill-health. This was shown in the results of a recent initiative carried out by the ENWHP. Under the title “*Work in tune with life. Move Europe*”, the Network identified and evaluated around 50 *Models of Good Practice* from 18 participating countries and 15 of these were selected to present their activities at the European Mental Health Pact Conference in Berlin.

As part of the *Move Europe* project, the ENWHP carried out a European campaign to promote mental health at work. Under the leadership of Germany’s BKK Bundesverband, the initiative aimed to:

- increase the awareness of companies and the general public about the needs and benefits of mental health promotion at work
- attract companies to take part in the campaign and to convince them that investment in workplace mental health promotion initiatives has a payback
- design practical measures and models for promoting mental health in workplace settings and encourage an exchange of experience in this field

The campaign began officially in October 2009. National *Move Europe* websites were set up and went online in 18 European countries. About 2000 enterprises participated - public administrations, schools, hospitals, small and larger companies, at both beginner and advanced level - and they actively supported the campaign as a “Move Europe Partner”.

A gradual status and selection approach supported a wide-ranging enterprise participation and helped to identify good practices:



Move Europe-Community: Companies joined the campaign by filling in the “Mental Health Check” online. On the basis of the questions, they assessed themselves on the quality of the mental health promotion measures in their company or organisation. Companies with particularly good health-promoting programmes were invited to join the campaign as a “Move Europe Partner”.

Move Europe-Partner: Move Europe-Partners were made visible at national level. As an organisation with a successful mental health promotion programme, they received a Best Practice Questionnaire. This enabled them to present their concept of mental health promotion at work in more detail.

Move Europe-Partner Excellence: The concepts were evaluated and Models of Good Practice were identified by an expert team. Companies fulfilling various criteria received the title of “Move Europe Partner Excellence” in the field of mental health promotion at work.

Mental Health Pact Conference in Berlin: Representatives of the companies with the most convincing health management schemes in the field of mental health promotion at work were selected and invited to attend the European Mental Health Pact Conference in Berlin on 3rd – 4th March 2011 to present their activities.

Based on the available literature and the examples of good practice collected, materials were developed and produced for employers, employees and corporate experts in an effort to inspire and encourage the respective stakeholders to invest in programmes that help improve employees’ mental health.

Outlook

Against the background of constant, far-reaching change in the world of work, psychosocial health needs to be the focus of both public interest and workplace health promotion.

While social partners may continue to have varying views over the method of implementation of statutory occupational safety and health regulations, there is a growing consensus that action needs to be taken to strengthen measures aimed at combating threats to mental health.

A corporate culture based on partnership and a high quality of employee leadership are the most important resources and protective factors for mental health at the workplace. Better mental health also stimulates economic development, through increases in efficiency and an improvement in the quality of life. It therefore represents a great opportunity.

The following pages set out the ENWHP’s current position and approach to the subject of mental health in the world of work.



The Edinburgh Declaration on the Promotion of Workplace Mental Health and Wellbeing

This Declaration sets out the commitment of the members of the European Network for Workplace Health Promotion (ENWHP) to continue to campaign for the promotion of workplace mental health and wellbeing and to include it as an integral and central aspect of workplace health promotion efforts.

This Declaration calls upon European Employers, Employees, Trades Unions, Intermediaries and Governments to give greater emphasis to workplace mental health promotion and to implement measures to protect and improve mental health and wellbeing at work.

Workplace Mental Health and Wellbeing

The World Health Organisation defines positive mental health as “a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.” This definition is consistent with the International Labour Organisation concept of “decent work” in relation to mental health in the workplace. There is no health without mental health and work is a key influence in this respect.

The costs of poor mental health and wellbeing are significant for employers and for society:

- 25 percent of European citizens will experience a mental health problem during their life time – it is an issue that will touch all of our lives directly or indirectly.
- The WHO estimates that by 2020 depression will become the second most important cause of disability. It is already the second most important cause of disability between the ages of 15-44 years for both sexes.
- Absenteeism, unemployment and long-term disability claims due to work-related stress and mental health problems are increasing in Europe - around 10% of long-term health problems are due to mental and emotional disorders.
- The costs of mental health disorders in Europe are estimated to be €240 billion per year. €136 billion is due to lost productivity through sickness absence.

The causes of poor mental health and wellbeing are complex and multifaceted. Work and the working environment are only part of the problem, but they are fundamental to the solution. Work makes a significant contribution to mental health and wellbeing by providing self-esteem, fulfilment, opportunities for social interaction and a source of income.

Employers are a significant beneficiary of such measures; benefits include improved productivity, a more motivated workforce, reduced absence and lower staff turnover. Improving mental health and wellbeing can therefore have a direct impact on the bottom line.

Workplace Mental Health Promotion

The Luxembourg Declaration on Workplace Health Promotion (WHP) defines it as “the combined efforts of employers, employees and society to improve the health and wellbeing of people at work.” This “can be achieved through a combination of improving work organisation and the working environment, promoting active participation, and encouraging personal development”.

Since its foundation in 1996, ENWHP has been at the leading edge of WHP efforts in Europe. There is an increasing evidence base for what works and ENWHP actively promotes practical approaches to improving workplace mental health promotion. Such approaches, which need to be embedded in an overall WHP model, include:

1. Encouraging employers to provide meaningful and stimulating work opportunities and supportive work organisation for their employees
2. Providing opportunities for employee skill development including self-confidence and social competence
3. Promoting greater employee participation in decision-making
4. Recognising the key role of managers in supporting staff
5. Creating a positive working environment and setting clear job roles and expectations
6. Reducing sources of stress in the work environment and developing resilience to stress by promoting coping strategies
7. Encouraging a culture of enterprise, participation, equity and fairness and challenging stigma and discrimination in the workplace
8. Supporting, retaining and employing people with mental health problems
9. Developing and implementing strong policies on mental health and wellbeing at work
10. Monitoring the impact of these policies and interventions

Summary of activities and achievements in the area of mental health in workplaces - European Agency for Safety and Health at Work (EU-OSHA)

Introduction

Health is created and lived by people within the settings of their everyday life such as their workplaces. Health does not come in two versions – one at work and the other outside of work. Both safe and healthy working conditions and the individual's healthy choices contribute to good health, thus improving quality of life and prolonging healthy working years.

Mental health is an important aspect of general health, which is recognised at EU level. The previous Community strategy on health and safety at work 2002-2006 identified stress as a priority¹. The current Strategy (2007-2012)² reinforced the issue by focusing on psychosocial risks and mental health promotion at the workplace. This includes both, research and good practice.

The European Agency for Safety and Health at Work (EU-OSHA) supports implementation of the strategy. Its activities related to psychosocial risks at work aim at identifying emerging risks, consolidating knowledge in this area, and stimulating debate among policy makers, researchers, as well as employers and employees. This work is complemented by collecting and disseminating good practice information on prevention of psychosocial risks and mental health promotion in the workplace.

European Risk Observatory

Research activities

- **ESENER**, a pan-European Survey of Enterprises on New and Emerging Risks (2009, <http://www.esener.eu>).

EU-OSHA's Europe-wide establishment survey asks managers and workers' health and safety representatives about how health and safety risks are managed at their workplace, with a particular focus on the newer 'psychosocial risks', such as work-related stress, violence and harassment. The survey aims to assist workplaces across Europe to deal more effectively with health and safety and to promote the health and well-being of employees. To this end it provides policy makers with cross-nationally comparable information relevant for the design and implementation of new policies in this field.

The survey, which involves approximately 36,000 interviews and covers 31 countries, has the support of governments and social partners at European level. For EU-OSHA, this project represents one of its most important initiatives to date and is expected to provide valuable information for use over several years.

Support for policy makers: the survey investigates what enterprises do in practice to manage psychosocial risks; what are their main reasons for taking action; what holds them back; and what support they need.

¹ <http://osha.europa.eu/en/legislation/future/index.stm/#270>

² <http://eur-lex.europa.eu/Notice.do?checktexts=checkbox&val=443914%3Acs&pos=1&page=1&lang=en&pgs=10&nbl=1&list=443914%3Acs%2C&hwords=&action=GO&visu=%23texte>

Support for researchers: The survey provides researchers with comparable data that enables better analyses to be made of, for example, approaches to prevention, attitudes to safety and health, or involvement of workers across Europe, by different variables, such as sector or size class. The data from the 36,000 interviews are available free of charge to researchers.

Support for workplaces: enterprises are able to use the survey questions directly at workplace level to set a benchmark and to compare their own OSH management practices with those for their country, sector or size class.

Support for other Agency activities: EU-OSHA will use the results of ESENER to focus its campaigns more effectively on the key issues for enterprises.

ESENER shows that 79% of European managers voice their concern about stress at work, and around 40% are concern about violence and harassment at work. Regarding the factors contributing to psychosocial risks, managers' principal concerns are 'time pressure' (52%) and 'having to deal with difficult customers, patients etc.' (50%). However, it is rare for enterprises, especially for SMEs, to integrate psychosocial risks into the general OSH management. ESENER shows that less than 30% of EU organisations have procedures in place to deal with stress, workplace violence and harassment. While among bigger enterprises (250+) this percentage grows to 40-50%, for smaller workplaces it stays at around 20% (10-19 employees) or 25-30% (20-49 employees). The survey also shows that 42% of management representatives consider it more difficult to tackle psychosocial risks, compared with other OSH issues. The sensitivity of the issue (53%) and lack of awareness (50%) are the main barriers for dealing effectively with psychosocial issues. Lack of expertise and lack of technical support or guidance on how to manage psychosocial risks have been reported especially by smaller enterprises.

Two reports with the secondary analysis of the data "Factors associated with effective management of psychosocial risks" and "Managing psychosocial risks – drivers, obstacles and needs. Measures taken to manage psychosocial risks" are to be published Q2, 2011.

- **Expert forecast** on emerging psychosocial risks related to occupational safety and health (2007)

The report summarises the results of an expert forecast on emerging psychosocial risks related to occupational safety and health. The experts proposed 42 psychosocial risks and rated 8 as strongly emerging and 19 as emerging. The main emerging risks identified were related to the following five areas: new forms of employment contracts and job insecurity, the OSH risks for the ageing workforce, work intensification - high workload and work pressure, high emotional demands at work, including violence and bullying, as well as poor work-life balance.

In addition to a questionnaire-based survey of experts, a literature review was conducted to explore more in depth the main emerging risks singled out in the forecast in terms of context, workers at risk, health and safety outcomes and prevention, and the need for future research. The results of the expert survey should be seen as a basis for discussion among stakeholders to set priorities for further research and actions.

Consolidating knowledge

Overview reports and literature reviews present the current state of the knowledge on particular topics, international and national statistics, as well as legislative and socio-cultural background in relation to psychosocial risks and mental health problems at work. Some of the recent publications are:

- “Workplace violence and harassment” (2010), “Literature study on migrant workers” (2007), “Research on work-related stress” (2000), “MSDs and psychosocial risks” (in preparation).
- “OSH in figures” - series of reports with the main international and national figures related to stress (2009) and other topics and priority groups such as e.g. young workers (2007), women at work (in preparation).

Stimulating debate

Seminars organised by the Agency gather representatives from the European Commission and EU Agencies, international organisations (ILO, WHO), trade unions and employers representatives, as well as major European OSH research institutes and acknowledged experts from world-wide academic centres. The aim of the seminars is to consolidate and further discuss recent publications, and to identify concrete ways to tackle psychosocial risks at work. Seminar Online Summaries, with all presentations, the main points of discussions and conclusions are available from the Agency Website (<http://osha.europa.eu/en/seminars>). Recent seminars were related to:

- “Women at work” (2010), “Violence and Harassment at Work” (2009) or “Emerging psychosocial risks related to OSH” (2008).

Good practice

Prevention of psychosocial risks

Stress at work can affect anyone at any level. It can happen in any sector and in any size of organisation. Stress affects the health and safety of individuals, but also the health of organisations and national economies. Therefore, in 2002 a European Campaign focused on preventing psychosocial risks at work and the stress they cause (<http://osha.europa.eu/en/campaigns/ew2002/>). With the backing of all Member States, the European Commission and Parliament, trade unions and employers federations, it raised awareness and provided good practice information in EU and beyond.

The campaign was supported and followed-up by a number of information products such as:

- Single Entry Point on work-related stress (<http://osha.europa.eu/en/topics/stress>)
- Report on prevention of psychosocial risks and stress at work in practice (2002)
- Factsheets on psychosocial issues and work-related stress (2002); on violence at work (2002); and on bullying at work (2002)

- eFacts on prevention of psychosocial risks in the education sector (2008) and HORECA (2008)
- Online risk assessment tools in the searchable database to assess work-related stress (<http://osha.europa.eu/en/practical-solutions/risk-assessment-tools>)

Mental health promotion at the workplace

Mental health promotion is a part of the EU-OSHA long-term project on workplace health promotion (2008-2012) raising awareness and providing information materials for employers, workers and their representatives. This project aims to improve knowledge in health promotion and to strengthen abilities to put this knowledge in place. An expert group consisting of EU Member States' experts, representatives from the Commission, WHO, ILO and the European Network for Workplace Health Promotion (ENWHP) was established. This way it is made sure that all relevant stakeholders and organisations are involved in the project and most benefit can be gathered from European wide cooperation.

The following information materials on mental health promotion have been prepared:

- Single Entry point on workplace health promotion (<http://osha.europa.eu/en/topics/whp>)
- eFact on mental health promotion in the health care sector (2009)
- Factsheets for employers and workers on workplace health promotion (2010)
- Report on mental health promotion in practice (in preparation)
- Cartoon strips and captures (in preparation)

Good practice resources on prevention of psychosocial risks and mental health promotion at the workplace (in the searchable database)

- Case studies <http://osha.europa.eu/en/practical-solutions/case-studies>
- Frequently asked questions http://osha.europa.eu/en/practical-solutions/faqs/index_html/practical-solution
- Links to good practice information in EU and beyond <http://osha.europa.eu/en/practical-solutions/useful-links>

By organising campaigns and other events, and by providing information, the EU-OSHA aims at raising awareness on the importance of psychosocial risks prevention and mental health promotion, as well as contributing to the knowledge on these issues. It also put at workplaces disposal practical tools for risk assessment and management, and health promotion.

Quality of work, employment and mental health in Europe

By Agnès Parent Thirion, Greet Vermeulen, Gijs van Houten, Maija Lyly-Yrnanainen, Isabella Billetta, Eurofound and Isabelle Niedhammer, Inserm

The opinions expressed in this article may not reflect the views of the institutions they represent. Work presented is work in progress.

What is the European Foundation for the improvement of living and working conditions?

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite EU body, whose role it is to provide key actors in social policymaking with findings, knowledge and advice drawn from comparative research. By monitoring the latest development on living and working conditions and providing timely, in depth analysis and information in these areas to governments and social partners, Eurofound seeks to contribute to improving the lives of citizens in Europe. Eurofound was established by Council Regulation EEC No 1365/75 of 26 May 1975 and is located in Dublin, Ireland.

The European Working Conditions surveys series: 5 surveys to-date

From the late 80's the European Foundation was involved in developing monitoring instruments on working conditions¹, in particular through the development of a European-wide survey measuring a variety of aspects related to working conditions of workers (employees and self-employed) in the European Union. This aim of the European Working Conditions Survey (EWCS) is to describe and monitor trends in working conditions of people in employment² in a comparative context. Up to now, five editions of the EWCS have taken place, the last one being in the beginning of 2010.

The underlying concept of the survey is the concept of quality of work and employment, which has four key dimensions:

- career and employment security
- health and well-being
- reconciliation of working and non-working life
- skills and career development

At every new edition of the survey, the questionnaire is reviewed and expanded with a view to contributing to meeting the needs of Eurofound's tripartite stakeholders, addressing better European policy needs and contributing to new research. Gender mainstreaming has been an important feature in the development of the survey; it is reviewed at every new edition.

Fieldwork for the 5th EWCS took place from January to June 2010 with almost 44,000 workers interviewed in the EU 27, Norway, Croatia, Turkey, FYROM, Albania, Montenegro and Kosovo. The EWCS is a face-to-face survey, which takes place at people's homes. The average duration in the 5th EWCS is 42 minutes. The figures from the EWCS are estimations: they are based on a representative sample of European workers.

¹ Dhont Steven and Houtman Irene (1997), Indicators of working conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Dublin.

² Definition used is the one from the Labour Force Survey.

Results shall be interpreted keeping in mind the fact that the survey is cross sectional when health obviously is constructed over time. Indicators are self reported by the respondents: this method has limitations yet it is appropriate especially for those indicators (mostly psychosocial) which cannot be observed by an external observer; it is also cost effective. The measures of exposure to psychosocial work factors were constructed following theoretical models and concepts but they are not based on validated instruments. On the other hand, self-reported health as well as the WHO 5 well-being index are used. They have been validated and are used in international studies. Careful attention has been put on drafting questions which In order to ease international comparisons, questions have been drafted with a view to ensure the highest level of comparability between countries: for example, respondents

Work and (mental) health: a complex topic

The relationship between work and health are complicated to study and measure:

- Both work and non work will impact on the health of workers, and to some extent, are influenced by the broader political and economic context (the 'welfare regime'). They will influence on the definition of work (and therefore the extent of work, unemployment and inactivity). Redistributive mechanisms will impact on health outcomes and mediate the impact of social determinants of health. Furthermore, regulations on the working environment³ (including collective bargaining) will impact on work and its working conditions. Also, countries have various employment structures; this will impact on risks exposure s well as health outcomes
- Exposure to risk may have direct impact on health: for example exposure to high noise may lead to (temporary or long term) hearing problems. This is also true for work-related stress that may have direct effects on health through biological as well as psychological pathways.
- Exposure to a specific risks may have an indirect impact on health (for example, some studies have shown that as part of collective defence strategies⁴, in order not to experience fear all the time, male workers of the construction industry would tend to drink alcohol as well as taking risks). Work related stress has been shown to impacting on workers health through both direct and indirect mechanisms (behaviours at risk).
- Most of the effects of exposure to risks factors will be differed and will depend on the dose; they will impact differently based on a wide number of individual factors of workers (genes, lifestyles, socio economic positions etc)
- The healthy worker effect means that workers who would have the most difficult conditions and frail health would have left work situations which are health demanding or would have left the labour market at all. Other selection effects can be in place for example: less(er) exposure of workers with a temporary contracts can be partly explained by their recent hiring.

(Mental) health of workers in Europe: first findings from the 5th EWCS

In the 5th EWCS, the following information are collected on health⁵ of the workers

- health and safety at work⁶,
- self reported health⁷

³ See for example, Bambra, jech, 2011, Jan 30,2011

⁴ Desjours

⁵Information is also asked on self-reported health problems : respondents are asked to report any health problems out of a list containing 14 items whether they have suffered over the last 12 months of any of these symptoms. This is not covered in this paper

⁶ Do you think your health and safety is at risk because of your work? yes / no / Don t know / no opinion / refusal

- Mental well-being. The WHO 5 indicator is used. It is a validated instrument.
- Self reported relationship between work and health which can be positive or negative⁸
- And absence from work for reasons of health problems⁹ as well as presenteeism¹⁰

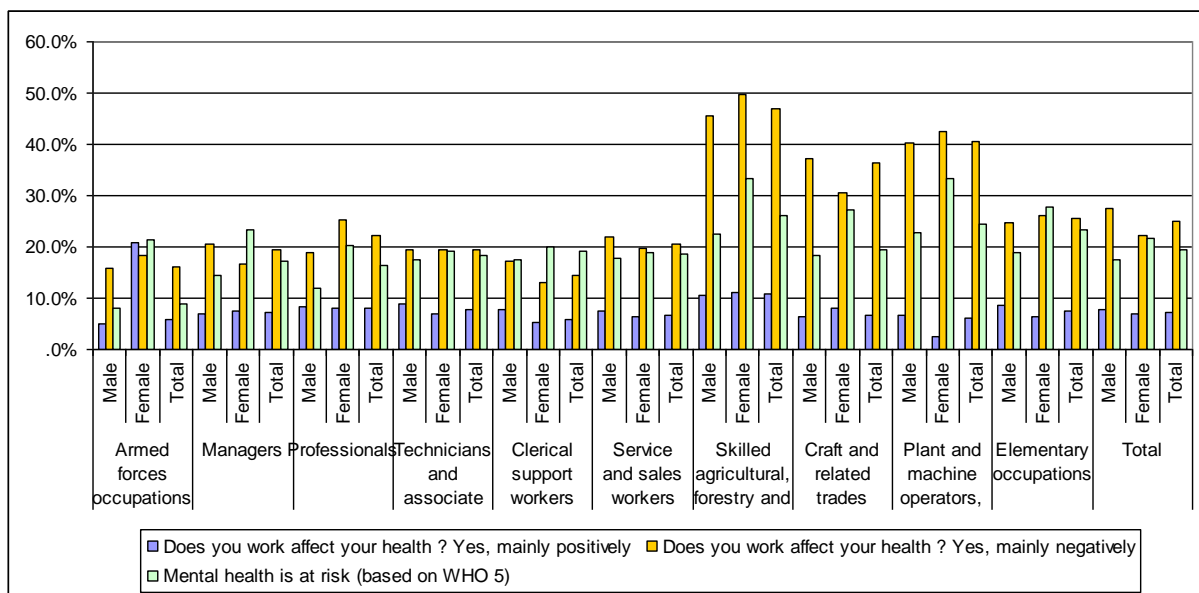
The proportion of workers who in the EU27 report that their health and safety is at risk because of their work has been declining since 2000, from 31% to 24%. Differences in frequencies between employment status (self employed 28%, permanent employed 24% and temporary employment 22%) and gender (men 29 % versus women 19%) are important, reflecting respectively partly differences in regulations and labour market segregation.

78% of workers in Europe report very good and good health, 19 a fair health and 2% a bad or very bad health. Again gender matters and women report 2 percentage points less having a (very) good health. Differences between occupations are important: 24 percentage points with 60% of skilled agricultural workers reporting enjoying a (very) good health and 84 % of managers reporting the same alternatives.

Mental well-being is measured by a raw score (from 0 to 25). Levels below 13 indicate a poor well-being and are an indication for testing for depression. This score has been transformed into an index comprised between 0 (worst imaginable well-being) and 100 (best imaginable well-being). On average in EU 27, mental well-being of men (67) is higher than that of women (65). Skilled agricultural workers report the lowest level of well-being (62), followed by elementary occupations and plant and machine operators (both 64) when managers (68) and professionals (67) report highest level of well-being.

In EU 27, 19% of workers (18% of men and 22% of women) report a raw score of well-being below 13. The gradient by occupation is the same as for mental well-being.

Figure 1 – Relationship between work and health, mental health at risk based on WHO 5 source EWCS 2010



⁷ 'How is your health in general? would you say it is ... ? very good, good, fair, bad, very bad, don't know, no opinion, refusal

⁸ 'Does your work affect your health, or not ? yes mainly positively, yes mainly negatively, no, don't know, no opinion, refusal

⁹ Over the last 12 months, how many days were you absent from work for reasons of health problems?

¹⁰ Over the past 12 months, did you work when you were sick? yes / no/ I was not sick (spontaneous), Don't know /no opinion

When workers assess the impact of their work on their health, 2/3 of them report that there is no relationship, one quarter that their work affect their health mainly negatively and 7 % that it improves it positively with highest reported levels reported by the skilled agricultural workers (11%) as well as professionals (8%). Nearly half of the skilled agricultural workers (47%), 41% of plant and machine operators and 36% of craft workers report that work impact their health negatively.

40% of workers report having worked when they were sick (women 41% more often than men 38%). By occupations, managers (56%) and professionals (46%) report the highest level whereas craft workers (32%), clerical staff (35%), elementary occupations (36%) and sales workers (37%) report frequencies less than average.

Work-related stress

Stress is one of a group of so-called psychosocial risks that are an increasing occupational health concern. There are, however, different forms of stress, ranging from acute stress in possibly life threatening situations, to more constant forms.

Work-related stress as discussed here is the result of sophisticated human organisational decision and in some cases can become chronic. It is related to issues such as work demands, emotional demands, room for manoeuvre, social relations, value and ethical conflicts and employment insecurity. Taken in isolation and occurring only at times, these issues would in most cases be considered benign and could indeed constitute part of the everyday emotional demands at a workplace. Yet, when they become chronic and individuals feel they are no longer able to deal with them, they can lead to serious problems for workers themselves, the company that employs them, their family and society as a whole. Indeed, a series of epidemiological studies have clearly established a relationship between exposure to work-related stress as a whole as well as to various components of it and particular health risks (cardiovascular diseases, multiple musculoskeletal disorders as well as mental health). These three pathologies account for a substantial part of mortality and morbidity in Europe and work-related stress has been shown to increase the risk of these diseases by 50 to 100%.

How exposure to work-related stress and health outcomes is related is not always clearly known and the relationship is complex. The mechanisms can be distinguished as 'direct' (raised blood pressure, raised levels of some hormones etc) and 'indirect' (people engaging in unhealthy behaviour such as overeating, drinking etc). They are likely to lead to various emotional, cognitive (difficulty in concentrating, remembering, making decisions, decreased creativity), and behavioural reactions (abuse of drugs, alcohol, and tobacco; destructive behaviour).

Work demands that can lead to increased stress include both quantitative demands such as efforts, quantity of work, time constraints and qualitative ones (complexity of tasks, contradictory demands). This dimension also includes work–life conflicts. Effects of high work demands on health (especially in relation to cardiovascular diseases and mental health problems) have been demonstrated especially in work situations where workers have little autonomy or little social support from colleagues and managers.

Recent data from the 5th European Working Conditions Survey (EWCS) indicate that overall, work demands have been increasing since the survey started in 1991 and remain at a high level, indicating a higher risk for all of those at work. Yet other research has also shown that workers to some extent adapt to increased work demands albeit in different ways. Long working hours, (defined as working more than 48 hours per week), for example, have continued to decrease over the same period. Yet more than one in 10 still work long hours

every week (the majority of those being self-employed). In 2010, 58% of workers report that their work includes complex tasks, showing little change over the last 15 years.

While social support has been more or less constant at a high level over time, the room for manoeuvre which is essential for workers to compensate for and adapt to increased work demands has not improved. This has most likely contributed to the rise in work-related stress. The impact of emotional demands plays a growing role in forms of work mostly concentrated in the service industry. There, workers when delivering their service, have to control their own emotions or are confronted with the emotions of those they are delivering a service to. With structural change taking place over time, these types of jobs have increased.

Another increasing characteristic of most work today is that contact with clients has become a feature of more and more workers. Over time, contact with a client (almost) all of the time has increased from 42% to 44% within the last 10 years. This type of contact, which sometimes could be a source of pleasure and gratification, can in certain circumstances become difficult: 5% of European workers deal with an angry client most of their working time. It is also important to mention are also work situations where workers are required to hide their emotions (30% of workers) and/or fears (18% of workers in Europe report that a mistake in their work could cause physical injury and 35% that it could cause financial loss for their company).

Ethical conflicts (9% of workers in the EU27) can also contribute to work-related stress. Not being able to achieve a good quality of work can also contribute to work-related stress. 16% of workers report facing this situation. The same proportion of workers also report not doing a useful job.

Employment insecurity (either objective through having a limited contract or subjective by fearing that your job is at risk, e.g. through restructuring) is another important factor. In the current context of the crisis, it has been increasing. It can be associated with under-employment (such as involuntary part time) as well as specific risks linked to major restructuring (see also the article on the health outcomes of losing your job).

Poor leadership is a further factor which in combination with others can contribute to the development of work related stress.

Violence and harassment are very difficult to qualify and measure. Yet evidence show that they are affecting some proportion of workers and that their impact at all levels are very serious. They are a symptom of very poor relations at work

Trends over time suggest some worrying developments which require attention and action to deal with this phenomenon. It will be important to address both the potential for positive outcomes (developing a productive workforce which can contribute to increased competitiveness and recovery) as well as negative factors (avoiding direct and indirect costs linked to poor health developing over time).

Work-related stress and mental health

Numerous studies have underlined the associations between work-related stress and mental health. In these studies, various measures were used for both work-related stress and mental health. Indeed, mental health may be explored either using self-reporting of symptoms (well-being, depressive or anxiety symptoms, quality of life, etc.) or diagnostic interviews that provided more clinical diagnostics and consequently allowed the evaluation of more severe forms of mental disorders (major depression, generalized anxiety disorder, etc.). The epidemiological literature reports that work-related stress may have an impact on both mental symptoms and disorders. Various work-related stressors have been identified as risk factors for mental health; a meta-analysis by Stansfeld and Candy (2006) provides robust consistent evidence that the combinations of high demands and low latitude (i.e. job strain according to Karasek) and of high effort and low reward (i.e. effort-reward imbalance

according to Siegrist) are risk factors for common mental disorders in prospective studies (i.e. where exposures were measured before mental health outcomes). Both job strain and effort-reward imbalance may increase the risk of common mental disorders by more than 80%. Other stressors may play a substantial role in mental health: job insecurity, organisational injustice, workplace bullying, other forms of violence and discrimination, long working hours, and work-life imbalance.

Further research is still needed to better understand the underlying mechanisms linking work-related stress to mental health. Furthermore, more intervention studies would be useful to test whether modifying work-related stressors may lead to better mental health at work.

Sustainable work

Over 70% of workers in The Netherlands and Germany feel able to do their job at 60, compared to 26% of workers in Slovenia. This percentage of workers thinking they will be able to do their job at age 60 closely corresponds with the actual percentage of older workers in the workforce. Out of the ten European Member States with the lowest percentage of workers expecting to be able to do their job at age 60, seven Member States are also in the bottom ten in terms of the proportion of workers aged 50 and older in the workforce.

Not only countries differ, so do types of occupation: whereas around 72% of high-skilled clerical workers and 61% of low-skilled clerical workers think themselves able to do their current job at age 60, this is the case for only 49% of high-skilled manual workers and 44% of low-skilled manual workers.

Figure 2 – Percentage of workers expecting to be able to carry out their job at age 60, by level of ergonomic risk exposure and type of work organisation

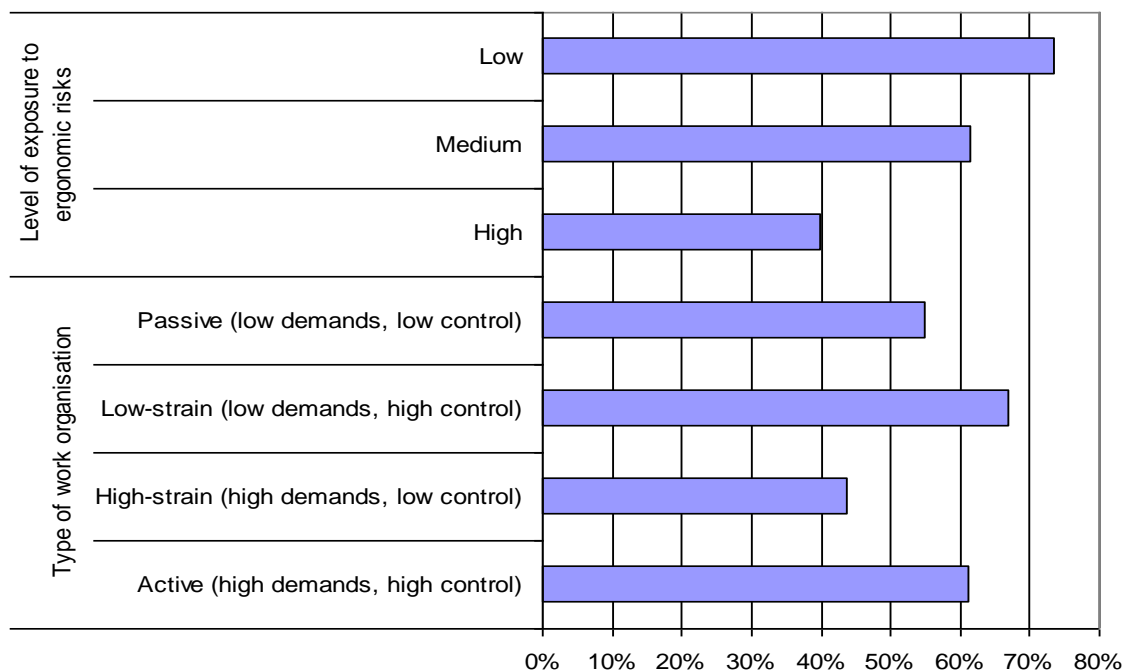


Figure 2 shows that the more workers are exposed to ergonomic risks (such as vibrations from machinery, working in painful positions, lifting people or other heavy loads and repetitive movements), the less likely they are to expect to be able to do their job at 60. Furthermore, workers exposed to high levels of psychosocial risk — those in high-strain jobs who have limited autonomy to deal with high levels of demands — are much less likely to expect to be

able to do their job at a later age, than those in less demanding jobs (passive and low-strain) or those in demanding jobs that do enjoy an adequate level of autonomy to deal with the pressures they are faced with. Again, workers' expected ability to do a job at age 60 corresponds closely with the percentage of older workers in that type of jobs.

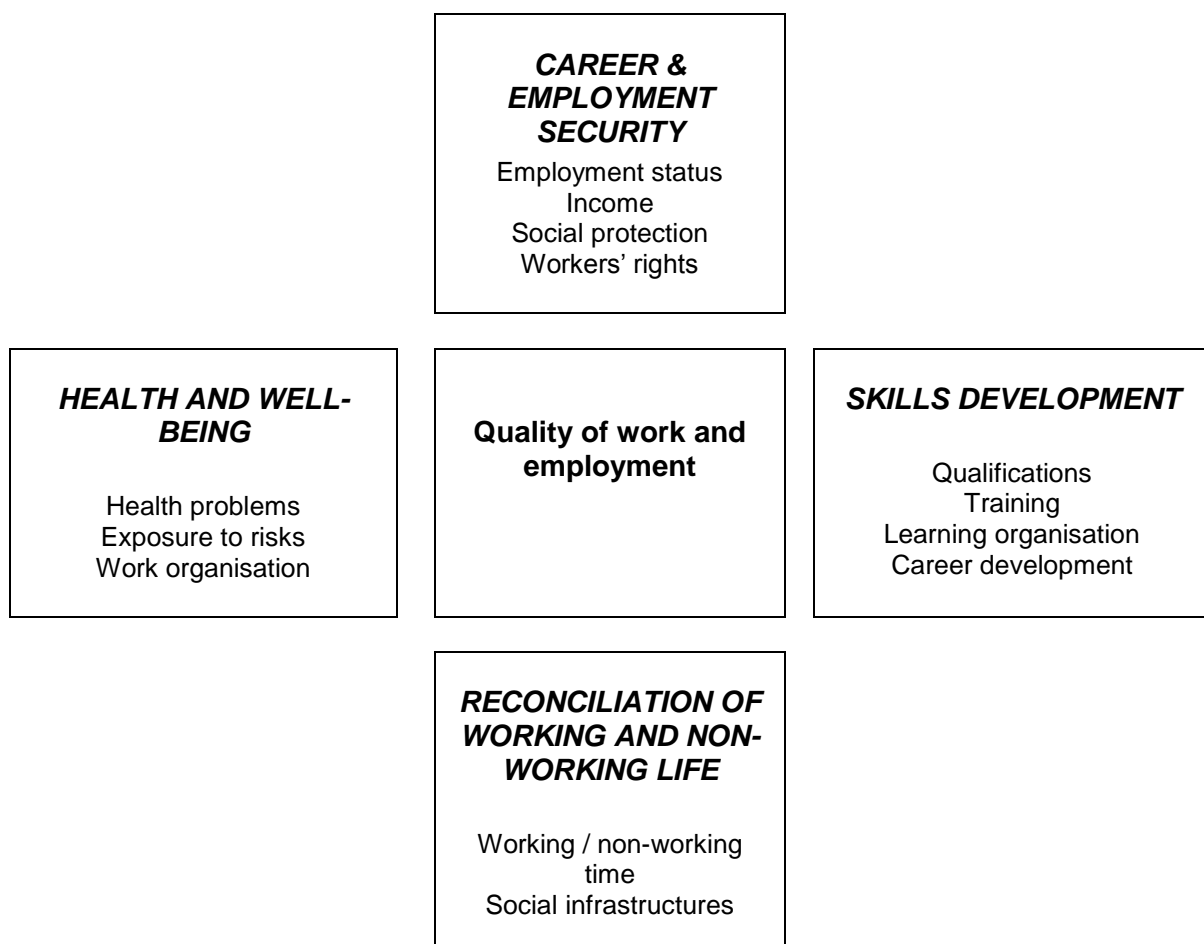
This association, between the physical and psychological demands different types of jobs put on people and the proportion of older workers in these jobs, indicates that those who are no longer able to do their job, are forced to either move into jobs they are still capable of doing or exit the workforce altogether. To some extent this could be avoided. Making jobs and work in general more sustainable requires good quality of work and employment

Towards a better quality of work and employment?

All these facts clearly highlight the importance of quality work and employment in Europe as an important tool to achieve objectives set in Europe 2020.

In 2002, Eurofound undertook an exercise in developing a framework of quality of work and employment based on four main dimensions of quality of work and employment can be identified and are investigated¹¹, which allow structuring the indicators.

Quality of work and employment framework, developed by Eurofound



Source: Eurofound, *Quality of work and employment, issues and challenges*, p.6

¹¹ This is elaborated in *Quality of work and employment in Europe (2002)*, Foundation paper at <http://www.eurofound.europa.eu/pubdocs/2002/12/en/1/ef0212en.pdf>

The first dimension of quality of work and employment is career and employment security, which would consider employment status, income, social protection and workers' rights (non-discrimination, right to be represented etc).

The second dimension covers maintaining and promoting the health and well-being of workers, looking at various aspects of health and safety outcomes, exposure to risks at work, worker's participation, occupational health and safety prevention, and healthy work organisations.

The third dimension looks at reconciliation of working and private life: it looks at working time (duration and organisation), work-life balance, the blurring frontiers between working and non working, social infrastructure.

The fourth dimension is skills development which covers initial education, cognitive content of the work, training and lifelong learning, learning organisations, and career development.

This framework can contribute to the reflection of the development of smart sustainable and inclusive jobs/growth which is in the heart of the current European political thinking. It would consist of a number of dimensions which are embedded in the different dimensions of the quality of work and employment framework:

- sustainable jobs
 - continuation of participation of men and women of all ages in the workforce, work which workers can keep up with work over their life course
 - health and well-being (over the life course), healthy work organisation, negative effects of work intensity/health
 - working time/ work life balance
- smarter working
 - work organisation which leads to better innovation, participation of workers in the innovation processes
 - work organisation, education, training & lifelong learning, employability, participation, learning organisation
- inclusive work/society
 - more employment: creating the conditions that people can participate in employment
 - employment rates, employment status and salaries, rights at work, social protection
 - work life balance, working time arrangements, social infrastructure

Forthcoming research

An overview report of results of the 5th EWCS survey will be published in the next months. In the meantime, first findings mapping changes over time are available on eurofound website. Further most results are presented on eurofound's survey mapping tool. In 2011, further secondary analysis of the EWCS will be carried on issues such as quality of work and employment in Europe, employability and security, working time and work life balance, work and health as well as restructuring. More work on work organisation as well as the ageing workforce, sectoral profiles and gender will be carried in 2011/2012.

Other relevant research

The European Quality of life survey was carried for the second time in 2007. results and analysis on mental well-being of citizens in Europe are available on Eurofound 's website. Fieldwork for the 3rd edition of the EQLS will take place in the second semester of 2011.

Mental health and wellbeing at the workplace – What psychology tells us – European Federation of Psychologists' Associations (EFPA)

By Robert Roe

The psychology of work and organization (W&O psychology) sheds a different light on the aetiology of mental health and wellbeing at work, emphasizing the role of the work organization and of human agency, and emphasizes the necessity of extending customary health promotion with a preventive strategy that involves work design, people-oriented management and workplace democracy.

PART I: what produces positive and negative mental health & wellbeing?

The workplace is not just a setting in which mental health manifests itself, but also one that profoundly influences mental health. It can *harm, heal, and protect*, leaving long lasting effects. Personal vulnerabilities of employees may exacerbate negative workplace impacts but are *not* a prime cause of mental health problems at work.

Negative impacts

There is a vast body of evidence on work producing dissatisfaction, disengagement, cynicism, apathy, irritability, anxiety, stress and burnout (including the clinical category of depression)[1-4]. Workplace experiences can also lead to suicide[5, 6].

People do not passively undergo the influences from the workplace, but actively respond to shield from, undo or compensate adverse conditions. Moreover, they seek support of others (e.g. colleagues, leaders) to redress negative impacts Workplace health effects are governed by: *primary* factors, workplace characteristics, that are potentially harmful (also “stressors”); *secondary* and *tertiary* factors, which relate to people’s efforts to reduce the workplace’s harmful influence and enhance their resources, in a direct and indirect way respectively. The most harmful mental health effects occur when primary, secondary and tertiary factors are all negative. This principle has been well illustrated by research with the “demand-control-support model” of stress [2, 7, 8].

1. Primary factors

Aetiological factors that have drawn most attention in psychological workplace research are

- a. *Job factors*, such as physical stressors (e.g. noise); high work demands (e.g. precision, sustained attention, emotional demands, responsibility, task multiplicity and complexity, interruptions); task incompleteness; obscurity of work processes; poor feedback; role ambiguity, role conflicts, role overload; time pressure, forced rhythm, long, irregular working hours; fragmented and blurred working days [9-12].
- b. *Tool factors*, such as intensive use of information and communication technology (ICT) tools, their usability and functionality [13, 14].
- c. *Social factors*, such as poor relationships, conflicts, discrimination, social exclusion, harassment and bullying – between individuals as well as in teams, and work climate [15-18].
- d. *Organizational factors*, such as flexible forms of working, working in multiple places, mobility of work, collaboration with others from afar, and 24/7 availability demands[19].
- e. *Management factors*, such as poor or abusive leadership [20, 21]; inconsiderate and inconsistent human resources management (HRM) practices; organizational changes, and poor change management[22, 23]. Organizational changes such as mergers, downsizing, outsourcing and restructuring, which imply significant job loss and job change, tend to threaten employment and income security, to reduce psychological safety, trust and loyalty, and to boost cynicism among “survivors”[24, 25]. Poor change management adds to these effects[26].

- f. *Work-family or work-home interface factors*, such as incompatible demands from different life domains, overload, time conflicts, blurring work-life balance, and lack of facilities for accommodating these issues[27, 28].

2. *Secondary and tertiary factors*

The above factors affect people's activities at work, their mental workload, psychophysiological state (fatigue, boredom, satiation), emotional state (mood and emotions), vitality and self-image[29]. *They trigger a number of self-regulative processes aiming to maintain* an acceptable psychophysiological state (changing activity to accomplish the goal; changing the work strategy as to mobilize extra effort, reduce workload; resting as to reduce fatigue; seeking variety as to reduce boredom etc.), to restore their mood and emotions, to prevent deterioration of their health condition, and to uphold their self-image[30, 31]. In connection with stress these processes are known as "*coping*" [32]. *Work roles and organizational practices tend to restrict* the degree to which people can use these mechanisms, thereby enhancing the workplaces' potentially negative impacts. Important *secondary factors* are:

- *Control*, i.e. the possibility to influence the method or timing of task performance, as a protective factor against stress [33].
- *Support*, i.e. the availability of significant others who can help in sense-making or give care and help [34].
- *Recovery*, i.e. the opportunity and time to replenish energetic resources by resting or changing activities [35, 36].
- *Absenteeism*, i.e. the possibility to legitimately withdraw from the workplace to prevent and undo harm [37].

The case of absenteeism is worth considering. Despite its negative connotations for the organization and the individual, it is also a protective mechanism that isolates the worker from the work environment. In fact, it is used in this way by health professionals who prescribe employees to stay home (e.g. in the case of burnout). Policies aiming to constrain absenteeism can lead to *presenteeism*, which does not solve the underlying problem and typically raises costs [38, 39]. The eroding social effects of organizational change (lesser trust, more cynicism) may weaken employees' possibility to provide support when new stressors emerge.

Organizational practices that discourage employees from accessing supervisors and managers and that restrain workplace democracy represent *tertiary factors*, that reduce the organizations' self-restoring capacity and inadvertently elongate or aggravate mental health problems[40].

Positive impacts

Primary factors

Although less numerous, there are also studies showing *positive impacts* of work. They show up in joy, job satisfaction, sense-of-accomplishment, pride, self-esteem, enhanced identity, work engagement, growth, resilience and so on – phenomena that have been captured by the general term happiness[41, 42]. There are also social effects such as enjoying friendship and support. Given the positive relationship between positive mental health and productiveness and innovativeness, it is worth looking at the workplace conditions from which they originate. *The primary factors are largely the opposite of those associated with negative health outcomes.* They include work: that comprises complete tasks with well-calibrated demands, that meets peoples needs (e.g. autonomy, competence, relatedness), is meaningful and evokes a sense of responsibility; good relations with peers, leaders, managers; with employee focused management practices, including employee involvement in organizational change.

At a more *basic level* there are characteristics such as performing meaningful social roles, working with others, having a structured workday, being mentally and physically active,

producing value, which are known to heal those who return to work after unemployment or sickness [43, 44].

Secondary and tertiary factors

When there are possibilities to exercise control over one's work, to access to other people and ask for their support, and to be heard and exert influence through workplace democracy - this can add to positive mental health effects. Even when problems do emerge, e.g. too high workload, tight deadlines, or rapid organizational changes, they are likely to be handled with some degree of effectiveness and hence better outcomes.

Worth mentioning is the role that *rewards* (in the sense of recognition and appreciation of efforts and achievements by superiors and colleagues) play in countering the effects of workplace stressors [45]. Rewards are typically part of an employee centred organizational culture with good employee-manager relationships.

There is one downside to the combination of highly demanding work and high rewards, i.e. the risk of *addiction* in the form of workaholism which may pose health problems in the long run[46].

Non-homogenous impacts

Mental health and wellbeing do not result from exposure to a naturally evolving ecology that affects all people in a homogeneous manner. Research has shown that the same workplace factors do not necessarily produce the same mental health effects in all people, and that differences in effects between types of work (occupations, work roles, job levels) are due to specific profiles of demands, resources, lack of control over the work and/or a lack of rewards [47-50]. Mental health effects are not the same in all countries and at all times. The current research evidence reflects the changes in ecology of work (i.e. in the society and the economy) in the world, particularly North America and Europe, during the past decades. Evidence on the rise in negative mental health in the Western world should be seen in relation to economic and technological development, increasing knowledge-intensity, flexible forms of working, growing public ownership of organizations, large scale restructuring and outsourcing, and demographic changes (growing work force diversity due to migration, ageing and resulting labour shortages)[51, 52]. Mental health effects are not the same for all organizations. Although there are no controlled studies to support this, there is reason to assume a link between the pursuit of particular business strategies and the way in which and the way in which the human factor is employed and valued. For example, the emphasis on "lean organizing", "just-in-time production" and "agility" has led to smaller staff and work intensification, which have subsequently translated into a particular range of mental health issues[53, 54]. Business strategies and ensuing decisions on where to locate firms, how to use global networks for outsourcing and dynamically distribute work, how to structure and manage the organization and its subsidiaries, including what kind of HRM practices to install, how to deal with typical mental health issues cannot be isolated from economic philosophies. Firms operating on the premises of liberal as compared to a social market economy may be more prone to practices that threaten employee (mental) health, as is illustrated by the existence of sweatshops and reports of employee suicides coming from the developing world. These examples should remind us of (mental) health risks of illegal migrant workers in Europe[55].

PART II: What can be done to promote MH?

With alarming figures on declining mental health in the Western world, *it is understandable that the focus is on reducing absenteeism and alleviating the symptoms of those suffering from poor mental health.* Yet, mental health promotion should not be equated to activities taking such a focus. Neither should it take a "preventive" focus by running wellness programs in order to improve the general health of organizations' employees. From the viewpoint of (European) W&O psychology *prevention starts somewhere else, i.e. at the root of the issue,*

the way in which organizations are structured, changed, and managed. Concentrating on sickness figures and wellness while maintaining poor jobs, work procedures, leadership practices, organizational structures, and change management approaches, is putting the horse behind the carriage.

A rational approach is to simultaneously address the most urgent mental health issues *and* take measures that can effectively reduce the numbers of employees with health concerns and raise wellbeing in the future. Considering that the health effects of the workplace unfold over time, passing through multiple cycles with the potential to maintain or restore mental health, these two overlapping strategies can be followed at the same time.

Backward approach

Working backward one would need to start with accurate assessments of workplaces and people (using criteria for job quality and wellbeing) and to engage in therapeutic measures for those unable to work. In this context, it is important to understand that workplace is not anymore only the 'main office' but has extended to many locations. Next, one would need managerial interventions that improve communication about workplace issues as well as access for employees to HR experts, workplace professionals, facility managers, line-managers and employee-representatives that can address workplace and staffing issues. In addition, one would look into the skills, capacity and rights of first-line supervisors to resolve problems with workload, work time, deadlines etc. This might subsequently lead to corrective actions regarding the level of individual employees.

Forward approach

Working forward one needs to start from the roots of mental health problems, that is, the (re)design of work systems and the principles of management, including the underlying strategic principles. *Interventions beginning at early moments in the causal chain take more resources and time, but also have greater potential for improvement in terms of scale (numbers of people affected) and sustainable effects. They also provide opportunities for engendering positive rather than negative effects.* Increasing mental health issues in work are challenges for workplace designers, premise and facility managers in companies, as well as for workplace consultants, not to mention employees themselves, who have to change their mind-sets to adapt and participate in the change. Helping corporations to gain the competence to design the infrastructure to support and enable healthy work and wellbeing is at the core of helping them to be also productive and agile. Alignment of work, physical space, information technology and social support is a practical necessity for all organizations. Building on many decades of research from W&O psychology, the greatest effects are to be expected when one would successively consider:

Work (re)design

Much is known about principles of sustainable work design [56-59]. To achieve optimal (mental) health outcomes, work design should aim at *primary factors* such as: completeness of tasks, calibrated work demands, feedback from the work, tasks and work time schedules that match worker needs; opportunities for developing collaboration and teamwork; psychical working conditions at central sites, outside workplaces, multipurpose premises; and availability of adequate tools. It should also address *secondary factors* such as regulative options in the job and at the team level, e.g. room for control and mutual support (e.g. rescheduling work, share workload, time-management).

Management

To produce benefits good jobs need to be part of a good organization. It is a management responsibility that the organization's structure satisfies both technical and social criteria design criteria[60] and that its functioning is characterized by transparency, openness of communication, and operational efficiency[61]. Management can also install competent people-oriented leadership at all levels, that allows dealing with emerging employee

issues[62]. A main challenge for executives is to provide for change management in ways that employees can identify with and adapt to. HRM can do much to create a healthy environment, namely by acting against discrimination, harassment and bullying, by offering schemes for working hour, rest breaks, time off-time and absenteeism that allow room for recovery at the workplace (and at home) [63, 64] and by providing arrangements facilitating the work-home interface. HRM can make further contributions by means of employee assistance, wellness programs and sustainable workplace programs[65]. It is worth noting that “best employers” have little problems with workplace mental health. Finally, there should, of course, be a proper level of employee health care to identify risks and treat emerging health issues.

Workplace democracy

If the preceding recommendations are followed there is limited chance for mental health issues to arise. *And if problems emerge, they can largely be intercepted and addressed by managers and through the formal mechanisms of workplace democracy – work consultation, works councils and trade unions – provided that executives are supportive of and responsive to queries and proposals for corrective action.* It is worth noting that recognizing workers’ rights, social protection and workplace democracy are also important elements in the Decent Work Agenda of ILO[66].

Organizational strategy

Work is not a naturally occurring macro-level phenomenon that presents itself to a workforce of whom certain people are vulnerable to mental health problems and others are not. *Work is inherent in organizations that are structured and operated in ways that depend on strategy-driven decision-making by executives and key stakeholders – in private firms owners and shareholders, in public organizations policy makers. How work affects employees’ health is primarily dependent on these strategies.* Strategies aiming at maximizing profit or outcomes while minimizing costs, particularly with a short-term focus, tend to prefer scarce staffing, wage minimization, low investment in employee outcomes that do not immediately influence the bottom line. Strategies aiming at sustainability take a different perspective. Emphasizing long-term benefits for stakeholders, they are conducive to the protection and development of employee health and wellbeing, and to maintaining mutually beneficial relationships with society. Thus, the strategies pursued by firms and public organizations, inspired by a liberal or social market economy may – through the impact on the profile of organizations and work – affect the mental health condition of a larger or smaller number of employees.

The social market economy, emphasized by the European Union in its 2020 agenda, allows or greater emphasis on organizations’ responsibilities for long-term impact on employees and more balanced sharing of costs with governments and society. In articulating these responsibilities in the context of promoting mental health at the workplace the European Commission can build on earlier directives, such as the Directive 89/391EC on occupational safety and health and the Directive 2002/14/EC on works councils.

Considerations for action

Target groups

Measures should partly be generic, partly be tailored to particular target groups, with different risk profiles (e.g. part-time women, employees from minority groups, people with mental illness, young professionals, older workers, health care workers, teachers, managers!).

SMEs and larger corporations

Particular attention is needed to SME’s as they may not have the expertise and resources to follow best practices in mental health promotion and to international corporations as such practices might conflict with current prevailing business interests.

Best practices

Organizations in most of Europe operate against an institutional background that is significantly different from that in the e.g. the United States. The presence of a works council, in addition to trade unions, and executive bodies monitoring working conditions based on specific legislation regarding employee safety, health and wellbeing, points at institutional factors that may alleviate the potentially negative impact of certain business strategies on (mental) health. They also represent mechanisms that may protect and improve employees' mental health to a certain degree. Another difference is that the US has lacked a general public health care system and that private firms are held to cover employees' health expenditures. The ways in which employers deal with employee health and the way in which employees respond may therefore differ widely. An implication is that *one must be careful with generalizing findings from US-based studies to the Europe and adopting best practices from the US*. More research on workplace mental health promotion in Europe is needed.

Part III: what psychologists can contribute

The role of psychologists in the field of work and organization reaches significantly beyond the care for individual employees suffering from mental health symptoms. With the knowledge of work and organization that has accumulated over they can be expected to contribute to the development of organizations and work settings that systemically prevent the emergence of health problems and promotes wellbeing of future generations of employees [67].

Psychologists can be expected to:

1. Provide measures for mental health and workplace quality.
2. Monitor working conditions and predict trends (including "early warning") in mental health and wellbeing.
3. Suggest an appropriate portfolio of prevention and intervention measures.
4. Contribute to prevention by means of e.g. recruitment, selection, placement & training of workers, supervisors and managers.
5. Provide intervention by coaching and psychotherapy (the latter requires specialist clinical expertise).
6. Develop positive individual level and organizational level interventions to facilitate employee engagement and flourishing.
7. Conduct evaluative studies to assess the effectiveness of various interventions.
8. Advise executives about sustainable and effective forms of organizing that respects the interests of all stakeholders.

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Workplace Wellness Alliance

February 2011

Wellness for All: Responding to the Call for Action

During the World Economic Forum Annual Meeting 2008, CEOs from 13 main corporations called on business leaders to strengthen action on workplace wellness.

Following the 2008 "Call to Action", a group of leading companies has continued to champion workplace wellness, expanding their commitment to health and well-being at work and spearheading a World Economic Forum community of thought leadership in this area.

Did you know?

- One-third of the workforce suffers from preventable diseases in a given year.
- The four main risk factors for non-communicable diseases (NCDs) are nutrition, physical activity, smoking and alcohol consumption.
- Workplace wellness schemes addressing lifestyle changes and promoting health can prevent up to 40% of NCDs.
- Wellness programmes have demonstrated clear return on investment with cost savings of up to US\$ 4 per US\$ 1 spent.

During the financial downturn, the emphasis of the work in 2009 focused on understanding the return on investment of health and well-being schemes, and the compelling arguments underpinning the fact that investing in health increases employee resilience, productivity and competitiveness while reducing associated costs of presenteeism and absenteeism.

Join the Workplace Wellness Alliance

To support and recognize employers that promote healthy work environments, the World Economic Forum invites its Members and Partners to join its "Workplace Wellness Alliance" (the Alliance), the aim of which is to:

- standardize a set of common metrics, and
- launch an on-line knowledge sharing platform

In addition, the work of the Alliance will be featured at World Economic Forum meetings, showcasing gold standards, stimulating others to engage in the issue and continuing to raise awareness through a global platform of excellence and innovation while working

"The Alliance is a consortium of global CEOs dedicated to measuring the link between employee wellness, engagement and productivity. By applying metrics and best practices, the Alliance will enable employees to achieve their full potential while making optimum contributions to their enterprises' growth and success."

Michael B. McCallister, Champion of the Workplace Wellness Alliance
Chairman of the Board and CEO, Humana Inc., U.S.A.

Alliance Charter

The Workplace Wellness Alliance (the Alliance) is a consortium of companies committed to advancing wellness in the workplace. Initially, the Alliance will focus on knowledge sharing and developing and promoting the use of standardized metrics with the goal of achieving a global standard of wellness to enhance population health and workforce productivity.

Aim: To improve global health and productivity by making wellness a priority, starting in the workplace

Objectives

1. Provide a forum for knowledge and best practice sharing, supporting innovations in workplace wellness through on-line tools
2. Standardize a set of common metrics to help companies compare themselves to their peers
3. Foster knowledge of the economics of workplace wellness, including how to optimize the return on investment (ROI)
4. Leverage the workplace as an entry point for prevention and health at a community level

How to join

Through a voluntary sign-up system, businesses can join by:

- Choosing a level of engagement
- Signing the Charter
- Returning the completed sign up form by email or fax: +41 22 786 2744

For more information, contact wellness@weforum.org

Membership Value

- **Standardized metrics:** access to a framework for measuring and benchmarking workplace wellness programmes
- **Best practices:** contributing to and benefiting from a shared body of knowledge on successful programmes
- **Return on investment:** tools demonstrating return on investment on workplace wellness programmes
- **Reports:** executive reports on trends and customized in-depth data analysis
- **Global standard of Wellness:** collaborating with international organizations to develop new global standards of wellness to both enhance population health and workforce productivity
- **Other advantages:** quarterly best practice case studies, invitations to relevant World Economic Forum Events, and peer-to-peer engagement

A consortium of 39 companies committed to advancing wellness in the workplace



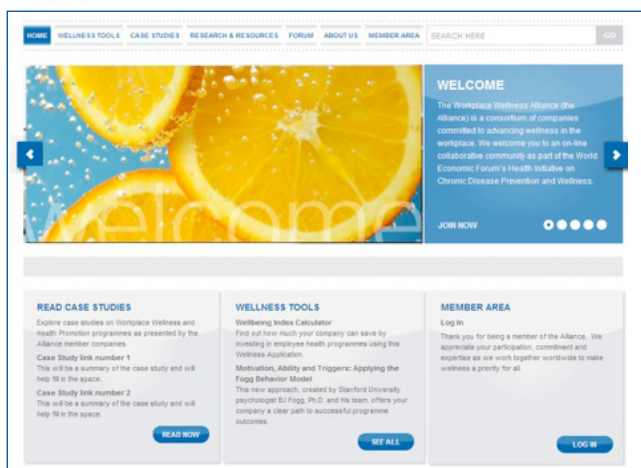
Signing up: Membership Levels

Companies are welcome to join any of the three membership levels - please check the box according to your chosen level of engagement:

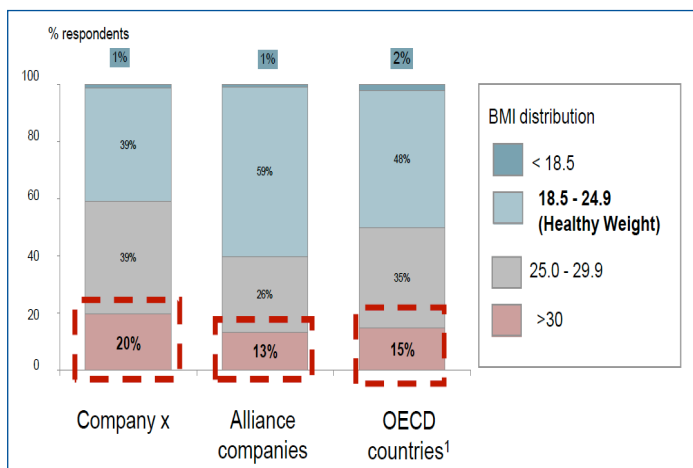
Level 1, Charter Signatory	<input type="checkbox"/> Adhere to the values embodied by the Charter and commit to move up at least one level within a year*
Level 2, Core Member	Contribute to one of the options below: <input type="checkbox"/> Metrics collaboration <input type="checkbox"/> On-line repository of workplace wellness programmes
Level 3, Leadership Member	<input type="checkbox"/> Contribute to both the metrics and the on-line repository and engage in shaping the Alliance offering (only level 3 members are invited to join the leadership board)

*Within a year of signing the Charter, general members commit to either rolling out an employee health survey to capture data for baseline metrics or to either having a plan of action developed or have implemented a workplace wellness programme.

Note: No contribution other than those mentioned, financial or otherwise, is required.



Visit the Alliance web portal for case studies and more information: <http://alliance.weforum.org>



Metrics will generate data analysis including blind benchmarking and identification of trends

We hereby join the Workplace Wellness Alliance at the level marked above.

Company:

CEO/Board level signatory name:

Position:

Date, place:

Contact person for the alliance within the company, and his/her position:

