Depression in the Workplace

Policy recommendations on how to tackle the leading cause of disability worldwide

Stephen Hughes MEP Initiative on Depression in the Workplace

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Foreword

Stephen Hughes
Member of the European Parliament from the United Kingdom for the Group of the Progressive Alliance of Socialists and Democrats

Over the past few years, I have been working on the topic of depression in the workplace in my capacity as a long-standing Member of the Employment and Social Affairs Committee. My interest in this important topic, which has direct consequences on the lives of an individual and his or her family, friends and co-workers, led me to start an initiative entitled “Depression in the Workplace”. Under its umbrella, I, along with my fellow MEPs, hosted several meetings that brought together key experts in this area to share their experiences and expertise on this topic. Depression is a serious condition, whose impact on the workplace is very high. This disease has the ability to lower an individual’s capability of functioning in the workplace and in some cases renders employees incapable of performing their jobs and function in their daily lives (cognitive effects of depression). I am proud to see the launch of this important recommendations paper, which is a major step towards making depression a priority in employment policies at EU level and across Europe. I would like to thank the leading European experts who have contributed their time and knowledge to make this paper a reality, and to thank my fellow MEPs for their commitment to putting focus on depression as a major future challenge for Europe and for their support for this recommendations paper.

Angelika Werthmann
Member of the European Parliament from Austria for the Alliance of Liberals and Democrats

The launch of this recommendations paper is an important milestone towards raising awareness of depression and its consequences for the individual and society in particular due to its effects in the workplace. The recommendations paper is a first step towards increasing the knowledge of psychosocial risks and addressing the stigma associated with mental health problems, which often leads employees to hide their conditions from their colleagues and employer.

In my work with the Women’s Rights and Gender Equality Committee, I have made it a priority to address the consequences of depression in women, both in relation to specific mental health risks for women in the workplace and depression in other phases of women’s lives such as depression following childbirth.

As an MEP, tackling depression in and outside the workplace remains a personal and political priority of mine, and I look forward to continue working for the inclusion of depression in relevant policies.

Emer Costello
Member of the European Parliament from Ireland for the Group of the Progressive Alliance of Socialists and Democrats

As a Member of the European Parliament, I have become increasingly aware and concerned about the consequences of depression in the workplace in Ireland and across Europe. Rising unemployment, job insecurity and more stressful working conditions have led to an increase in depression and depression-related suicides. I have been following and am enormously impressed by the work of the Irish organisation Aware, which seeks to help patients and their families overcome depression.
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Tackling depression in the workplace should be a major European priority, primarily through the European Pact on Mental Health and Wellbeing and the EU Strategy on Health and Safety at Work (2013-20). I am strongly committed to ensuring that depression receives the attention it deserves, at both European and at Member State level, and am grateful for the opportunity to contribute to addressing this major societal challenge.

Jutta Steinruck
Member of the European Parliament from Germany for the Group of the Progressive Alliance of Socialists and Democrats

As a Member of the Employment and Social Affairs Committee in the European Parliament, I am pleased about the launch of this recommendations paper, which addresses depression as one of the most important challenges that needs to be addressed in occupational health and safety, if we are to ensure the sustainability of work life in Europe. In my work within the Stephen Hughes Initiative on Depression in the Workplace, I have become aware of the scale of the problem of depression in the workplace and the immense costs to the individual and society, and as such I am strongly committed to work towards ensuring that these recommendations are reflected in policies at EU and national level.

Alejandro Cercas
Member of the European Parliament from Spain for the Group of the Progressive Alliance of Socialists and Democrats

As a contributor to the Stephen Hughes Initiative on Depression in the Workplace, I am pleased to see that our work over the past two years is coming together in this highly relevant paper. However this is only the first step towards tackling depression in the workplace, and much work is still left to be done. Going forward I am particularly keen to work towards seeing these recommendations reflected in concrete policy action by the European Parliament. Starting with the forthcoming revision of the Strategy on Health and Safety at work, I am committed to fight this important battle towards the inclusion of depression and psychosocial risks as a priority in all relevant policies, together with my colleagues from the different political groups.

Martin Kastler
Member of the European Parliament from Germany for the European People’s Party

The significance of addressing depression in the workplace is immense, and it is crucial that this is not overlooked when developing future health and safety at work policies. As Rapporteur for the proposal for a decision of the European Parliament and of the Council on the European Year for Active Ageing (2012), I am especially aware of the significance of ensuring good mental health and preventing depression, as a prerequisite for keeping individuals active and healthy throughout their working life, which is a necessity to ensure that Europe develops in a sustainable way in the face of an ageing population. This recommendations paper makes an important contribution to addressing the cognitive effects of depression in the workplace that leads to loss of workability, and I am happy to support this important initiative.
I. Introduction

We are at a defining moment in the way in which we approach the challenge of depression among our working populations across Europe.

Depression has a corrosive effect on the individual’s ability to function at home, at work, and within everyday social networks. Symptoms such as sadness and lethargy are often associated with depression. Less well understood are the cognitive symptoms of depression that directly affect an employee’s ability to function both inside and outside the workplace. Examples of cognitive symptoms of depression are lack of concentration, indecisiveness and forgetfulness. If adequately managed, people with depression can lead productive lives and make valuable contributions to society as a whole: the barriers to societal participation are being progressively weakened by advances in medical management of this frequently disabling disease.

The cognitive symptoms of depression can have a large impact in the workplace, and it is important that this is defined and better understood. From there we are in a stronger position to develop effective treatment strategies. The peer-reviewed literature makes the case all too often that application of guideline-supported standards of care can help restore the lives and productivity of many. When depression has been diagnosed, multidimensional treatment strategies can reduce cognitive and other symptoms of depression. Such intervention can directly increase attendance at work and productivity while at work. Healthcare professionals working in communities and hospitals strive to apply the accepted standards of care to their patients. But for many people with depression, this treatment can be suboptimal or absent. Moreover, many with depression struggle to make sense of what they are experiencing, and all too often will be unwilling or unable to seek professional help. These obstacles can lead to a downward spiral of performance at work causing financial loss to both the employer and the employee, further escalating to become a burden on society at large as worsening illness is left untreated.

There are important differences between the employer-employee relationship, and the doctor-patient interaction. While healthcare professionals rely on the individuals to explain the scope of any problems, employers have objective measures of productivity and subjective reports of social function provided by the affected employees and their colleagues. In addition, employers have specific and well-defined reasons to discuss an employee’s performance and where necessary to encourage changes in behaviour. This creates an opportunity for policy makers to better support effective interventions by employers.

Indeed it is the prerogative of policy makers to support employers in their efforts to reduce the impact of depression on the individual employee, society and ultimately businesses across Europe. Such initiatives will yield benefits that extend beyond the workplace; this is as much about broader health policy as employment policy. Moreover, any changes may also benefit the large numbers of unpaid workers, such as carers and those supporting family businesses, who are often in similar situations and exposed to the same risks as paid workers. The case for such intervention has been made, and will continue to be made.

As authors of these policy recommendations, it is our objective to improve understanding of depression in the workplace and how specific facets of this disease can place a devastating burden on businesses in Europe and their competitiveness worldwide. These recommendations are part of a broader initiative on Depression in the Workplace, which was launched by MEP Stephen Hughes in May 2012. The Initiative is now supported by a cross-party group of Members of the European Parliament who have committed to addressing one of the great public health and employment challenges of our time through the use of policy and legislation.

The specific aim of this paper is to advise and sensitise policy makers building employment as well as public health policy and law on approaches to addressing depression and its cognitive symptoms. The recommendations are applicable both at the European Union level, and within the Member States. Moreover, it is our intention that such recommendations and initiatives be applicable to large and small companies, and to the public and private sectors.

* The term “depression” is used throughout this document to mean all forms of depression, including clinical depression.
II. Experts on Depression and the Workplace

The Policy Recommendations in this document have been drafted in collaboration with Experts listed below. The individuals listed either participated in a live meeting or were interviewed by telephone, or both.

Paul Arteel
As long-term advocate and stakeholder expert, Paul Arteel, the current Executive Director of the Global Alliance of Mental Illness Advocacy Networks – Gamian-Europe, is a key opinion leader at EU level on tackling depression. In his home country Belgium, Paul Arteel was the initiator and head of several major campaigns such as the “2001 year of mental health” and the “Anders Gewoon” project designated to tackle stigma of psychiatric patients.

Stephen Hughes MEP
Stephen Hughes has been a Member of the European Parliament (MEP) for the Labour Party in the North East of England since 1984. Stephen Hughes champions a raft of health and safety protections, equal treatment rights for part-time, fixed term, and temporary agency workers, as well as the need to making much progress in tackling all forms of discrimination.

Stephen Hughes launched the initiative on depression and the workplace in 2012. The intention has been to work with Members of the European Parliament from different political and geographical backgrounds, responsible persons in EU and international institutions, Member State representatives, and stakeholders to tackle depression through employment and social affairs policy. The intention of this recommendations paper, as part of the initiative on depression and the workplace, is to make specific policy proposals to be implemented at EU and Member State level and to influence the international debate beyond the borders of the European Union.

Dr. Jesper Karle
Dr. Karle is a leading Danish psychiatrist and Director of the specialised psychiatric centre “PP-Clinic” in Copenhagen. In his role at PP-Clinic, Dr. Karle is implementing an innovative treatment model to tackle depression, which integrates medical care with social and workplace-based initiatives focusing on integrating working life in the treatment as a contributor to good health.

Prof. Dr. Raymond W. Lam
Prof. Lam is a psychiatrist and Associate Head for Research in the Department of Psychiatry at the University of British Columbia in Vancouver, Canada. He is internationally recognised as a leading expert on depression and has published 9 books on depression and over 300 research papers. Prof. Lam is currently the Executive Chair of the Canadian Network for Mood and Anxiety Treatments.

Prof. Dr. Pierre-Michel Llorca
As the Head of the Department of Psychiatry at the Mental Health Centre of the University Hospital Centre of Clermont-Ferrand, Prof. Llorca is one of the leading psychiatric researchers and doctors in France. Prof. Llorca has published several books and a number of research papers on psychiatric issues and on how to address them.

Prof. Dr. Roger S. McIntyre
Dr. McIntyre is Professor of Psychiatry and Pharmacology at the University of Toronto, and is Head of the Mood Disorders Psychopharmacology Unit, University Health Network, University of Toronto. He has authored hundreds of academic papers on many aspects related to mood disorders. His particular interest is the impact of cognition and medical comorbidity (e.g., diabetes) on functional outcomes (e.g., workplace) in adults with mood disorders. Dr. McIntyre is also Director of Mental Health Insights (MHI). MHI is an international group of experts from academia.
as well as from private, public, and non-profit sectors who are spearheading education, awareness campaigns, screening, care modelling, treatment, and prevention of depression in the workplace.

Amelia Mustapha
As a Director of Saint Mary Abbots Rehabilitation and Training, a UK charity that supports people affected by mental ill-health through training, work and recovery activities, Amelia Mustapha has contributed actively over a number of years to highlight the need to tackle depression in the workplace. As the Executive Director of the European Depression Association (EDA), Ms. Mustapha is an expert on the consequences of depression on the individual patient, and on the practical application of the tools to prevent and manage depression in the workplace.

Prof. Dr. Norman Sartorius
Prof. Sartorius is recognised as one of the leading psychiatrists in the world. As a professor at the University of Geneva, Zagreb, and Prague as well as a former President of the World Psychiatric Association and a Director of Mental Health at the World Health Organisation (WHO), Prof. Sartorius has played a leading role in addressing problems related to depression and other mental disorders worldwide for more than 50 years. He has been particularly active in promoting the rights of patients with depression and other mental disorders as well as highlighting the need to address the stigma associated with mental illness. Prof. Sartorius is currently President of the Association for the Improvement of Mental Health Programmes—Action for Mental Health (AMH).

Prof. Dr. Martin Schütte
Prof. Dr. Schütte is one of the leading experts in Germany on the interaction between psychosocial impact of work and the consequences of stress and depression on the ability to work. He is the Scientific Director of the Division of “Work and Health”, German Federal Institute for Occupational Safety and Health (BAuA).
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With thanks to the following persons for their advice and contributions:

Dr. Małgorzata Milczarek
Dr. Milczarek is a psychologist who graduated from the University of Warsaw and completed her Ph.D. in psychology from the University of Silesia. She is a Project Manager in the Prevention and Research unit at the European Agency for Safety and Health at Work (EU-OSHA). In her current function, she is responsible for EU-OSHA’s projects on work-related stress and management of psychosocial risks.

Christopher Prinz, Ph.D.
As Senior Economist Project Leader, Mental Health and Work Reviews, Organisation for Economic Co-operation and Development (OECD), Dr. Prinz has been a leading figure in developing the OECD’s ambitious approach to tackling depression in the workplace and has contributed to put the consequences of depression on top of the international agenda of health issues to be tackled.

Dr. Shekhar Saxena
As a psychiatrist, Dr. Saxena has more than 30 years of experience in addressing mental health through research and implementation of prevention programmes. Dr. Saxena is currently Director of Mental Health Programme at the World Health Organisation (WHO), where he is responsible for implementing the agency’s ambitious mental health gap action programme.

Shruti Singh
Ms. Singh has been a strong contributor to the development of the Organisation for Economic Co-operation and Development’s (OECD) strong recommendations to tackle mental health and depression in the workplace. As part of the Mental Health and Work Reviews Team, Ms. Singh has been contributing to many important publications that are highlighting the need to address depression as a key social and labour market issue and loss of ability to work.

Editors

Steven Bridges, Malvika Vyas, Rune Pedersen
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III. Depression Today

What is depression?

Depression is a chronic, recurring, and progressive disorder affecting 350 million people worldwide. In a recent survey of 7065 working people in Europe, commissioned by the European Depression Association (EDA), 20% said they had been diagnosed with depression at some point in their lives; an estimated 21,000 work days were lost because of the most recent depressive episodes experienced by the people in this survey. Other studies have shown that the incidence rises to over 25% of the working population if anxiety and lighter forms of depression are included.

About half of all major depressive episodes are untreated. People suffering from this condition may attempt to continue life as normal, and hide their problems from family, friends, and work colleagues. Each patient presents with a unique pattern of symptoms influenced by his or her environment, as well as family and personal history. Similarly, the severity of symptoms and their debilitating effects on patient function and quality of life vary across individuals. While the symptoms differ considerably across patients, some are more common than others. Most prominently depressed patients self-report deficits in cognitive function during major depressive episodes up to an estimated 94% of the time. In addition, cognitive symptoms impair function at home, school, and the workplace where it adversely affects attendance and productivity.

A complicating consideration for anyone involved in the care of people with depression is the co-occurrence of other illnesses that may also need treatment. Comorbidities may include psychiatric disorders such as anxiety and substance abuse, as well as somatic disorders such as cardiovascular disease and obesity.

Depression and disability

In 2004 the World Health Organisation predicted that depression would become the leading cause of disability worldwide within 30 years. This forecast still holds today, and in 2012 the World Health Assembly called for a comprehensive, coordinated response to depression and other mental disorders at the country level.

Depressed individuals struggle to function at home, in the community, and in the workplace. But the functional impact of the chronic psychiatric disease extends well beyond the patient, and includes employers, colleagues, as well as caregivers who frequently struggle with the demands of patient care. Indeed, it is in the workplace where depression imposes the greatest economic burden, as measured by disability-related reductions in attendance and productivity.

Depression and the workplace

Depression is primarily a disease affecting the working age population. In the EDA survey described earlier, 1 in 10 working people had taken time off from work because of depression, with a mean time off from work of 35.9 days the last time they experienced this illness. But only about one-third said they would tell their employer that they had depression and 37% said they would definitely not tell their employer. Thus depression is a common condition that has a significant and often unrecognised impact on employees and, consequently, their employers. Depression affects people from all professional and social backgrounds, whether in paid or unpaid work, employed or self-employed, of working age or who are retired. Initiatives to reduce the impact of depression in the workplace need to consider these various groups and the degree to which depression can impair their contribution to their work, to society more broadly, and ultimately to economies across Europe.

The Europe-wide costs of this illness are described in Box 1.
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Box 1. Direct and indirect costs of depression in the European Union

- €92bn: the estimated costs of depression in 2010
- €54bn: the estimated indirect costs of depression in 2010, which include lost productivity at work, due to, for example, sick leave and early retirement. These costs are unrelated to healthcare
- 50%: the overall proportion of long-term sick and disability payments resulting from mental disorders, mostly depression, in Denmark and The Netherlands
- 50%: the approximate proportion of the costs of depression that come from absenteeism* and presenteeism**
- Nearly 50%: the proportion of people taking sick leave while being treated for depression, of which more than one-third take over 26 weeks off work

* Absenteeism is lost days of work
** Presenteeism is low performance while at work, which transformed into lost day equivalents

Box 2. The cognitive symptoms in depression

The cognitive symptoms of depression:

- Are present up to 94% of the time during depressive episodes
- Cause absenteeism
- Reduce productivity at work
- Are characterized by concentration problems, indecisiveness, and greater time needed to understand situations and react to them
- Can even impact an individual’s ability to move
- Are often overlooked by teams caring for people with depression
- Need adequate treatment, a critical factor in reducing symptoms and improving employment prospects for people with depression

The PERFORM study (Prospective Epidemiological Research on Functioning Outcomes Related to Major Depressive Disorder) is a 2-year research initiative being conducted across France, the UK, Germany, Spain, and Sweden measuring the impact of depression on daily function and work impairment. Data from the first 1000 subjects studied show that patient-reported cognitive dysfunction is associated with poorer functioning, work productivity, and quality of life. Moreover, other studies have shown that these symptoms frequently harm the interpersonal relationships between friends, family, and colleagues that might otherwise form part of the sufferer’s support system during depressive episodes.

These and other published data have helped to describe the burden of depression on the individual, society, and employers. This burden can be reduced with improved diagnosis and effective treatment. There are, unfortunately, many barriers that limit the effectiveness of these interventions, including the very real stigma of depression. Public stigma – how society at large views the condition – and self-stigma, or how individuals cope with their depression and whether and how they seek help, are both formidable barriers that must be overcome. Certainly, removal of stigma from the workplace represents an invaluable mechanism that can be used to reduce the burden of this disease both on those affected by the condition and on the workplace as a whole.
Treating depression

Treatment strategies for depression aim to get depressed patients to remission, which means their scores on validated rating scales such as the Montgomery-Asberg Depression Rating Scale (MADRS) fall to below the cutoff point for depression.

It has been demonstrated that by treating the cognitive symptoms of depression, workers can increase their ability to function and work. Early and complete treatment responses with resolution of all functionally impairing symptoms predict sustained wellness. Treatment guidelines recommend multidimensional approaches, often combining drug treatment with cognitive behavioural therapy.

Clearly people with depression need to see a clinician to receive a diagnosis that can put them onto a treatment path. Once depression is diagnosed, sustained adherence to any treatment plan is an essential determinant of long-term outcomes. There is a need, therefore, to build upon the improved diagnosis of depression with strategies and practical tools that will support individuals as they strive to get well.

The path to achieving change in the workplace

The nature of the relationship between employers and employees provides a framework around which the burden of depression in the workplace, and indeed in society more widely, can be addressed.

Employers will generally have objective measures of staff performance, and may also accumulate feedback on individuals’ affect and behaviour through the usual performance appraisal process. Even in companies with relatively unsophisticated (or absent) performance review processes, data on absenteeism are routinely collected. Thus employers can be aware of problems long before a clinician has been consulted.

The environment and working atmosphere within individual organisations can present challenges that employers need to address. Psychosocial stressors in the workplace – for example, pressures to perform, fear of redundancy, poor conflict management – can precipitate depression among vulnerable staff, or exacerbate pre-existing symptoms.

Tackling depression in the workplace requires a holistic approach focused on prevention, early intervention, and treatment. It is clearly in the employer’s interest to reduce the burden of depression in the organisation, given its impact on absenteeism and presenteeism. Besides, a growing body of evidence supports the value of treatments in reducing the burden on employers.

But many employers have neither the expertise nor the focus on this issue to improve rates of absenteeism and presenteeism. The above-mentioned EDA survey found that nearly 1 in 3 managers within various organisations felt there was no formal support in place for managing staff members who have depression. Almost all managers questioned in the survey stated that they would value more support and tools to cope with employees who might be experiencing depressive episodes. In this same survey, 43% of respondents called for better policies and legislation to protect employees. Box 3 shows the kinds of questions that managers in organisations of all sizes should be able to answer.

Box 3. Questions managers should be able to answer

1. What kinds of support should the employee with depression seek?
2. What support is available within the company for employees with depression?
3. If a working relationship is a contributor to depression, what conflict resolution support can be offered?
4. What flexible employment options are available to support the treatment and recovery process?
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Human Resource and Occupational Health Professionals are well placed to help reduce the occurrence of precipitating or aggravating factors of depression in the workplace. It is, however, more challenging for these professional functions to be trusted as confidential sources of support and advice for employees struggling with depression. There is a need, therefore, to introduce policy which can help organisations with a necessarily commercial focus to take a longer and broader view as they offer impartial and confidential advice, and provide structured support to employees with depression. The cost-benefit case for intervention is being made as results emerge from interventions by individual companies. For example, British Telecom (BT) has implemented a mental health strategy with a clear financial return and a measurable impact on employees’ quality of life.

Following are the key results from implementation of the BT mental health strategy:

- 30% reduction in sickness absence rates due to mental health problems
- 68% of employees learned something new about ways to look after their mental health
- 56% of employees tried some of the recommendations and were continuing to practise them at the time of the follow-up
- 51% of employees had noticed improvements in their mental well-being

Though few countries have made a genuine impact on the burden of depression in the workplace, several current programmes can help shape policy. In Canada, the governmental Commission for Mental Health and the programme “Workplace Strategies for Mental Health” are supporting both the public and private sectors to implement specific measures nationwide. These include structured discussions with employees to understand their mental health and satisfaction levels within each mandatory performance assessment. There are also examples within individual companies, including the “Let’s Talk” campaign run by Bell Canada (the country’s largest telecommunications company), which helps to achieve similar openness around mental health issues among its staff.

Public policy and depression

Public policy must acknowledge the devastating effects of depression in the workplace. There is a need to prioritise policies, legislation, and stand-alone initiatives that can enable individuals with depression in the workplace to be identified sooner, and encouraged to seek help. Interventions and recommendations must be based on robust evidence. The deficiencies in the available evidence supporting intervention must be identified and addressed.

EU health and safety legislation provides vehicles from which guidance can be drawn alongside employment legislation. In addition, expert groups and committees can steer both policy and targeted initiatives to help employers better support their staff with depression. Certainly, it is hoped that imminent updates to the Health and Safety at Work Strategy by the European commission will acknowledge the need to address shortfalls in policy on mental health overall and depression in particular.

The role of legislation

The Member States of the European Union have made significant progress in protecting workers from physical risks to their health. There are, of course, still improvements to be made; the European Parliament is still advocating for stronger protection of workers from asbestos exposure and injuries caused by medical sharps. In recent years, governments have recognised that workers’ mental health has been neglected. It is, therefore, appropriate to explore and propose legislation that can help address a clearly defined need in the workplace. Mental health is such a need, but there are challenges for policy makers and stakeholders within the field.

Health and safety legislation frequently deals with quantifiable issues such as electromagnetic fields and toxic chemicals. Similarly, policy plays a role in helping to prevent mental disorders and to improve mental well-being in
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Interventions should clearly be seen as an investment rather than a cost given the gross financial burden that impaired mental health poses today. These preventive measures can focus on education for stakeholders that encourages a workplace culture where mental health issues are addressed sympathetically and with the same sensitivity as somatic illnesses such as cancer. Furthermore, policy and legislation closely related to health and mental well-being, such as posting of workers, health and safety at work, corporate restructuring (often referred to as downsizing), and working conditions, generally need to acknowledge their potential impact on mental health.

That said, it is not possible to quantify risks to mental health in the workplace in the same way as for toxins and radiation. What is considered an inappropriate level of stress by one person can be seen as motivating and enjoyable by another. Moreover, there are huge differences in work environments across different sectors. As such, it is not feasible to develop policy and legislation to regulate what psychosocial factors workers can be exposed to, irrespective of whether or not they have depression. The answer perhaps lies in legislation that supports better working conditions combined with provision of practical support for staff members who have depression or other mental illnesses.

Policy can play a role in fostering creation of solutions that help to address depression in the workplace. It is often the simple, inexpensive initiatives that can have the greatest impact. It is in this spirit that policy can facilitate engagement by those stakeholders that are in a position to reduce the burden of depression on the EU economy.

Again, Canada provides inspiration for future initiatives. Canada’s Provincial Health Services Authority has created a toolkit for various stakeholders: for employees who are at risk of developing depression, for employers, for family members, and for treatment providers. This toolkit provides an integrated information source to attain a better outcome for all concerned.

In Europe, however, there are insufficient effective measures to address depression in the workplace. Current policies fail to consider employers and workplaces as partners to the healthcare system, and to date, there is no existing systematic approach to integrate employment in the management of mental health. Moreover, the few available case studies often come from independent initiatives from within companies.
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Conclusions

Depression is a disease that is often invisible. Sufferers tend to hide the problem, and employers are ill-equipped to connect it to absenteeism and impaired performance among employees. Employers are therefore unlikely to recognise the impact it is having on their organisation. That said, robust epidemiological data, accompanied by exhaustive economic analyses, paint a vivid picture of the impact of depression and its cognitive symptoms across Europe, an impact carried in large measure by employers. Member States are becoming more sensitised to the need to act. And it is appropriate that the European legislature considers pan-European support to help Member States address these issues.

In the following section, there are a number of policy recommendations that were developed to specifically address the need to reduce the burden of depression on the individual, families, employers, and the European economy as a whole.
IV. Summary of Recommendations

Legislative Imperatives

1. The European Union and its Member States shall ensure that workers are protected from inappropriate psychosocial risks in the workplace through employment policy and legislation. Policies and legislation that have a clear potential impact on mental health in the workplace should contain specific measures to improve mental well-being, and at the minimum ensure the mental health of the workforce is not impaired. Outcome measures that help Member States and individual companies to assess the impact of any changes should be proposed. Examples of such measures include the Working Time Directives, posting of workers, corporate restructuring, and anti-discrimination law. Implementation of adopted recommendations will often rest within EU Health and Safety at Work policy with Member States responsible for local implementation of policy or specific recommendations.

2. Policy makers need scientifically based outcome measures that can be used to assess work environments and measure the impact of interventions designed to reduce the impact of depression in the workplace. These measures need to be grounded in the available evidence and supported by expert opinion.

3. Legislation needs to acknowledge the role employers have in improving each of the following:
   • Prevention of onset of depression through improvements in the work environment. This can be through appropriate design of the workplace and its environment to help support physical and mental well-being
   • Early intervention to support recognition of depression and the impact of any cognitive symptoms on the employee's performance; and from there, implementation of a plan to support recovery
   • Promoting good mental health through sound management programmes for depression
   • Providing support when mental health is at risk and focusing on early training to ensure a reduction in the overall impact of depression on individual companies
   • Managing mental health issues by ensuring the availability of Employee Assistance Programmes and mental health services

4. Enterprises shall be encouraged to develop plans that reduce the impact of depression and its cognitive symptoms on the workplace. The cognitive symptoms of depression, such as lack of concentration, indecisiveness, and forgetfulness impose a significant burden on organisations by reducing an individual's productivity and encouraging absenteeism. Employers and employees need to be supported in their efforts to increase understanding and recognition of these symptoms. From there, employers will be better placed to develop and implement strategies to improve mental health at work for the benefit of the individual and the organisation.

5. Responsibilities of employers and employees as they relate to depression and the workplace must be clearly delineated and communicated. Within policy there must be no ambiguity surrounding employer obligations to staff, and vice versa, as they relate to depression. This means employers and employees alike must understand fully their respective responsibilities in reducing the burden of depression in the workplace. Those framing policy should recognise that effective interventions will rely on a productive partnership between employers, employees, and other stakeholders.
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Guidance for Member States

6. Encourage Member States to establish Mental Health Commissions to oversee mental health provisions in the workplace.

Canada has provided a blueprint for this approach in the form of the Mental Health Commission of Canada and the “Workplace Strategies for Mental Health” programme. The commission is a multidisciplinary body involving the general public (including people with depression), caregivers, employers, trades unions, and health professionals tasked with addressing the specific challenges associated with depression in the workplace. They take a holistic view of the various issues seeking solutions across health and employment policy. The remit of this commission could include the following:

- Ensure employers, employees, and other stakeholders fully understand their respective responsibilities and the possibilities for intervention in relation to depression and other mental illnesses in the workplace.
- Create educational materials for use in the workplace and adaptable toolkits for organisations to help them develop their own internal strategies to address this issue.
- Foster communication between groups responsible for health and employment policy to ensure concordance of policy from these groups as it relates to mental health. The European Commission has led by example in this respect as DG Health and Consumers and DG Employment, Social Affairs and Inclusion collaborate in their programmes on the European Pact for Mental Health and Health and Safety at Work Strategies.
- Further develop the value argument to support interventions that aim to reduce the impact of depression in different kinds of organisations.
- Manage a form of follow-up with employers to ensure appropriate action is being taken to improve the provisions for mental health issues in the workplace. The function responsible for follow-up would be defined by the Member States, and equipped with instruments to recognise improvement, and to impose sanctions where there are shortfalls. Actions could range from positive incentives through to financial penalties.

7. Health policy must recognise the role healthcare professionals have in ensuring that patients with depression are treated according to established evidence-based guidelines.

Healthcare professionals play a critical role in developing and maintaining treatment plans for their patients. They must continue to be empowered to combine clinical judgement with evidence-based recommendations as they support individual patients on their path to wellness. In addition, healthcare professionals need to recognise that interventions will often require consideration of the patients’ work situation with necessary adjustments incorporated into the treatment plan.

8. Member states should develop national Mental Health Action Plans to reduce psychosocial risks in the workplace.

Employers and employees will be positioned as equal partners in the implementation of these Action Plans. The structure will involve execution of a simple risk assessment, followed by practical advice to help improve the workplace environment if necessary. The EU-OSHA (European Agency for Safety and Health at Work) is well placed to support the development of an action plan that can be implemented on a national level. These Action Plans should specify goals and objectives for interventions that address risks in the workplace, including but not limited to psychosocial stressors. In addition, a suite of educational resources for different stakeholders could be included, and also provide the cost-benefit rationale to support such investment in different types and sizes of organisations.
Supporting Stakeholders

9. Targeted discussions between professional medical societies and policy makers.

Policy makers need to engage professional medical societies to ensure there is a shared understanding of the impact of the day-to-day clinical management on wider public health. In addition, this kind of engagement can help ensure policy is based on evidence and expert insights from the medical and research communities.

Thus the objectives of such engagement are:

- To ensure that new policy dovetails with the needs of clinicians to supply evidence-based standards of care to patients with depression
- To ensure political initiatives within this field are indeed practical and have value in the real world
- To encourage a greater understanding within the medical profession of public health policies surrounding depression. In addition, to ensure that the most recent policies are reflected in medical education programmes that are supported by the professional societies. The UK and Austria are examples of two countries in which this kind of change is underway with training curricula for GPs including greater emphasis on mental health.

Specific Policy Changes

10. Update legislation that supports workplace employee education to include advice on depression and overall mental health.

Legislation must underscore the importance of educating employers, employees with depression, and the broader employee community on recognising problems that could indicate serious mental illness. These educational needs should also de-stigmatise depression and other mental illness in the workplace. The guidance will need to explain in simple terms how depression is a syndrome with cognitive symptoms that can affect an individual’s ability to earn a living. Advice will be given on the steps that can be taken to seek help. Gaps in existing legislation will be identified and addressed.

Supporting Long-term Interventions

11. Promote financial support for research to measure the impact of alliances between employers, healthcare professionals, employees, and families to improve the identification and care of depression among employees.

A number of alliances in various forms have been created, which are to be encouraged with suitable capture of outcome measures. Interventions should measure the impact of initiatives on absenteeism and presenteeism using expert advice. A good example of such an alliance includes that undertaken by the teaching hospital CHRU Clermont-Ferrand in partnership with Michelin and the Regional government. Moreover, funding should be made available to support such studies within small- to medium-sized businesses.

12. Provide funding to support creation of a model “Workplace Recovery Pathway”.

Policy has, in this context, a role to play in promoting effective approaches and initiatives. For example, an employee recovery strategy should be developed as a collaboration between medical professionals, occupational health professionals, and human resource professionals. This alliance would create a model pathway in which the recovery needs of employees with depression are supported as they embark on a treatment plan. Implementation of this kind of approach will necessarily require clear explanation of the cost-benefit argument supporting it. In addition, financial incentives should be considered to encourage participation by the varied stakeholders in these kinds of schemes.
Depression in the Workplace

V. References


