# *Chapter 4*

# From workplace stress prevention to employer incentives and support for workers with mental health problems

*Employers are ideally placed to help their employees deal with mental health problems and retain their jobs. Workers who suffer from mental ill-health take sick leave more frequently and are absent for longer than those who are mentally healthy. At the same time they also report reduced productivity at work more often. Stress prevention in the workplace is both a necessary and effective means of tackling existing mental health issues. However, the pervasiveness of mental health stigma complicates the solution of work problems that are related to mental health problems. If managers are to be able to identify mental health problems, they need adequate training and support.*

*Policy conclusions:*

- *Enforce legislation for psychosocial risk prevention.*
- *Improve (line) managers' responses to workers' mental health issues.*
- *Design effective return-to-work management processes.*
- *Strengthen incentives and obligations for employers to prevent and address sick leave.*

Most people with a mental health problem have a job and go to work. Often, though, they are not fully productive. The workplace is thus a key area from which to develop policy that addresses the issue of mental health-related exclusion. Moreover, although work is a generally protective environment and fosters good mental health, it can also distress employees and worsen poor mental health. Stigmatising attitudes, evasive, counter-effective managerial interventions, and ignorance of psychosocial workplace risks are all factors that contribute to excluding workers with mental health problems from the labour market.

Although there is growing awareness of such risks and of the need for stress prevention in many OECD countries, there are few procedures or support mechanisms for translating that awareness into concrete action. The challenge is to provide effective early intervention and support for employers to address workplace risks and work problems. Mental health problems are related to performance deficits and interpersonal problems in the workplace. Not all mental ill-health can be prevented and employers must manage sickness absences, return-to-work, and workplace conflicts. Small and medium-sized enterprises (SMEs) in particular have little scope to adjust and are often left to their own devices.

## Stigma and disclosure, a vicious circle

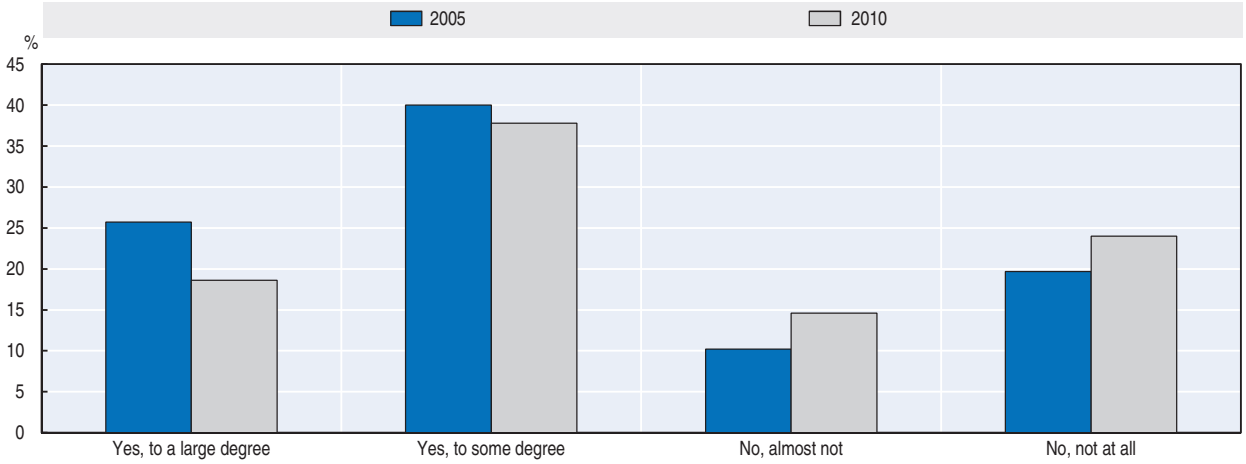
Awareness of mental health problems in the workplace and psychiatric treatment capacity have both grown in recent decades (Henderson et al., 2013). Yet the stigma that attaches to mental illness has not abated to the same degree. Prejudice is still very prevalent and is in sharp contrast to attitudes towards physical ill-health (Figure 4.1, Panel A). In 2005 as many as 65% of Danish employees, for example, were reluctant to work with someone who suffered from mood swings. Five years later more than one in two (55%) felt the same way. Yet only one in six would not wish to work with a blind colleague and only one-tenth with a co-worker in a wheelchair (OECD, 2013c).

Stigma complicates the management of mental-health-related work issues and makes it difficult for workers who suffer from mental ill-health to find, resume, and hold on to jobs (Stuart, 2006; Brohan et al., 2012). Many employers would not hire even highly-qualified applicants if they knew they had suffered from mental illness (Baer, 2007). Stigma makes it hard to fit back into the workplace, so making spells of unemployment even longer and increasing the number of disability benefit claimants (Rosholm and Andersen, 2010). Finally, many employees who suffer from poor mental health choose not to mention it because they fear discrimination and dismissal. As a result, co-workers and managers have trouble determining the reasons for their poor performance or interpersonal problems and do not offer support or understanding.

The pervasiveness of mental health stigma is surprising in view of the prevalence of mental ill-health in the working population, which is currently between 15% and 18% (OECD, 2012). Prejudice towards people with mental illness in general and the ability to collaborate closely with them in the workplace are common, not necessarily contradictory stances (Thornicroft et al., 2007).

Figure 4.1. **The stigma attached to workers with mild-to-moderate mental ill-health in Denmark persists despite improvements**

Percentage of workers who would be reluctant to work with a colleague who has mood swings




*Source:* Thomsen, L.B. and J. Høgelund (2011), "Handicap og beskaeftigelse. Udviklingen mellem 2002 og 2010", Report No. 11:08, Danish National Institute for Social Research, Copenhagen.

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Fighting stigma is a challenging task. In the past decade, there have been workplace campaigns to that effect in a number of countries:

- The United Kingdom – the Shaw Trust in 2010; Munday in 2010; Time to Change in 2009; the "see me" anti-stigma campaign; the Mentally Healthy Workplace Programme.
- The United States, where most action has been to support military personnel suffering from posttraumatic stress disorder.
- Australia – the National Workplace Program from *beyondblue*; Business in Mind; Mental Health First Aid.
- Canada – the Copernicus Project: Risk Management for Workplace Mental Health; Mind Matters: Opening Minds.
- Continental European countries, like Denmark's "One of us" (OECD, 2013c) and Switzerland's "How are you?" (see also Malachowski and Kirsh, 2013; Szeto and Dobson, 2010).

Few of the campaigns have been evaluated extensively or for long periods, having got under way only in the last few years. Yet there are doubts as to whether they will yield sustainable results, as their awareness-raising approaches do not effectively change long-term behaviour when distressed employees are a burden on supervisors and co-workers (Clement et al., 2013; Corrigan et al., 2014; Baer et al., 2011; Corrigan and Shapiro, 2010).

Policies to curb stigma should seek not only to raise awareness but to build good relationships between workers with mental health problems and their colleagues. Supervisors, for example, should be fully instructed in how to behave in problematic situations. Similarly, policies should not only prevent discrimination but also encourage

workers with mental ill-health to talk about their resulting work problems and supervisors to take early action in order to address workplace issues related to poor mental health. In other words, anti-stigma policies should give supervisors the backing they need.

Prejudice against workers with mental illness and their unwillingness to disclose them are frequent, interrelated problems. Self-stigma often prevents people from speaking up for themselves or tempts them to give up in the face of real or perceived hostility. More active policies than awareness-raising are needed to compel the workplace to include and maintain people with common mental health problems.

There are four particular key areas for workplace policy action: i) psychosocial risk prevention; ii) training and support for line managers; iii) the effective management of sickness absence and return-to-work; and iv) incentives and obligations for employers and employees.

## Enforced legislation for psychosocial risk prevention

Employment is usually good for mental health. But poor-quality jobs, bad leadership, and psychosocial stress in the workplace can put mental health under strain and even trigger problems (Stansfeld and Candy, 2006). The cause-and-effect relationships between the work environment and mental health are multi-directional, as described in OECD (2012):

- Job-related strain and a poor psychosocial work environment can cause mental ill-health.
- Workers with mental health problems tend to work in lower-quality jobs and poorer work environments.
- Workers with mental health problems perceive their work situation more negatively because of their condition.

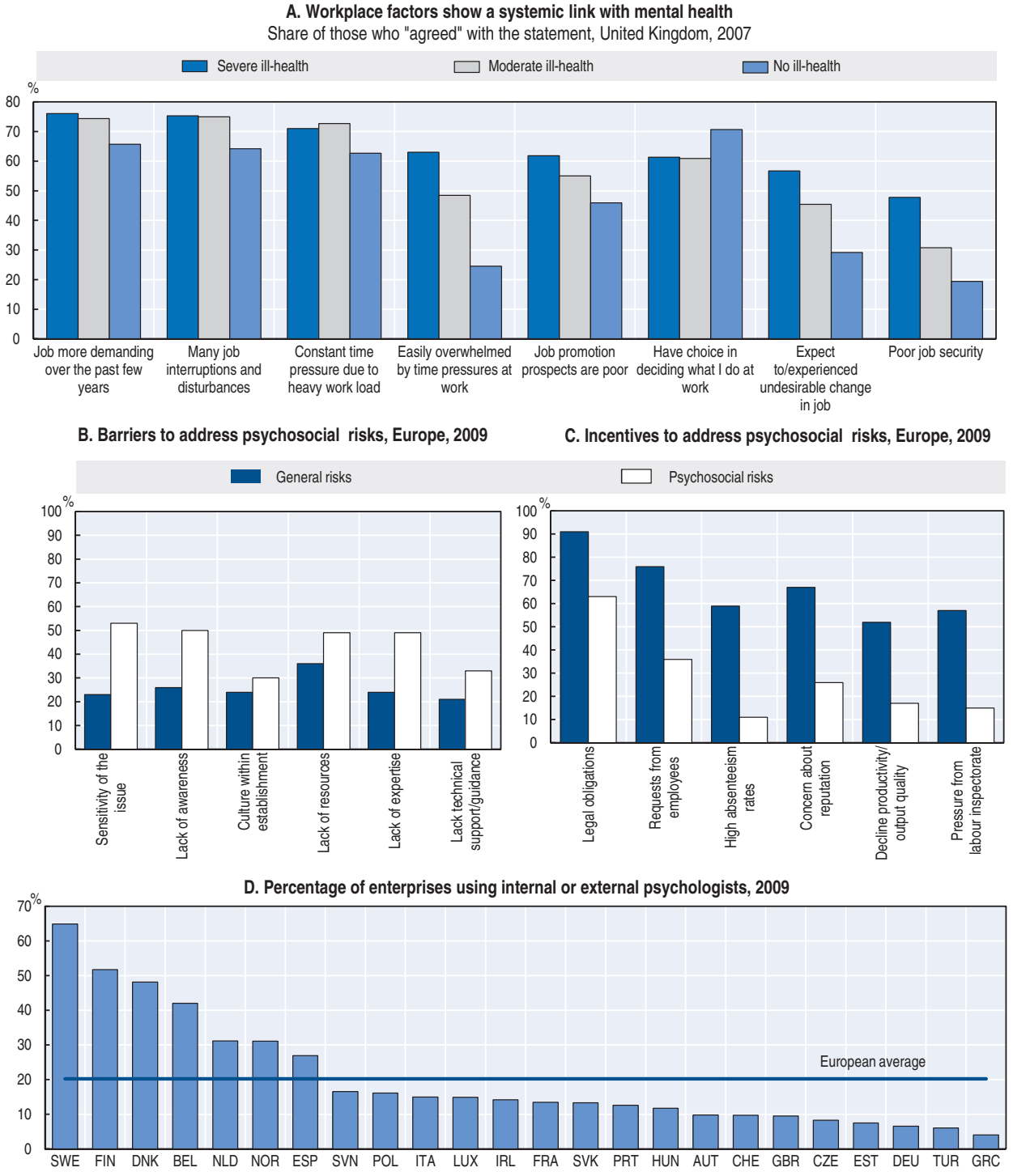
### *The relationship between the workplace and mental ill-health*

Figure 4.2 (Panel A) shows how closely linked working conditions and mental ill-health are. There is evidence that more and more workers in most European countries are experiencing the joint effects of high job demands and low decision latitude – a combination that leads to job strain (OECD, 2012). Depending on the country, between 20% and 40% of employees report feeling job strain, a state that is associated with more frequent and longer sickness absences.

Many workers with a mental health problem in the United Kingdom report that they feel overwhelmed by the pressures of time at work, fear undesirable changes in their jobs, and do not feel secure in them (OECD, 2014b). Surveys in other countries yield comparable results. In Denmark, for example, workers with mental health problems report that they do not have enough time to complete all their tasks and receive little support from their supervisors. They also speak of limited co-operation with their colleagues and low appreciation of their work by management (OECD, 2013c).

However, it is important not to overstate the job strain paradigm. Depression is more closely related to high levels of stress in private life than to work strain (OECD, 2013a). And it is not even certain that work-induced psychological stress has increased. Data from Austria, for example, suggest that self-reported work strain has steadily declined in the past 15 years (OECD, 2015).

Figure 4.2. **Significant barriers and lack of incentives hinder better prevention policies**




*Note*: EU-24 comprises the average of the 24 countries covered in the European survey of enterprises on new and emerging risks (ESENER).

*Source*: Panel A: OECD calculations based on Adult Psychiatric Morbidity Survey, 2007; and Panels B-D: OECD compilation based on the 2009 European survey of enterprises on new and emerging risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

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The vast majority of countries have tackled psychosocial workplace risks and job strain through labour legislation. Examples are the Working Environment Acts of Norway, Sweden and Denmark, the Labour Conditions Law in the Netherlands, Austria's recent Labour Protection Act, and Belgium's Well-Being at Work Act. All require employers to routinely assess, prevent and control psychosocial risks at work – a substantial shift away from the traditional health and safety focus of the labour inspection authorities.

Accordingly, a number of countries have drawn up guidelines to help employers assess and prevent psychosocial risks, although they remain free to decide how to meet their obligations. Other countries, however, compel enterprises to employ or contract with occupational health or prevention specialists. Consequently, they call more extensively on the services of psychologists than do firms in countries like Switzerland or the United Kingdom, where employers have a legal duty to secure employee health but are not bound by legislation on work-related stress (Figure 4.2, Panel D).

Legislation on psychosocial risk prevention has triggered growth in the professional support and tools available and greater public awareness of psychosocial workplace risks. But the picture remains flawed:

- Many enterprises do not comply with legislation;
- The vast majority of SMEs struggle to comply with regulations and receive only minimal, if any, support;
- The focus of psychosocial risk prevention is almost entirely on organisational and structural factors to the neglect of individuals' workplace problems;
- Occupational health professionals – the actors who provide companies with the most support – still tend to lavish their attention on physical rather than psychosocial risks;
- Legal obligations, pressure from employee representatives, and high absenteeism prompt employers to address general risk factors at work, not their understanding of psychosocial risks, which is still very low.

Many enterprises perceive the obligation to address psychosocial workplace risks as a burden (Figure 4.2, Panel B). Sensitivity of the issue, low awareness, lacking resources, the workplace culture, and lack of expertise are the factors that make employers so grudging about addressing psychological issues. Employers consider the incentives for reducing psychosocial workplace risks – among them e.g. legal obligations or high sickness absence – as less compelling than for general workplace risks (Figure 4.2, Panel C).

### *Making risk prevention a stronger policy tool*

A number of countries have developed promising policies to: i) provide workplace-specific tools that strengthen action for improving the psychosocial work environment, ii) require concrete psychosocial risk prevention plans from firms, iii) introduce specialist workplace psychosocial risk advisors, and iv) offer counselling to employers seeking help.

- Denmark has put in place sector- and job-specific guidance tools that describe in concrete terms risks and the resources a company may use to prevent problems (Factsheet 4.1). Inspectors from the Working Environment Authority (WEA)

have been trained to use the tools and support employers. Preliminary results suggest employers find the guidance tools very useful.

- In Belgium, employers are required to draw up five-year prevention plans that meet the problems identified by their psychosocial risk assessments. They must establish annual action plans to prevent psychosocial distress at work and limit its consequences (Factsheet 4.2). Evaluations have shown that implementation has so far been weak. But the obligation to draw up concrete actions plans goes in the right direction.
- In Norway, employer support centres offer courses and support from specialised workplace counsellors (Factsheet 4.3). Tens of thousands of enterprises have received courses and counselling in managing problematic workplace situations.
- In Switzerland, cantonal disability benefit offices may advise employers on how to deal with employees who are perceived as difficult – long before they submit any disability benefit claim (see Factsheet 5.1). A guidebook is available to help labour inspectors identify mental health risks in a company.
- Austria's Labour Protection Act requires employers to evaluate psychological strain in the workplace, implement measures in the event of problems, and evaluate their effectiveness. Occupational psychologists can be mandated to evaluate workplace risks and develop measures accordingly (Factsheet 4.4).

**Key messages**

Over the past decade, many OECD countries have put in place more and more highly developed psychosocial risk prevention regulations. Although they yield new opportunities for preventing mental-health-related problems in the workplace, they need to be balanced with more specific, better targeted measures. Awareness raising and enforced psychosocial risk prevention may be successful when support is sufficiently specific, compulsory, and conducive to collaboration between employers and specialised services. Legislation is often poorly implemented and few policies support small and medium-sized enterprises. SMEs need highly practical tools to help them prevent and manage the psychosocial risks encountered in their particular work environments.

Ways to implement and enforce legislation to prevent psychosocial risk include:

- Specifying employer obligations in regard to psychosocial risk assessment and risk prevention.
- Providing targeted tools and support mechanisms that enable employers to make adjustments to the work environment.
- Directing labour inspectorate and occupational health service resources to psychosocial health issues.

## Mental health training and support structures for line managers

Around two-thirds of all mental illness start before people enter the labour market. Measures to prevent mental health problems at work must be complemented by effective action to tackle existing mental health issues when they lead to reduced performance or workplace conflict.

### *Ignorance of the critical role of good management*

Workers with a mental health problem are involved in workplace conflicts with superiors and co-workers twice as often as other workers (Figure 4.3, Panel A). Accordingly, difficulties in managing relationships with management and supervisors are the most frequent reason for employees to seek psychological help from employment advisors in the United Kingdom (Figure 4.3, Panel B).

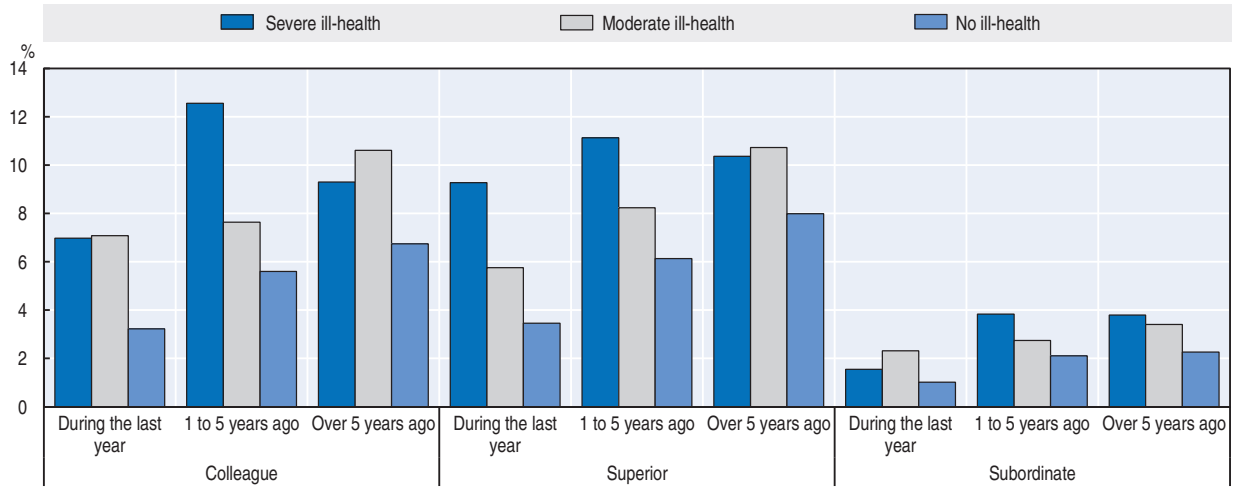
Effective management of workplace conflicts is essential as they weigh heavily on the work environment and significantly heighten the risk of recurrent sickness absence (Arends et al., 2014). They can also weaken employee solidarity, which isolates the worker involved in the conflict and makes him or her more prone to dismissal (Baer et al., 2011). Although workplace conflicts are often related to mental health problems, employers usually fail to perceive a change in behaviour and conflicts as warning signs. Consequently, they may fail to manage situations adequately. Supervisory staff tends to feel too inhibited to deal with behavioural problems in a clear and timely manner. They shy away from asking or ordering an employee to seek professional help – something that many (larger) enterprises would do, however, to address drinking problems.

Large companies usually have in-house departments or contract outside consultants to prevent and manage mental-health-related work problems. The lack of such provision in SMEs is related to their ignorance (Figure 4.3, Panel C). Half of all very small firms consider that professional knowledge of burn-out and psychological strain is not relevant to them, even though managers – particularly in small firms – are often emotionally involved and do not have the resources to compensate for a worker's chronic performance problems. Not surprisingly, SMEs almost never offer their workers employee assistance, while big firms usually do (OECD, 2014b). The main challenge to policy in this respect is SMEs' low take-up of support services.

Figure 4.3. **Work conflicts correlate with mental health and are a main reason for seeking help**

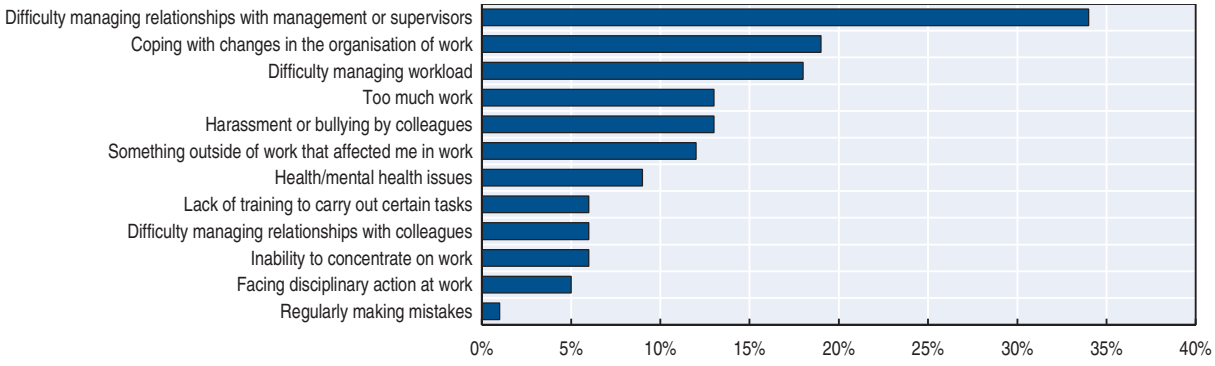
**A. Workplace conflicts in the past five years and mental ill-health**

Share of persons who experienced a conflict in the work environment, by severity of mental ill-health, Denmark, 2005



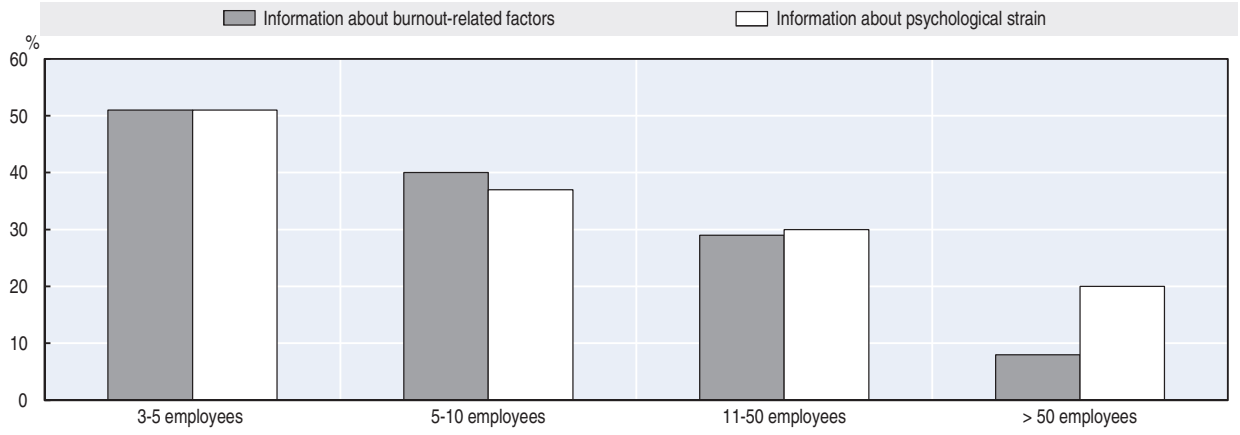

**B. Conflicts with managers are a main reason to seek help**

Proportion of individuals seeing an IAPT employment advisor, by reason, the United Kingdom, 2012




**C. Employers of small firms are unaware of the need for better information to deal with mental health complaints**

Tasks of occupational medicine considered not relevant for the enterprise, by size of the enterprise, Austria, 2011




*Source*: Panel A: National Health Interview Survey 2005; Panel B: Hogarth, T. et al. (2013), "Evaluation of Employment Advisers in the Improving Access to Psychological Therapies Programme", *DWP Research Report No. 826*, London; and Panel C: OECD compilation based on data of: Spectra (2011), "The Position of Occupational Medicine in Enterprises. A Survey Commissioned by the Austrian Academy for Occupational Medicine".

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### *Enabling management to deal with mental health problems*

In order to provide employers with greater support for addressing and handling mental ill-health among their employees, governments can consider different strategies.

- Promote employee mental health screening and give managers the tools they need to improve their ability to spot mental health problems. The United Kingdom's *Mental Health First Aid* programme, for example, teaches people how to identify and respond to mental health problems on a first-aid basis (Knapp et al., 2011; Borril, 2011). However, take-up is generally low, especially among SMEs.
- Pay for short-term mental health services, which can be cost-effective for employers. Positively screened employees, for example, could seek telephone-based care from trained clinicians (Wang et al., 2007). In English-speaking countries, many big companies have put in place *Employee Assistance Programmes* (EAPs) which offer short-term counselling to employees with personal problems that affect their work performance (Factsheet 4.5).
- Shift labour inspection and social security resources from traditional health and safety tasks to mental-health-related activities. Labour inspectors and occupational health and safety professionals should be required to build their knowledge of how to actively support employers in managing workplace problems and sickness management. The issue could, for example, be included in their training curriculum.
- Provide systematic manager training in how to address problematic behaviour in the workplace at an early stage. Such training should be particularly directed at SMEs, as they are unlikely to contract external providers to supply the service.
- Train the personnel of human resource departments to support line managers in their leadership role when it comes to handling mental health problems in the workplace.

**Key messages**

There are far fewer support mechanisms for line managers in dealing with employees who have a mental-health-related work problem than there are for promoting health and instituting preventive measures. And where, in recent years, countries have introduced such mechanisms, take-up is low. New policies should focus on supporting the affected worker and the entire work environment, as many mental health problems are long-lasting and affect inter-personal relationships. For this, competent managers and human resource departments are needed.

Measures for improving managers' ability to respond to workers' mental health issues include:

- Mental health training for managers and workers alike.
- Toolkits for helping line managers to deal with workers' mental health problems.
- Developing human resource staff understanding of mental health so that they can supervise line managers in their dealings with workers who suffer from mental ill-health.
- Promoting employee mental health screening and employer-funded mental health first aid.

## Actively managing return-to-work

Although some sickness absence is inevitable, it is a crucial issue from a medium and long-term policy perspective. Workers on long-term sick leave run a much higher risk of exiting the labour market and being granted permanent disability benefits. Active return-to-work management in the event of sick leave should be a strategic priority. And it should target workers who suffer from mental ill-health, as they are highly prevalent among long-term absentees.

### *Long absences make return-to-work difficult*

Data for Sweden show that after 90 days of sickness absence, around 75% of workers with a physical problem are back to work. After 180 days, almost 90% are back. The corresponding percentages in mental health-related sick leave are just 50% and less than 70% (Figure 4.4, Panel B). These low figures are worrying in themselves. They are even more so because it is generally after around 90 days of sick leave that return-to-work becomes particularly difficult, as data for Belgium confirm (Figure 4.4, Panel A).

Factors intrinsic to their illness may mean that certain workers with mental health problems take long sick leaves – it takes time to recover from disturbed cognitive functions or exhaustion, for example. However, co-workers, employers, and treating physicians also contribute to absences that are longer than necessary in some of the following ways:

- Employers' and co-workers' behaviour is driven by fear avoidance, in the case of workplace conflicts, for example.
- General practitioners are uncertain and ineffective when certifying sickness and may prescribe unproductively long sickness spells because they feel pressured by the desire to "protect" patients from job strain and workplace conflict.
- Enterprises do not monitor sickness absence or have effective return-to-work measures in place. In European countries, only one in two takes systematic measures to support an employee's return to work after a long-term sickness absence (Figure 4.4, Panel C).

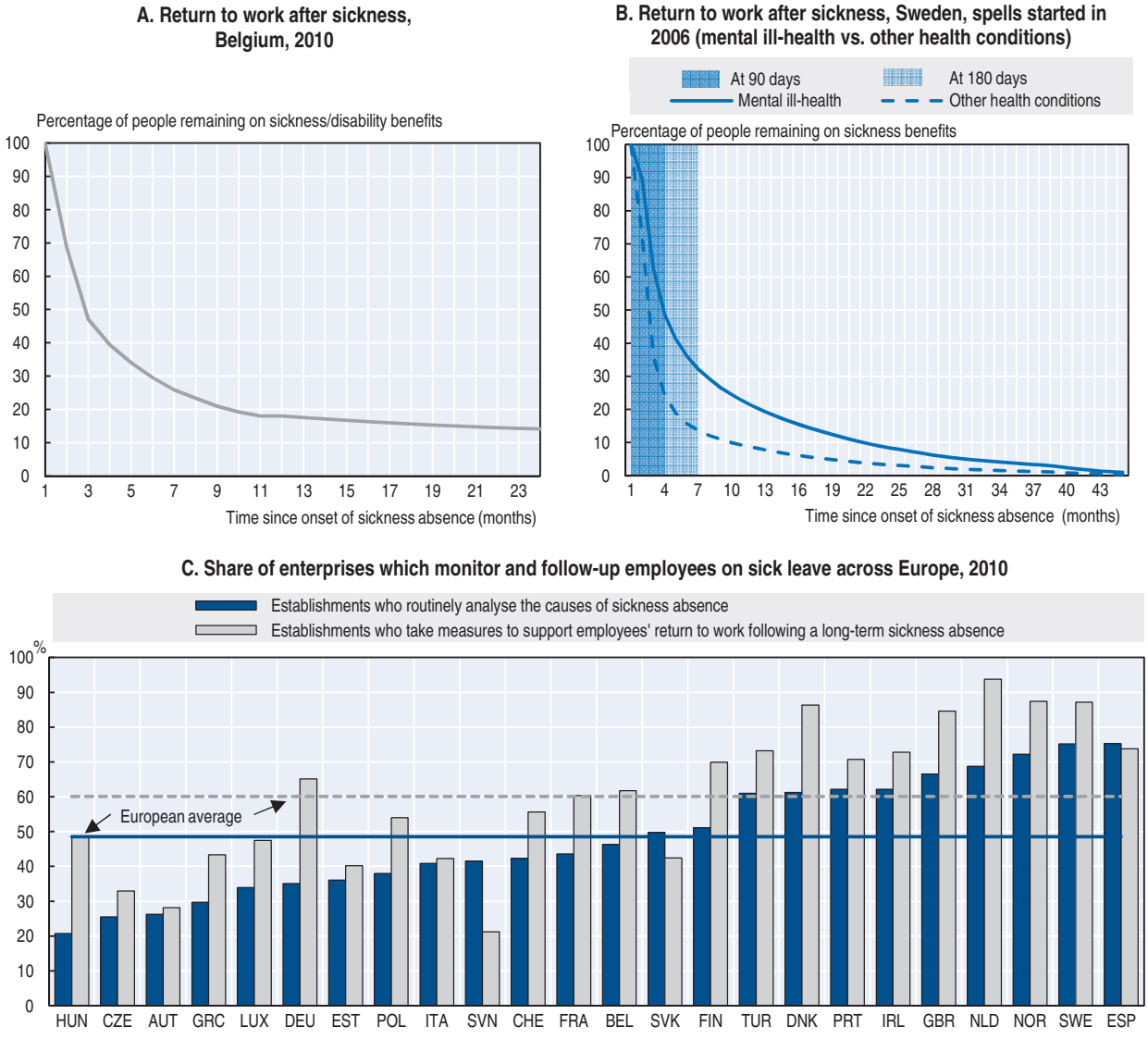
### *Countries are developing return-to-work strategies*

Most countries are now developing strategies to support return-to-work. Most use – and sometimes combine – practices from five sets of measures.

*Gradual early return-to-work*

- Some countries seek to promote gradual return-to-work as early as possible instead of allowing workers to stay away sick until they are fully able to resume work. Norway recently made partial sick leave the default option for certifying physicians, so compelling them to justify why they may have prescribed full sick leave. At the same time, it introduced tools to support physicians, e.g. by online feedback about their certification behaviour (OECD, 2013c). Denmark's Flexjob system is another good example. The state subsidises the wage bill for employees who return to work on a full-time basis, but work fewer or less productive hours. Although *Flexjobs* are so far only seldom used for people who suffer from mental ill-health, they could help prevent recurrent sick leave and enable quicker return-to-work (Factsheet 4.6).

Figure 4.4. **Return to work becomes difficult after three month's sick leave**




*Note*: Panel A: The National Institute for Sickness and Invalidity Insurance has only information on the sickness absences for which the mutualities pay sickness benefits, i.e. after the guaranteed wage period. To provide a consistent picture across blue-collar and white-collar people, the vertical axis shows the number of people receiving sickness or disability benefits as a percentage of the number of people receiving sickness benefits for at least one month. However, the time since onset of sickness absence (horizontal axis) includes the guaranteed wage period. The outflow curve is constructed on the basis of the duration of sickness benefits (first twelve months) and disability benefit outflows (from the thirteenth month onwards) for 2010.

*Source:* OECD calculations based on: Panel A: Data from the National Institute for Sickness and Invalidity Insurance; Panel B: Data provided by the Swedish Social Insurance Agency; and Panel C: The European survey of enterprises on new and emerging risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

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## *Employer and employee seek joint workplace solution*

The second broad strategy is to leverage the all-important employer-employee relationship and compel employers to address an employee's work problems at an early stage. To facilitate return-to-work an employer could, for example, work out a

return-to-work plan jointly with the employee, and introduce concrete adjustments and a communications strategy in the workplace. Treating physicians and/or occupational doctors should be involved in this procedure as necessary.

The Netherlands, Norway, and Sweden have implemented a procedure which requires employer and employee to agree, within around eight weeks of sickness absence, to an action plan with different responsibilities incumbent on both sides (Factsheet 4.7; Factsheet 4.8; Factsheet 4.9). Such initiatives may be accompanied by guides and advice for employers, as in Denmark which recently published guidelines for managers on how to deal with workers on sick leave with a mental health problem.

A further example are the *Access to Work* grants in the United Kingdom for practical support to help people go back to, or stay in, work. People with mental health conditions may request the grant for work-related support (Factsheet 4.10). In Switzerland, employers often outsource casework to private insurance companies which work with the treating physician, employee and employer to draw up a back-to-work plan (Factsheet 4.11).

### *Fit notes versus sick notes*

Changing sickness certification by requiring informative, capacity-oriented doctors' certificates is a third avenue. It is one that the United Kingdom has explored with the so-called "fit note" which it introduced in 2010. Physicians must focus on the work a patient can still do and describe in some detail what tasks he or she can reasonably perform and what workplace adjustments may be necessary (see Factsheet 3.7).

A similar trial in Switzerland tested so-called "expanded medical work incapacity certificates". Under this scheme, an employer sends the sick-listed employee's job description to the doctor and asks for an expanded certificate that describes in detail what he or she is capable of doing (see Factsheet 3.10). Denmark has done something similar with its new "fitness for work" assessment. It requires GPs to think about what patients can do and to describe the tasks and functions they can perform without worsening their condition. The Swedish Government, finally, has worked with medical associations to draw up diagnosis-specific sickness absence guidelines which, among other things, lay down the typical duration for a sick leave for a particular illness. They have been effective and welcomed by medical practitioners who feel to receive guidance (see Factsheet 3.8).

### *Early intervention for off-sick workers*

A number of countries have developed early-intervention services to provide counselling and treatment referrals to sick-listed workers, usually with a case management approach. The Austrian Government, for example, came together with the social partners in 2013 to introduce *fit2work*, a programme of counselling services for supporting employees who have been sick for more than 40 days (Factsheet 4.12). The United Kingdom has trialled a similar programme in England, Wales, and Scotland. *Fit for Work* provides occupational assessments of employees and case-managed, multidisciplinary telephone advice to them in the first 4-12 weeks of sickness absence (Factsheet 4.13). However, neither in the Austrian nor in the British example the services have reached the target group of employees at an early stage of their sick leave – in most cases, only people on long-term absence or those already unemployed use the service.

### *Occupational doctors, professional certification*

A fifth strategic course is to use the specialist knowledge of occupational physicians. The most prominent example is that of occupational doctors in the Netherlands, who are by law responsible for analysing workplace problems and producing return-to-work plans. Certifying sickness absence is exclusively their duty, not that of treating physicians. Certification is thus not complicated by the role conflict vis-à-vis patients that may affect a GP, though occupational physicians who work for and are answerable to an employer may experience a role conflict of a different nature.

Mental health competence of occupational doctors is generally limited, just like for GPs, and addressing mental-health-related work problems is a relatively new field. There are evidence-based guidelines in the Netherlands for occupational physicians on how to coach workers with mental health problems back to work, though doctors do not always adhere to them. A further point is that when occupational physicians also get involved in return-to-work, there has to be better collaboration, also with the treating doctor – something that is not always easy to achieve (Factsheet 4.14).

SMEs seldom have the resources to contract occupational health services. To address this issue, the United Kingdom introduced an occupational health advice service for small businesses which gives them "instant" access over the telephone to professional advice on all health conditions, particularly mental ill-health. The SMEs that have used the telephone service appear to have particularly appreciated it (Factsheet 4.15).

**Key messages**

Countries now widely acknowledge the importance of taking active measures to prevent unnecessary long-term sickness absence and stop workers with mental health problems from exiting the labour market. A number of governments have introduced promising policies to assertively promote early return-to-work. The stumbling block is the very low take-up and low compliance among the various actors – physicians, employers and employees.

Action to support an effective return-to-work management process should include:

- Putting in place fit-for-work counselling services to help sick-listed workers quickly.
- Promoting gradual return-to-work which can also help restore full work capacity.
- Strengthening the role of occupational physicians and occupational psychologists.

## Incentives and obligations for employers to prevent and address sick leave

Several factors contribute to successfully preventing longer-term sick leave and managing return-to-work. Financial incentives and legal obligations for employers to actively follow up and support sick-listed employees play a crucial role.

### *Employer incentives are poorly developed*

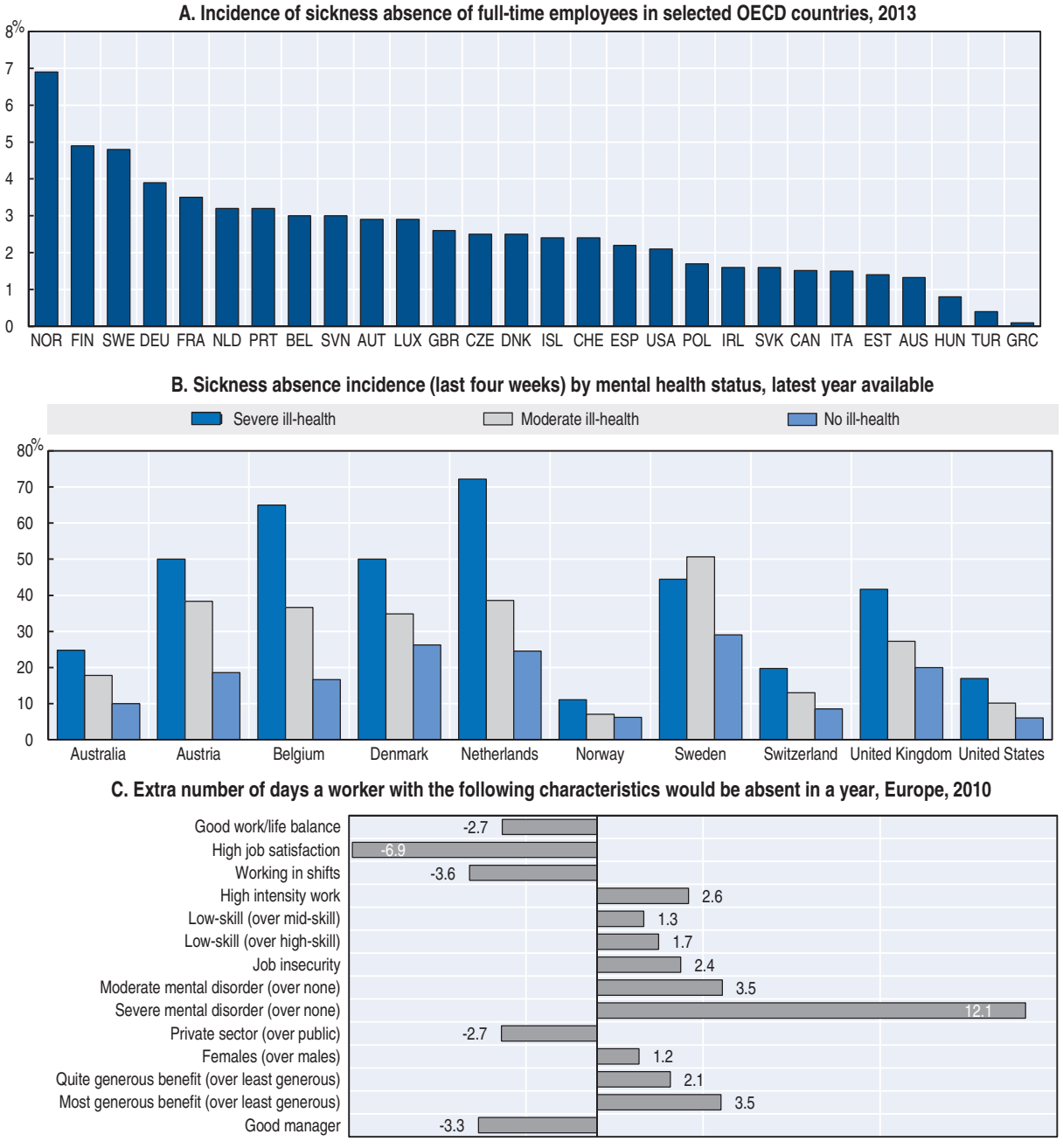
Incentives and obligations for employers are one factor that accounts for wide disparities between countries' sickness absence rates (Figure 4.5, Panel A). Absence rates are high in most Nordic countries where financial incentives for employers to actively manage long-term absences are limited. Companies have to provide sick pay only during the first two weeks of sickness absence – a minimal amount when it comes to sick-listed workers with mental illness who have an average absence rate that is around twice as high as that of workers with good mental health (Figure 4.5, Panel B).

There are further examples in other countries. In Switzerland, for example, although firms are required to provide sick pay for longer, the duration is related to the length of the employment contract (the same holds for the period in which dismissal is regarded as unfair in case of an illness). Employees with a mental health problem usually have shorter job tenures; this reduces an employer's obligation and incentive to actively do something about the absenteeism of workers with mental health conditions (Figure 4.5, Panel C).

Because employers and managers play a key role in the run-up to long-lasting sickness absences, during absences, and when employees return to work, they should be held accountable for the consequences. In other words, they have particular duties:

- It is their responsibility to settle workplace conflicts as they trigger many sickness absences.
- They should keep in regular contact with sick employees to shorten absences.
- They should adapt the workplace as possible to enable the sick employee to work, and co-operate in proper return-to-work procedures to increase the chances of job retention.
- They should co-operate and actively seek to communicate with sick employees' treating physicians and other relevant actors and authoritative parties.

Figure 4.5. **Employers have limited obligations for addressing the high rate of sickness absence among workers with mental ill-health**




a. Absence is defined as follows: absence in the last four weeks for EU OECD countries, absence in the last two weeks in Australia (2004 instead of 2013) absence in the last week in Norway and absent for ten days or more in the last year in the United States (2012 instead of 2013).

*Source*: Panel A: European Labour Force Survey and national labour force surveys for Australia, Canada and the United States; Panel B: OECD calculations based on the Eurobarometer 2010 for Austria, Belgium, Denmark, the Netherlands, Sweden and the United Kingdom; National Health Survey 2011/12 for Australia, Swiss Health Survey 2010 for Switzerland and National Health Interview Survey 2008 for the United States; Panel C: OECD calculations based on European Working Conditions Survey 2010.

StatLink http://dx.doi.org/10.1787/888933184204

### *Better incentives for swift return-to-work management*

There are indications that stiff employer obligations may help lower the incidence of sickness absence and foster job retention. The Netherlands has effectively reduced its rate of sickness absence with the stepwise introduction of the companies' obligation to provide sick pay for two years, actively draw up an action plan for ensuring a quick return-to-work, monitor sickness absences, record all actions taken, and adapt employees' tasks to their abilities (Factsheet 4.14).

There are also duties in the Netherlands incumbent on the sick-listed employee. He or she must see an occupational physician within the first six weeks of sickness absence, for example. Should employers and employees fail to agree on an action plan, they are liable to stiff sanctions. Employers who do not co-operate have to pay the worker's salary for a full third year. If it is employees, they may have their salary docked or stopped, be laid off, or have their disability benefits reduced later on.

Norway, Denmark, and Sweden have also ushered in duties for employers and employees to address actively and early workplace problems and return-to-work, hold meetings with caseworkers, develop action plans, and contact the treating physician (OECD, 2013b; OECD, 2013c; OECD, 2013d). Some countries, such as Sweden, also have strong statutory protection in place to prevent the dismissal of sick employees. However, in the Nordic countries these stronger obligations are not matched by corresponding financial incentives for either the employer or the worker.

Evidence across the countries reviewed by the OECD shows that regulations are fully effective only in combination with financial incentives and effective penalties for non-compliance; however, many of the reviewed countries do not enforce provisions for sanctions, particularly against sick employees (OECD, 2014a; OECD, 2013b), and their financial incentives are not deterrent enough. In Belgium, for example, administrative sanctions for employers who fail to conduct workplace risk analysis are lower than the cost of the analyses themselves (OECD, 2013d). Moreover, employers' sick-pay obligations are often short-lived and public sickness benefit for the employee is high relative to wages, so tempting employers and employees not to actively seek return-to-work solutions. This setup represents a moral hazard. Such shortcomings may explain in part why promising policies to beef up employer obligations have not yet achieved their full potential.

**Key messages**

Financial incentives for employers and employees to prevent long-term sickness absence are limited in many OECD countries. Only a few countries, especially the Netherlands, have gone further by giving employers a long-term responsibility for paying for sick leave and sanctioning them as well as employees when insufficient efforts have been undertaken to ensure return-to-work. In most countries, active return-to-work management is advocated for but not backed up with incentives or deterrents. Policies for return-to-work management therefore remain piecemeal and implementation often weak.

Strengthening employer incentives and obliging them to address the reasons for sick leave and foster return-to-work should include:

- Making employers responsible for developing and following up return-to-work plans for sick employees and monitoring the fulfilment of these plans.
- Compelling employers to be in contact with sick employees and where necessary also treating doctors to be able to adjust work.
- Extending employers' sick-pay obligations to spur them to action to prevent sickness absence and support returns to work.

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## FACTSHEETS 4.1 to 4.15

## Factsheet 4.1
## Denmark: Assessing and monitoring the psychosocial work environment

### Context

While psychosocial demands in the workplace have increased in recent decades, workplace risk assessment has not always kept pace. There is a need for stronger legislation on psychosocial risk assessment and better monitoring and support when problems have been identified. Workplace-specific tools can help to improve the psychosocial work environment.

### Programme

Workplace health and safety in Denmark is regulated in the Working Environment Act, addressed through agreements between the social partners but overlooked by the Working Environment Authority (WEA). Legal provisions require employers to manage psychosocial work environment (PWE) risks in the workplace. Since 2007, the WEA has been responsible for inspecting the PWE in all enterprises. It is a big shift from the more traditional health and safety focus of the WEA and has prompted it to develop an inspection strategy.

Based on Danish research findings, the WEA has developed 24 sector- and job-specific guidance tools. Each guidance tool describes the prevalence of risk factors and the potential resources of a company to prevent problems – the aim being for each company to seek a balance between risks and prevention resources. The tool also describes the possible organisational consequences of an imbalance between risks and resources, such as bad reputation, loss of commitment, long delays, complaints from customers, high turnover rates, or long-term sickness absence rates.

WEA inspectors have been trained in how to use the guidance tools and how to assess and evaluate the PWE health and safety risks. The job of inspecting PWE risks has been facilitated through method descriptions and instructions, by templates on how to prepare improvement notices (in case improvements are needed), and through the sharing of best-practice examples. In each of the four regional WEA inspection centres, a task force has been established. The task forces comprise between six and eight highly skilled PWE inspectors who assist other inspectors in assessing PWE problems, preparing improvement notices, and giving guidance to enterprises that have received an improvement notice.

### Outcomes

A full impact assessment of the WEA strategy and the guidance tools has not yet been carried out. However, preliminary results from focus group interviews with inspectors suggest that the guidance tools are used widely before, during, and after inspections and that employers consider them very useful. Although the number of improvement notices in relation to PWE problems has increased, they still comprise only 5% of all notices issued by the WEA in relation to health and safety aspects.

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## Factsheet 4.2
## Belgium: Services for prevention and protection at work

### Context

Policies to prevent work-related stress are critical. At the same time, employees with mental disorders need adequate support to prevent long-term sickness absence. Similarly, employers need support to create a psychologically healthy work climate and help workers with mental ill-health to retain their job or resume work as quickly as possible.

### Programme

In Belgium, employers are legally obliged to take all necessary preventive measures to preserve the well-being of their employees. Belgian legislation gives explicit instructions on how to deal with the mental health requirements mandated by law. All employers must carry out risk assessments to identify situations and risk factors at the workplace that can generate psychosocial distress. On the basis of such an assessment, the employer must draw up a five-year global prevention plan and an annual action plan to avoid psychosocial distress at work and limit its consequences. The risk analyses and prevention and action plans are conducted in collaboration with a team of prevention advisors and employee representatives.

Employers have to appoint a psychosocial prevention advisor to assist them in implementing the risk prevention policy. For companies with up to 50 employees, the prevention advisor must be from an external provider to avoid conflicts of interest. These external services employ both occupational doctors and prevention advisors who are specialised in one or more of the following five fields: safety at work, occupational medicine, ergonomics, occupational hygiene, and psychosocial aspects of work.

It is strongly recommended but not obligatory for an employer to appoint an internal confidential counsellor who is thoroughly familiar with the company's in-house workings.

### Outcomes

An evaluation has revealed that the practical implementation of the legislation on well-being at work remains deficient. First, employers seldom carry out psychosocial risk analyses, chiefly because of the high cost involved and the resistance of employers who fear a negative analysis and the implications it may have on the organisation of work. Second, many employers are not aware of their legal obligations and the importance and advantages of prevention policies. Third, on the side of the employees, there is a lack of awareness of the role and existence of the psychosocial prevention advisors and confidential counsellors. Finally, prevention advisors have little to no time for the prevention of psychosocial risks in the workplace as they are fully occupied with individual complaints of harassment at work. They are not always trained to execute the wide range of possible risk assessments and prevention programmes, and are seldom familiar with the workplace. Because of the lack of financial incentives for employers to adapt the work and workplace, some are unwilling to co-operate, which discourages occupational health specialists from specialising in the field psychosocial risk prevention – less than 5% of prevention advisors are specialised in this field.

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## Factsheet 4.3
## Norway: Supporting employers through specialised work advisors

### Context

Many OECD countries have developed psychosocial risk prevention regulations in order to prevent mental health-related problems in the workplace. Specialised work advisors who can support employers is one way of dealing with psychosocial risks at work.

### Programme

In order to support employers at an early stage in dealing with health-related problems in the workplace, the Norwegian Labour and Welfare Administration has implemented inclusive workplace support centres for employers in each of its 19 counties. The centres are based on the Working Environment Act, which promotes a healthy working environment, and the tripartite Inclusive Workplace Agreement, which seeks to reduce sickness absence and increase reintegration. The centres provide not only support for health promotion and sick-leave prevention, but also support for employers who have signed an IW-agreement.

One of the policy objectives is to motivate human resource staff in enterprises to engage more in health promotion. The centres have a strong information- and awareness-related approach, seeking to educate employers about the stigma that attaches to mental ill-health and to inform them about the professional support systems available for people with poor mental health. Recently, the centres have started a very promising trial scheme for providing advisors on work and mental health issues. It has now been extended to seven counties. Employers may also contact advisors directly in concrete problem situations for advice on possible work adjustments, for example.

### Outcomes

Employer support centres provide a good structure for systematically offering early, highly competent interventions in the workplace. They have already built numerous contacts with employers which could be expanded, deepened, and made more systematic. Most of the services provided by the employer support centres have so far been in education and raising awareness. Although thousands of enterprises have been given courses and information about mental ill-health in the workplace, support for work-related problems does not yet seem to have received sufficient attention. If the centres are to deliver their full potential, they should i) be accessible to all employers; ii) be multidisciplinary and include mental health professionals; iii) collaborate with mental health specialists (e.g. psychiatrists) or care institutions and; iv) focus on employer counselling instead of awareness campaigns.

### Further reading

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## Factsheet 4.4
## Austria: Employer obligations to evaluate psychological work strain

### Context

Preventing mental-health-related problems in the workplace is crucial to preventing long spells of sick and labour market drop-out. Obliging employers to evaluate work strain and involve occupational psychology is one promising way to address the issue.

### Programme

The new Austrian Labour Protection Act came into force in January 2013. The act obliges employers to evaluate psychological strain in the workplace, implement specific measures in the event of problems, and evaluate the effectiveness of such measures. The new act's predecessor already compelled employers to comprehensively protect the health of their employees, which implicitly included mental health problems. The new act ushers in some important changes.

First, it identifies psychological strain (*e.g.* lack of social support or feedback from line managers, unclear or conflicting work targets, job monotony) as a risk factor. Second, it defines health as physical and mental. Third, it requires employers not only to secure a healthy work environment, but to actively evaluate whether there is psychological strain in their enterprise. Such evaluations should be carried out systematically, with a steering committee involving employee representatives and using standardised screening instruments or questionnaires. Fourth, the workplace evaluation must have a preventive focus – in other words, evaluate work tasks and how they are organised, the working environment, and operational procedures. Fifth, the act requires a workplace evaluation in the event of incidents with significantly elevated psychological strain. Sixth, occupational psychologists are explicitly included as qualified professionals (in addition to chemists, toxicologists, or ergonomists) who may be mandated to conduct evaluations as well as providing acknowledged preventive services.

### Outcomes

The explicit recognition of psychosocial risks and the inclusion of occupational psychologists as professionals who can be mandated to evaluate workplace risks and develop suitable measures is promising. Although no evaluation is yet available, the role of occupational psychologists is still not wide-reaching enough. They are not acknowledged as preventive professionals and can be mandated only for up to 25% of the total time enterprises are obliged to engage occupational health and safety specialists every year. Moreover, the increased involvement of occupational psychologists intended by the new Labour Protection Act may not materialise because it is only voluntary for employers to work with them.

### Further reading

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## Factsheet 4.5
## United States: Employee Assistance Programs to address productivity

### Context

Although most people who suffer from mental ill-health have a job, they frequently show reduced productivity and greater sickness absence. Employers play a key role in securing good working conditions, addressing mental ill-health issues among their employees, and minimising productivity losses.

### Programme

Employee Assistance Programs (EAPs) offer confidential, short-term counselling services for employees with personal problems that affect their work performance, whether or not those problems originate in the workplace. EAP services to individuals and their family include services and referrals related to mental health, drugs, alcohol and personal issues, such as divorce and parenting problems; wellness and health promotion; and work-related supports such as career counselling. EAPs also provide support to line managers, which may take the form of education on handling mental health, stress and addictions in the workplace, for example, or managing absence.

### Outcomes

EAPs are free of charge for employees and their family members as they are pre-paid by the employers, and are typically available 24 hours a day. In the United States, EAPs are mandatory for federal agencies, while coverage in the private sector is around 65% among companies with more than 100 employees. EAPs are often offered by external providers.

EAPs have been shown to contribute to decreased absenteeism, greater employee retention, and significantly reduced medical costs through early identification and treatment of mental health issues. The programme has been criticized for its lack of impartiality in cases where an employee seeks assistance in work-related issues.

### Further reading

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## Factsheet 4.6
## Denmark: Flexible wage subsidies for people with partial work capacity

### Context

OECD countries have developed different strategies for supporting the return-to-work of workers with reduced work capacity. One example is to allow workers to work fewer hours at lower productivity levels, but to receive full wages through subsidies for employers.

### Programme

The Danish "flexjob" scheme is a wage subsidy scheme targeted at people with reduced work capacity who are unable to work in the regular labour market but not incapacitated enough to be entitled to a disability benefit. The scheme was not originally created for people with mental health conditions and formally only some 15% of all flexjob users are registered as mental ill. The flexjob scheme has potential for people with poor mental health because it allows employees to be paid in full for working fewer hours with lower productivity and the employer to pay only for effective output.

A reform in 2013 addressed several weaknesses in the system: i) the gradual shift towards a higher subsidy; ii) the high share (around 50%) of flexjobs that employers assigned to employees in the company because they are allowed to convert existing positions into flexjobs; iii) the dominance of public municipal flexjobs; and iv) the frequent move to a flexjob on expiry of a sickness benefit entitlement. Moreover, the dead-end character of flexjobs has turned into a substantial financial problem, because the system has spread fast to include many people who used to work in unsubsidised jobs. The reform aims to eliminate these major flaws.

### Outcomes

Very little is known about the use of flexjobs by people with mental health complaints. Many of the changes to the flexjob scheme will probably be especially helpful for clients with poor mental health who are among the most disadvantaged. The new system is temporary in principle, far more flexible in terms of hours and changes over time, and has a stronger focus on activating and reintegrating those eligible for a flexjob.

Since reform, the number of flexjob subsidies has continued to increase. The preliminary assessment of the reform says that it has been successful in several ways. There is a significantly higher percentage of flexjob users with mental health problems in the scheme, and the share of flexjobs in private companies is also considerably higher. At the same time, the number of people waiting to be placed in a flexjob and receiving a so-called "waiting allowance" has been noticeably reduced.

### Further reading

OECD (2013), *Mental Health and Work: Denmark*, OECD Publishing, Paris, http://dx/doi/org/10.1787/9789264188631-en.

## Factsheet 4.7
## Netherlands: Strong financial incentives for employers and workers

### Context

Sickness absence rates are high among workers who suffer from mental ill-health. For such workers, early sickness management and return-to-work policies are crucial in preventing long-term absence, disability, and labour market exits. Employer incentives to invest in sickness management can improve the labour market inclusion of those with poor mental health.

### Programme

In the Netherlands, several policy changes have been introduced to compel employers (and workers) to face up to their responsibility in sickness matters. In particular, the Reduced Absenteeism Act (1994), the 2004 extension of the 1996 Wage Payment during Sickness Act, and the Gatekeeper Improvement Act (2002), have all contributed to significant improvements in sickness management.

When a worker becomes sick, the employer is obliged to continue paying 70%-100% of his or her salary for two years during which the worker is protected by law against lay-off. Moreover, employers are required to hire a case manager to oversee the return-to-work process. Within six weeks of going off sick, employees must visit an occupational physician who is paid by the employer. Within eight weeks, employer and employee are obliged to agree on an action plan, which spells out the responsibilities of both sides in ensuring a quick return to work. The employer is responsible for monitoring the return-to-work process every six weeks and for recording all actions undertaken – something often done by the return-to-work case manager. Both employer and employee may be penalised for not collaborating in the return-to-work process, which is assessed by the Employee Insurance Agency after two years of sickness absence.

If an employer cannot adjust a job to enable a sick worker to return to work, both are obliged to look for suitable work for the worker in another company. Occupational health services, reintegration offices, and employer branch organisations can facilitate the new job search. Some companies have a social worker, in addition to the return-to-work case manager, who provides support – such as work conflict mediation – in dealing with psychosocial problems that impact on work.

### Outcomes

The sickness absence rate in the Netherlands has fallen sharply in the past 15 years and is now close to the OECD average. Yet it remains high among people suffering from mental ill-health. Moreover, not all employers live up to their responsibilities in return-to-work management. For example, every second employer has no guideline on when to contact an occupational physician in case of sickness absence. Employer sanctions are frequent: in one in five sickness absences longer than two years employers fail to meet their obligations.

### Further reading

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## Factsheet 4.8
## Norway: A tripartite agreement to improve sick-leave outcomes

### Context

Both employers and employees are responsible for active return-to-work management. Employers can contribute to the process by addressing work problems at an early stage and facilitating working conditions for employees with special needs.

### Programme

In 2001, the Norwegian Government and the social partners signed an inclusive tripartite workplace agreement (IWA). It has been renewed several times so far, with the latest agreement being valid until 2018. The IWA seeks to: i) reduce sickness absence by at least 20% compared to 2001; ii) increase work participation among people with disabilities; and iii) raise the effective retirement age. In 2013, the agreement covered around 25% of all Norwegian enterprises and around 60% of all employees.

Signing up to the IWA requires enterprises to support its goals. In return, they benefit from the services of a liaison officer at the Norwegian Labour and Welfare Administration and special (possibly financial) support in preventing sickness absence and making workplace adjustments. IWA firms also have additional obligations: i) ensure a good working environment; ii) facilitate working conditions for special needs employees; iii) systematically prepare sick-leave statistics; and iv) seek and facilitate dialogue with sick-listed employees.

### Outcomes

The tripartite structure provides a sustainable basis for initiating and implementing new policies and measures, and gives the social partners new responsibilities. It is particularly important, as the financial incentives for employers to increase job retention and avoid long-term absences are weak in Norway. The overall achievements from 2001 to 2014 concerning the three sub goals are:

i) Sickness absence was reduced by 12%;

ii) The employment rate of disabled persons remained almost constant (43%), but the incidence and prevalence of disability pensioners stagnated;

iii) The employment of persons 50 years and older increased by 18% (1½ years).

There are small differences between IW-enterprises and non-IW-enterprises when it comes to achievements and outcomes. Evaluations so far hardly seem to find direct causal effects from specific "IW-measures" on the outcomes. Nevertheless, more use of graded sick-leave seems to have a positive effect.

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## Factsheet 4.9
## Sweden: Stricter sick-leave policy to prevent long-term absence

### Context

Sickness absence rates are relatively high among workers with mental health problems. Early intervention and support for those on sickness benefits due to mental illness is crucial in preventing long-term sickness absence, disability, and early labour market exit.

### Programme

Since 2003, Sweden has undertaken a series of reforms to address the long-term structural problems in its sickness and disability policies. The new sick-leave process provides incentives for a more active procedure and aims to prevent long periods of sick leave and ensuing permanent exclusion from the workplace. The main feature is a much stricter timeline for work-capacity assessment at different stages. It is first assessed in relation to the sick employee's own job, then – within no more than three months – in relation to other positions with the same employer and, last, after six months in relation to the regular labour market as a whole in order to facilitate early return-to-work.

Moreover, sickness benefit periods have been reduced to a maximum of 364 days within a time frame of 450, although payment can be extended to 914 days under certain conditions. This is in contrast to previous practice in which there was no limit on the number of days over which employees were entitled to sickness benefit. Sweden has also introduced an earned income tax credit (EITC) to strengthen the incentive to stay in work.

### Outcomes

The extensive structural reforms to the sickness and disability system have been successful in tackling the large numbers of sickness and disability recipients. Long-term sick leave of more than one year initially fell by 80% from its peak in 2003, although it has increased again recently. The number of new disability benefit claims also fell by 80% during the decade after 2003.

It is argued that the EITC may have had a substantial impact on lengths of sickness absences. As employees on sick leave are not entitled to the credit, it entails an increase in income from work relative to compensation for sick leave. It is estimated that the EITC may have shortened average sick leave by around three days, or 7%.

The paradigm shift in sickness and disability policy towards early activation over this period is an example to be emulated by other OECD countries. However, whether reforms have been equally effective for people who suffer from mental ill-health merits further attention.

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## Factsheet 4.10
## United Kingdom: Access to work scheme offers practical work support

### Context

Early intervention and support for workers on sickness benefits due to health problems is crucial in preventing long-term sickness absence, disability and early labour market exit. Although work-related changes may be essential in enabling return to work, employers do not always have the resources to make those changes.

### Programme

Access to Work is a government-run scheme that targets workers and the self-employed with a disability or a health condition that will last for at least 12 months. The scheme provides flexible grants to workers and their employers for practical work support, typically for specialist equipment or transport to the workplace.

In 2011, Access to Work was also redesigned to include support for people experiencing depression, anxiety, stress, and other mental health issues affecting their work. The support offered may include: i) assessment of individual needs to identify coping strategies; ii) work-focused mental health support for six months, tailored to identified needs; iii) a personalised support plan, detailing the steps needed to remain in, or return to, work; iv) suggestions for adjustments in the workplace, or in work practices, that could help individuals fulfil their role; and v) advice and guidance for employers on how they can support employees with mental health problems. The modifications to Access to Work mark a significant step in recognising and responding to the specific needs of individuals with mental health problems.

### Outcomes

Take-up by people with mental health problems has been very low. In 2012, only 3% of participants in the programme cited mental health problems as their primary disability. Another criticism levelled at the programme is that few employers are aware of it. To address low take-up and awareness, the government announced an extra GBP 15 million for the programme and launched a 12-month targeted marketing campaign to raise awareness of the scheme amongst under-represented groups and employers. The measures are welcome as Access to Work could be a major boost in support for employees struggling with mental ill-health in the workplace. However, it will be important to monitor the impact of the measures on take-up and further invest in the scheme if individuals with mental health conditions continue to be underrepresented.

### Further reading

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## Factsheet 4.11
## Switzerland: Individual case management by private health and daily allowance insurers

### Context

In order to prevent long-term sickness absence, employers should be encouraged to address an employee's work problems at an early stage. They should ideally do so in collaboration with treating physicians, occupational doctors, or return-to-work case managers.

### Programme

In Switzerland, most private health and daily allowance insurers have implemented a range of prevention measures (such as health promotion, risk assessment, and absence management systems in enterprises) and reintegration services (case management in particular). Sickness-related case management starts early, often after around 30 days of sickness absence, depending on the contract between the enterprise and the insurance. The case manager assesses whether case management might be useful for a reported sickness absence – for mental ill-health it is often assumed to be so. He or she then contacts: i) the treating physician for information about the health-related work incapacities; ii) the employer; and iii) the employee to discuss the situation and support the return-to-work process.

Case managers are usually non-specialists with, for example, a human resources management background and substantial professional experience. They have a key role in sampling the information gathered from the different actors and in establishing a co-ordinated return-to-work plan. In the event of possibly long-term sickness absence and/or severe mental health problems, the case manager often also contacts the invalidity insurance provider – in principle, after one month of sick leave. The case manager normally has an established relationship with the insured enterprise.

### Outcomes

The outcomes of case management provided by insurers have not been evaluated so far. Practice shows, however, that clients suffering from a mental health problem are not only increasing sharply in number. They are also especially challenging for case managers, who are seldom familiar with mental disorders. A further difficulty that case managers face is their often problematic relationship with treating physicians. In response, the Swiss association of private insurance companies and the federal association of treating psychiatrists very recently drafted a letter of agreement which should give guidelines to case managers and psychiatrists on how to collaborate.

### Further reading

OECD (2014), *Mental Health and Work: Switzerland*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204973-en.

## Factsheet 4.12
## Austria: One-stop shop to tackle longer-term sickness absence

### Context

An active return-to-work management process is crucial for workers with a mental illness who often face long-term absences. Many OECD countries have developed strategies to support the return-to-work process through, for example, early-intervention services that provide initial counselling and timely referrals for treatment for sick-listed workers who need further care.

### Programme

Sickness absence due to mental health problems has steadily increased in Austria (albeit from a very low level). Austria is among the OECD countries where the relatively fewest firms routinely analyse causes of sick leave and take measures to follow up on employees on long-term sick leave. This creates a special problem for sickness absences related to poor mental health and which are often long term. Sickness absences in Austria follow an all-or-nothing principle: the lack of a gradual return-to-work process is a barrier to sick employees resuming employment.

In order to provide greater return-to-work support for people on long-term sick leave, the Austrian Government – together with the social partners and social insurance providers – has initiated a new low-threshold information, counselling and support service for sick-listed employees and jobseekers as well as enterprises. The new "Fit2work" service, fully implemented in 2013, seeks to avert job losses and long-term unemployment. Health insurance contacts sick-listed employees after around 40 days of absence, offering general information (on possible treatment, for example) and – if necessary – counselling and return-to-work support, provided by a network of counselling firms. Psychotherapy is not provided but access to psychotherapists is facilitated in the event of mental health problems.

### Outcomes

Initial evaluations show that only around one-quarter of all sick-listed people who were contacted and given information, considered to be counselled by a Fit2work service provider. Of all workers who had been on sick leave for more than 40 days and were contacted by the health insurers, only about 10% responded. To date, the Fit2work service has been used chiefly for workers and jobseekers suffering from mental disorders.

Fit2work's rationale of increasing sick workers' job retention and reintegrating unemployed people with health problems is valuable in view of Austria's weak focus on sickness absence. A number of critiques may nevertheless be made: i) Fit2work does not link with the health system; ii) it chiefly provides general information instead of direct and workplace-focused counselling, which is often needed more urgently; iii) employers are also a Fit2work target group, yet it has not reached out to them yet; and iv) counselled employees generally do not want any contact between the Fit2work service and their treating physician.

### Further reading

Egger-Subotitsch, A. and M. Stark (2013), *Fit2work Implementierungsevaluierung, Bericht II* [Evaluation of the implementation of fit2work], Bundessozialamt, Vienna.

OECD (forthcoming 2015), *Mental Health and Work: Austria*, OECD Publishing, Paris.

## Factsheet 4.13
## United Kingdom: Fit for work services offering support to sick employees

### Context

Sickness absence rates are relatively high among workers with mental health problems. Early intervention and support for those on sickness benefit due to a mental disorder are crucial in preventing long-term sickness absence, disability and early labour market exit. Return-to-work case management support has proven to be a successful approach.

### Programme

The Fit for Work Service (FFWS) was piloted in several regions in the United Kingdom from April 2010 to March 2013. Its chief aim was to provide personalised back-to-work support for people in the early stages of sickness absence (4 to12 weeks of absence) and reduce the drift into welfare benefits.

The pilots brought together health, employment and local community organisations and offered biopsychosocial assessments of need and case-managed support to aid quick return-to-work. The service targeted people in work with a health condition, including those on sick leave and those at risk of sickness absence. Case managers offered support with goal setting, progress monitoring, confidence-building, motivation, and other forms of assistance. Individuals could access FFWS either by being referred by their general practitioner (GP) or other health service providers, or by contacting the pilot themselves after seeing the publicity or being told about it by their GP or employer.

### Outcomes

Over the first year, take-up was significantly lower than expected. In addition, nearly all FFWS clients were employed, with only one-third on sick leave, even though they were the original policy target group. Among the clients on sick leave, fewer than 30% had been off work for 4-12 weeks. In most pilots, mental health conditions were the most commonly reported condition and many clients had more than one health condition. Those with a musculoskeletal disorder, for example, also widely suffered from common stress, depression, or anxiety-related mental health conditions. The average length of time people stayed with the service was four months. Most respondents said they would not have benefited from interventions had it not been for the support of the FFWS.

All services had difficulties securing the volume of referrals expected from GPs and from small businesses. Some pilots specifically sought to engage with employers, using a range of marketing and awareness-raising activities. As with GPs, direct approaches – such as tele-marketing and targeting specific employers – appeared to work best, but most had trouble sparking interest among smaller businesses.

The full Fit for Work Service, implemented in 2014, builds upon the pilot schemes. The new service will provide a work-focused biopsychosocial assessment to employees earlier in sickness absence – from around four weeks of absence onwards. It also offers advice to employers and employees on needs for rehabilitation and return-to-work support for both workers on sick leave and those still at work. It will thus continue the role previously played by the Occupational Health Advice Services (see Factsheet 4.15).

### Further reading

Hillage, J. et al. (2012), "Evaluation of the Fit for Work Service Pilots: First Year Report", *DWP Research Report*, No. 792, London

OECD (2013), *Mental Health and Work: United Kingdom*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204997-en.

## Factsheet 4.14
## Netherlands: Occupational physicians in every company

### Context

Integrating occupational health knowledge into the workplace is of paramount importance in the light of research findings that i) good health improves employment outcomes and ii) work contributes to good health. One way to bring occupational health expertise into companies is by ensuring they all have an occupational health professional available to them.

### Programme

In the Netherlands, occupational physicians (OPs) are very much a part of company life, as the law obliges employers to consult an OP in sickness management. Most OPs are employed by occupational health services, but they can also work independently. One of OPs' most important functions is to carry out problem analyses and provide advice in the form of a reintegration action plan within six weeks of an employee calling in sick. The OP is also responsible for writing a reintegration report for the employee insurance agency after the 90th week of sickness absence (before the worker can file a disability benefit claim).

### Outcomes

A national survey among employers showed that 81% have arranged for an OP to support sickness management. A comparable survey among employees showed that only 64% are aware that they can consult an OP. However, 35% had seen an OP because of their health at some point during their working life – a large minority given that sickness absence rates range between 2% and 6% in most Dutch companies.

An important drawback is that OPs are funded by employers, prompting questions over their neutrality. Research among 541 OPs showed that 21% of them were not able to conduct their work independently due to interference by employers and 52% thought workers did not trust their formally neutral position. Among 220 surveyed workers, 29% felt the OP defended the employers' interests rather than the employees'.

### Further reading

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Koppes, L. et al. (2013), Nationale enquête arbeidsomstandigheden 2012. Methodologie en golbale resultaten, TNO, Hoofddorp.

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van der Helm, I. (2013), "The Privacy Protection of the Sick Employee: The Dutch Case from a Comparative Perspective", *European Journal of Social Security*, Vol. 15, No. 3, pp. 273-296.

## Factsheet 4.15
## United Kingdom: Occupational health advice for smaller enterprises

### Context

Companies with fewer than 250 employees generally have little or no access to occupational health support to help them deal with sickness absence or to tackle mental health issues at work. This is problematic because early intervention is central to vocational rehabilitation; the greater the length of absence from work, the more difficult the return to work becomes.

### Programme

The Occupational Health Advice Lines pilots were launched in the United Kingdom in late 2009 to provide small and medium-sized enterprises with easy access to high-quality professional advice on all health conditions with a specific focus on mental health. The service was designed to provide practical advice to both employers and employees about health conditions affecting a staff member. Important policy objectives were to provide managers with better information in order to aid them in reducing sickness absence, retaining a productive workforce and, where appropriate, assisting employees back into the workplace as soon as possible following a period of sickness absence.

The service was delivered and managed by different teams in England, Scotland and Wales, with separate budgets in each region and a separate initial telephone number to ensure access. It was decided that a local angle to the service would make better use of existing services and infrastructure (and thereby ensure value for money). Local partnerships would have better know-how about businesses in their area and thereby be more effective at targeted marketing and offering advice on local services.

### Outcomes

An evaluation of the Advice Lines service pilots found that users considered it extremely useful. They particularly appreciated access to "instant" advice and the one-stop-shop nature of the service. Most service users were, in line with policy aims, small companies dealing reactively with an employee who was either off work or struggling to stay in work due to a health condition. Employers often sought reassurance for actions they had taken or were about to take, with the service able to offer confirmation for those considering a range of different options. A few weeks after using the service, the vast majority of users had taken action as a result of using either Advice Lines or a service which an Advice Lines advisor had signposted. The measures taken by employers generally reflected good practice in absence management – e.g. communicating with the employee, conducting return-to-work plans, or changing the employee's role.

While most employers would probably have taken action in the absence of the service, one of its major advantages was that it reduced the amount of management time required to search for and implement solutions. As a result, employers using the service are likely to have been able to intervene more quickly, an important factor in effective absence management. Take-up in the period between December 2009 and March 2011 was lower than expected, but has improved considerably since then.

### Further reading

OECD (2013), *Mental Health and Work: United Kingdom*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204997-en.

Sinclair, A., R. Martin and C. Tyers (2012), "Occupational Health Advice Lines Evaluation: Final Report", *DWP Research Report*, No. 793, London.