Eunoia European Report

Eunoia

Wellbeing Across The European Workplace

JULY 2021

Acknowledgements

The following report is based on an overview on mental health supports in the workplace of each following participating countries: Greece, Ireland, Slovenia, Spain, UK and Turkey. Each partner has engaged directly with Organisations (workplaces) in conducting this research and interviewed a minimum of one management person and one general employee in each organisation to get a balanced view. The project partners would like to thank all those who participated in the research.

Project partners

Inn Training (UK)
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Good2Talk (IE)
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Dramblys (ES)
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Mullingar Employment Action Group (IE) www.meag.ie

Ekpaideftiria Kaloskami S.A. (GR) www.kek-axia.gr

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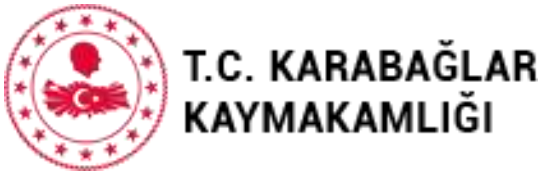

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Co-funded by the Erasmus+ Programme of the European Union

Foreword

It is important to clarify what we mean when we talk about mental health.

By mental health we do not mean mental illness. We mean the mental health we all have, just as we all have physical health. The World Health Organisation defines good mental health as

'A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community'

Poor mental health has substantial personal and economic impacts across the European Union, and associated stigma or discrimination can exacerbate these impacts. Mental illnesses can be described as health conditions involving changes in emotion, thinking or behavior (or a combination of these), and are associated with distress and/or problems functioning in social, work or family activities. Mental illness can affect anyone regardless of age, gender, ethnicity, social status, religion or sexual orientation.

The **Eunoia Project** results are designed to enable SME's all over Europe to implement important mental health initiatives, and incorporate them into how they do business.

This research document includes a detailed review of existing research on the topic, as well as National and European studies and policy documents, complemented by primary research in the form of conversations with employees and managers across the partner countries. The aim is to describe the environment of supports, training, expertise and best practices for managing mental health in European workplaces. From this we hope to gain a deeper understanding of the;

1. Needs of employees in understanding and managing their own mental health, and that of their work colleagues
2. The needs of employer's in managing mental health competently within their workplace.

This is the context in which the Eunoia project will proceed.

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Introduction

EU-OSHA reported in 2014 that the total cost of mental ill-health in Europe is €240 billion/per year, €136 billion of which is the cost of reduced productivity, including absenteeism, and €104 billion/per year is the cost of direct costs such as medical treatment. Studies suggest that between 50% and 60% of all lost working days have some link with work-related stress, and absences tend to be longer than those arising from other causes. It has been calculated that each case of stress related ill-health leads to an average of 30.9 working day lost (Mental Health Foundation, 2007).

Additionally, there are substantial costs to welfare systems when individuals leave work because of poor mental health. EU-OSHA (2000). In Europe, governments are usually responsible for paying the majority of long term sickness and disability benefits for people absent from work because of poor mental health.

The World Health Organisation (WHO) define health, and mental health as follows;

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'

'Mental health can be understood as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community'

This definition recognises the mental, physical and social dimensions of health. It also recognises that health does not just refer to the absence of disease or illness, but that health is a more positive state which involves wellbeing.

Mental ill-health, (as compared to mental illness), is fairly common and often experienced during periods of high stress or following upsetting events. Anxiety or stress symptoms can be of short durations and not qualify as mental disorders, but can develop into mental illness if the individual receives no support.

One of the key states of mental ill-health that can have severe consequences is work-related stress. Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope. The European Commission (2002) defined work-related stress as;

'*The pattern of emotional, cognitive, behavioral and physiological reactions to adverse and noxious aspects of work content, work organisation and work environment'*

While in the framework agreement on work-related stress (European Social Partners, 2004), stress is defined as;

'A state, which is accompanied by physical, psychological or social complaints or dysfunctions and which results from individuals feeling unable to bridge a gap with the requirements or expectations placed on them'

Stigma and discrimination associated with poor mental health exacerbates the impact of the illness. Fear of being labelled as having a mental health problem can reduce the likelihood of individuals seeking help. Stigma can also reduce the willingness of public policymakers to invest in mental health. Some public surveys have indicated that mental health is seen as a low priority when it comes to determining how to allocate health system funds.

Key facts:

- 50% of people will suffer from a mental illness at some point in their lifetime (WHO)
- 25% of the population suffer from depression or anxiety in any one year (WHO)
- A further 2.6% suffer from a psychotic disorder (WHO)
- 15% of people had sought help for a psychological or emotional problem (Eurobarometer on mental health)
- 72% of people had taken antidepressants at some point in their lives (Eurobarometer on mental health)
- About 50% of major depressions are untreated (WHO)
- Up to 50% of chronic sick leave is due to depression/anxiety (WHO)
- The total cost of mental ill-health in Europe is €170 billion/per year (WHO)
- €136 billion/per year is the cost of reduced productivity including absenteeism (EU-OSHA)
- There are 228.7 million employees in the EU
- The average person spends more than 90,000 hours in their lifetime at work (Wiley-Blackwell)
- 91.4% of EU households have a working adult (Eurostat)
- 40% of establishments in the EU-28 report not having enough information on how to include psychosocial risks in risk assessments (European Agency for Safety & Health at Work)
- One third of establishments report providing workers with training on the prevention of psychosocial risks. (European Agency for Safety & Health at Work).

Impacts of Work on Mental Health

There is increased awareness that work is generally good for you, contributing positively to personal, financial and social need and growing awareness that (long-term) unemployment is harmful to physical and mental health. While it is clear that work is good for mental health, a negative working environment can lead to physical and mental ill-health. Features of working life that are known to promote mental health and wellbeing include;

- Being valued at work
- Having meaningful work
- Being able to make decisions on issues that affect you
- Being adequately trained for the work that you do
- Having the resources you need to do the work
- Having a job that is well designed, i.e. not overloaded
- Having work that is well organised in terms of work schedules and time off.

Recent reviews indicate that physical and mental health are interrelated, and psychosocial risks that may cause mental ill-health are related to other physical health problems such as heart disease and diabetes. Other studies show that many people who develop a physical health problem will go on to develop a mental health problem as well. A relationship between psychosocial work environment and accidents has also been indicated.

Work-related psychosocial risks and stress are considered a new and emerging area of Occupational Safety & Health (OSH), with the awareness about their importance growing. The challenges associated with this issue are multifaceted, especially in the context of today's changing world of work, including digitalisation, remote working and new forms of contractual relationships. While research shows that

stress factors outside of the workplace contribute to mental ill-health, there are many risk factors for mental health that may be present in the working environment. Most risks relate to interactions between type of work, the Organisational and managerial environment, the skills and competencies of employees, and the support available for employees to carry out their work.

The cumulative effect of increased working hours is also having an important effect on the lifestyle of a huge number of people, and the more hours you spend at work, the more hours outside of work you are likely to spend thinking or worrying about work. (Mental Health Ireland, 2020).

The costs of mental ill-health in the workplace

The link between psychosocial risks, work-related stress and workers' health and safety has been confirmed in a wide range of studies carried out across different countries, sectors and organisation. While acknowledging the role of individual dispositions and general life circumstances, it has been shown that stress stemming from work-related factors may significantly affect workers' functioning in and outside work. When prolonged, neurobiological stress response may lead or contribute to serious health impairments. (Rugulies et al., 2006; Nieuwenhuijsen et al., 2010; EU-OSHA, 2011). Its symptoms include problems that are

- Emotional (for example irritability, becoming withdrawn, feeling exhausted)
- Cognitive (for example difficulties in concentrating and making decisions, negative thinking)
- Behavioural (becoming negligent, making errors, abusing alcohol or drugs).

The costs of mental ill-health have a major impact on workplaces. As part of the work on the European Mental Health Pact, it has been estimated that the total productivity costs of absenteeism due to mental illness was €136 billion in 2007. This equated to approximately €624 per employed person in the EU at that time. €99 billion of these costs were linked to depression and anxiety related disorders. These costs do not relate to treatment, social welfare benefits or other costs to society at large.

Promoting mental health at work has become a vital response to these challenges since the workplace is both a major factor in the development of mental and physical health problems but also a platform for the introduction and development of appropriate preventive measures. An important element of achieving a healthy workplace is the development of strategies and polices specifically addressing mental health. Findings from numerous scientific studies demonstrate that workplace interventions aid in the prevention of common mental ill-health, as well as facilitating the recovery of employees diagnosed with depression and/or anxiety. Robust data also proves there is a return on investment for money spent on mental health promotion in the workplace.

Work-related risk factors for health

Estimates from the Labour Force Survey in 2013-14 suggest that the total number of cases of work-related stress, depression or anxiety accounts for 39% of all cases of work-related illnesses, where work-related illness relates to conditions which people think have been caused, or made worse, by work. The ESENER survey (EU-OSHA, 2010, 2015) showed that within the EU, work-related stress is of some or major concern in nearly 80% of establishments. At the same time, less than 30% of Organisations in Europe have procedures for dealing with workplace stress. Issues such as stress are particularly important in considerations of Workplace Mental Health, since there is abundant evidence

that prolonged exposure to unmanageable pressure can result in stress that might, in turn, result in several more severe mental ill-health (WHO, 2010).

For the employer, there is a strong relationship between levels of staff wellbeing and performance. Taking a positive, proactive approach to mental health at work can make good business sense, as well as satisfy the moral and legislative duty of care within the workplace. A mentally unhealthy workforce has adverse economic consequences for business. Even very minor levels of depression are associated with productivity losses through absenteeism and presenteeism (poor performance due to being unwell while at work), and potentially loss of highly skilled workers due to poor health or early retirement. Taking a positive, proactive approach to mental health at work also makes good sense for the wider community.

ESENER-1 (2009) found that over 40 % of employers consider psychosocial risks more difficult to manage than 'traditional' OSH risks. The 'sensitivity of the issue' was reported to be the most important obstacle to dealing with psychosocial risks, followed by a lack of support, guidance or expertise. Workplace interventions and measures used must be specific to psychosocial issues; nevertheless, the systematic approach and principles of risk assessment can follow those adopted for other OSH risks. An academic report from 2014 suggests these strategies should take a 3-pronged approach:

- Protect mental health by reducing work–related risk factors. (Physcosocial risk assessment)
- Promote mental health by developing the positive aspects of work and the strengths of employees
- Address mental ill-health regardless of cause.

Conversations on Workplace Mental Health

Our research involved the cooperation of 15 Organisations across the partners regions, with the aim to acquire a deeper understanding of the needs of employers and employees in managing mental health at work. In order to add plurality to our research we selected Organisations with varied scope of activities and size. The Organisations were included from Public, Private and Third Sector with number employed ranging from 2 to 1780. Employees age range of 20 and 80 years, with a good gender mix. We talked with two from each Organisation (representing management and general employee) while keeping a common approach both for employers and employees.

The following is a numerical summary of responses, followed by a discussion on results and conclusions.

Existing workplace provisions for Mental Health

81% of interviewees confirm that their organisation has a Workplace H&S management system (HSMS) and this appears to be well communicated in all organisations. However, much less awareness is shown when specific reference is made to Mental Health, with 85% saying that no specific reference to mental health in the HSMS, and no overt policy, or Wellbeing Charter existing. A number of interviewees (mainly management) suggest that, although not specifically identified, workplace Mental Health is inherent in the HSMS. 81% report no persons in the organisation have received training in the area of workplace mental health, with a further 7% not sure, or unaware of any training

in the area. When asked about what resources are available in their workplace to support employees mental health, 57% could identify no specific resources are available, although most thought that support, if needed, would be made available. 24% referenced specific supports such as Human Resources or H&S manager.

Every organisation involved in our research did have a system for managing Occupational Health & Safety (OHS), even if all staff are not aware of it. All staff we spoke to were aware of the requirement to have OHS management in place. Some suggested that the OHS managing system merely follows specific 'obligatory' requirements of the Health and Safety at Work legislation i.e. have a declaration of safety, safety policy or safety statement, and provision certain specific trainings prescribed (i.e. induction training, manual handling, 1st Aid and fire protection). However, a 'wellbeing charter' or specific Mental Health provisions are much scarcer. It is suggested from the responses that while there are specific rules to provide physically healthy conditions within the scope of OHS legislation, there is no specific strategy that supports the mental health of employees. Despite this, there is a general awareness of the need for balancing family life and work, and for protecting mental health. This is probably best summed up by the following comment;

'A workplace environment can have a significant impact on an individual's mental well-being (a crucial determinant in their overall health) and consequently also on company's business performance'.

We also asked all our interviewees how they would describe the attitude towards employee's mental health in their workplace. In most cases the response was positive and can be summarised by the following comments.

'They care for their employee's wellbeing, but not sure company does enough'.

'Whenever I needed I had the friendly support from my manager'

'When an employee faces a difficulty there is a tolerant attitude on behalf of the management'

One respondent recalled an example of an ex-employee who was experiencing some difficulty and the employer offered to help pay for some treatment and support. While acknowledging good intentions and positive attitude, it is clear that since the EU and National legislation often, does not specifically mention mental health of employees, there are no overt systems for recognising, documenting or managing mental health of employees in the vast majority of workplaces. Generally it comes down to the compassion or understanding of a manager who has no specific training in this area. We have learned from our conversations that the attitude towards mental health of the employees in the workplace may vary according to the personality structure of the department supervisors, and there are no clear rules. Often, it seems that issues of this nature will come to light through Human Resources rather than OHS. More concerning perhaps, some cases are uncovered as part of the disciplinary process.

Personal position on Mental Health

85% of interviewees rated their knowledge of mental health as good or excellent, and 89% say they have confidence that they know where to find mental health help or support for themselves, or a colleague if needed. (It is worth noting that all who engaged in this research did so voluntarily which may already indicate a positive disposition to the subject). This finding, though, is juxta-positioned by 81% confirming they have never received any training in the area, and 52% confirming they would not

feel confident to help, advise or recommend mental health support services to a colleague or staff member.

We asked those participating about their own personal knowledge or awareness on the subject. The feeling shared by some who had personally encountered problems, a result of understanding gained, are now much more patient with people who may be suffering. Many suggested that due to the pressures and stresses brought on by the pandemic that there is more awareness, which can only be seen as a good thing. The result of the new awareness is a more sympathetic view.

'There are *slow changes in the society's attitude towards mental health related issues'*

'Step by step, people are becoming more accepting of mental ill-health and more supportive of people with issues'

'People are more aware of common mental disorders such as depression and anxiety, and are more willing to talk to health professionals and seek treatment'

One business owner described their own journey towards mental health awareness as follows;

'Due to childhood life experiences and how I was brought up has always been to tough it out and work things out in my own head. My attitude since working in the real world and running my own business with employees has changed somewhat, in that it is ok to ask for help, and it is ok to show vulnerabilities. I believe I am much more open to the idea that mental health has an everyday effect on everyone, and we all must be empathetic to this'

Despite this perceived growth in awareness and positive attitude we found that the amount of training on this topic in workplaces is still very low. The existing knowledge people had generally came from a passing interest in the subject, or very detailed knowledge in a specific aspect where they have personal experience themselves, or that of a friend or family member. The apparent result of this deficit of training is that those who otherwise feel knowledgeable about the provision of mental health services admit to being hesitant to give help or advice to a colleague. Reasons for this hesitancy comes from an awareness that '*our acts have consequences'*, as was suggested by one of our interviewees, as well as fear that any such intervention *'would not be well received, or accepted'* or they would be *'afraid of facing a bad reaction'.* In this context, upon further reflection most participants revised their original positive responses to an acceptance that they had some knowledge about mental health, but it is not sufficient to help a suffering colleague. Notably, the response from an employee who had received training in First Aid for Mental Health was much more positively proactive.

'I feel that personally I should be able to help and should know where to look for outside solutions and or support. Due to the training completed I should be more aware of the potential signs and signals that people display or try to hide, and be able to start a conversation'

The Stigma of Mental Health

Another interesting aspect of our research is the juxta-position between participants 'positive' view of mental health and their perception of society's stigmatised view. 100% of those we talked with describe their attitude to mental as positive, while on the other hand, 96% believe there is a stigma attached to mental ill-health.

'I don't personally attribute stigma to persons bearing psychological issues. However it is quite common that people discuss other people's problems in a very superficial level. Society tends to stigmatise them with the line: "this person has psychological issues"'

It has been pointed out by our participants that the core of the stigma is attributed to lack of knowledge i.e. the stigma exists because it is difficult for someone to understand the nature and the depth of a problem.

'In the cases where a close person is facing mental ill-health we tend to read relevant books, articles etc. and consult experts on the field. Otherwise we tend to avoid, underestimate or overestimate the severity of someone's mental health status'

It was stated that mental ill-health is generally not easily understood by people who are not educated on this subject, and this leads to stigmatisation in the society. The stigmatisation may cause the individual to feel powerless and therefore to be pushed into loneliness. People do not accept their own problems due to this stigmatisation, and they do not want to receive any support because they fear that they will appear weak even if they do. Psychological problems are perceived as a personal weakness because they are situations that cannot be embodied, and often are put down to negative personality traits. On the other hand, there is a view expressed that while many people might perceive a stigma

'*There is not much of a stigma as there was 20 years ago, society has moved on from that*'

Unfortunately, perceived or real, most people we spoke to believe that negative attitudes and beliefs toward people who have mental ill-health are common, and that stigmatising views about mental illness are not limited to uninformed members of the general public;

'*Even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illnesses*'

It is also believed by some of the interviewees that stigma is evident in the way laws, social services, and the justice system are structured as well as ways in which resources are allocated.

Mental Health Management in the Workplace

70% of those we spoke to would describe their Organisations attitude towards employee's mental health as good, while 92% would be in favour of a specific mental health component to the OHS management system, and 85% would volunteer to be part of that. 52% said that they would you be comfortable to discuss their mental health with a manager, supervisor or co-worker, a further 26% would be very cautious in doing so while 22% said they would definitely not. However, if that manager, supervisor or co-worker was a designated mental health first responder with appropriate training, the level of comfort rises to 85%, a further 4% would be reasonably comfortable but still cautious, while those who said 'definitely not' is halved to 11%. We asked if the gender of that trained 'mental health first responder' matters, with a view to understanding if a mixed workplace should consider this when deciding on appointee(s) to the role of mental health first responder. 74% stated that it would not impact on their comfort if the person was male or female, while 26% would be more comfortable with a person of the same gender. 5% responded that while gender would not matter to them, they could understand that it might matter to others.

When we discussed the implementation of mental health management in the workplace, some participants who worked in small Organisations felt it unnecessary. This seems to stem from the idea

that they are few staff working in tightknit teams. Otherwise, reactions to the proposition that workplaces have a dedicated mental health strategy and specifically staff trained was almost unanimously positive.

'Having designated people with particular skills would be a very positive addition'

'Yes this would be interesting and an added value to their simple workplace health & safety management system'

What is very encouraging is that a significant majority said that they would volunteer to be part of such an initiative, and would like to receive the relevant training. Those who said they would not volunteer, rather than a lack of interest, cited reasons such as workload or thought that their position within the organisation was not the best fit for such a role (e.g. a manager feeling that such personal conversations with sub-ordinate staff members crosses a line).

Meanwhile, many others not only welcome the proposition, but believe that it should be, and inevitably will be, a mandatory required part of any OHS system in the workplace.

While a mental health component to OHS is welcomed, some concerns are expressed as to how it would work. Among the concerns expressed are trust issues. Many of those we spoke with had reservations about speaking about mental health with somebody in their place of work.

'It is very dependent on the person and the personality, as well as the mental health issue at hand'

'If the need arose I think I would, but I wouldn't particularly want to'

'In theory yes, but wouldn't want to'

'Confident in sharing mental health within certain limits… as long as the sensitivity of the confidentiality of the conversation is trusted'

'It depends, there are colleagues at work with whom I would discuss such personal issues such as family, relationships or personal health issues'

'I would open up to some colleagues whom I consider friends, or a trained person'

'If they had training, I would trust this person more easily. I would feel safer'

It is also clear from some of the responses that this trust issue is well founded as some responses evidenced what can happen if appropriate systems and training are not in place.

'I tried before but I would not do it again. I don't think it benefited me. I expected some change but the response was weak. Nothing really happened'

'(previously) I asked for support with problems about my own mental health, but was exposed to humiliating behaviors, and would be cautious and pay attention to talking with people about this issue... whether trained or not'

Although, despite this negative experience, this same person was optimistic that *'done right, this can be important and supportive.'*

In general, the level of confidence to disclose mental ill-health increased considerably in the case that the person with whom they would confide in would be a designated 'Mental Health First Responder' with specific relevant training, and part of a formal system or procedure. Although even within such a framework some reservations still persist, and are possibly related to the (perceived) stigma that

mental health still holds i.e. it depends on the nature of the problem, how personal it is, and if it is stemming from inside or outside of the workplace. Perhaps this participant summed it up best when they said that they…

'believe that it might be easier to talk with such a (trained) person, as he or she will probably have to obey certain rules and introduce procedures that would make people comfortable enough to open up and speak. Nevertheless, such a person will also have to be able to build trust so that what is said is for his/hers ears only, and not a subject of further discussion'

Impact of the Pandemic

Symptoms of anxiety and depression are common reactions to COVID-19. It is felt by participants that the COVID-19 outbreak and resultant containment measures have, and will continue to have, a long-term impact on the economy, businesses and the working environment. For many, new realities like working from home are an abnormal situation. The added pressures of such an arrangement include social isolation. Risk assessments for remote workers traditionally focus on the physical workspace, but the realisation must be made that there is much more to consider, primarily the social distancing aspect, the lost interaction between colleagues and clients.

'After work there is limited separation, no socialisation, nowhere to go. In normal circumstances, i.e. not a lockdown, working from home would be easier as you could bookend your work hours by going out, seeing friends or family etc.'

Organisation will have to constantly adapt work processes. Done correctly this will include consultation, planning, co-ordination and staff training. Much more time will have to be devoted to communication internally, among employees, as well as externally with clients, partner Organisations, etc.

Summary of Workplace Study

Overall, employees and managers were positive about the possibility of participating in a mental health aid in the workplace course. However, in general, those in smaller workplaces reported that they work in a satisfying environment and had a good collaboration and relationship with their colleagues and managers to discuss their own mental health concerns. This dynamic is less likely in workplaces with larger employee numbers.

Employers seem to demonstrate a competency dealing with mental ill-health even if not all of them had the necessary knowledge. They stated that they are very supportive to their employees needs and that they have the willingness to assist them with their concerns if it is necessary. Additionally they know in which services or specialists to address in the case an employee needs it. What is more, they reported that they have busy schedule and other obligations and they wouldn't attend a course for dealing with mental ill-health in the workplace. Finally it seems that in small businesses managers are trying to maintain full control and cultivate a family atmosphere so they don't think that specialised knowledge or person in Mental Health is necessary.

Legislation & Policy Review

Introduction to EU OSH legislation

EU legislature has established a system of basic principles of safety and health management, which must be transposed into national law by the Member States. Thus the principles are applicable in all Member States of the European Union.

The European Union sets legislation in the form of directives. The most important legal act is the European Framework Directive (1989/391/EEC), which establishes general principles for managing safety and health, such as responsibility of the employer, rights and duties of the workers, using risk assessments to continuously improve company processes, and workplace health and safety representation. All subsequent directives follow these common principles. These subsequent directives include individual directives or 'daughter directives', based on Article 16 of the Framework Directive. There are also other specific EU Directives, which are not based on the Framework directive, but have direct and indirect impact on OSH.

The European Directives on OSH set minimum standards for protecting workers and are transposed into national law by the legislatures in each Member State. Member States may exceed those standards when transposing the directives, but they may not lower existing ones. In this way, EU Legislation has established a homogenous system of basic OSH management principles where previously, each EU Member State had its own system to regulate OSH.

EU OSH legislation is built around the terms 'working environment' and 'health'. Both terms are not defined in the EU legislation itself but important for the context and understanding.

The term 'Working environment' goes beyond the prevention of work related accidents and sickness and includes the humane design of work processes and work organisation and aspects of health promotion. The European Court of Justice (ECJ) acknowledged this broad interpretation in the judgement C-84/94 of 12 Nov.1996.

'Health' is also acknowledged by the ECJ in the same decision in the definition of the World Health Organisation (WHO) as the 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Article 3, the Framework Directive defines various terms which are essential for understanding of the European legislation on OSH

- The worker: A worker is any person employed, including trainees and apprentices, but excluding domestic workers and self-employed persons
- The employer: The Employer is any natural or legal person who has an employment relationship with a worker and has responsibility for the undertaking and/or establishment
- Workers' representative with specific responsibility for the safety and health: A workers' representative with specific responsibility for the safety and health of workers is any person elected or designated in accordance with national laws / and / or practices to represent workers where OSH problems arise
- Prevention: Prevention means all steps or measures taken or planned at all stages of work in the undertaking to prevent or reduce occupational risks.

The "Framework" Directive

Directive 1989/391/EEC (the Framework Directive) established the instrument of risk assessment in European OSH legislation, which, when it was adopted in 1989. Instead of merely complying with

prescriptions and limit values, employers can decide on improvement measures that best meet the risk profile of the company. Further important provisions of the Directive are:

- Establishing an equal level of safety and health for the benefit of all workers. However, domestic workers, certain public and military services, and self-employed are exempt
- Ascribing responsibility to employers for preventing ill-health at work; obliging employers to take appropriate measures to make work safer and healthier
- Defining role and key elements of risk assessment, such as hazard identification, workers participation, adopting adequate measures (with the priority of eliminating risk at source), documentation and periodical re-assessment
- With the new obligation for prevention processes in the companies, the Directive implicitly raises the question for new forms of safety and health management as part of general management processes.

Individual OSH Directives

There are single Directives that set out the principles and instruments of the Framework Directive with regards to specific hazards at work (e.g. exposure to dangerous substances, or physical agents), single tasks (e.g. manual handling of loads, working with visual display units), different workplaces of elevated risk (e.g. temporary work sites, extractive industries, fishing vessels). It also considers how these factors combine for sensitive workers, such as pregnant women and breastfeeding mothers. The individual Directives define how risks are to be assessed, and the setting and measuring limit of values at the workplace. Article 16 paragraph 3 of the Framework Directive states that its general provisions shall apply in full to all the areas covered by each individual Directive.

The 19 individual Directives within the scope of Article 16 paragraph 1 of the Framework Directive which are currently in force are:

- Directive 1989/654/EEC on ***minimum safety and health requirements for the workplace*** introduces minimum measures designed to improve the working environment, in order to guarantee a better standard of safety and health protection
- Directive 2009/104/EC concerning the ***minimum safety and health requirements for the use of work equipment*** by workers at work which repealed Directive 89/655/EEC
- Directive 1989/656/EEC on the minimum health and safety requirements for the assessment, selection and correct use by workers of ***personal protective equipment (PPE)*** at the workplace
- Directive 1990/269/EEC on minimum safety and health requirements for the ***manual handling of loads*** involving risk for the prevention of musculoskeletal disorders
- Directive 1990/270/EEC on minimum safety and health requirements for work with display screen equipment
- Directive 2004/37/EC on the protection of workers from risks related to the ***exposure to carcinogens and mutagens***
- Directive 2000/54/EC on the protection of workers from risks related to ***exposure to biological agents*** at work
- Directive 1992/57/EEC on the implementation of minimum safety and health requirements at ***temporary and mobile work sites***. This Directive aims at promoting better working conditions in the construction sector
- Directive 1992/58/EEC on the provision of health and safety signs at work introduces an harmonised system of ***safety signs*** across all workplaces
- Directive 1992/85/EEC on the protection of ***new and expectant mothers*** establishes guidelines for assessing the risks related to specific tasks, movements and postures (e.g. heavy lifting, handling loads, night work), related to the exposure to chemical, physical and biological agents, and to physical and mental stress which are considered to be particularly dangerous

for pregnant women, women who have recently given birth and women who are breastfeeding (and their child)

- Directive 1992/91/EEC concerning the minimum requirements for improving the safety and health protection of workers in the ***mineral-extracting industries*** specifically focusing on extractive industries concerned with exploration for and exploitation of minerals by means of boreholes (onshore and offshore)
- Directive 1992/104/EEC on minimum safety and health protection of workers in the ***surface and underground extractive industries***
- Directive 1993/103/EC concerning the minimum safety and health requirements working on board of ***fishing vessels***
- Directive 1998/24/EC on the protection of the health and safety of workers from the risks related to ***chemical agents*** at work
- Directive 1999/92/EC on the protection of the health and safety of workers from the risks from ***explosive atmosphere***
- Directive 2002/44/EC on the protection of the health and safety of workers from the risks arising from the exposure to ***mechanical vibration***
- Directive 2003/10/EC on the protection of the health and safety of workers from the risks to hearing, and other risks arising from the ***exposure to noise***
- Directive 2006/25/EC on the protection of the health and safety of workers from the risks arising from the exposure to ***artificial optical radiation***
- Directive 2013/35/EU on the minimum health and safety requirements regarding the exposure of workers to the risks arising from exposure to electromagnetic fields and waves. This Directive repeals Directive 2004/40/EC on ***electromagnetic fields.***

Further Directives with OSH relevance

The system of the protection of the safety and health of workers is completed by other relevant Directives which are not based on Article 16 paragraph 1 of the Framework Directive whose provisions are mainly aimed at technical aspects of OSH.

- Directive 1991/383/EEC supplementing measures to encourage OSH improvements for workers with ***fixed-duration employment contracts or temporary workers***
- Directive 1994/33/EC on the protection of ***young people at work*** (under eighteen years of age)
- Directive 2003/88/EC concerning certain aspects of the ***organisation of working time*** applies to rest time, holidays and shift work. Further Directives on the working time of seafarers and drivers are Directive 1999/63/EC, Directive 2002/15/EC, and Dir 2005/47/EC
- Directive 2009/148/EC on the protection of workers from the risks related to ***exposure to asbestos*** at work
- Directive 2010/32/EU on the ***prevention from sharp injuries*** in the hospital and healthcare sector
- Directive 2013/59/Euratom lays down basic and uniform safety standards for protecting workers and the general public against the dangers arising from ***ionising radiation***. It repealed the old Directive 1996/29/Euratom.

Summary of Legislation

The EU Framework Directive (89/391) creates a legal obligation on employers to protect their workers by avoiding, evaluating and combating risks to their safety and health (without mentioning specific risks). Inherent in this, although not specifically identified, are psychosocial risks in the workplace

which can cause or contribute to stress or mental health problems. There are also joint EU 'Framework Agreements' agreed by unions and employers, presenting common positions on how to deal with work-related stress and harassment and violence at work.

No specific directive exists on measures to encourage OSH improvements for workers mental health, or the prevention of psychosocial risks in the workplace.

Policy Trends at the EU level

In recent years there has been a change in occupational safety and health (OSH) trends in Europe. The nature of work has changed dramatically due to globalisation, migration, technological advances, the emergence of the knowledge-based economy and more recently COVID19. These changes have been accompanied by the prevalence of new and emerging types of risk such as work-related stress, workplace violence, harassment and bullying. These risks can have a significant impact on workers mental health. As a result, approaches to prevent and manage psychosocial risks have been implemented at the policy level in Europe.

Policies and approaches relevant to the management of psychosocial risks can take various forms. These initiatives include both 'regulatory policies' which comprise legal regulations (such as EU directives, national legislation, ILO conventions) as well as 'non-binding/voluntary' policies developed by recognised national, European and international organisation which may take, for example, the form of specifications, guidance and social partner agreements

While the regulatory standards set the minimum level of protection deemed appropriate by the Community, voluntary standards are intended to provide organisation with the elements of an effective OSH management system that can be integrated with other management requirements and help organisation achieve OSH and economic objectives.

Regulatory Policies

Even though regulations in EU addresses certain aspects of the psychosocial work environment, it should be noted that the terms 'stress' and 'Mental Health' are not mentioned explicitly in most pieces of legislation. The main example in this respect is the key EC regulatory OSH standard, the Framework Directive 89/391/EEC on Safety and Health of Workers at Work. Even though the Directive asks employers to ensure workers' health and safety in every aspect related to work, 'addressing all types of risk at source', it does not explicitly mention the terms 'psychosocial risk' , 'work-related stress' or 'employees mental health'.

However, it does require employers to 'adapt the work to the individual, especially as regards the design of work places, the choice of work equipment and the choice of working and production methods, with a view, in particular, to alleviating monotonous work and work at a predetermined work-rate, developing a coherent overall prevention policy which covers technology, Organisation of work, working conditions, social relationships and the influence of factors related to the working environment'. In this sense, it is implied that risks related to the psychosocial work environment are included.

It should be noted here that the level of specificity of the national regulatory OSH frameworks vary substantially between the different EU member states. As per OSHA Europe, some Member States limit their OSH legislation to that set by the EU Framework Directive and do not explicitly mention psychosocial risks (e.g. Luxembourg, Ireland, Romania and Spain), while others highlight that psychosocial risks or mental health do need to be considered as part of OSH (e.g. Denmark, Finland, Greece and Sweden). Others require psychosocial risk assessments (e.g. Bulgaria, Germany, Latvia,

Portugal and the United Kingdom) with a select few advocating the involvement of a psychosocial risk expert (Austria and Belgium).

Voluntary Policies

In the last decade, new 'softer' forms of policy which directly refer to psychosocial risks and its associated problems have been initiated in the EU through increased stakeholder involvement within such frameworks as social dialogue and corporate social responsibility. Participants in European social dialogue, trade unions, private sector employers), small businesses and public employers have concluded 'voluntary' framework agreements, on topics such as, work-related stress, and harassment and violence at work. A 'voluntary' agreement signed by the European social partners creates a contractual obligation for the affiliated organisation of the signatory parties to implement the agreement at each appropriate level of the national system of industrial relations (instead of being incorporated into a Directive).

The framework agreements mentioned aim at increasing the awareness and understanding of employers, workers and their representatives of the issues in question, and clarifies responsibilities for the management of work-related stress and psychosocial risks. However, it should be noted that both framework agreements work-related stress and on harassment and violence at work are broad and do not provide any guidance at the enterprise level on how to design, implement, and sustain Programmes for psychosocial risk management.

Additional examples of voluntary policy approaches in the form of guidance (and also of relevance to the EU) have been developed by international organisation such as the World Health Organisation (WHO) and the International Labour Organisation (ILO). These include guidance on psychosocial risks at work, work-related stress and psychological harassment.

Apart from the voluntary standards presented above, it should also be noted that in some EU member states efforts have been made to address psychosocial risks and work-related stress through a similar national approaches e.g. An initiative in Denmark is a collaboration between social partners, the Danish Working Environment Authority and the National Research Centre for Working Environment, that led to the development of a methodology supporting enterprises in identifying and managing psychosocial risks. In Slovakia regional public health offices and the labour inspectorate provide information and counselling on the prevention of work-related stress to employers and employees. In the United UK the Health & Safety Executive (HSE) has developed the Management Standards approach to help reduce the levels of work-related stress reported by British workers.

Summary of Policies

In spite of all progress that has been achieved, it has been widely acknowledged that there exists a gap between policy and practice. This gap is due to lack of clarity in regulatory frameworks and related guidance on the management of psychosocial risks and mental health in places of work. Despite the increasing awareness of the impact of psychosocial risks on workers mental health, countries differ in their acknowledgement, awareness and prioritisation of these issues. The variation between different Member States in the specificity of implementation of EU Framework Directives means that some limit themselves to that set by the European Union while others expand to include and define psychosocial risks. This contributes to a lack of awareness and prioritisation through the lack of clarity and specificity on the terminology used.

Further, although the different policies are rooted in the OSH legislation, very few of them provide specific guidance, tools and training on psychosocial risk management to SME's manage psychosocial risks successfully.

In addition, lack of awareness and prioritisation of these issues across the enlarged EU is often associated with lack of expertise, research and appropriate infrastructure.

These are issues picked up on in the European Commission's evaluation of the implementation of the EU Framework Agreement on Work-related Stress. On one hand the report found that the Framework developed consensus that work-related stress is a structural issue requiring attention and intervention, leading to additional discussion and the implementation of tools and resources. However, the same report also identified variation in the success of this Agreement across Member States, with the Agreement not implemented in all Member States or that not all workers are covered through national level agreements.

Occupational Safety & Health Management Systems (OSH MS)

In the 1990's standardised approaches for OSH MS were developed that made use of the experiences with Total Quality Management, specifically those with Quality Management Systems according to the ISO 9000 standard.

Following these developments OSH management system standards were developed. The main standard being OHSAS 18001 (note that the standard uses the term OHS while in this article the term OSH is used (first version 1999, updated in 2007). In 2001, the International Labour Organisation (ILO) also published OSH MS Guidelines

The OHSAS 18001 management systems, although explicitly addressing both occupational health and safety, are, in practice, focused more on safety than on health

However, there is a move for OSH MS to address occupational health issues using comprehensive and systematic approaches. The World Health Organisation (WHO) recently published a model for "healthy workplaces" with many of the characteristics of an OSH MS. More recently, the British Standards Institute (BSI) has developed a publicly available standard for the management of psychosocial risks which can be considered a supplement to the OHSAS 18001 standard.

The OHSAS method is based on the 'Deming PDCA cycle', which consists of an iterative process of four steps, known as 'Plan, Do, Check and Act'. The involvement of top management in all steps of the process is essential for an effective management system. Risk assessment is the most important in the 'Plan' stage. The participation of employees with relevant skills and competences, and available resources is critical for 'Do'. Performance measures and corrective and preventive action are the essence of 'Check', while 'Act' centers around the management review, taking into account OSH performance measures.

Initially, management of occupational safety and health focused on technical inspections, with the later inclusion of Organisational, human factors and behavioral issues. Today, it is broadly acknowledged that all these factors are important and the management of OSH requires an integrated approach.

OSH MS combine occupational safety and health objectives with management systems designed to deliver on these objectives. Within the MS. the OSH MS objectives are to be defined by the organisation and may include ethical, economic, legal and Organisational goals.

The five basic characteristics of any occupational safety and health managements systems are:

- It includes all components of OSH that are relevant to the members of the organisation and the business process
- In principle, its functions are:
    - to increase the effectiveness of OSH management

    - to guarantee compliance with existing legislation
    - to improve OSH performance.
- It is a holistic approach, specifying and requiring implementation of a series of elements and (positive) interactions between them
- It has provisions for system maintenance and continuity. The functioning of an OHS MS is evaluated on a regular basis (through OSH audits)
- A periodic review of its objectives and effectiveness is necessary to ensure continuous improvement
- Its outputs (OSH performance) are important to the evaluation of the management system.

OSH MS help deal with complex issues, such as the changing work environment (legislation, processes, materials etc.), the dynamics within Organisations, and the interactions between management and employees. They lead to a better understanding of processes, problems and possible solutions, and enable the implementation of measures to reduce hazards and control risks.

Conclusions

It is clear from our research that there is a desire across the board to deal with issues of mental health in the community and in the workplace. Employers and employees both display an understanding of the issues that can arise. However, the desire to help is counterbalanced with a fear of crossing a line, or even exasperating a situation. This fear results in stagnation, and a sense of letting sleeping dogs lie.

On the basis of this review it can be concluded that while the regulatory policies set the minimum level of protection for workers, voluntary policy initiatives can enable organisation to go beyond their legal obligations in relation to the management of psychosocial risks. However, reports by the European Commission and EU-OSHA/Eurofound have found an inconsistency in the use of 'stress' and 'psychosocial risks' and voluntary standards fail to provide specific guidance on psychosocial risk management to enable organisation to manage successfully.

European research shows that from the establishments that implemented at least one measure to deal with psychosocial risks during the last 3 years, one out of five admitted that this was triggered by 'concrete problems with stress, bullying, harassment or violence in the establishment'. Other major motivations for addressing health and safety in establishments in the EU-28 are identified in research as follows;

- Fulfilling legal obligation
- Meeting expectations from employees or their representatives
- Avoiding fines from the labour inspectorate
- Maintaining the organisation's reputation
- Maintaining or increasing productivity.

While legal obligation remains the main motivation for dealing with OHS issues, no specific directive exists on measures to encourage OSH improvements in the area of psychosocial risks and workers mental health. This can explain why this topic is less likely to be addressed in the workplace than physical health. Without clear direction this situation is unlikely to change.

In the same study, barriers to addressing health and safety in establishments in the EU-28 include the following;

- Lack of awareness among staff
- Lack of expertise or specialist support
- Lack of awareness among management.

The gaps in awareness and training specific to the topic of workers mental health has been borne out in our research, and the indication is that without leadership in the form of legislation, the motivation for employers to address the awareness and training gaps is diminished.

Appendices

Interview Guide

We propose a research approach which will be common for all target groups: employers, employees, managers etc. This will ensure compatibility between the partner reports facilitating the final analysis.

The following is a series of questions designed to guide your research and extract the information from your interview subject. This is not a survey or questionnaire, rather a series of discussion points or prompts to help develop the conversation and keep it focused.

Organisational information
• Organisation Name? • Website? • Person(s) Interviewed (Name, and Position within the Organisation)? • Interview Date / Time / Location?
• Type of Organisation (i.e. public, private, social, community etc.)? • Main area of business (sector)? • Number of employees? • Employees gender breakdown (male / female)? • Employees age profile?
Interview Topics
• Does your organisation have a system for managing workplace Health & Safety? • Does your Organisation have a 'wellbeing charter' or wellbeing strategy in place? • Is there a person(s) in your workplace specifically responsible for Workplace Health & Safety? (Please describe the structures in place)? • Does this management system have any specific provisions for managing Mental Health? • Does your workplace have a trained First Aid or First Responder? • Does the First Aider(s) / First Responder(s) have any training specific to dealing with Mental Health and Wellbeing? • What resources are available in your organisation to deal with employees Mental Health?
• How would you rate your knowledge of mental ill-health? • How would you describe your attitude towards mental health? • How would you rate your confidence to help, advise or recommend mental health support services to a colleague/employee? • Have you ever received any training specifically relating to mental health in the workplace?
• Do you think that mental ill-health carry a stigma compared to physical health issues? • In the event you or a colleague needed it, do you know where to find Mental Health help or support? • Would you be confident to discuss your own mental health with a manager/supervisor or co-worker?

• Would you be confident to discuss your own mental health with a manager/supervisor or co-worker who is designated 'mental Health First Responder' and had specific training in Mental Health? • Does gender matter? I.e. would you be more comfortable discussing your mental health with a male or female (are you male/female)? • Does gender matter? I.e. would you be more comfortable discussing with a colleague his/her mental health with a male or female (are you male/female)?
• How would you describe your Organisations attitude towards employee's mental health? • Do you feel the mental health support is there if you or a colleague need it? • What impact, if any, is Covid-19 likely to have on your Organisation Health & Safety strategy over the coming year? • Would you like to see a specific Mental Health component to the workplace Health & Safety management system? • Would you volunteer to be part of that occupational Mental Health team, and receive specific training in the area?

Profile Overview of Engaged Workplaces

WORKPLACE 1 Social Enterprise	Number of employees Male/female split Age Range	13 Predominantly female. Predominantly 40-60 age range.
WORKPLACE 2 Public Sector	Number of employees Male/female split Age Range	29 13 / 16 M 20-29: 1 Person, 30-39: 7 People, 40- 49: 14 People, 50-59: 7 People
WORKPLACE 3 Public Sector	Number of employees Male/female split Age Range	125 53 F/ 72 M 25-30: 17 people, 30-40: 51 people, 40-50: 45 people, 50+: 12 people
WORKPLACE 4 Public sector	Number of employees Male/female split Age Range	1780 %65 F/ %35 M 20-65 years old
WORKPLACE 5 Public sector	Number of employees Male/female split Age Range	19 12f / 5m 25-30: 6 People, 31-35: 4 People, 36-40: 5 People, 41-45: 4 People
WORKPLACE 6 Private Enterprise	Age Range	Ages 45-55 in our team.
WORKPLACE 7 Social Enterprise	Number of employees Male/female split Age Range Average age:	3 + 43 volunteers 1m/2f Average age: 49.7
WORKPLACE 8 Private Enterprise	Number of employees Male/female split	2 2 females
WORKPLACE 9 Private Enterprise	Number of employees Male/female	2 1m/1f
WORKPLACE 10 Private Enterprise	Number of employees Male/female split Age Range	14 60/40 20-80's
WORKPLACE 11 Public Organisation	Number of employees Male/female split Age Range	8 in team / 6000 across all campuses 70/30 40- 65
WORKPLACE 12 Private Enterprise	Number of employees Male/female split Age Range	2 50/50 44/63
WORKPLACE 13 Private Enterprise	Number of employees Male/female split Age Range	92 34m/ 58f 20-70 years
WORKPLACE 14 Private Enterprise	Number of employees Male/female split Age Range	6 1m/ 5f 25-53 years
WORKPLACE 15 Private Enterprise	Number of employees Male/female split Age Range	33 21m/12f 27-54 years

Interviews Statistical Summary

Question	N	Y	Other	
Does your organisation have a system for managing workplace Health & Safety?	15%	81%	4%	Don't know / Not sure
Does your Organisation have a 'wellbeing charter' or wellbeing strategy in place?	85%	15%	0%	
Is there a person(s) in your workplace specifically responsible for Workplace Health & Safety? (Please describe the structures in place)?	41%	59%	0%	
Does this management system have any specific provisions for managing Mental Health?	74%	22%	4%	Don't know / Not sure
Does your workplace have a trained First Aid or First Responder?	48%	52%	0%	
Does the First Aider(s) / First Responder(s) have any training specific to dealing with Mental Health and Wellbeing?	81%	7%	11%	Don't know / Not sure
What resources are available in your organisation to deal with employees Mental Health?	57%	24%	19%	Don't know / Not sure
Would you rate your knowledge of mental ill-health highly?	15%	78%	7%	Not good or not bad
Would you describe your attitude towards mental health as positive?	0%	100%	0%	
Would you be confident to help, advise or recommend mental health support services to a colleague/employee?	22%	48%	30%	Somewhat confident - depends on the issue
Have you ever received any training specifically relating to mental health in the workplace?	81%	19%	0%	
Do you think that mental ill-health carry a stigma compared to physical health issues?	4%	96%	0%	
In the event you or a colleague needed it, do you know where to find Mental Health help or support?	11%	78%	11%	Somewhat confident - depends on the issue

Would you be confident to discuss your own mental health with a manager/supervisor or co-worker?	22%	52%	26%	Would be very cautious about it, and would require certain assurances
Would you be more confident to discuss your own mental health with a manager/supervisor or co-worker who is designated 'mental Health First Responder' and had specific training in Mental Health?	11%	85%	4%	Would be very cautious about it, and would require certain assurances
Does gender matter? I.e. would you be more comfortable discussing your mental health with a male or female (are you male/female)?	69%	26%	5%	Doesn't matter to me, but I can understand how it might matter to others
Would you describe your Organisations attitude towards employee's mental health as good?	22%	70%	7%	Don't know / Not sure
Do you feel the mental health support is there if you or a colleague need it?	26%	70%	4%	Don't know / Not sure
Would you like to see a specific Mental Health component to the workplace Health & Safety management system?	4%	92%	4%	Don't know / Not sure
Would you volunteer to be part of that occupational Mental Health team, and receive specific training in the area?	4%	85%	11%	Would like to but would not have the time

Partners National Summary

Greece

Mental Health First Aid is a relatively new service profession in the field of OSH and so far there isn't any relevant Organisation. According to the ESENER survey of Enterprises on New and Emerging risks: Managing Safety and Health at Work, (2012), Greece was among the countries that are least likely to implement measures to manage psychosocial risks at work.

Over the last decade there has been incremental government initiatives towards the alignment of the National Policies to the EU framework on addressing mental ill-health in the workplace. As a result a number of tools (policy documents, references, guides etc.) have been developed to support all actors in the work environment into achieving a better understanding of the psychological risks at work and into building a proactive attitude towards this matter.

The European public service union (2017) has published a guide for the well-being and occupational safety and health (OHS) in central government and administration which mainly focuses in tackling psychosocial risks at work. The guide has been made available in Greek language.

The lack of a Mental Health framework for the workplace has provided the stimulus for private interventions in many areas for sustainable health care of employees. What has been an outstanding best practice in the business environment in Greece is the case of Elais, a leading Greek food processing company that has registered a good example of workplace health promotion. ELAIS S.A. is part of a multinational group (Unilever) and it is a long established company that produces and markets edible fats (margarine, oils, and cooking fats), beverages (tea) and other food products. The company has integrated Work Health Promotion in human resources policy and work Organisation with great success since 1984. The company's Mental Health innovative programme has been awarded for Work Place Health Promotion as the best.

Turkey

It is reported that there is no support in the national policy, and there is no study on the mental health of employees in the workplace, in Turkey. It has been observed that the funds transferred to mental health in the country were generally transferred to institutions providing individual and community mental health services under the Ministry of Family, Labour and Social Services and the Ministry of Health. It is stated that every citizen in the society can access these services by their own means.

There are psychiatry units, social service units, fight against substance addiction, community mental health centers, and mental and nervous diseases units in hospitals in the country. Generally, all institutions work in coordination with drug and treatment-based, skills-based, social competence and need-based, as well as mental health-based treatment approaches in disasters. While meeting the needs of people with mental problems, it is aimed to provide all the necessary assistance to adapt to the society in an integrated way, and family medicine is considered as the first step. (Mental Health Policy of the Republic of Turkey)

There is no institution working especially in 'mental health first aid' in the country, and all the organisations mentioned in cases such as disaster and emergency aid voluntarily provide first aid service in mental health. It has been learned that there are plans to actively carry out these studies. Training is given to mental health professionals in disasters and traumas under the body of psychological first aid, and training booklets are created and presented. It has been learned that those who work in the field of mental health within their own groups receive voluntary training on mental health and self-care. Recently, it was learned that interactive projects were initiated by the Mental Health Association in order to prevent suicide cases due to psychological problems.

UK

According to published statistics from the HSE in 2020, 828,000 employees in Great Britain were diagnosed as suffering from work-related stress, depression or anxiety. This equated to 17.9 million working days lost. 'Labour Force Survey (LFS) 2019/20'.

Public Health England was set up with the purpose to 'protect and improve the nation's health and wellbeing and reduce health inequality.' Public Health England is there to support government, local government, NHS, parliament, industry and the general public with evidence based professional, scientific expertise and support. Public Health England set out its executive summary in September 2019 for the strategy over the next 5 years. The main aim of Public Health England is to protect and improve the nation's health and reduce health inequalities.

NICE is the National Institute for Health and Care Excellence, and its aim is to provide national guidance and advice to improve health and social care. NICE guideline which includes the following:

- Promoting mental wellbeing at work
- Managing long term sickness and incapacity for work
- Workplace interventions to promote smoking cessation
- Promoting physical activity in the workplace. Workplace health: policy and management practices.

In 2017, the government asked for an independent review to be carried out into mental health in the workplace. The review was conducted in October 2017 and is called 'Thriving at work'- The Stephenson/Farmer review on mental health and employers. The review was to look at how employers could better support all individuals in employment to remain in and thrive in their work. The report set out a framework of actions which were called 'core standards', which were designed for employers of all different sizes to be able to put into place. The core standards were designed to help employers improve the mental health of their workplaces to enable individuals with mental health conditions to thrive. (HSE. Stress at work-mental health conditions. August 2020)

As the awareness and significance of mental health in the workplace becomes less of a stigma and a more acceptable form of ill-health, the support and help that is available to those who feel that they need has grown. Many training organisation, providers and awarding organisation are offering courses around the different mental ill-health that people could be living with and offering support as to how to approach. Other organisation such as charities are set up to offer advice and support to anyone who may be experiencing a mental health problem, as well as campaigning to raise awareness, to encourage understanding. Others are helping in implementing wellbeing strategies in the workplace for both the employer and the employee.

Ireland

Mental Health Ireland was founded in 1966 on the recommendation of the Commission on Mental Illness. Today, they are a leading provider of mental health promotion in the voluntary sector. Mental Health Ireland has been an innovator in the promotion of positive mental health and wellbeing in Ireland for almost half a century. Mental Health Ireland offer training specifically designed for the workplace, they offer 3 different types of workshops for workplaces, and they have developed two four-hour workshops for Managers and another for Employees. There workshops equip participants with the knowledge and understanding necessary to nurture and enhance mental health and wellbeing in the workplace.

As well as the workplace they also offer support to people in communities and schools and third level. There website offers great resources for users looking for more information on mental health and anyone who is looking for assistance with their own mental health.

Saint John of God Hospital is a not-for profit, independent provider of mental health services. In May 2014 the Hospital signed a Memorandum of Understanding with MHFA Australia to adapt the course for Ireland and in October 2014 Betty Kitchener came to Saint John of God Hospital to advise on the roll out of the MHFA Ireland Programme. The course teaches managers, supervisors and individuals how to assist a co-worker who may be developing a mental health problem or experiencing a mental health crisis. Participants learn a framework for communications, how to offer and provide initial help and how to guide a person towards appropriate professional help, and other supports, in an understanding and empathetic way.

Spain

Mental health does not have a specific regulation within the health and safety at work programmes. The basic state legislation refers to mental occupational diseases, it was not until 2006 - 2007 that mental health began to be given importance as a specific area within risk prevention. More regularly, we can see that companies have timidly implemented specific actions for the promotion of mental health at work. According to an article "Spain is at the bottom in terms of psychosocial health management at work. Only four out of 10 Spanish companies report having policies to support mental health and wellbeing"

In Spain, it was estimated that between 11 % and 27 % of mental disorders can be attributed to working conditions (UGT, 2013). The direct health cost of mental and behavioral disorders attributable to work was estimated to be between €150 and €372 million in 2010. This represented 0.24 % to 0.58 % of total health expenditure in Spain for that year.

In Spain, the obligation to establish measures for the prevention and care of mental health at work is regulated in the law on the prevention of work-related risks. The actors involved in the prevention policy are:

- Public administration (state - regional - local / depending on their competences) 2.
- Employers (and their representatives)
- Employees (and their representatives)

The Ministry of Work and Social Economy is the state dependent public administration that manage the health and safety at work policy. The Ministry has created a public body responsible to develop information and consultation activities as well as the implementation of policies to support innovative practices at work place in the area of heal and safety. This is the Instituto Nacional de Seguridad y Salud en el Trabajo- INSST (National Institute for helar and safety at work).

Employers are responsible to adapt the workplace to the legislation in order to prevent and eliminate the risk of the activities and ensure a safer workplace for all, employees and people who can visit them.

Employees are responsible to fulfill the measure to prevent and eliminate risk at work. They have the duty of fulfill with all their requirements and they can be sanctioned by the Company; but at the same time, they have the right to receive training in proper Health and Safety at work.

Slovenia

According to key data from regular health statistics and research, performed by the National Institute of Public Health data (2008 – 2016), show that sick leave due to mental and behavioral disorders was the third most common in the period 2008–2016 and was among the longest in terms of duration. In 2015,

there were 18,215 cases of absence from work and 747,401 lost calendar days due to mental and behavioral disorders, most of them in the age group of 45 to 64 years. Additionally, data from the CINDI Periodic Survey (2012, 2016) on the behavioral style of adults show an increase in the proportion of adults who report daily stress/tension due to workload (48% in 2012 and 55% in 2016) and bad relations at the workplace (the share of these persons was 10% in 2012 and 19% in 2016). The share of people who manage stress and tension with difficulty was 26% in 2012 and 22% in 2016.

Two ministries in Slovenia are regulating health and safety at work and mental health - these are the Ministry of Labour, Family. Social Affairs and Equal Opportunities (MoLFSA) – health and safety at work, and the Ministry of Health (MoH) – workplace health promotion & mental health.

The Health and Safety at Work Act (HSWA) regulates the entire area of health and safety at work. Psychosocial risks at work are addressed in Articles 24 and 29 of this Act. The employer must adopt measures to prevent, eliminate and manage cases of violence, mobbing, harassment and other forms of psychosocial risks at the workplace that can pose a threat to workers' health. It is the safety officer's task to coordinate measures to prevent psychosocial risks.

Due to the high prevalence of mental ill-health among employees and the impact of psychosocial risks on the health status and reduced efficiency of employees, the work environment is one of the key environments for the promotion and prevention of adults' mental health.

In 2015 MoH refreshed the Guidelines for workplace health promotion. These guidelines provide only the basic principles for planning workplace health promotion. They have been prepared primarily as assistance and support in the implementation of workplace health promotion programs determined by the Health and Safety at Work Act. (HSWA-1; OJ RS, No. 43/11;). Workplace health promotion is systematic targeted activities and measures aimed at all workers and carried out for all workers under the same conditions, with the aim of maintaining and strengthening the physical and mental health of employees. It is a combination of changes in the physical and social environment and a health-related lifestyle. Employers who employ up to 10 employees should follow the guidelines sensibly and prepare a tailored plan.

Mental health in Slovenia is regulated (in general) by the Mental Health Act (MHA) and implementing regulations, while workplace mental health is regulated by the Resolution on the National Mental Health Programme 2018 - 2028 and the Health and Safety at Work Act (HSWA).

Workplace mental health is being addressed under priority area 5.2 "Promotion of mental health, prevention of mental disorders and destigmatisation of mental disorders among various target groups" and it should contribute, via measures mentioned bellow, to the following specific objectives: