

Mental Health Problems and Mental Disorders: Linked Determinants to Work Participation and Work Functioning

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Marc Corbière, Alessia Negrini, and Carolyn S. Dewa

Understanding the relationship between mental health and work conditions. Specific determinants of mental health problems in the workplace and significant work reintegration factors of workers with mental disorders are discussed.

17.1 Introduction

Organizational, economic, and technical changes in our societies have important repercussions on employees' mental health. The consequences of these types of changes in the workplace represent a burden not only to people but also to economies. In several countries, the costs related to health

care and loss of work productivity due to mental health problems and mental disorders exceed several billion dollars annually (OECD 2010). Presenteeism in the face of mental health problems (e.g., depressive and anxiety symptoms) is a significant burden for the organization, while disability claims have doubled in the last decade for employees with common mental disorders (i.e., adjustment disorder, anxiety, and depression disorders), accounting for 30% of disability claims (OECD 2009). Furthermore, approximately 50% of employees who are absent from work because of common mental disorders will take several days, or even months, off or will never return to work (Stephens and Joubert 2001). Though many people with severe mental disorders (e.g., schizophrenia and bipolar disorder) are ready and available to integrate into the competitive workplace, 70–80% of these workers continue to be unemployed (Corbière and Lecomte 2009).

Distinctions made in the literature concerning mental health conditions and the work situations in which they occur have led to the terms “mental health problem,” “common mental disorder,” and “severe mental disorder” being used to differentiate a person's symptomatology and their ability to function at work. While the term “mental health problem” means any deviation from the state of mental or psychological well-being, the terms “illness” and “disorder” refer to clinically recognized diseases, and they suggest that significant distress or dysfunction, or a tangible risk of undesirable or harmful outcomes, exists (Government of Canada 2006). While mental

M. Corbière, Ph.D. (✉)
School of Rehabilitation, Université de Sherbrooke,
Sherbrooke, QC, Canada

Centre d'Action en Prévention et Réadaptation de
l'Incapacité au Travail (CAPRIT), 150 Place Charles-Le
Moyne, 9ème étage, Longueuil, QC, Canada J4K 0A8
e-mail: Marc.Corbiere@USherbrooke.ca

A. Negrini, Ph.D.
Institut de recherche Robert-Sauvé en santé et en sécurité
du travail (IRSST), 505, boul. de Maisonneuve Ouest,
Bureau 1127, Montréal, QC, Canada H3A 3C2
e-mail: Alessia.Negrini@irsst.qc.ca

C.S. Dewa, MPH, Ph.D.
Department of Psychiatry, University of Toronto,
Toronto, ON, Canada

Centre for Research on Employment and Workplace
Health, Centre for Addiction and Mental Health,
455 Spadina, Suite 300, Toronto, ON, Canada M5S 2G8
e-mail: carolyn_dewa@camh.net

health problems can have a negative impact on job performance (e.g., presenteeism) and cause pain for individuals and their families, they do not necessarily lead to the development of mental illness (World Health Organization 2005). According to Nieuwenhuijsen et al. (2003), the majority of workers who are absent from work due to a “common mental disorder” can be grouped into three categories: adjustment disorders, mood disorders (including major depression), and anxiety disorders (Shiels et al. 2004; van der Klink et al. 2003). It remains difficult to precisely establish the incidence and prevalence of these three mental disorders in a working population (St-Arnaud et al. 2011); however, they are most common in the labor force and have a higher prevalence compared to a severe mental disorder such as schizophrenia, which has a prevalence of approximately 1% in the general population. The Ontario Ministry of Health (Ministry of Health and Long-Term Care 1999) and other international institutions (e.g., National Institute of Mental Health) define “severe mental disorders” using three tangible indicators: (1) the disabilities or difficulties that interfere or limit the person’s functioning in one or more areas of life activity; (2) the expected duration refers to the problem identified either through facts or subjective experience suggesting a persistence of health problems over time (e.g., frequency and intensity of use of psychiatric services); and (3) the predominant diagnoses are schizophrenia, schizoaffective disorders, bipolar disorders, and major depression. Other psychiatric diagnoses, such as personality disorders and severe concurrent diagnoses (psychiatric diagnosis with substance abuse), are also included in the term “severe mental disorder.” In using the term “severe mental disorder,” it is important to consider not only the psychiatric diagnosis and severity of symptoms but also the functioning of the person in his or her social and work environment (Corbière and Durand 2011).

Even though preventive interventions for employees with mental health problems, return-to-work programs for employees absent from work due to common mental disorders, and supported employment programs for people with

severe mental disorders are available, these programs still encounter difficulties in returning to and/or maintaining jobs in these groups of people. The relationship of these mental health problems and severe mental disorders as they are associated to a work situation is represented as a continuum in Fig. 17.1. For example, people with common mental disorders are likely to be absent from their organization and can be in the process of return to work, while people with severe mental disorders are often unemployed or on long-term disability and can be in the process of work reintegration. The parallel of mental health with work conditions during the process of work participation and work functioning is not strictly defined: people with mental health problems may be absent from the workplace, and people with mental disorders may try to stay at work (e.g., presenteeism).

We think that understanding the nuances in the relationship between mental health and work conditions, as well as the more common parallel relationships shown in Fig. 17.1, will help us to better understand the specialized literature. To illustrate this, the four objectives of this chapter are (1) to demonstrate the economic burden of mental health problems and mental disorders in the workplace, particularly relating to presenteeism, work absences, and long-term disability; (2) to present the determinants of mental health problems of employees in the workplace; (3) to present the significant return-to-work factors for people with common mental disorders; and (4) to present the significant work integration factors for people with severe mental disorders. For the last three objectives, we will support the linked determinants of work participation with theories, when possible, to better explain the combination of factors affecting the work outcomes of different populations. At the ends of these sections, we will present services/programs or interventions designed to facilitate the work participation of people with mental health problems or mental disorders. Finally, we will discuss similarities in the factors affecting work participation of people with mental health problems or mental disorders as well as future avenues of research.

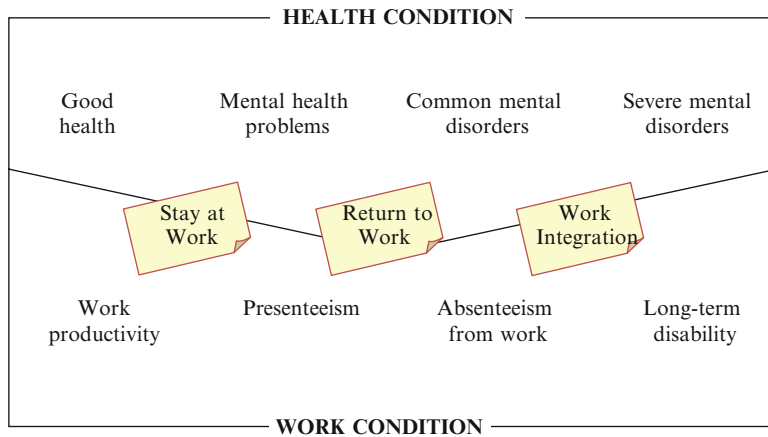


Fig. 17.1 Mental health conditions associated to work participation and work functioning (adapted from Corbière and Durand 2011). *Note:* Colored stamps represent the

three different types of individuals' work participation and work functioning

17.2 Economic Burden of Mental Health Problems and Mental Disorders in the Workplace

One of the most significant costs to society related to mental health problems and mental disorders is the lost productivity of their working population. Estimates suggest annual productivity losses total in the billions worldwide (Greenberg et al. 2003; Lim et al. 2008; Hilton et al. 2010). Decreased work productivity in the work force has been reported as reduced production by workers remaining at work, work absences, and long-term disability.

17.2.1 Presenteeism

One source of decreased work productivity losses is presenteeism. Presenteeism has been defined as being present at work but unable to work to full capacity. Studies from around the globe indicate that presenteeism is responsible for a significant cost burden related to mental health problems and mental disorders (Dewa and Lin 2000; Kessler et al. 2003; Lim et al. 2000; Sanderson and Andrews 2006; Holden et al. 2011). A higher prevalence of presenteeism among Korean workers with depressive feelings has

resulted in this group being 7.4% less productive (Lee 2010). During a 2-week period, it has been estimated that US workers lose an average of 4 h/week due to depression-related presenteeism; this translates into \$36 billion USD (Stewart et al. 2003). Other studies suggest annual presenteeism losses to be \$24.5 billion (USD) for major depressive disorder and \$7.6 million (USD) for bipolar disorder (Kessler et al. 2006).

A number of factors could account for presenteeism, including the ways in which mental health problems and mental disorders decrease productivity at work. A Canadian study showed that they can interfere with a worker's social participation, understanding and communicating, and day-to-day functioning (Wang et al. 2006). A US study found that depression limited the performance of physical jobs at an average of 20% of the time and limited mental interpersonal demands 35% of the time, on average (Lerner and Henke 2008). Individuals with more severe depression had more job performance deficits than those with moderate or mild depression, and individuals with dysthymia had fewer job performance deficits than patients with major depression (Lerner and Henke 2008). In addition, Lerner et al. (2004) observed that workers with depression experienced more impairment with time management.

17.2.2 Work Absences

Workplace productivity costs due to mental disorder-related absences are substantial. Work absences take two primary forms: One form is sporadic absence, such as sick days taken for a cold, and the second form is absence associated with prolonged leaves from work, such as those covered by disability benefits. Below we will discuss recent findings on sporadic absence and its significance.

Population-based surveys of workers estimated that the annual average depression-related absenteeism productivity loss is about 1 h/week/worker; this is equivalent to \$8.3 billion USD (Stewart et al. 2003). Kessler et al. (2006) observed fewer days of work lost. Their estimates also indicated that workers with major depressive disorders experienced average annual work absences of 8.7 days; this totals about \$24.48 billion (USD) or a total of 150.5 million days lost. In addition, \$5.97 billion (USD) or a total of 40.7 million days are lost each year due to work absences related to bipolar disorder (Kessler et al. 2006).

Studies from The Netherlands and the USA have reported that the number of absences related to depression is greater than those for many chronic medical conditions (Druss et al. 2001; Grzywacz and Ettner 2000; Buist-Bouwman et al. 2005). A multinational European study compared to people with physical conditions with those with mental disorders and observed that on average more days during which they cannot carry out their usual activities (Alonso et al. 2011). Using data from one US firm, Druss et al. (2000) observed that workers experienced an annual average of almost 10 sick days for depression compared to 7 days for diabetes, heart problems, and back problems, and 3 days for all other problems. Using population-based data from The Netherlands, Buist-Bouwman et al. (2005) found that chronic back problems were associated with 25 additional work loss days compared to 29 additional work loss days associated with mood disorders and 18 days with anxiety disorders.

There is also increasing evidence that when they occur together, mental and chronic physical

disorders further increase work loss. A Dutch study found that the likelihood of experiencing a common mental disorder (especially a mood or anxiety disorder) increases significantly when someone has a chronic physical disorder (Buist-Bouwman et al. 2005). Studies from North America and The Netherlands indicated that workers with comorbid mental and chronic physical disorders experience a greater number of sick days than those who do not have comorbid conditions (Buist-Bouwman et al. 2005; Druss et al. 2000; Dewa et al. 2007; Braden et al. 2008). Canadian workers with both mental and chronic physical disorders are almost four times as likely to experience an absence day compared to a worker who has neither (Dewa et al. 2007). Buist-Bouwman et al. (2005) reported significant increases in work loss days for Dutch workers experiencing comorbid anxiety and mood disorders with chronic back problems or hypertension compared to either type of condition alone. US workers with chronic pain disorders (e.g., migraine/chronic headache, arthritis, back problems) and a common mental disorder were more likely to have missed at least one work day in the past month (Braden et al. 2008). Holden et al. (2011) observed increased absenteeism among Australian workers with comorbid psychological distress and either an injury, cancer, or arthritis.

17.2.3 Long-Term Disability

In contrast to short-term work absences, long-term disability can be defined as a leave from work that requires a lengthy absence. Disability leave can take the form of either short-term or long-term disability leaves. In general, these are absences requiring a worker to file an insurance claim to receive income replacement benefits, often called disability benefits (i.e., short-term or long-term disability). These benefits may be either publicly or privately sponsored. Because these benefits are a form of insurance, they are defined by the insurance policy. As a result, there are no universal definitions for this type of disability. Eligibility criteria and length of coverage differ from one disability insurance plan to another.

Despite the caveats, in the early 1990s, insurers (governments and employers) began to become aware of the rise in mental and nervous disorder disability claims. The Health Insurance Association of America (HIAA) (1995) reported that between 1989 and 1994, disability claims doubled. The HIAA (1995) also found respondent companies spent between \$360 and \$540 million on disability claims related to this group of disorders. Over half of short-term mental or nervous disorder disability claims among North American workers are attributed to major depression (Health Insurance Association of America [HIAA] 1995; Conti and Burton 1994; Dewa et al. 2002). In Canada, mental illness-related short- and long-term disability accounts for up to a third of claims and about 70% of the total costs, translating into \$15–33 billion annually (Dewa et al. 2002). For some Canadian companies, mental disorders account for 30–40% of all short-term disability claims (Sairanen et al. 2011).

About 76% of workers in Canada return to their jobs at the end of a short-term disability episode, while approximately 8% go on to receive long-term disability benefits (Dewa et al. 2002). Although a smaller proportion of workers receive long-term disability, a long-term disability episode in Canada can cost almost four times as much as a short-term disability episode (Sairanen et al. 2011; Dewa et al. 2010). There have been reports that annually, Canadian long-term disability episodes have increased by 0.5–1.0% and account for as much as 30% of total claims (Sairanen et al. 2011).

Compared to other types of disability leaves, US studies indicate that those related to major

depression are generally longer than leaves for other types of disorders such as rheumatoid arthritis, heart disease, and diabetes (Druss et al. 2000; Conti and Burton 1994; Adler et al. 2006; Burton and Conti 1998). Canadian studies report that disability leaves related primarily to common and severe mental disorders can be double that for physical disorders (Dewa et al. 2010). As a result, compared to disability leaves for physical disorders, the average disability episode for mental/behavioral disorders can be double the cost per episode (Dewa et al. 2010).

17.3 Determinants of Mental Health Problems of Employees in the Workplace

Psychosocial risk factors refer to adverse psychosocial characteristics unfavorable to the health and well-being of an individual (Cox and Rial-Gonzalez 2005; Theorell and Hasselhorn 2005; Kompier 2005). These characteristics can be work and non-work related. Many studies have demonstrated that exposure to adverse psychosocial factors at work (e.g., high job demands) determines the individual's stress response (e.g., changes in pulse) and the related physical and psychological symptoms (e.g., musculoskeletal [MSD] disorders, burnout) (see reviews: Bonde 2008; Nieuwenhuijsen et al. 2010; Stansfeld and Candy 2006). These symptoms are, in turn, predictors of withdrawal behaviors from an organization (Table 17.1).

To define and assess the relationship between potential psychosocial risk factors and health

Table 17.1 Work and health: relationship between psychosocial risk factors, health, and withdrawal behaviors

Exposure to adverse work conditions	Stress response	Symptoms	Withdrawal behaviors
	→	→	→
Psychosocial risk factors	<i>Objective indicators, e.g., changes in hormones, blood pressure, and pulse</i>	<i>Mental health problems, e.g., depression, burnout, psychological distress, anxiety</i>	The most studied outcomes
Work		<i>Physical health problems, e.g., cardiovascular diseases, musculoskeletal disorders, cancer</i>	Absenteeism
Non-work			Retirement
Personal			Turnover
			No return to work
			No job maintenance

problems, particularly mental health problems, we suggest a multifactorial classification integrating both work- and non-work-related psychosocial factors (Stansfeld 2002; Marchand and Durand 2011).

First, *work-related psychosocial risk factors* refer to the characteristics of the design, organization, and management of work, as well as to its social context. These factors include all organizational characteristics and interpersonal relationships in the workplace that constitute potential risks for the deterioration of physical and mental health conditions (Stansfeld and Candy 2006; Cox et al. 2000; Gilbert-Ouimet et al. 2011; EU-OSHA-European Agency for Safety and Health at Work 2007; Vézina et al. 2004). Work-related psychosocial risk factors consist of four levels: content of work, context of work, individual, and interpersonal. The first two levels refer to the sets of “stressful characteristics of work” (Cox et al. 2000). The content level specifically consists of objective job characteristics. For example, several studies have shown that repetitive tasks, unclearly defined roles, and intensified workload can negatively affect an individual’s mental health condition (e.g., Nieuwenhuijsen et al. 2010; Karasek 1979; Kompier 2006). The context level includes characteristics of the organization. For example, many studies have demonstrated that an organizational culture characterized by discrimination, unfair treatment of workers by supervisors, or job insecurity can determine an individual’s stress reaction that leads them to quit the organization (Kivimäki et al. 2003; Siegrist 1996). Individual characteristics at work, such as little latitude allowed for employees’ decisions, little decision authority, and low skill discretion, have been identified as significant determinants of mental health problems (Stansfeld and Candy 2006; Karasek 1979). Interpersonal factors concern the fundamental social roles and relationships at work. For instance, a lack of social support from coworkers and from supervisors, and isolation at work were all found to increase psychological strain at work and, thus, depression (Bonde 2008; Karasek 1979; Netterstrom et al. 2008) (about organizational variables, see also Chap. 11) (Table 11.2).

Second, *non-work-related psychosocial risk factors* are classified into three levels, including the family situation, participation in social networks, and the individual’s community exchanges (Marchand and Durand 2011). Several studies showed that poor quality of life outside of work (e.g., work-family conflict, lack of partner support, poor social contacts) can determine mental health problems such as psychological distress (Marchand et al. 2005; Beaugregard et al. 2011). Table 17.2 also shows a third domain, referring to *personal characteristics*—i.e., sociodemographic, psychological, and behavioral characteristics. In the literature, these factors are generally studied as indirect determinants of mental health problems. For example, as control variables, gender (women), age (young people), personality traits (having poor coping strategies), low educational level, poor physical status, and unhealthy behaviors (e.g., overweight, tobacco use) may modulate the impact of work- and non-work-related psychosocial risk factors on mental health problems (Stansfeld 2002; Marchand et al. 2005).

The multilevel classification integrating both work- and non-work-related psychosocial factors described in this chapter derives from the two main theoretical models used to explain the relationship between work and mental health: (1) the *job demand-control* (JD-C) model (Karasek 1979), extended by the JD-C-support model (Johnson et al. 1989), and (2) the *effort-reward imbalance* (ERI) model (Siegrist 1996). The basic assumption of the JD-C and ERI models is that psychosocial risk factors (job demands and effort) lead to job strain when job resources are lacking (low control, low social support, and low reward). In the JD-C model, control and social support buffer the impact of job demands on job strain (Karasek 1979). In the ERI model, rewards are offered that may minimize the unfavorable effects of effort (Siegrist 1996). Though the JD-C and ERI models are the most influential job stress models (Bakker and Demerouti 2007), they do not exhaustively explain the relationship between psychosocial factors at work and mental health status (Bakker and Demerouti 2007). Thus, the *job demands-resources* (JD-R) model

Table 17.2 Psychosocial risk factors: a multifactorial classification

Psychosocial risk factors		
Domain	Levels	Factors (examples)
Work	Content	• Lack of task variety • High psychological/physical job demands • High workload/overwork • Inappropriate work schedules
	Context	• Job insecurity • Poor organizational justice • Organizational stress intervention • Lack of health and safety policy
	Individual	• Low control • Low skill utilization • Low decision authority
	Interpersonal	• Lack of social support (coworkers, supervisor) • Poor teamwork • Efforts/rewards imbalance • Lack of recognition
Non-work	Family	• Marital status (single) • High parental responsibilities • Work-family imbalance
	Social network	• Lack of participation in social networks • Lack of social support (friends)
	Community	• Poor economic situation • Difficult to access daycare
Personal	Sociodemographic	• Age (young) • Gender (female) • Low educational level
	Psychological and behavioral characteristics	• Personality traits (negative affectivity) • Poor coping strategies • Unhealthy lifestyle habits (tobacco use) • Lack of physical activity • Stressful life events (divorce)

(Demerouti et al. 2001) will be introduced to further explain the determinants of mental health problems at work. The JD-R model (Demerouti et al. 2001) classifies a wide range of psychosocial risk factors into two general categories: job demands (JD) and job resources (JR) (Schaufeli et al. 2002).

The JD-R model can also detect the complex reality of working conditions for different occupations. The central assumption of this model is that JD and JR imply two different underlying processes that play a role in the development of employees' well-being. First, a *health impairment process* in which high JD (physical, psychological, social, or organiza-

tional aspects of the job that require sustained physical and/or psychological effort or skills) exhausts employees' mental and physical resources, leading to general health problems, repetitive strain, and injury (Bakker and Demerouti 2007; Demerouti et al. 2001; Leiter 1993; Bakker et al. 2003b). Second, a *motivational process* in which JR (physical, psychological, social, or organizational aspects of the job that drive employees to achieve work goals) has intrinsic and extrinsic motivational potential, fostering employees' growth, learning, and development (Bakker and Demerouti 2007; Demerouti et al. 2001; Schaufeli and Bakker 2004) (Fig. 17.2).

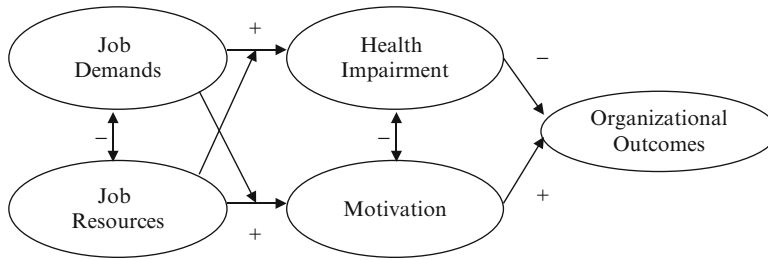


Fig. 17.2 The Job Demands-Resources model (adapted from Bakker and Demerouti 2007)

Empirical evidence showed that JD was directly responsible for job strain, including burn-out,¹ lack of energy, and development of health problems, and indirectly responsible for sickness absence duration. Job Resources were directly related to motivation, including work engagement² and organizational commitment, and indirectly related to absenteeism (Bakker et al. 2003a) and turnover intention (e.g., Bakker and Demerouti 2007; Bakker et al. 2003a, b; Schaufeli and Bakker 2004). Moreover, JD and JR have been found to be interactive, with JR buffering the impact of JD on job strain (Bakker et al. 2003c). From a practical point of view, organizations must enhance JR (e.g., social support) and/or decrease JD (e.g., workload) in order to lead to a low level of job strain. Bakker et al. (2010) have recently demonstrated that JR (skill utilization, learning opportunities, autonomy, colleagues' support, leader's support, performance feedback, participation in decision making, career opportunities) may maintain work engagement under conditions of high JD (i.e., workload, emotional demands). This additive effect arises because under demanding work conditions, the need for challenge translates JR into task enjoyment and work engagement (Demerouti and Bakker 2011). In sum, changes regarding JD and JR levels lead to promote the performance and health of employees.

Based on the theories described above, three common interventions for workplace prevention

and stress management (primary, secondary and tertiary) and three levels of application based on different targets (individual, group or organization) have been described in the literature (e.g., Cooper and Cartwright 1997; Cottrell 2001; Dollard and Winefield 1996; Kompier et al. 1998; Murphy 1988; Wilson et al. 1996). *Primary intervention* occurs in the absence of symptoms in order to reduce the incidence of stressors and to maintain an individual's good health. This can be achieved by, for example, assessing psychosocial risk factors, monitoring the organizational and human resource management, and/or investing in life-long training (e.g., Kompier 2006; Golembiewski et al. 1987; Jones et al. 1988). *Secondary intervention* occurs after the emergence of the first symptoms in order to reduce the prevalence of the disease. Preventive programs, such as one-to-one peer counseling or self-help groups, were found to be good practices for treating critical events promptly (e.g., Lindquist and Cooper 1999), and have helped workers to develop the psychological skills to control stressful situations (Karimi and Alipour 2011). *Tertiary intervention* also occurs after the emergence of symptoms but focuses on employee assistance. Counseling the employee to power self-awareness, reestablishing confidence between the people involved, and restoring the normal work and health conditions are, for example, good practices to reduce the consequences of the stressful conditions.

The *individual level* of application refers to the employee's mental and physical health. Preventive programs focusing on employee mental health are very rare and are usually performed by "Employee Assistance Programs." At this level, work-family conflict management, development of professional

¹*Burnout* is defined as a three-dimensional syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach et al. 2001).

²*Work engagement* is defined as a positive, fulfilling, work-related state of mind characterized by vigor, dedication, and absorption (Schaufeli et al. 2002).

skills, time management, and role clarification seem to be the most successful primary and secondary interventions to reduce potential stressors at work (Cottrell 2001). The *group level* involves the employee's coworkers, supervisors, family, and non-work social network. It has been well demonstrated that working in a self-managed team, receiving social support from coworkers and supervisor, and receiving performance feedback are among the most significant practices for preventing mental health problems at work (Bourbonnais et al. 1999). The *organizational level* consists of the company's formal and informal policies, rules, standards, and workplace accommodations (Corbière et al. 2009). Five main factors have been identified as the key mechanisms for successful preventive interventions to reduce psychosocial risk factors and promote employees' health at work (Vézina et al. 2004; Vézina and St-Arnaud 2011): (1) support from senior management and involvement of all hierarchical levels, (2) employee participation in discussions of problems and efforts to develop solutions, (3) prior identification of worker populations at risk based on validated theoretical models or related events, (4) rigorous implementation of necessary changes in targeted worker populations, and (5) evaluation and management of the process and changes in the workplace (Vézina et al. 2004; Kompier et al. 1998; European Agency for Safety and Health at Work 2002). It is important to note that even if preventive interventions at the individual level have a lower risk and cost associated with their implementation than those at an organizational level (Murphy and Sauter 2004), intervening at the organizational level has been more effective (Kompier and Kristensen 2001).

17.4 Significant Factors Impacting Return to Work for People with Common Mental Disorders

At least three systematic literature reviews have recently been conducted on the factors impacting return to work/work disability for people with common mental disorders (Lagerveld et al. 2010; Blank et al. 2008; Cornelius et al. 2011). Blank et al. (2008) conducted a systematic review of

the factors predicting return to work or risk of job loss for employees with common mental disorders and concluded that this type of prediction was multifactorial in nature. The significant factors were categorized as work factors (e.g., high job stressor), social status (e.g., older employees and low education), health risk behaviors (e.g., being drug dependent), and medical factors (e.g., severity of symptoms). Due to the limitations of the 14 studies retained in this systematic review (e.g., diverse work outcomes and definitions of mental disorders), the authors could not clearly identify the most significant (or evidence-based) factors affecting return to work for people with common mental disorders.

Two years later, Cornelius et al. (2011) presented results from a systematic review including seven studies. In contrast to Blank et al. (2008), they included studies with a prospective or longitudinal design only and did not consider the duration of prior sickness absence. More precisely, their inclusion criteria for participants included being on sick leave from 2 to more than 90 days due to common mental disorders (claiming disability benefits or receiving disability pension at baseline). In their systematic review, they divided 17 potential predictors (modifiable or not) into three categories: (1) health-related factors (e.g., stress-related), (2) personal factors (e.g., age), and (3) external factors (e.g., supervisor communication with employee). For health-related factors, limited evidence was observed only for the association of stress-related factors and depression/anxiety disorder with longer durations of disability. For personal factors, strong evidence was shown for age; for example, older workers (>50 years old) had a higher risk for continuing disability and a longer time to return to work. For other variables included in this category (e.g., gender, sole breadwinner, history of previous sickness absence, socioeconomic status), limited evidence was found for their effect on work outcomes. For external factors, only limited evidence was found for any of the variables (e.g., continuity of occupational care, supervisory communication with workers having mental disorders, supervisors' consultation with other professionals) to have a specific effect on work outcomes. In the end, Cornelius et al. (2011) concluded that age

(>50 years old) was the only significant predictor of disability and return to work for people with common mental disorders. These results suggest limitations since age is not a modifiable variable allowing health professionals to intervene. To overcome these limitations, Cornelius et al. (2011) suggested developing age-specific interventions to facilitate the return to work. No further information was given to specify how this type of intervention should be designed.

In parallel, Lagerveld et al. (2010) also conducted a systematic review of employees with common mental disorders to identify predictors of work participation (e.g., sick-leave duration) and work functioning (e.g., work limitations) to provide evidence for the development of specific interventions related to these two work outcomes. They defined work participation (WP) *as the capability and/or opportunity to participate in the work force, fulfilling one worker's role*, and work functioning (WF) *as the productivity or performance of employees that participate, at least partly, in work, and is the result of a relationship between an individual's health resources and the expectations and structural conditions that operates within social settings such as the workplace* (Lagerveld et al. 2010; Anema et al. 2006). The main difference between these two work outcomes is for WP to indicate taking on the role of worker while WF reflects the functioning of employees in the workplace. From the 30 studies selected in this systematic review, the authors observed that 5 studies addressed WP and WF together, 14 studies included only WP, and 6 included only WF. The authors divided the variables into three categories: (1) personal factors (e.g., age, education, self-esteem), (2) work-related factors (e.g., type of occupation, supervisor contacts), and (3) disorder-related factors (e.g., severity of symptoms, duration of depression). For personal factors, only 2 variables (out of 15) had moderate evidence for a negative relationship with work participation: age (older) and history of sick leave (longer leave). Other variables from this category had limited evidence (e.g., low self-esteem) or were inconclusive (e.g., alcoholism/substance abuse) for predicting WP and/or WF. For work-related factors, limited evidence was

found for three variables (out of 9) to predict WP: level of functioning at work, contact with supervisor, and supervisor contacting other professionals besides occupational physicians. For disorder-related factors, strong evidence was found for one variable to predict WP; moderate evidence was found for four variables to predict both outcomes, WP and WF; and evidence was limited or inconclusive for the remaining variables. Strong evidence was found between duration of depression and WP, where longer duration was associated with work disability. Moderate evidence was most often found for severity of symptoms, type of disorders, comorbidity (physical and mental), and clinical improvement to predict both outcomes: WP (e.g., short- or long-term disability) and WF (e.g., mental-interpersonal demands, time management demands). The strongest level of evidence for all factors, regardless of the category, was related to the duration of depression and WP. To reduce the duration of episodes of mood disorders, the authors suggested several strategies: (1) to improve the knowledge of health professionals in recognizing depression to avoid delays in consultation and treatment, (2) to facilitate access to treatment either by appropriate psychiatric care or through workplace channels, and (3) to increase general awareness or literacy about depression and other mental health problems. In this systematic review of the literature, the authors focused on modifiable factors (e.g., self-esteem, supervisor contacts) even if they presented only limited evidence.

To understand the importance of considering modifiable factors from diverse stakeholders (e.g., attitudes and behaviors of people with common mental disorders, supervisors and return-to-work coordinators) in a work disability paradigm (Loisel et al. 2001), we will concentrate on three key studies. First, in a longitudinal cohort study, Brouwer et al. (2009) suggested using the Theory of Planned Behavior (Ajzen 1991, 1996) to explain the return to work of employees on sick leave. This theory has already been applied to different contexts of health behaviors (Hwu and Yu 2006) and vocational domains (van Ryn and Vinokur 1992). Brouwer et al. (2010) also showed that several concepts—work attitude, social

support, and willingness to expend effort to complete the behavior (return to work)—were significant factors affecting time to return to work of people on sick leave due to physical or mental symptoms. Even though this study is important for better understanding the influence of different factors on work participation, disorder-related factors and external factors were not included. In the second key study Nieuwenhuijsen et al. (2004) filled the gap by assessing three factors using a standardized telephone interview: (a) communicating with the employee, (b) promoting a gradual return to work, and (c) consulting with professionals such as human resource (HR) managers and psychologists when dealing with mental disorders (depression vs. other mental disorders). Survival analysis (Cox's regression) of the results demonstrated that better communication between supervisor and employee was associated with favorable full return-to-work rates in nondepressed employees. Third, van Oostrom et al. (2008, 2009) added that the worker-supervisor relationship could be facilitated by a return-to-work coordinator arranging meetings with stakeholders both separately and together to identify return-to-work barriers (e.g., mental workload) and suggest a plan of action (e.g., participatory workplace intervention).

Based on the results of these three key studies, we hypothesize that evaluating modifiable factors (attitudes and intentions towards return to work, communication with the supervisor, and the return-to-work coordinator) together can improve the work participation and work functioning of employees with common mental disorders. In this way, the Loisel et al.'s work disability paradigm (Loisel et al. 2001) helps by considering the key actors stemming from four pillars or systems (legal, organizational, insurance, and personal) to identify each one's role in the work participation of people with disability due to MSD or mental disorders (Loisel et al. 2001; Franche et al. 2005; Marois 2007; Waddell et al. 2003).

Return-to-work interventions dedicated to people with common mental disorders have often been inspired by interventions offered to people with MSD disorders (Goldner et al. 2004)

(see Chap. 20). In this vein, Briand et al. (2006, 2007) transferred knowledge and methods from MSD to common mental disorders. This knowledge transfer was possible since a strong association had been identified in the literature between chronic pain and psychosocial and cognitive factors and, more specifically, between chronic pain and depression (Williams et al. 2004; Fishbain et al. 1997; Gatchel et al. 1995; Gatchel 2004; Rush et al. 2000; Dersh et al. 2002). Corbière and Shen (2006) systematically reviewed the literature on psychological return-to-work interventions for people with common mental disorders and/or physical injuries. Of the 14 studies retained in their review, only 2 were classified as work-related common mental disorders (adjustment disorders), with the remaining 12 studies focusing on mental health problems associated with physical injuries. Results from these studies reinforced the difficulty in finding interventions with the aim of helping employees with common mental disorders to return to work. Despite the heterogeneity of approaches or the type of components chosen, the most popular psychological intervention (nearly two thirds of the 14 studies) remained cognitive behavioral therapy (CBT). Cognitive behavioral interventions were usually more effective than the control treatment or condition. However, the type of CBT used in these studies varied in both length and content, which ranged from improving coping skills to developing problem-solving strategies. Briand et al. (2007, 2008) also noted that challenges existed with interventions for people with common mental disorders. Examples included the lack of stakeholder involvement (e.g., employer, insurer) in the return-to-work process (more often only a medical follow-up is offered to this population) or the lack of work accommodation arranged for the specific needs of people with common mental disorders (e.g., time flexibility). Yet, in Nieuwenhuijsen et al.'s (2008) review, in which the main objective was to evaluate the effectiveness of interventions to reduce work disability of employees with depression (all studies were randomized controlled trials), the results showed that no work-directed interventions were found. Systematic reviews of the work participation or

work disability literature emphasized the need to intervene with people directly and also with the organization (e.g., communication with the supervisor). Furthermore, Nieuwenhuijsen et al. (2008) reported that no evidence existed for or against the effectiveness of psychological interventions to reduce work disability of employees with depression. It seems that psychological interventions alone (individual focused ones) are not sufficient in order to maximize the return to work of people with depression.

To conclude, Pomaki et al. (2010) summarized the best practices (based on a systematic review of the literature, including stakeholder input) for return-to-work/stay-at-work interventions for people with common mental disorders. The five principles can be arranged over three levels of intervention (organizational, individual, and disability management practices interventions): (1) Clear, detailed, and well-communicated organizational workplace mental health policy supports the return to work/stay at work; (2) return-to-work coordination (with a trained return-to-work coordinator) and structured, planned, close communication between different stakeholders (e.g., employers, unions, worker, health professionals) are required to optimize return to work and stay at work; (3) application of systematic, structured, and coordinated return-to-work practices (e.g., guidelines for occupational physicians) improves return-to-work outcomes; (4) work accommodations (e.g., reduction of work demands) are an integral part of the return-to-work process and the context of their implementation determines their effectiveness. It is noteworthy that these work accommodations should be feasible for the employer and need to be reassessed regularly regarding their usefulness for the employee (Durand, submitted); (5) facilitating access to evidence-based treatment (based on CBT interventions) reduces work absence. These principles must be considered carefully, and the next step will be to identify significant specific components of return-to-work interventions to facilitate the continuum of work participation and work functioning for people with common mental disorders (Durand and Briand 2011).

17.5 Significant Factors of the Work Integration of People with Severe Mental Disorders

In their literature review, Cook and Razzano (2000) found that people with schizophrenia spectrum disorders obtained fewer remunerative jobs than people with other psychiatric diagnoses (e.g., major depression). Wewiorski and Fabian (2004) carried out a meta-analysis studying the association between psychiatric diagnosis, individual characteristics (gender, race, and age), and employment outcomes and, conversely, found that these characteristics had only modest effects on work outcomes, particularly with respect to job acquisition in the regular labor market. Other studies have demonstrated that sociodemographic and clinical variables such as age, gender, civil status, ethnic group, level of education, age of first hospitalization, and drug abuse could not distinguish individuals with severe mental illness who obtained employment from those who did not (Becker and Drake 2004; Drake et al. 1998). Several authors have pointed out that the socioeconomic factors *work history* or *length of absence from work* significantly predict obtaining employment and are correlated to achieving employment goals (Fabian et al. 1993; Midgley 1990; Xie et al. 1997; Corbière et al. 2005).

In addition, other authors recommend that the indirect benefits inherent to disabilities also be studied because they may influence or restrict an individual's decision to obtain competitive employment in the regular labor market by acting as a disincentive to return to work (Latimer et al. 2006; Resnick et al. 2003). Yet, the OECD (2010) suggested limiting these disincentives to facilitate work participation for people with long-term disability, particularly by revisiting pension disabilities to transform disability into ability.

Other significant predictors for obtaining a job consist of characteristics typically lacking for many individuals suffering from severe mental disorders, such as appropriate social support (Lewis 1990). Alverson et al. (2006) highlighted that the more people with severe mental disorders are satisfied with their social and intimate

relationships, the less they are motivated to seek work. More straightforward results might arise if, for instance, the impact of social encouragement on work integration was evaluated, rather than the larger concept of perceived social support (Corbiere et al. 2011).

Albeit and Luzzo (1999) observed that the work-related barriers an individual perceives can strongly influence their behavior, self-efficacy, and overall work integration process (i.e., getting competitive employment), even when that perception is not based on factual information. For instance, Johannesen et al. (2007) noted that the more barriers to employment perceived by people with severe mental disorders registered in supported employment, the less likely they were to attain vocational success. In this vein, Regenold et al. (1999) demonstrated that people who possessed a certain sense of self-efficacy in their job search were more likely to attain their employment goal, and Bassett et al. (2001) stressed the importance of self-esteem and a person's confidence in their ability to make decisions for achieving vocational goals. A lack of these characteristics may result in deeply held beliefs that a person is incapable of getting employment or is too unstable or fragile to work (Lysaker et al. 2005). Indeed, people who anticipated negative attitudes from others or who had negative expectations demonstrated poor self-efficacy and poor performance at getting employment (Fabian 2000).

In line with previously mentioned results, some authors have found that the longer the unemployment, the greater the perception of barriers to employment and the greater the erosion of self-efficacy and self-esteem (Banks 1995; Eden and Aviram 1993). Other researchers (Midgley 1990; Xie et al. 1997; Anthony and Jansen 1984; Catty et al. 2008) have shown that work history or past work experience was the most significant predictor of obtaining employment, regardless of whether a person was registered in a vocational program or not (Campbell et al. 2010). Corbiere et al. (2005) added that both the use of job search strategies and previous work experience provided better understanding about how competitive employment was obtained.

Behavioral actions are also essential when predicting getting competitive employment. In fact, *active seekers* who look for a job on their own, seek help from their assigned counselors, express a desire to work, and, consequently, use more job search strategies are more likely to obtain a job compared to *passive seekers*, who present with a lack of intrinsic motivation (Alverson et al. 2006; Mueser et al. 2001).

Thus, how do the variables described above fit with the significant variables recognized in the literature? How do they contribute to work integration? As suggested by Fabian (2000), social cognitive theories are relevant to better understand work outcomes related to mental health for individuals with severe mental disorders. More recently, Corbiere, Zaniboni, Lecomte et al. (2011) suggested adapting the theory of planned behavior (Ajzen 1991, 1996) and self-efficacy theory (Bandura 1977a, b) to the work integration of people with severe mental disorders. In other words, the centrality of work in life (attitudes), social encouragement to obtain employment (subjective norm), career search efficacy (self-efficacy), and perceived barriers to employment (internal and external obstacles) can predict the intention to obtain employment (in this case, intention means people who are looking for employment). Taken together, these variables predict the use of job search strategies, which influence the ultimate goal: obtaining employment. In addition, since relevant and significant variables have already been observed in the literature, past work experience (the length of absence from the workplace), social support, self-esteem, and severity of symptoms are included in the model, linked directly to other determinants of the Theory of Planned Behavior and indirectly to work outcomes. Based on data collected in Canada, the explained variance of the behaviors (use of job search strategies) was 26%, and the explained variance of getting employment was only 8%. One of the limits of this study was that other important personal variables, such as cognitive and social interaction deficits, were not assessed. Some studies have ascertained a link between cognitive deficits and poor community functioning, including work outcomes in

individuals with severe mental illness (McGurk and Meltzer 2000; McGurk and Mueser 2003; McGurk et al. 2003). In their recent review, Tsang et al. (2010) highlighted the continuous refinement of cognitive functioning (e.g., executive functioning, attention and work memory, verbal memory) in studies with people with severe mental disorders looking for employment. Results from their review indicated that cognitive functioning was a significant and stable predictor of work outcomes. Individuals with severe mental illness have been reported as frequently demonstrating specific deficits in social skills (Kopelowicz et al. 2006), which could translate into having difficulties relating to coworkers, building a social network, interacting with others, or responding to feedback from supervisors (Mueser et al. 2005). These modest results, obtained in Corbière, Zaniboni, Lecomte et al.'s study (2011), open the door to other significant variables, particularly environmental variables, to explain the work integration of people with severe mental disorders. Stigma is one of the most important variables in the literature (Corbière et al. 2002; Krupa et al. 2009; Stuart 2004, 2006) along with the type of employment program engaged to find employment or the competencies of counselors in helping their clients find employment (Corbière and Lecomte 2009; Krupa et al. 2009; Stuart 2004, 2006; Ravaud et al. 1995).

Corbière and Lecomte's (2009) review of vocational programs dedicated to people with severe mental disorders, distinguished the programs according to their philosophy: Train-Place or Place-then-Train programs (Corrigan 2001). Train-Place vocational programs (e.g., sheltered workshop) aim to help people with severe mental disorders develop specific skills; Train-Place is a step-by-step process allowing people to reintegrate into the workplace. Conversely, Place-then-Train programs place the person in a real work situation prior to offering them specific training. Training is offered as needed (if there is disclosure of the mental disorder in the workplace) to help the person quickly achieve their vocational goals. Supported employment (SE) programs have been recognized as following the philosophy Place-then-Train (Corbière and Lecomte 2009). Several forms of SE programs

exist, including the well-established Individual Placement and Support (IPS) model (Corbière and Lecomte 2009; Crowther et al. 2001; Roush 2009) which is considered to be the SE standard (Bond et al. 2008, 2001). Supported employment programs are recognized in several countries as evidence-based practices to help people with severe mental disorders integrate into the regular labor market (Latimer et al. 2006; Crowther et al. 2001; Burns et al. 2007; Cook et al. 2005; Corrigan and Wassel 2008; Corrigan et al. 2008; Wong et al. 2008). The principles/components of the IPS model of SE programs (Corrigan et al. 2008; Bond 2004; Drake et al. 1999; Drake 1998) are the following: (a) Eligibility is based on consumer choice and zero exclusion philosophy; (b) SE is integrated with mental health treatment; (c) attention is focused on consumer preferences; (d) competitive employment is the goal; (e) the job search is rapid from the start; (f) follow-along supports are continuous and time-unlimited (Bond 2004; Drake et al. 1999; Drake 1998); and (g) benefits counseling is systematically offered, and informs the clients about social security and other financial concerns. A recent review of 11 randomized controlled trials of IPS programs indicated that almost 60% of the participants with severe mental illness were successful at obtaining competitive employment (Bond and Drake 2008) compared to 25%, on average, for control groups. However, when randomized controlled trial results were considered separately, we noted work outcome variations from 27 to 78%. The study authors also tried to identify evidence-based components or ingredients in SE programs. For example, in their study including a literature review of the salient ingredients of SE programs, Corbière and Lancôt (2011) observed that counselors' or employment specialists' competencies, along with the philosophy of the SE program, or supported by the partnership with key actors of the organization (employers, supervisors), were crucial in explaining work integration for people with severe mental disorders. These salient components included employment specialists' competencies related to (a) the working alliance, (b) the recovery philosophy, (c) support, and (d) disclosure and work accommodation.

17.6 Conclusion

In this chapter, we first defined mental health conditions and work situations as observed in the specialized literature, noting the economic and human burden. Second, we identified factors related to the development of mental health problems in the workplace and factors associated with the return to work and work integration for people with common and severe mental disorders. These different work situations and health conditions are often segregated in the literature, while work participation and work functioning should form a continuum (Corbière and Durand 2011; Lagerveld et al. 2010). Future studies of mental health conditions linked to the workplace should include different work outcomes to represent this continuum and should consider the different stakeholders involved in work participation/work functioning (employers, unions, supervisors, insurer, health professionals, employees with a mental condition, etc.).

Even though systematic reviews of the literature have uncovered relevant information with moderate or strong evidence in the area of work participation and work functioning for people with a mental condition, little information is available about the return-to-work process. The return to work does not occur at the end of a complete health recovery, but through a continuous process where health is rebuilt gradually through the work activity itself (St-Arnaud et al. 2011). It would be preferable if literature reviews allowed us to better understand the direct or indirect influences on work outcomes, supported by a theoretical framework.

In the last decade, more sophisticated methods and statistical analyses such as path analyses and structural equation modeling have been used to test the direct and indirect relationships between variables to predict work outcomes, supported by a theoretical framework. Authors have also stressed the importance of modifiable variables (e.g., self-efficacy, self-esteem) to produce more efficient interventions. This new methodology in our domain and theory is useful not only for preventing mental health problems in the workplace

but also for improving our understanding of the return to work or work integration of people with mental disorders. The use of different theories such as the JD-C-support model (Karasek 1979; Johnson et al. 1989), the ERI model (Siegrist 1996), the JD-R model (Demerouti et al. 2001), the self-efficacy theory (Bandura 1977, 1997), and the theory of planned behavior (Ajzen 1991, 1996) improves our understanding of work participation and work functioning of people with a mental condition. Moreover, these theories could be embedded in larger theories such as the work disability paradigm (Loisel et al. 2001) in which several systems are identified (legal, insurance, organizational, and personal), as well as the work participation theory in which different work situations (work (re)integration, return to work, maintain employment) of people with a mental condition are considered (Corbière and Durand 2011).

Special attention must also be paid to the levels at which the interventions occur. Researchers and health professionals must consider the individual, the group/community, and the organization as intertwined “actors,” all playing an active role in determining the quality of work conditions and associated health conditions. Thus, an “integrated multifactorial approach” involving work- and non-work-related factors should be considered when assessing psychosocial factors at work and detecting the resources for coping with these problems (see JD-R model, Demerouti et al. 2001; Cooper and Cartwright 1997; Cottrell 2001; Kompier and Cooper 1999). In order of relevance, primary and secondary interventions should be priorities because they reduce the need for tertiary interventions (Corbière et al. 2009). Moreover, an “integrated multilevel approach” involving individual, group, and organization levels should be considered in future studies for preventing mental health problems at work, maintaining/improving employees’ mental health and organization’s productivity, and reducing costs to society (e.g., Vézina et al. 2004; Corbière et al. 2009). Several authors have stressed the importance of more rigorous assessment of intervention implementation to better understand the underlying reasons for excluding components/

ingredients that are recognized in the literature as evidence-based components (Marshall et al. 2008; Swain et al. 2010; Rapp et al. 2010; Rinaldi et al. 2010; Corbière 2012). To accomplish this, many authors have suggested strategies to overcome the barriers to implementation such as using fidelity scales to assess the implementation of the intervention, solid leadership, health professional's and/or return-to-work coordinator's attitudes, and specific and applied training for health professionals and/or counselors (Marshall et al. 2008; Swain et al. 2010; Rapp et al. 2010; Rinaldi et al. 2010; Loisel and Corbière 2011; Tjulin et al. 2009).

Finally, authors stress the importance of considering at the same level, individual and organizational variables and interventions as well as the various stakeholders (i.e., employer, supervisor, return-to-work coordinator, union, employee/person with a mental disorder) involved in the return to work or work integration of people with mental disorders (see also Chap. 25 on stakeholders' perspectives). Further research is warranted on processes and implementation issues encountered in the work disability domain.

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