Global Journal of Arts, Humanities and Social Sciences
Vol.4, No.1, pp.35-44, January 2016
Published by European Centre for Research Training and Development UK (www.eajournals.org)

HEALTH PROMOTION INITIATIVES FOR REINTEGRATING EMPLOYEES WITH DEPRESSION DISORDER INTO THE WORKPLACE

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ABSTRACT: *This paper focuses on health promotion initiatives for reintegrating employees with depression disorder into the workplace. The paper see depression disorder as a mood disorder that is usually characterized by sadness, fatigue, loss of interest in most activities, and lack of energy in doing work. It discusses the causes and its impacts on the health of employee. Health promotion in this context is the combined efforts of employers, employees and society to improve the health and wellbeing of people at work. The paper notes that the essence of these health promotion initiatives is to create a workplace that provides workers with a mentally healthy and supportive environment while returning to work. Such initiatives discussed in this paper are supportive work health education, health screening, quality circle, holistic approach, communication, incentive, special and multi-modular methodology initiatives. Thereafter, the paper concludes that health promotion initiatives for reintegrating employees with depression disorder into the workplace is important for the employees, the families, employers and the society in general so that such employee may not be a nuisance to the world in general. It is recommended among other things that health promotion in the workplace should be a top priority of the government and employers since one's health determines his or her ability to work effectively in any organization.*

KEYWORDS: Health promotion, depression disorder, employee, workplace

INTRODUCTION

There is growing evidence of the global impact of mental illness in the workplace. Depression disorder is among the most contributors to the burden of this diseases and disabilities worldwide. Miller (2002) noted that five of the ten leading causes of this disability worldwide is depression disorder. He further stressed that they are as relevant in low-countries as they are in rich ones, cutting across age, gender and social strata, and all predictions indicate that the future will see a dramatic increase in this illness.

The burden of depression disorder on health and productivity has long been underestimated. It has serious consequences not only for the individual but also for the productivity in the workplace. Employee performance, rates of illness, absenteeism, accidents and staff turnover is all affected by this disorder. For example Conti and Burton (2000) explained that in the United Kingdom, 80 million days are lost every year due to depression disorder and costing employers and average of 1-2 billion pounds sterling each year. In the United Sates, estimates for national spending on depression are US$30-40 billion, with an estimated 200 million days lost from work each year and in Nigeria it has caused most of the employees to leave their work and never return back.

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

It is a common sight to observe that among the workforce, majority might be experiencing depression disorder. The world of work continues to adapt to the change of the global marketplace (EU-OSHA, 2007). Across a number of employees in the workplace, there is an observed trend of increased absenteeism and early retirement particularly in relation to depression disorder (McDaid, Curran & Knapp, 2005). Stakes (1999) affirmed that as a result of increase in stress in the workplace that an estimated 20% of the working population will experience some form of depression and anxiety during their working lives. In general, depression disorder especially in relation to the workplace has remained a salient issue and under recognized problem (The Sainsbury Centre for Mental Health, 2004).

Depression Disorder in the Workplace

Depression is one of the most common mental health problem found in the general community and in the workplace. Depression disorder is a mood disorder that is typically characterized by a mood and a loss of interest or pleasure in usually enjoyable activities. It is usually characterized by sadness, fatigue, a loss of interest in most activities, and lack of energy. Other features include insomnia (or hypersomnia), loss (or gain) of appetite, a tendency to blame oneself and difficult in concentrating. It can lead to suicidal thoughts and eventually to suicide (WHO, 2001). Depression disorder can be difficult to diagnose and can manifest as physical symptoms such as headache, back pain, stomach problems or angina. Hunt (1995) listed the following as the common depression symptoms: Markedly depressed mood, loss of interest and enjoyment, reduced self-esteem, pessimistic view of the future, ideas or acts of self-harm or suicide, disturbed sleep, disturb appetite, decreased Libido, reduced energy and reduced concentration and attention.

Depression varies in its severity and the pattern of symptoms. Individual symptoms will be of short duration and disappear spontaneously. For others, symptoms persist but with proper treatment most people recover. It has been estimated that 5.8% of men and 9.5% of women will have a depressive episode in any 12-month period. WHO (2001) estimated that if current trends are maintained, depression will be the second most important cause of disability by the year 2020 and in the 15-44 year age bracket, and depression is already the second highest cause of morbidity, accounting for 8.3% of the global burden of disease in that age group. Goldberg and Steury (2001) affirmed that in United States, it has been estimated that between 1.8% and 3.6% of workers suffer from depression. Birnbaum (1999) stressed that the average annual costs including, pharmaceutical and disability cost, for employees with depression may be 4.2 times higher than those for an average employee who receives health benefit. Jenkins (1993) noted that depression is estimated to cost approximately 2 billion pounds sterling a year in Britain and, on top of absenteeism, has an impact on reduced productivity, labour, turnover, timekeeping and accidents.

While it is difficult to know exactly how many employees have depression disorder, the figure is likely to be significant (Liimatainen,2000).In the United States, for instance, 18.2% of employed people had evidence of these disorder which had impaired their work performance within the previous 30days (Kessler and Frank,1997). In a study in Germany, incapacity for work due to depression disorder accounted for 5.9% of loss workdays and appeared to be increasing (Limatainen & Gabriel, 2000).The disability effects of these disorder vary according to the type and severity of the problem, and also to other factors such as the availability of social support.

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

Causes of Depression Disorder

WHO (2001) affirmed that depression disorder is the result of complex interplay between biological, psychological and social factors. Depression disorder associated with biological factor is genetic characteristics and disturbance in neural communication. Psychological factors- individual psychological factor are associated with the development of depression disorder, for example, children who are separated from their primary caregiver or deprived of nurturing for extended periods of time have a greater chance of developing depression disorder either in the childhood or later in life. So depression disorder can occur as a result of failing to adapt to a stressful life event. Social factors such as urbanization, poverty and technological change have been associated with the development of depression disorder.

Huxley (2001) opined that there is evidence that the poor organization of work plays a significant role in the development of depression disorder in the workplace among the workforce. The factors frequently associated with depression disorder in the workplace include: content of work such as work overload, job content, participation and control, and context of job such as role in organization, reward, equity (fairness), interpersonal relationship, working environment, workplace culture, and home-work interface (World Health Organization, 2004; Maslach, 2001; Karasek & Theorell, 1990; Siegrist, 1996; Brockner & Greenberg, 1990). Research (McDaid, Curran, Knapp, 2005) has shown that work can both contribute to the development of depression disorder through poor working conditions and conversely provide individuals with purpose, financial resources and a source of identify that which promotes increased positive wellbeing. The workplace has been identified as one important social context in which to address this disorder and promote employees positive mental health and wellbeing. Without a doubt, one of the key areas that affect our employee's health is the work environment. Work can be beneficial to worker's health through an increased sense of social inclusion, status and identity and by providing a time structure (Harnois & Gabriel, 2000).

Cox, Griffiths and Rial-Gonzatez, (2000) noted that worker's physical, mental and social health can be impacted by their work and working conditions through two pathways, the direct and indirect pathways. A direct physical pathway can be observed between physical work environment and its associated risks and worker's health. In addition, bad physical working conditions can also have an indirect impact by causing stress. Also negative physical and psychological working conditions have detrimental impact that can extend beyond the health of workers, and on the healthiness of organization and employee's availability for the performance at work.

Furthermore, Michie and Williams (2003) conducted a systematic review of the psychosocial work factors that were found to be associated with depression disorder. The review found out that the organizational and work factors such as working hours, work overload and pressure, lack of control over work, lack of participation in decision making, poor social support and unclear management and work role contribute to depression disorder in the workplace.

Impacts of Depression Disorder in the Workplace

Crown (1995) explained that depression disorder has the following impact both to the employee and the employer. Such consequences are: decrease production and productivity rates ,increased sickness, absenteeism, impaired working efficiency, decrease job satisfaction and organizational commitment ,increased intention to quit and turnover, decrease morale

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

and employee loyalty, increase causes of accidents and occupational risks, and decrease organizational culture and employee retention. Harnois and Gabriel (2000) found that several consequences that are commonly related to these disorder among workers include absenteeism, reduction in productivity, increase in error rates, poor timekeeping, increase in turn over and tension and conflict between colleagues.

The Workplace

Workplace is a place where one work such as an office or factory. It could be the location at which an employee provides work for an employer (Winston, 2012). Capra and Williams (2010) noted that employees spent most of their time in the workplace than in any other location, that workplace health promotion deserves special attention. For instance, in Nigeria, employees spend almost 9 hours or more in their workplace while in United Kingdom employees spend up to 60% of their time in the workplace (Clark, 2010). The report by Nebosh (2010) revealed that about 40% of employees were unhappy, and almost one in ten described self as extremely unhappy when working. In United Kingdom over 25% of the workforce suffered from a work-limiting illness or injury and as working ages are rising, the burden of chronic disease in the working age population is expected to increase over the next 30 years (Vaughan-Jones & Barham, 2009). Therefore, workplace directly influences the physical, mental, economic and social wellbeing of workers and is an excellent setting for delivering the key messages of health and for performing health promotion (Capra & William, 1993).

Health Promotion

Workplace health promotion deserves special attention as the state of one's health determines his/her ability to work effectively in any organization. However, the practice of workplace health promotion gained its first international recognition with the Ottawa Charter for health promotion in 1986. This Charter defined workplace health promotion as the process of enabling people to exert control over the determinants of health and thereby improve their health (World Health Organization, 1986). According to the European Network for Workplace Health Promotion (ENWHP, 1997) in the Luxembourg Declaration, workplace health promotion can be defined as the combined efforts of employers, employees and society to improve the health and wellbeing of people at work. As results, workplace health promotion is important to both organization and employees. Sochert (1998) noted that workplace health promotion improved working conditions for employees and even the organization. These improvements include; reduced stress as a result of optimized work organization and reduced physical strain due to ergonomic improvements. This concept of health promotion is also important to the occupational health and safety, in particular as it concerned with employees' influence over the organization of the physical and psychological aspects of work (Shain & Kramer, 2004).

Health promotion as applied to reintegrating employee with depression disorder into the workplace connote with the active participation of individuals and organization in the process of achieving positive health and wellbeing and enhancing quality of life of employee while returning to work; it is an enabling process done by, with and for the people in order to return depressive employee into workplace (Jane-Liopis, Katshchnig, McDaid, & Wawbeck, 2007). It also means to create a workplace that provides workers with depressive disorder supportive environment while returning to work. Pollett (2007) noted that the essence of the health promotion is to enhance protective factors that contribute to good mental health. It implies

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

the development of individual's social and environment conditions, which enable optimal health and promote personal empowerment and development. Aust and Duck (2004) maintained that health promotion in the workplace promote less sick leave, improve psychological wellbeing and work satisfaction and lowered cholesterol levels. It lead to greater health awareness, help to manage and reduce work-related stress and strains, promote or enhance health promoting behaviours, and in turn, enhance the worker's overall health and wellbeing.

HEALTH PROMOTION INITIATIVES FOR REINTEGRATING EMPLOYEES WITH DEPRESSION DISORDER INTO THE WORKPLACE

Returning to work is often an important component of an individual's recovery from a depression disorder. The workplace can play an important role in ensuring a successful return. In addition, people with depression disorder are an important part of the human capital needed for a successful work. Returning them to work will ensure that their knowledge and skill are not lost to the workplace. Both the employer and employee require special initiative in order to function effectively (Bond & Meyer, 1999; Fabian, 1993; McDonald &Wilson, 2002). These initiatives include supported work education initiatives, health screening initiatives, quality circle initiatives, holistic approach initiatives, communication initiatives, incentives initiative, special initiatives and multi-modular methodology initiatives, and are discussed as follows:

Supported work education initiatives

This initiative is geared towards raising employee awareness (health education) (Sullivan, 1993). The focus of the initiative is on the participant processes rather than on practitioner activity. The initiative has three phases called choose, get and keep phases.

In the choosing phase the employee is helped in describing why he or she wishes to go back to work and making an enlightened choice as to the type of environment which suits his or her needs, as well as in making a choice as to which workplace might meet expectations. The eliciting of educational goals, the assessment of personal criteria, and the realistic objective evaluation of the employee's abilities are paramount in facilitating the decision-making process. Part of this phase also involves the identification and securing of other sources of support for the employee, including family and friends. In the getting phase a decision for getting to the workplace is made by the practitioner and the employee concerning the assignment of responsibility for getting to the workplace including obtaining the financial support needed. The decision is also made concerning the amount of information which the employee may wish (or may not wish) to disclose concerning the health situation. In the keeping phase efforts are made to continue to support the employee in the workplace. The practitioner will health educates both the employer and the employer on the special skills which the employee might need to pursue throughout his/her work life in the workplace.

Health screening initiatives

Health screening is seen as a key element in health promotion initiatives (Taitel, Haufle, Heck, Loeppice, & Fetterolf, 2008). Such screening may include body mass index, blood pressure and blood cholesterol level. He further stressed that Lifestyle risk indicators could also be screened such as physical activity levels, smoking status, nutrition habits and

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

perceived levels of stress. Individual risk reports, based on such assessments, provide feedback to employees regarding their relative risk for various mental and physical health conditions. In one large study conducted in the US, approximately 60% of respondents reported taking action on their health, based on feedback from health screening (Taitel, Haufle, Heck, Loeppice, & Fetterolf, 2008).

Quality circle initiatives

A quality circle initiative involves groups of employees who meet regularly to discuss and monitor the welfare of employees, and encourage organizational processes that promote employees' return to work. The initiative is a dynamic system that allows the workplace to adapt according to feedback from employees. The initiative is particularly concerned with the quality of resources, quality of life at work, communication and participation, working relationships, team spirit and motivation (Bernard & Jacob, 2004).

Holistic approach initiatives

This initiative optimally involves comprehensive interventions that solely target changing individual behaviour and organization level towards mental health promotion (Leka & Cox, 2008). In the individual levels those activities that are aimed at the individual seek to increase emotional resilience, by promoting self-esteem, coping skills and social kills and enhancing relaxation abilities and mental calm are maintained, while in organization level involves those initiatives aimed at the level of the workplace that are meant to improve working conditions of the employee, the environment as well as the working organization and to increase social support, social inclusion and participation in work (Michie & William, 2003). Holistic approach also involves promoting employees' health by addressing their physical, mental and social wellbeing. This approach is in line with the definition of health as given by the World Health Organization, and should be an integral component of any depression disorder health promotion initiative.

Communication initiatives

Communication was found to be essential in order to encourage and facilitate the return of workers with depression disorder into his/her workplace. Good communication initiative enables employees to be aware of the ongoing initiative, to understand why certain actions are taken and to understand the reasoning behind the decisions made by the management. Nohammer, Schusterschit and Stummer (2010) saw communication as information flow and the way in which information is presented and received. Lovato and Green (1990) provided some examples of communication initiatives that can be used to reintegrate employees with depression disorder into the workplace to be posters, bulletins, articles in newsletters, and including information with the pay cheques. Further, the use of reminders during the course of the initiatives has been found to be effective increasing the return of employees into the workplace (Terry, Fowles, & Harvey, 2010). Seaverson, Gross Meier, Miller, and Anderson (2009) found that strong and purposeful communication initiatives led to a strong health promoting culture. Nohammer, Schusterschit and Stummer (2010) stressed that personalized emails and workshop can be useful forms of direct communication initiative for reintegrating employees into the workplace and may be effective in raising employees' level of awareness of key health issues and health promotion programmes offered by the organization.

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

Incentives initiative

The use of incentives which includes material and social incentives can be helpful initiatives for employees with depression disorder. The material incentives are for example, money or price, offering loans to employees, funded childbirth, and offering provision of housing for workers facing housing problems while social incentives can be achieved by positive appraisal, and recognition or feedback (Lavato & Gren, 1990). Incentives initiatives have a significant impact, not only on the reintegrating the employees with depression did order into the workplace but also motivating them to participate in health risk assessments which will help to determine the level of progress and ill health expenses (Seaverson, Gross Meier, Miller, & Anderson, 2009), Taitel, Haufle, Heck, Loeppice, & Fetterolf, 2008).

Special initiatives

These initiatives are aimed to promote health of the employee's both within the workplace and beyond the workplace as well (a focus on workplace health and also on health in the private life). These services include offering a healthy lunch that employees can choose to take home, comprehensive assessment of health state and lifestyle of employees, offers several steps for learning how to live healthier and monitor the success, a corporate social responsibility, encouraging employees to spread the lessons learned and to inform people within their community (Keyers, 2002).

Multi-modular methodology initiatives

These initiatives involves following the viewing of films, and interactive dialogues with experts. The experts uses documentary films as a method of informing employees about health-related topics such as stressful life situations, disabilities, family violence, effects of politics on families (McDaid, Curran & Knapp, 2005).For example a combination of information materials, videos, role playing or learning with models. In this way, the training takes on a workshop character that is more effective than up-front teaching.

CONCLUSION

It has long been known that severe depression disorder often impairs dramatically one's capacity to work and to earn a living. It can lead to impoverishment, which in turn may worsen the illness. Loss of productivity is often substantial, especially since absenteeism caused by depression disorder can be prolonged, the more so if it is not officially recognized and adequately addressed as part of the health coverage benefits available to the employee. There will be instances in which depression disorder will appear to be mostly related to difficult working conditions. Therefore, all efforts to reintegrate them into their different working places are essential since they improve quality of life and reduce both impoverishment and the high service and welfare costs engendered by this group. Whatever the etiology, the issue must be addressed adequately.

RECOMMENDATIONS

The following recommendations were made to the government, private sector, society and organization and workers.

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1. Government should have stronger political will and legislation which will postulate that disability shall be included in a meaningful life with respect to access to work. These laws will dictate that reasonable accommodations should be made by employers.

2. Health educators should organize seminar/workshop to educate employers to understand the relationship between health and productivity and improving their management strategies by developing and implementing programmes supportive of work/family/ life issues, such as the flexi time, part-time schedules, child care benefits, personal leave, wellness health programmes and family counseling

3. Government should break the circle of discouragement and eliminating the numerous societal barriers that affect employment. As this is the key to enhancing the economic and social integration of people with depression disorder.

4. Social cooperation organization should be established as they will help to provide many rehabilitation packages and professional education and programmes to depressive employee.

5. Employers and workers should support the individual in order to establish a working relationship based on known expectations, cooperation and partnership.

6. Organizations should adopt a more proactive approach by encouraging employers and employees to promote positive mental health promotion in the workplace policies.

7. Non-governmental organizations should equally be more proactive in promoting a positive understand about mental health in the society.

8. Health promotion in the workplace should be a top priority of the government and employers since one's health determines his/her ability to work effectively in any organization.

REFERENCES

Aust, D., & Duck, L. (2004). Health promotion at work. *Journal of the Royal Society of Medicine, 86*(12), 694-696.

Birnbaum, D.J. (1999). The economic impact of depression in a workplace. *Journal of Occupational Medicine, 24*(7), 646-660.

Bond, G.R., & Meyer, P.S (1999). The role of medications in the employment of people with schizophrenia. *Journal of Rehabilitation, 2,* 9-6

Brochner, J., & Greenberg, J. (1990). The impact of layoffs on survivors: An organizational perspective. In J. Carroll (Ed.), *Applied social psychology and organizational settings* (p. 45). Hillsdale, NJ: Erlbaum.

Capra, S., & William S.T. (2010). Nutrition intervention at the workplace-some issues and problems. *Australian Journal of Nutrition and Diet, 500,* 2-3.

Clark, A. (2010). Workplace health for a healthy place to work. *Complete Nutrition, 10*(1). Retrieved July, 16, 2015 from http://www.achn.co.uk/workplace-Health-for-A-Healthy-Place-T-work.pdf

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

Conti, D.J., & Burton, W.H. (2000). The economic impact of depression in a workplace. *Journal of Occupation Medicine, 36*(6), 22-32.

Cox, T., Gnffiths, A., & Rial-Gonzalez, E. (2000). *Research on work related stress.* Luxembourg: Office for Official publications of the European Communities. Retrieved July 16, 2015 from http://.Osha.europa.eu/en/publications/reports/203

European Network for Workplace Health Promotion-ENWHP. (1997). *The Luxembourg declaration on workplace health promotion in the European Union.* Retrieved July 16, 2015 from http://www.enwhp.org/fileadmin/rsdoknmen/dakien/luxembourgDecharationpdf

Fabian, E.S. (1993). Reasonable accommodations for workers with serious mental illness: type, frequency, and associated outcomes. *Journal of Psychological Rehabilitation, 17,*163-172.

Goldberg, R.J., & Steury, S. (2001). Depression in the Workplace: Costs and barriers to treatment. *Psychiatric Service, 53*(12), 16-39.

Harnois, G., & Gabriel P. (2000). *Mental health and work: Impact, issues and good practices*. Geneva: World Health Organization.

Huxley, P. (2001). Work and mental health: An introduction to the special section. *Journal of Mental Health, 10*(4), 367-372.

Jane-Liopis, E., Katshchnig, H., McDaid, D., & Wawbeck, K. (2007). *Commissioning, interpreting and making use of evidence on mental health promotion and mental disorder prevention: An everyday primer.* Direccao Geral de Saude, Lisbon, Portugal.

Jenkins, R. (1993). Mental health at work-why is it so under researched? *Occupational Medicine*, 65-67.

Karasek, R., & Theorell, T. (1990). *Healthy work-stress, productivity and the reconstruction of working life.* New York: Basic Books.

Kessler, R.C., & Frank, R. (1997). The impact of psychiatric disorder on work loss days. *Psychological Medicine, 27*, 861-873.

Keyes, C.L.M. (2002). The mental health continuum from languishing to flourishing in life. *Journal of Health and Social Research, 43,* 2027-222.

Leka, S., & Cox, T. (2008). *The European framework for psychosocial risk management.* Nottingham: World Health Organization.

Liimatainen, M. (2000). *Mental health in the workplace: Situation Analysis.* Geneva: International Labour Office.

Liimatainen, M., & Gabriel, P. (2000). Mental health in the workplace. *Situation Analysis*: United Kingdom. Geneva. International Labour of Office.

Lovato, C.Y., & Green L. (1990). Maintaining employee participation in workplace health promotion programs. *Health Education and Behaviour, 17*, 73-88.

Maslach, C. (2001). Job burnout. *Annual Review of Psychology, 52,* 397-422.

McDaid, D. Curran, C. and Knapp, M. (2005). Promoting mental well-being in the workplace: a European Policy perspective. *International Review of Psychiatry 17(5),* 365-373.

McDonad, E., & Wilson, K.L. (2002). An investigation of reasonable workplace accommodations for people with psychiatric disabilities: quantitative findings from a multi-site study. *Community Mental Health Journal, 38*(1), 35-50.

Michie, S., & William, S. (2003). Reducing work related psychological ill health and sickness absence: A systematic literature review. *Occupational and Environmental Medicine, 60,* 3-9.

Miller, D. (2002). Work problems caused by mental ill health and their management. In J. Coney (Ed.), *Prevention of mental ill-health at work.* New York: Conference.

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)

Natural Examination Board in Occupational Safety and Health, Happiness. (2010). Health and well-being at work: Research summary. Retrieved July 16, 2015 from http/www.nebosh.org.uk/fileupload/upload/happiness%20report%200103111432011116 46pdf

Nohammer, Schusterschit, Z, C., & Stummer, H. (2010). Determinants of employee participate in workplace health promotion. *International Journal of Workplace Health Management, 3*(2), 97-110.

Osha, E.U. (2007) *Expert forecast on emerging psychosocial risks related to occupational safety and health.* Luxembourg: Office for official Publications of the European Communities.

Pollett, H. (2007). Mental health promotion: A literature review. Retrieved July, 16, 2015 formhttp://www.cnhan.calpdf/mental%20Health%20Promotion%20Lit%Review%20June%2018pdf

Seaverson, E.L.D., Gross Meier, J., Miller, T.M., & Anderson, D.R. (2009). The role of incentive design, inventive value, communications strategy, and worksite culture on health risk assessment participate. *America Journal of Health, 5,* 343-352.

Siegnst, J. (1996). Adverse health effects of high- effort/low-reword conditions. *Journal of Occupational Health Psychology,* 127-141

Sochert, S.I. (1998). The effects of lifestyle and stress on the employee and organization: Implications for promoting health at work, anxiety, stress and coping. *An International Journal, 6*(3), 155-177.

Stakes. (1999). *Introduction to mental health issues in the E.U.* Finnish: Ministry of Social Affairs and Health, Helsinki, Finland. Retrieved July, 16, 2015 from http://groups.stakes.fi/mtr/en

Sullivan, A. (1993). Choose/get/keep/: A Psychiatric rehabilitation approach to supported education. *Journal Psychological Rehabilitation, 17* (1), 45-50.

Taitel, M.S., Haufle, V., Heck, D., Loeppice, R., & Fetterolf, D. (2008). Incentives and other factors associative with employee participation in health risk assessments. *Journal of Occupational and Environmental Medicine, 50,* 863-872.

Terry, P. Fowles, J.B., & Harvey, L. (2010). Employee engagement factors that affect enrolment compared with retention in two coaching programs-The ACTIVATE study. *Population Health Management, 13*(3), 115-122.

The Sainsbury Centre for Mental Health. (2004). *Framework for mental health.* London: UK.

Vaughan – Jones, H., & Barham, (2009) Healthy work, challenges and opportunities to 2030. *A report for Buna in partnership with the Oxford Health Alliance.* The work Foundation and RAND Europe. Retrieved July, 16 2015 from http://www.bupa.com/about-us/information-centre/uk/uk-healthy-work

Winston, E. (2010). Workers' health in Latin America and the Caribbean: Looking to the future. *Perspectives in Health, 5*(2). Retrieved July 16, 2015 from www.paho.org

World Health Organization. (1986). *Ottawa Charter for Health Promotion.* Retrieved July 6, 2015 from http://ww.who.into/hpr/NPH/docs/Ottawa-charter-hp.pdf

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

World Health Organization. (2001). *Mental health policy: Plans and programmes* (WHO mental health Policy and service Guidance Package). Geneva: World Health Organization.

World Health Organization. (2004). Prevention of depression disorders: Effective interventions and policy options. Geneva: World Health Organization.

ISSN: 2052-6350(Print) ISSN: 2052-6369(Online)