Work, mental health, sickness absence and return to work

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Overview

Definitions of disability and sickness absence
Interventions to reduce mental ill-health at work
The size of the problem
Predictors of sickness absence
Predictors of disability pension
Interventions to reduce sickness absence
Definition of a ‘disabled person’ – someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities

(Disability Discrimination Act 1995, 2005)
Definitions of Sickness Absence

Short spells < 7 days (self certified)
Long spells > 8 days (requires medical certificate)
Very long spells > 21 days
Degrees of Disability

Presenteeism → Short spells → Long spells → Incapacity

Sickness Absence → Early retirement
## Impairment in role functioning in NCS-R

### Prevalence of severe impairment

<table>
<thead>
<tr>
<th></th>
<th>Any domain</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>22.7</td>
<td>16.3</td>
</tr>
<tr>
<td>Cancer</td>
<td>14.0</td>
<td>10.9</td>
</tr>
<tr>
<td>Heart disease</td>
<td>26.7</td>
<td>20.3</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>70.1</td>
<td>37.2</td>
</tr>
<tr>
<td>Major depression</td>
<td>64.2</td>
<td>31.8</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>60.4</td>
<td>29.3</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>50.9</td>
<td>28.1</td>
</tr>
<tr>
<td>Social phobia</td>
<td>36.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Any mental illness</td>
<td>42.0</td>
<td>20.5</td>
</tr>
</tbody>
</table>

(Druss et al, 2009)
## Estimated annual costs to UK employers of mental ill health

<table>
<thead>
<tr>
<th></th>
<th>Cost per average employee £</th>
<th>Total cost to UK employers (£billion)</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism</td>
<td>335</td>
<td>8.4</td>
<td>32.4</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>605</td>
<td>15.1</td>
<td>58.4</td>
</tr>
<tr>
<td>Turnover¹</td>
<td>95</td>
<td>2.4</td>
<td>9.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1035</strong></td>
<td><strong>25.9</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

¹ The cost of replacing staff who leave their job due to a mental health problem

(Sainsbury Centre for Mental Health, 2007)
Contribution of mental ill-health to absence and incapacity

In UK 175 million working days lost to sick absence (2006)
1 in 4 sick notes have a mental health diagnosis
40% of total sick note time off is for mental health
Average mental health sick notes 15 weeks vs 8 weeks
Incapacity benefits risen from 2% (1970s) to 7% today
Incapacity for mental health risen from 26% in 1996 to 41% in 2006
Mental illness accounts for 35% of all disability benefits
Figure 1 - Incapacity benefits caseload over time

7. In 2009/10, DWP spent a total of £13.4bn on incapacity benefits, comprising of £6.1bn on Incapacity Benefit, £6bn in Income Support by virtue of a disability and Severe Disablement Allowance combined and £1.3bn on ESA.
# Increase in psychiatric sickness absence in Norway 1994-2000

Cumulative incidence (>1 spell, 14 days+)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>1.8</td>
<td>2.5</td>
<td>3.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Men</td>
<td>0.8</td>
<td>1.1</td>
<td>1.7</td>
<td>2.2</td>
</tr>
</tbody>
</table>

For women highest cumulative incidence 40-49 years
For men cumulative incidence increased in all age groups

(Hensing et al, 2006)
Increase in psychiatric sickness absence in Norway 1994-2000: by diagnostic group and gender

<table>
<thead>
<tr>
<th></th>
<th>Psychoses</th>
<th>Anxiety disorder</th>
<th>Neurotic conditions</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>+0.05</td>
<td>+0.16</td>
<td>+0.84</td>
<td>+1.8</td>
</tr>
<tr>
<td>Men</td>
<td>+0.04</td>
<td>+0.10</td>
<td>+0.41</td>
<td>+0.84</td>
</tr>
</tbody>
</table>

(Hensing et al, 2006)
Possible explanations for the increase in psychiatric sickness absence

- Changes in the attitude to psychiatric diagnoses in both patients and doctors
- Improved identification and treatment of psychiatric disorders
- Increase in psychiatric disorders
- Increased demands from workplaces
- An inclusive labour market
Estimated prevalence rate of *self reported work related illness in people who worked in the last 12 months in England & Wales

Rate per 100 000

Possible Reasons for Increased Prevalence

• Increased readiness to report work stress

• Increased recognition of work stress

• Increased attribution of stress to work

• Increased incidence of stress/ job strain

(Stansfeld et al, 2009)
Rise in mental health and fall in MSK diagnoses between 2000 and 2007

Those with poor employment history more likely to claim for a mental health problem

Main mental health reason depression – psychosis only small proportion

Modest increase in depression, alcohol and drugs between 2000 and 2007

(Brown et al, 2008)
Predictors of Sickness Absence
Depressive symptoms and the risk of long term sickness absence

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample</th>
<th>Mental health measure</th>
<th>RR  95%CI</th>
</tr>
</thead>
</table>
| Vaanenen et al 2003 | 3,895 employees      | Psychological symptoms Absence > 21 days | Men = 1.68 (1.4-2.1)  
|                     |                      |                                     | Women = 1.66 (1.2-2.2) |
| Bultmann et al 2005 |                      | Absence > 42 days                   | Men = 1.33 (1.2-1.5)  
|                     |                      |                                     | Women = 1.45 (1.2-1.7) |
| Bultmann et al 2006 | 4,747 employees      | 5 item Mental Health Inventory Absence > 8 weeks | Men = 2.69* (1.2-6.1)  
|                     |                      |                                     | Women = 2.27 (1.3-4.1) |
| Stansfeld et al 2011| 5,104 employees      | 30 item GHQ Psychiatric Absence > 7 days | Men = 1.67** (1.1-2.5)  
|                     |                      |                                     | Women = 1.02 (0.7-1.6) |

*Adjusted for age, education, cohabitation, no of children at home, diagnosed disease and lifestyle factors
**Adjusted for age, employment grade, work characteristics, social support, material problems, self rated health, alcohol consumption, physical illness
# Mental health and sickness absence

## DSM-III-R disorders* as predictors of sickness absence

<table>
<thead>
<tr>
<th></th>
<th><strong>Men</strong></th>
<th>95% CI</th>
<th><strong>Women</strong></th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD</td>
<td>1.87</td>
<td>(1.2-2.8)</td>
<td>1.29</td>
<td>(0.8-2.1)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>2.97</td>
<td>(1.2-7.4)</td>
<td>1.13</td>
<td>(0.6-2.1)</td>
</tr>
<tr>
<td>Any Anxiety Disorder</td>
<td>1.37</td>
<td>(1.0-1.9)</td>
<td>0.94</td>
<td>(0.7-1.3)</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>0.97</td>
<td>(0.6-1.5)</td>
<td>0.74</td>
<td>(0.3-2.1)</td>
</tr>
<tr>
<td>Drug abuse/dependence</td>
<td>3.83</td>
<td>(1.6-9.5)</td>
<td>1.64</td>
<td>(0.4-6.4)</td>
</tr>
</tbody>
</table>

*3695 from NEMESIS gen popln sample using CIDI DSM 111-R diagnoses (Laitenen-Krispijn & Bijl, 2000)
Work and psychiatric sickness absence
Occupation and sickness absence

<table>
<thead>
<tr>
<th>Occupation</th>
<th>%</th>
<th>95% CI</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>All employed</td>
<td>2.1</td>
<td>(2.0-2.2)</td>
<td>1.3</td>
<td>(1.3-1.4)</td>
</tr>
<tr>
<td>Saw mills/carpenters</td>
<td>5.2</td>
<td>(1.8-8.7)</td>
<td>4.4</td>
<td>(3.3-5.5)</td>
</tr>
<tr>
<td>Metal industry</td>
<td>6.3</td>
<td>(5.1-7.6)</td>
<td>2.0</td>
<td>(1.8-2.2)</td>
</tr>
<tr>
<td>Textile industry</td>
<td>4.0</td>
<td>(2.6-5.4)</td>
<td>3.5</td>
<td>(1.5-5.5)</td>
</tr>
<tr>
<td>Social work</td>
<td>2.8</td>
<td>(2.5-3.2)</td>
<td>3.6</td>
<td>(2.2-5.0)</td>
</tr>
<tr>
<td>Food industry</td>
<td>4.4</td>
<td>(2.4-6.3)</td>
<td>2.2</td>
<td>(1.3-3.1)</td>
</tr>
<tr>
<td>Hotel, restaurant</td>
<td>2.4</td>
<td>(2.0-2.9)</td>
<td>2.6</td>
<td>(1.4-3.8)</td>
</tr>
<tr>
<td>Teacher</td>
<td>1.1</td>
<td>(0.9-1.4)</td>
<td>0.9</td>
<td>(0.6-1.2)</td>
</tr>
<tr>
<td>Administration</td>
<td>1.1</td>
<td>(0.8-1.5)</td>
<td>0.7</td>
<td>(0.3-1.1)</td>
</tr>
</tbody>
</table>

(Hensing et al, 1995)
Rate ratios for long spells of sickness absence (> 7 days) by change in work characteristics (1985-88) and (1991-93)

<table>
<thead>
<tr>
<th></th>
<th>Increase</th>
<th>Stable</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision latitude</strong></td>
<td>0.97 (0.8-1.1)</td>
<td>1</td>
<td>1.34 (1.1-1.6)</td>
</tr>
<tr>
<td><strong>Job Demands</strong></td>
<td>1.21 (1.0-1.4)</td>
<td>1</td>
<td>0.89 (0.8-1.1)</td>
</tr>
<tr>
<td><strong>Work social supports</strong></td>
<td>0.80 (0.7-1.0)</td>
<td>1</td>
<td>0.96 (0.8-1.1)</td>
</tr>
</tbody>
</table>

Adjusted for age, sex, employment grade and other work characteristics

(Head et al, 2006)
Hazard ratios (95% CI) for the association between excess bed occupancy and future sickness absence due to *depressive disorders*

<table>
<thead>
<tr>
<th>Bed occupancy rate</th>
<th>N of Events</th>
<th>Hazard Ratio&lt;sup&gt;a&lt;/sup&gt;</th>
<th>95% CI</th>
<th>Hazard Ratio&lt;sup&gt;b&lt;/sup&gt;</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>No excess occupancy&lt;sup&gt;c&lt;/sup&gt;</td>
<td>41</td>
<td>1.00</td>
<td>referent</td>
<td>1.00</td>
<td>referent1</td>
</tr>
<tr>
<td>Excess occupancy ≤ 5%</td>
<td>46</td>
<td>0.94</td>
<td>0.62–1.44</td>
<td>0.99</td>
<td>0.65–1.50</td>
</tr>
<tr>
<td>Excess occupancy &gt;5 ≤10%</td>
<td>24</td>
<td>1.32</td>
<td>0.82–2.11</td>
<td>1.44</td>
<td>0.90–2.30</td>
</tr>
<tr>
<td>Excess occupancy &gt;10%</td>
<td>23</td>
<td>1.94</td>
<td>1.14–3.28</td>
<td>1.95</td>
<td>1.18–3.24</td>
</tr>
</tbody>
</table>

<sup>a</sup> Unadjusted.

<sup>b</sup> Adjusted for sex, age, occupation, type and length of employment contract, hospital district, and speciality.

<sup>c</sup> 12-month mean bed occupancy of ≤ 85%.

(Virtanen et al. *J Clin Psychiatry* 2009)
Childhood temperament and long-term sickness absence

- Aberdeen children of the 1950’s study (n=12,150)
- Rutter ‘B’ scale in 1964, 64% followed up in 2001
- 5.5% ‘permanently sick or disabled’ at follow up
- Permanently sick or disabled predicted by school absence, ‘often complains of aches and pains’ (OR=6.8, 95% CI 1.3-35.5), ‘often appears miserable or unhappy’ (OR=3.8, 95% CI 1.0-14.4) adjusting for year of birth, gender, IQ and father’s social class

(Henderson et al, 2009)
Mechanisms for the influence of direct effects of support on illness behaviour and absence (Stansfeld et al, 1997)

Negative aspect of close relationships

Work support

Confiding emotional support

*Illness*

Absence

Mechanisms for the influence of direct effects of support on illness behaviour and absence (Stansfeld et al, 1997)
Sickness absence in its social context

- Sickness absence rates are influenced by workforce conditions and the local economy
- Major organisational downsizing was associated with an increase in the rate of medically certified sickness absence in permanent but not temporary employees
  
  (Vahtera et al, 2004)

- Working in areas with a poor local economy (low municipal revenue, high unemployment) was associated with increased long term sickness absence but less short-term absence
  
  (Virtanen et al, 2005)
Absence culture and the psychological contract

Absence culture – ‘the set of shared understandings about absence legitimacy…and the established custom and practice of employee absence behavior and control’

(Johns and Nicholson, 1982)

Psychological contract – ‘the set of unwritten reciprocal expectations between the individual employee and the organization. The contract is the essence of individual – organizational linkage, because employment entails an implicit exchange of beliefs and expectations about what constitutes legitimate actions by either party’

(Schoen, 1980; Nicholson and Johns, 1985)
More complex model: Henderson 2011

- Parental work history
- Coping style / personality
- Attitude to work and employer
- Perception of health / vulnerability
- Stress at work
- Ill Health
- Sickness Absence
Factors that can affect sickness absence

<table>
<thead>
<tr>
<th>Macro level</th>
<th>Organisational level</th>
<th>Individual level</th>
</tr>
</thead>
<tbody>
<tr>
<td>climate</td>
<td>the nature of the industry</td>
<td>age</td>
</tr>
<tr>
<td>epidemics</td>
<td>working conditions</td>
<td>sex</td>
</tr>
<tr>
<td>provision of health care services</td>
<td>job demands</td>
<td>occupational status</td>
</tr>
<tr>
<td>social insurance systems</td>
<td>size of the enterprise</td>
<td>job satisfaction</td>
</tr>
<tr>
<td>sickness certification practices</td>
<td>characteristics of the workforce</td>
<td>length of service</td>
</tr>
<tr>
<td>taxation</td>
<td>workforce availability</td>
<td>personality</td>
</tr>
<tr>
<td>pensionable age</td>
<td>industrial relations</td>
<td>life crises</td>
</tr>
<tr>
<td>social attitudes</td>
<td>supervisory quality</td>
<td>family responsibilities</td>
</tr>
<tr>
<td>economic climate</td>
<td>personnel policies</td>
<td>social support</td>
</tr>
<tr>
<td>availability of alternative employment</td>
<td>labour turnover</td>
<td>leisure activities</td>
</tr>
<tr>
<td>unemployment</td>
<td>the provision of occupational health services</td>
<td>alcohol intake</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the health status of the individual</td>
</tr>
</tbody>
</table>

(Whitaker, 2001)
Recurrence of sick absence due to CMD

- Workers with mental/behavioral disorders 7 x more likely to have another episode compared to workers with a physical disorder related episode
  
  (Dewa et al 2009)

- Of 9,904 possible employees with first absence due to CMD:
  
  19% had a recurrence
  
  90% of recurrences occurred within 3 years

  Depression symptoms not distress related to greater risk of recurrence in men not women

  (Koopmans et al, 2010)
Predictors of return to work (RTW) from absence

For general sickness absence:

In 730 absent workers 71% fully RTW after 1 year, 20% had not
High physical demands, contact with medical specialists, high
physical symptoms, moderate – severe depression, older age
predicted continued absence

Vlasveld et al 2011

For CMD:

In 298 absent workers 85% fully RTW after 1 year
DSM-IV ‘case’ depression, poorer self-rated health, type of
workplace (municipal, private rather than public) predicted
slower return to work

Nielsen et al 2011
Predictors of Disability Pension
# Effects of anxiety and depression on disability pension awards for non-mental health conditions

<table>
<thead>
<tr>
<th></th>
<th>OR</th>
<th>95% CI</th>
<th>OR+</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>1.56</td>
<td>1.23-1.96</td>
<td>1.02</td>
<td>0.80-1.30</td>
</tr>
<tr>
<td>Depression</td>
<td>1.93</td>
<td>1.48-2.52</td>
<td>1.49</td>
<td>1.14-1.96</td>
</tr>
<tr>
<td>Both</td>
<td>2.59</td>
<td>2.05-3.28</td>
<td>1.51</td>
<td>1.18-1.94</td>
</tr>
</tbody>
</table>

* Excluding pension for psychiatric diagnoses
+ Adjusting for number of somatic diagnoses and symptoms (Mykletun et al 2006)
Absence as a risk factor for work disability and termination

- Prospective study of 53,990 Dutch Postal Workers
- **Risk of termination of employment higher in prior absentees** (RR=1.2-2.1) compared to reference population
- Neoplasms and mental disorders associated with a higher risk of job termination in men, infections and neurological disorders in women
- Median time to recurrence 328 days: 21% of recurrent sickness absence days

(Koopmans et al, 2008; Roelen et al, 2010)
Sickness absence and disability pensions (DP)

- In 1999 cohort of 4891 Swedish employees, 20-61 with new psychiatric diseases >90 days
- By 2002, 26% granted disability pension, higher among men, higher rate of sickness absence among women
- Only 35% <17 sick leave days in 2002
- Low SES (OR=3.40, CI 2.28-5.08) increased risk for DP
- Employees aged 55-61, lower risk of sick leave, highest of DP

(Vaez et al, 2007)
Predictors of duration of sickness and the transition to long term incapacity

- Study of 13,127 sickness certificates from 9 general practices over 12 months
- 39.7% mild mental disorder most frequent cause
- MMD claimants younger, more deprived, more female
- Males longer duration of absence
- Longer certification for alcohol/substance (men 24.1 weeks) than depression (18.3 weeks), anxiety (13.4 weeks)
- Compared with ‘stress’ claimants those with ‘addiction’ were 8 x more likely to be sick long term
- Longer term absence associated with age, addiction and deprivation

(Shiels et al, 2004)
Transition from Long-term sickness absence to disability pension

- 106,674 men and 89,356 women employed in a Norwegian county
- 314 women, 203 men with long term absence (LTSA) were followed to disability pension
- Annual incidence of LTSA: 7.0/1000/year (women); 3.8/1000/year (men)
- 32% of men, 25% of women obtained disability pension in follow-up
- Increasing age, male, low income, psychosis diagnosis increased DP risk

(Gjesdal et al, 2008)
Predictors of disability pension

- 11,072 Oslo participants, aged 40, 45, 59 & 60 years
- 5% of eligible sample received a disability pension
- Age adjusted odds of disability pension greater for women
  \[ OR=1.41 \]
- Gender differences explained by poorer self-reported health, higher levels of mental distress, lower wages and higher job strain

(Claussen & Dalgard, 2009)
Health anxiety and disability pension risk

(Mykletun et al, 2009)
INCAPACITY CLAIMANT RATE,
February 2009

% of working age

- 10 +
- 7.5 to 10
- 5 to 7.5
- 0 to 5
Implications for intervention
Points of intervention to improve health

Interventions | Individual
--- | ---
education system | Social position
A | improving working conditions
B | Causes
C | influencing impact of differential exposures on health
D | Disease or injury
 | minimise disability
 | Social consequences

(Whitehead, 2005)
Meta-analysis of Work Health Promotion

- Systematic review of papers 1970-2005
- 46 studies included in analysis

  Exercise increases overall wellbeing  \( RR=1.25 \ (1.05-1.47) \)
  work ability  \( RR=1.38 \ (1.15-1.66) \)

  Education and psychological methods not effective

  Promoting healthy lifestyle reduces absence  \( RR=0.80 \ (0.74-0.93) \)

(Kuoppola et al, 2008)
Exposure based return to work programme and CMD

- Cluster randomised controlled trial
- Randomised 56 occupational physicians
- 75 workers received return to work programme and 85 received care as usual (problem-solving strategies, graded activities)
- Workers receiving return to work programme had a prolonged time to full time work (209 days) compared to workers receiving care as usual (153 days)

(Noordik et al, 2012)
Recommendations of the Black Report

• New positive approach to health and work needed
• Change perceptions around benefits of work for health
• Health professionals are over cautious about their health-related advice
• Health care professionals should be more committed to helping people, enter, stay in or return to work (electronic fit note)
• Expand pathways to work initiatives

(Working for a healthier tomorrow, 2008)
Work capability assessment

- Introduced in 2008
- Assesses entitlement to Employment and Support Allowance (ESA)
- Replaces incapacity benefit, income support and severe disablement allowance
- ‘It intends objectively to evaluate a person’s capability for work so that appropriate support can be provided to help them back to work or, if, they cannot work, unconditional support is provided’
- Focuses on functional capability rather than diagnosis
- ATOS carry out WCA, and DWP decision makers monitor them

(Harrington, 2011)
Employment and support allowance

- November 2009 2.6 million people on incapacity benefits
- In 2009/10 DWP spent £13.4bn on incapacity benefits
- Since ESA launch 66% found fit for work
- New claims: Fit for work 39%, work related activity 14%, Support group 6%, Other outcomes 41%
- Concern about criteria for assessing WCA; fluctuating conditions, mental health conditions, multiple conditions

(DWP, 2010)
Effectiveness of a collaborative mental health care programme for short term disability benefits for psychiatric disorders

- Quasi experimental design – short term disability benefits for psychiatric disorders
  - treatment groups (CMHC programme (n=75))
  - control group just received benefits
- With CMHC program for every 100 on short-term disability benefit:
  - $50,000 savings
  - 23 return to work
  - 24 not transferring to long term disability
  - 1600 more work days

(Dewa et al, 2008)
Interventions to reduce sickness absence

• Individual and organisational level factors need to be tackled

• Stress management techniques: problem solving skills, exercise, rehabilitation

• Brief individual therapy (CBT) with booster sessions

• Early identification (screening), enhanced treatment, keeping up contact with work - increases remission, return to work and productivity

(Seymour & Grove, 2005; Wang et al, 2006; Rost et al, 2004; Godard et al, 2006)
Sickness absence: intervention studies

- Systematic review: six studies found training and organisational approaches to increase participation in decision making, increased support, communication reduced sickness absence
  
  (Michie & Williams, 2003)

- Increasing control and support leads to decrease in absence
  
  (Michie et al, 2004)

- Increased worker control linked to better mental health and attendance at work
  
  (Bond & Bunce, 2001)
Supervisor behaviour and return to work from psychiatric sickness absence

- Employees on sick leave (< six weeks) and their (85) supervisors from a longitudinal cohort study were interviewed.
- Better communication between supervisors and employers was associated with quicker return to work in less depressed state rather than more depressed employees.
- Supervisors communicate better, consult professionals more frequently if supervisor responsible for return to work and has financial consequences for supervisor.

(Nieuwenhuijzen et al, 2004)
Conclusions

• Sickness absence and disability for CMD have been increasing
• Models to explain absence and disability should include the influence of current mental ill-health, substance use, work, attitudes to work and illness, family and childhood factors
• Greater focus needed on prevention, including work reorganisation and exercise promotion, flexible working

• Greater focus on early identification, early intervention and treatment of CMD- and on earlier return to work

• Enable people to remain in or return to work and improve the health of those out of work
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