EUROPE

Mental health and well-being at the workplace – protection and inclusion in challenging times

Edited by: Anja Baumann and Matt Muijen, WHO Regional Office for Europe, and Wolfgang Gaebel, German Alliance for Mental Health

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Introduction

Anja Baumann & Matt Muijen, WHO Regional Office for Europe

Conference on Mental Health and Well-being at the Workplace – Protection and Inclusion in Challenging Times

The WHO Regional Office for Europe, the German Alliance for Mental Health, the German Federal Ministry of Health and the Directorate-General for Health and Consumers of the European Commission held the Conference on Mental Health and Well-being at the Workplace – Protection and Inclusion in Challenging Times in Berlin, Germany, on 17 and 18 March 2009. About 130 representatives of user and family caregiver associations, enterprises, trade unions, politicians and researchers from 20 countries in the WHO European Region discussed ways to respond to how modern working life challenges mental health and well-being, how to overcome barriers to employment for people with mental health problems and opportunities for integration and empowerment given the global economic downturn. This publication is based on the presentations given at the Conference.

Workplace and mental health

Both the Mental Health Declaration for Europe and Mental Health Action Plan for Europe (WHO Regional Office for Europe, 2005a, b) and the European Pact for Mental Health and Well-being (European Commission, 2008) recognize the importance of mental health and well-being and prevention of mental health problems at the workplace as well as overcoming stigma, discrimination and reintegration. The reasons are easy to explain.

Globally, mental disorders are leading causes of disability. In some high-income countries, as much as 40% of disability can be attributed to mental disorders. In the WHO European Region, depression alone causes 13.7% of all years lived with disability, the leading cause. Alcohol disorders are ranked second with 6.2%, and schizophrenia and bipolar disorders, much rarer but often lasting many years, rank numbers 11 and 12 respectively with just over 2% each. It is no surprise that policy-makers are concerned about the effects of mental disorders on society and on the economy.

Associated with the level of disability, mental health problems have become one of the leading causes for absenteeism from work and early retirement all over the European Region. Mental health problems in the workplace have serious effects not only for the individual but also for the productivity and competitiveness of businesses and thus the economy and society as a whole. Employees' mental health status affects employees' performance and rates of illness, absenteeism and staff turnover. Sickness absenteeism can lead to substantial productivity losses. Early retirement and exclusion from the labour force due to work-related stress and mental health problems account for an enormous share of long-term social welfare benefits. In the United Kingdom, for example, the total cost to employers of mental health problems among their staff is estimated to be nearly £26 billion each year, equivalent to £1035 for every employee in the workforce. The business costs comprise £8.4 billion per year in sickness absence, £15.1 billion per year due to reduced productivity at work and £2.4 billon per year in replacing personnel who leave their jobs because of mental ill health (Sainsbury Centre for Mental Health, 2007).

Mental health problems have many effects on the individual at the workplace. The productivity of individuals with unsupported mental health needs may decline while at work: presenteeism. Mental health problems can affect work performance in terms of increase in

error rates, poor decision-making, loss of motivation and commitment, tension and conflicts between colleagues (Harnois & Gabriel, 2000). Burnout and depression as well as stress-related physical conditions such as high blood pressure, sleeping disorders and low resistance to infections can result in an increase in overall sickness absence. Work-related stress and poor mental health are major reasons not only for absenteeism but also for occupational disability and for workers seeking early retirement.

Mental disorders affect individuals and their employment much beyond the economic issues. People with mental disorders face stigmatization, social exclusion and barriers in obtaining equal opportunities at all levels of life. Finding a job in the open labour market, returning to work or retaining a job after sickness absence due to mental health problems is often a double challenge because of the stigma attached to the label "mental". People with mental health problems have twice the risk of losing their jobs and are disproportionately out of work.

Mental health and economic recession

The economic recession and its effects on the job market are likely to add to the problems in employment and quality of life experienced by people with mental health problems and their families. There is concern that the global economic downturn will adversely affect public health not only because of job losses but also because of the indirect effect on lifestyles and access to health care.

Strong evidence indicates that loss of employment and the risk of unemployment are associated with an increased rate of harmful stress, anxiety, depression and psychotic disorders. Recent statistical studies show that rising unemployment is also associated with small but significant short-term increases in premature deaths from suicide (Stuckler et al., 2009). Unemployment causes significant deterioration of mental health for people of all ages and especially for middle-aged men.

Loss of employment and/or lower salary cause both loss of income and loss of status. Loss of income in high-income countries alone has a complex range of effects, some improving health such as the increased time for physical exercise and reduction in alcohol intake and, more rarely, reduction in smoking, but loss of employment and lower salary predominantly have negative effects, both on behaviour and mental health. Loss of employment can result in poor diet and increasing high-risk behaviour and violence. It can also lead to loss of social contacts, including divorce, and social withdrawal. The loss of job status can result independently in physical disorders such as high blood pressure, stroke and cardiovascular disease (Marmot & Wilkinson, 2006; Wilkinson & Marmot, 2003). In combination, the negative effects of loss of employment and/or reduction in salary are directly correlated with harmful stress and depression, which in turn are correlated with a range of physical disorders. As jobs are threatened and more people need to seek new employment, competition for jobs is expected to intensify and tolerance of employment difficulty will diminish. Opportunities for people with a history of mental disorders will fall even further, and discrimination against people with mental disorders will increase, resulting in a potential spiral of deterioration and deprivation.

In this context, debt is particularly important as a factor causing depression. The recent downturn with a high prevalence of mortgage arrears and the continued job losses will continue to make personal debt a severe burden for many vulnerable people. Debt and poor mental health were clearly linked in a cross-sectional nationally representative survey of private households in England, Scotland and Wales (Jenkins et al., 2008). According to this

study, both low income and debt are associated with mental illness, but the effect of income is mediated by debt. Of those with a mental disorder, 23% were in debt versus 8% of those without a mental disorder. The more debt people had, the more likely they were to have mental health problems.

Negative effects on dependents cannot be ignored. Children of unemployed people are at increased risk of dropping out of school and have an increased incidence of disruptive behaviour. Partners are at risk of depression and its consequences.

Promoting mental health, preventing mental disorders and solutions

During economic recession and the implementation of austerity measures, public sector spending is carefully considered and cuts are made in areas not considered a priority. Mental health services specifically and disease prevention and health promotion activities in general are often cut, and their capacity may paradoxically be reduced at times of increased need. People with severe and enduring mental health problems are especially likely to be affected by these cuts, leading to inequitable suffering but also resulting in limited availability of rehabilitation and supported employment places for people already at disproportionate risk of exclusion.

Work increases self-esteem and the quality of life. Providing a healthy and inclusive working environment can prevent mental health problems and enhance opportunities to enter, remain at or return to work when experiencing such problems. Good health contributes to quality and productivity at work, which in turn promotes economic growth and employment (McDaid, 2008) and the ability to invest in good employment practices. Numerous measures have been shown to be effective in promoting mental health and well-being, preventing and managing mental illness and helping reintegrate people into work – including effective programmes to tackle stigma and discrimination. Some of the most successful and promising are reflected in the chapters in the publication, contributions to the Conference on Mental Health and Well-being at the Workplace – Protection and Inclusion in Challenging Times.

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Conference theme

Protecting and including vulnerable people in times of economic crisis

Paul Schnabel, Netherlands Institute for Social Research/SCP, The Hague, Netherlands

If the theme of protection and inclusion of vulnerable people had been raised in 2007, attention would undoubtedly have focused on the slim opportunities on the labour market for people with a learning disability or mental disorder. Concerns would have been expressed about their difficulties in meeting the high qualification requirements set by the modern labour market or the need for flexibility and the ability to work under high pressure. These people would also undoubtedly have been considered less suitable to work in informally organized but highly productive teams. The modern world of work demands from people precisely what the people with disabilities are unable to offer. Almost no employment today can be performed in a calm atmosphere, at a slow pace, surrounded by people who are familiar and trusted and without stress. For years, researchers have noted that a person with schizophrenia living in rural India or Ethiopia had a better chance of making a useful contribution to society than a counterpart living in a city in a high-income country.

Everyone has become vulnerable

All this still applies, but since 2007 the world has experienced a period of economic crisis, and the situation on the labour market has deteriorated even for people without disabilities. Unemployment in the European Union (EU) is rising rapidly, and no one expects recovery any time soon. This means that even many of those who had imagined themselves to be safe in their positions are in danger of losing their jobs. Although the risk of individual vulnerability caused by such factors as illness, age or lack of training is not formally related to the risk of unemployment in many countries, vulnerable people know that, if they become unemployed, their chance of finding a new job is slight.

Economic crises are also social and mental crises. This has always been the case. As consumers, people put off major purchases. Employees are careful not to be too critical or to take sick leave too readily. Employers hesitate to take risks, including in their personal lives. A crisis makes people uncertain and anxious; they look at each other with greater envy and especially try to make their own position as secure as possible. It is hard to blame them for this, because they also often have a family for whom they are responsible. In many countries, social benefits are less generous today than they were 10–20 years ago. People in their mid-thirties living in the Netherlands who have a family and lose their job and cannot find work again within a year are at great risk of becoming dependent on social assistance benefit. For a family with children, this means an income of about €1500 taxable per month; in most cases, this is 25–50% of their previous income.

The recent recession, which began as a financial crisis, is not just a threat to those in work. Many people receiving pensions – and in the EU countries that means at least 15–20% of the population – are suddenly afraid that they will not receive the pension on which they had been counting or that the amount they receive will be less than they had been anticipating. This especially applies to the people who have to provide their own pensions, who have often seen the capital they had been building decline considerably and rapidly. However, this also

applies to employees who participate in a compulsory pension fund. This is more likely to happen, and have greater effects, where the pension is based on a defined contribution system (in which the amount members pay in is fixed but not the amount they receive in benefit) than in a defined benefit system. In the Netherlands, the combined capital held by all pension funds was €700 billion at the start of 2008 – 20% more than the annual gross domestic product (GDP) of the Netherlands. This pension capital shrunk to less than €500 billion in 2009. That is still a lot of money, but the third largest pension fund in the world, the Netherlands civil service pension fund, still decided in 2009 that pension benefits could not be adjusted for price increases and that pension contributions would have to increase. Although all pension funds in the Netherlands operate based on defined benefits (70% of the recipient's average salary or final salary after 40 years of service), the possibility is now being raised that pension amounts could be reduced. This would be the first time this has happened, and it is already causing concern among those already receiving pensions. However comfortable their retirement is at present – with pensioners having a 3% poverty rate, the lowest of any age group in the Netherlands – these pensioners find themselves in a vulnerable position, especially those who are older. They can no longer return to the labour market, and the need for care and nursing among people older than 75 years increases rapidly. In a shrinking economy, the costs of providing this care are more of a problem than during the economic boom years, when the greatest problem was a shortage of care personnel.

Falling GDP and reduced prosperity: for almost everyone, stepping backwards in wealth and certainty is a new experience. In the more than 60 years since the Second World War, and despite regular recessions, both prosperity and social security have improved steadily in the western part of the WHO European Region. This led to an unprecedented sense of well-being among the populations of the welfare states of western and northern Europe. Even those who were unable to earn their own income were looked after to the highest possible degree. The countries of southern Europe succeeded some time later in creating at least partly comparable systems to protect the most vulnerable members of their societies. The former regimes in eastern Europe had guaranteed employment and a welfare state despite low prosperity. The sweeping aside of the Iron Curtain abruptly ended this, but today the level of prosperity in these countries has grown so strongly that many now once again have a form of social security. However, the economic downturn is hitting precisely these countries, with their still relatively unbalanced economies and low reserves, very hard.

The affluent countries of western and northern Europe, and especially the smaller countries such as Iceland and Ireland, are now facing a loss of prosperity that will not be easily restored. Many forecasters believe that the present recession will not have a V-shape or a U-shape but an L-shape, with a steep and rapid decline in the economy being followed by a protracted period of stagnation. For the United Kingdom, the cost of the economic crisis has been estimated at an average of €50 000 per inhabitant, more than the annual GDP per person. The average GDP in the EU declined by 4.2% in 2009, ranging from 2% growth to 18% decline in the 27 countries. Very modest growth overall is forecast for 2010 in the EU.

A reduction in prosperity inevitably affects the performance of a welfare state, which is already facing the problem that demand for services is increasing while revenue from taxation and social security contributions is declining. The level of national debt is already rising rapidly, but if the recession does assume the predicted L-shape, governments will be very quickly forced to cut budgets. This will mean less money for social security and pension benefits, less money for health care and ultimately less money for investment that generates jobs.

Obtaining a clear picture of the extent of the crisis and the recession at the level of individuals or the population at the national level is difficult. Most people saw relatively few effects on their daily lives in the first half of 2009. In the Netherlands, fewer people were worried about economic developments in the second quarter of 2009 than six months earlier; however, if some predictions prove to be accurate and unemployment rose to almost 10% by the end of 2010, the optimism would quickly evaporate. The macroeconomy is still clearly running ahead of the microeconomy. The greatest problem in the microeconomy of households is that most people have very substantial fixed commitments (mortgage payments, insurance and loan repayments), and reducing these rapidly is difficult. In the 1930s, most people had very little money but also very few fixed commitments. This has changed, which leads to an entirely new kind of vulnerability: an unstoppable increase in indebtedness, which will continue to impose a heavy burden on many households for years to come even when the economy recovers.

The lot of perpetually vulnerable people

How will people with learning disabilities, older people with dementia and people with mental disorders fare during these difficult times? Their number in society as a whole is considerable; on an annual basis, almost 25% of the people aged 18–65 years experience a diagnosable mental disorder (Bijl et al., 1998). The proportion of people with learning disabilities is estimated to be about 1% of the population, and about 10% of the population aged older than 65 years have dementia, with the prevalence increasing rapidly among those aged older than 80 years to about half of those aged 100 years or more. These figures only relate to the more serious cases; problems such as anxiety, stress, fatigue, burnout, excessive alcohol use and so on are much more widespread than can be observed based on the criteria of the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, classification system (American Psychiatric Association, 2000). One also sees this reflected in the sickness absenteeism figures and the incidence of mental problems as a reason for people being declared unfit for work. In one of every three or four cases, people exit the labour market because of mental symptoms. There has usually been no serious diagnosis or treatment; the cause is often irresolvable conflicts at work, a wrong career choice (such as teachers unable to maintain order in the classroom), lack of stamina and sometimes also problems with alcohol or drugs. Although new legislation, at least in the Netherlands, has made the escape route via disability benefit (in reality early retirement) less easy and also less financially attractive, during the recession in the early 1980s, these schemes were used widely as a means of protecting people who had lost their jobs from the pressure of the (usually pointless) requirement to apply for jobs, which is mandatory for an unemployed person but not for someone receiving disability benefit.

In recent years, employers had much to gain from retaining staff and ensuring they stayed as long as possible. There was a labour shortage in 2008, and in the first quarter of 2009 more people than ever were still in employment. As early as the 1990s, the very generous system whereby employees continued to receive their salaries when sick was changed substantially, making it compulsory for employers to work actively to reintegrate sick employees. This was largely successful and helped to reduce sickness absenteeism from more than 10% to about 4%. Today, now that employers are responsible for paying employees' salaries during sick leave, they have become more reticent than ever in recruiting people whose age or disability could put them at greater risk of being off work from illness.

At the same time, employers are giving more attention than ever to measures to prevent sickness absence. Providing good working conditions, special leave arrangements, child-care facilities and the ability to work part time, fitness facilities and measures to relieve stress at work and combat bullying and harassment is also in their interest. Meanwhile, work itself has not become less burdensome, while job security has declined considerably, including for civil servants. The labour market is more flexible, and employers can more easily respond than in the past to reduced demand for their products or services by laying off employees (Vrooman, 2009).

Employees with mental problems and disorders pose more problems for employers than those with physical problems and disorders. The diagnosis is usually more difficult and takes longer to establish; the symptoms are often somewhat diffuse and are not always easy to distinguish from problems in and with the work; the problems are usually long-lasting; and the risk of relapse is high. Mental problems manifest themselves cognitively, affectively and relationally, and this gives rise to uncertainty and disquiet about the functioning of the employee and the interaction with their colleagues on their return to work. Will he or she be able to cope with contacts with customers, operate the same machines with the same precision as in the past and display the same reliability as in the past in carrying out instructions? There is a taboo about asking questions of this kind openly; nevertheless, and especially where the employee is still taking medication, people like to have a degree of certainty that no health care professional can give.

The person with a mental disorder at work

A person who develops a mental disorder while employed is in a totally different – and much more favourable – position than someone trying to acquire a job who already has a history of mental disorder. Securing mainstream employment is then very difficult, especially if the symptoms are clearly or apparently still present. A feeling of unease during a job interview, subtle behavioural oddities (coming just a little too physically close or avoiding eye contact just a little too often), an odd attitude or a presentation that is not entirely adequate in terms of clothing or make-up can quickly lead an interviewer to form a negative view of candidates, even without knowing anything of their history. If the interviewer is aware of that history, they are often reluctant to take the risk. Mental problems are almost by definition problems in relation to interaction and communication. In a service economy that strongly emphasizes working in relatively informal teams, this is a major obstacle to the opportunities for people with mental disorders at work. This becomes even more of a problem when unemployment is high or rising.

In practice, people with an obvious history of mental disorder are virtually absent from the mainstream labour market. The roughly 0.5% of adults with schizophrenia are in the worst position here, because they often also fail in tertiary education. People who are plagued by severe depression or anxiety and obsessions or who have a personality structure that rapidly leads to conflicts also have few opportunities. In an increasing number of cases, however, work is available for these people outside the world of mainstream employment. This may be work in a sheltered employment setting where the productivity and quality demands are less decisive or work carried out in the context of a special social security arrangement (Van Weeghel, 2002). The employer in these cases is spared most or all of the costs of employing these workers. The work they carry out is relatively simple and takes place under expert supervision. In many cases, these are forms of supervised work that are sometimes also offered to people with learning disabilities. However, a key difference is that most people

with learning disabilities are more stable and consistent in their performance than people with mental disorders.

In principle, this type of employment is relatively immune to recession, although if the government and social insurance organizations lack resources, the extent of this provision may have to be limited. Past experience has also shown that, when unemployment is high, people with learning disabilities and with mental disorders face competition from people who would never have sought or obtained a sheltered workplace in times of low unemployment. People who are more able in all respects may very well displace the original workers by competing for their positions, especially when the sheltered workplace is regarded as a special type of employment agency or production company and expected to generate the best possible financial results. This is possible partly because mental problems occur in many variants and the boundaries are diffuse. The label "mental problems" can also be used without too much difficulty in situations where using it generates more advantage than avoiding it.

After deinstitutionalization

The process of deinstitutionalization in psychiatry began half a century ago. It then became clear that people with mental disorders are among the most vulnerable groups in society; they are often alone and unable to look after themselves properly; they do not have a place on the labour market and, unlike people with learning disabilities, generally have no one to look after their interests and welfare. Living outside a psychiatric hospital requires all kinds of support and supervision. At the same time, the importance of being able to live independently has become increasingly clear. Being able to work and having a job are part of this. Work imparts structure and content to the day, makes social contacts possible and commonplace, gives people a sense of being useful and thus helps them build self-respect and pride. Life presents an even greater challenge for people with a serious physical or mental disorder than for those who are physically and mentally healthy. Their lives should not be made extra difficult, even in times that present a challenge for everyone.

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Mental health and well-being at the workplace: requirements and recommendations

The perspective of families of people with mental disorders

Gudrun Schliebener, German Federal Association of Family Caregivers of People with Mental Illness (Familien-Selbsthilfe Psychiatrie BApK e.V.), Bonn, Germany

Work or employment for people with mental disorders is a topic that their families know only too well. Nothing is more stabilizing than work, and no medicine, psychotherapy or living facility can replace it.

Work not only offers a secure livelihood but also provides self-affirmation which, in turn, leads to strengthening self-esteem. Further, work brings benefits such as long-term social contact, structured daily regimens and most importantly, a feeling of worth. Work is an important part of social integration.

Mental health problems have become one of the leading causes of absenteeism from work and early retirement all over Europe. In Germany, mental illness is now the main reason for occupational disability, causing more than 30% of cases. Today almost every third early retirement is related to mental issues.

I do not wish to speculate about what role the current economic climate and working conditions might play. It does, however, raise the question of whether excluding people with mental health problems from the job market is actually necessary or whether it makes more sense to amend the working conditions and regular workplace settings such that people with mental disorders receive the required support to enable them to return to the normal job market.

People who are more severely affected need to be provided a safe working environment; however, most people have a key role to play in today's job market even if they are less resilient than their counterparts because of illness.

Removing the existing historical prejudices that restrict employment opportunities and cause social exclusion at all levels of life is therefore imperative. Empowering vulnerable people and employees with mental health problems and informing the general public – including employers – about the specific experiences and needs of people with mental health problems are two key actions that can improve their lives.

There are many good ideas related to enhancing job opportunities for people with mental disorders. For several years, organizations in Germany have been actively engaged in work to address this problem by developing potential solutions.

Some work has already been done, and there are low-level jobs in some places, which are often also paid poorly.

Audi has supportive practices, and this large company can offer many opportunities, but most employees in Germany work for small companies without this kind of support.

The first step towards overcoming the negative effects of mental illness at the workplace would be companies starting to employ people with mental illness under the same terms as and on an equal basis with people without mental health problems. The members of the Familien-Selbsthilfe Psychiatrie BApK e.V. (Family self-help in psychiatry) already took this step in employing project staff.

I wonder which other organizations in the help system have taken this step, and I hope that we will jointly find ways to improve the conditions for people with mental illness to enable them to participate in and contribute to a productive and satisfying working life.

Challenge of modern working life to mental well-being and social inclusion

Workplace-related mental health problems – risks and prevention

Karl Kuhn, European Network for Workplace Health Promotion, Essen, Germany

The workplace is a predominant domain in an individual's working life and an ever-changing panorama to which people must adapt. In daily life and especially at work, such terms as anxiety or depression are not commonly used to describe people's personal feelings or state of mental health. More often people refer to stress: when the demands of the working environment exceed people's ability to cope with (or control) the demands. Employers should therefore implement preventive activities to optimize the fit between an individual worker and his or her psychosocial, organizational and physical working environment, to minimize adverse effects. This should be complemented by health promotion activities that aim at improving the individual's coping abilities and strengthening personal skills.

Good mental health is important, since it allows people to develop in many ways – emotionally, mentally, intellectually and socially. It also benefits the places where people live and work, leading to social development and economic growth. Good mental health reflects the interaction between individuals and their environment and such factors as biological and early childhood development, social support and self-esteem. Education, employment, income and housing also play a crucial role in maintaining good mental health.

Workplaces are diverse. They vary in size, type of activity, whether they are in the public or private sector and in the cultural traditions of the employees. Despite these differences, work remains an essential feature of most people's adult lives: it has personal, economic and social value. During recent decades, the nature of work has changed profoundly across Europe. Fewer jobs are defined by physical demands and more by mental and emotional demands.

Other changes include the centrality of computer-based information processing, part-time and flexible work, job instability and insecurity, forced mobility, forced early retirement and changes in the composition of the labour market, such as the growing proportion of women and older people (Marmot & Wilkinson, 2006; Wilkinson & Marmot, 2003). Although the strength of evidence on the relationship between workplace psychosocial risk factors and health varies, a social gradient of health according to occupation has been demonstrated for all-cause mortality, coronary heart disease, mental disorders (especially depression) and chronic bronchitis (Siegrist & Marmot, 2004). In the Whitehall II Study of civil servants in London, psychosocial characteristics accounted for about 25% of the social gradient in men and 35% in women (North et al., 1993).

There is extensive literature on the relationship between all aspects of working life and health and a growing evidence base on the importance of psychosocial factors in the workplace (Karasek & Theorell, 1990; Marmot & Bobak, 2005; Marmot & Wilkinson, 2006; Marmot et al., 1991; Siegrist et al., 2004; Stansfeld et al., 1998; Wilkinson & Marmot, 2003). Although no EU country has specific regulations on work-related stress, all countries' general legal frameworks refer to psychosocial risk factors that may cause or exacerbate work-related stress. In some countries, such as Belgium, Denmark, Germany, the Netherlands and Sweden,

the legal provisions go further than EU legislation by specifying the need for employers to act against such factors. In the United Kingdom, stress management standards are recommended, rather than mandatory, although case law has upheld addressing stress as part of the general duty of care within health and safety legislation (Health and Safety Executive, 2004).

Individual reactions to the same psychosocial exposure may vary. For example, high commitment and a high need for approval influence people's perceptions of job demand and their own coping resources (Marmot & Wilkinson, 2006; Wilkinson & Marmot, 2003). Some people can cope with high demands and high levels of psychosocial risk factors; others cannot. The subjective evaluation of the situation is always decisive for the stress reaction. This means that the situation alone cannot predict stress reactions without reference to the context, the individual and the group. However, this also applies to many other types of exposure in the working environment. Although stressors may exert effects on individuals and have specific manifestations, several factors that are common across individuals have been established as known sources and causes of stress and stress-related illness at work.

The most significant of these are:

- high demands and low control;
- lack of control and poor decision-making latitude (Stansfeld et al., 1999);
- low social support (Bildt & Michélsen, 2002);
- imbalance between effort and reward (Siegrist et al., 2004; Stansfeld et al., 1999);
- monotony (Suadicani et al., 1993);
- poor communication and information (Corey & Wolf, 1992);
- unclear or ambiguous instructions and role, unclear organizational and personal goals (Ingersoll et al., 1999; Kahn, 1973; Margolis et al., 1974);
- lack of participation (French et al., 1982);
- emotionally distressing human services work such as health care or teaching (Cox & Griffiths, 1995);
- job insecurity;
- time pressure (Jones et al. 1998; Schriber & Gutek, 1987):
- bullying (Vartia, 2001), harassment (Richman et al., 1999) and violence; and
- organizational change (Karasek & Theorell, 1990).

Social support is a modifying factor, so that high demands and low control have greater effects if workplace social support is absent. Poor social support at work predicts both mental illness and more brief periods of absenteeism (Tennant, 2001).

People with mental health problems can be divided into three groups. At any one time, one sixth to one third of the working-age population in the European Region experiences symptoms associated with mental ill health such as sleep disorders, fatigue, irritability and worry that do not meet criteria for a diagnosis of a mental disorder but can affect a person's ability to function adequately. A further group has symptoms that meet diagnostic criteria by virtue of their nature, severity and duration (depression or anxiety or a mix of both); these

would be treated if they come to the attention of a health care professional. A third group has or will have severe mental illness such as schizophrenia and bipolar disorder.

The number of enterprises across Europe setting up activities for promoting mental health and preventing mental illness has increased significantly during the past decade. The reasons include the high cost of sick leave and short-term absenteeism, growing recognition of the relationship between human capital and resources and business outcomes (Pfeffer, 1998), concerns (in some countries) about the potential legal effects of failure to tackle stress and, in practical terms, existing structures for occupational health and health and safety requirements in the workplace that facilitate the delivery of mental health promotion activities.

The European Network for Workplace Health Promotion (2007) has developed a definition for workplace health promotion. The Luxembourg Declaration on Workplace Health Promotion in the European Union (originally adopted in 1997 and last updated in 2007) is the combined effort of employers, employees and society to improve the health and well-being of people at work. This can be achieved through a combination of:

- improving the organization of work and the working environment;
- promoting active participation; and
- encouraging personal development.

The basic principles of good practice, established by the European Network for Workplace Health Promotion and reflected in the Luxembourg Declaration, include the need:

- to link workplace health with relevant enterprise policies and ensure that it becomes part of daily practice (integration);
- to involve the employees in planning, implementing and evaluating workplace health action (participation);
- to seek to improve the quality of working life and conditions and focus on the behaviour of the individual employee (a balanced approach); and
- to ensure that any action is based on an analysis of the health requirements and needs of the various stakeholders within enterprises and is part of continual improvement (need-based).

These principles also apply to mental health promotion at work, but this is often not declared explicitly enough. Interventions targeting psychosocial issues in the workplace can be divided into three categories: increasing individual resources to cope with or tackle stress; improving relationships, social support, the fit between the person and the environment or autonomy, such as decision-making latitude and, at the organizational level, changes in the organizational culture, structure and physical and environmental factors. For example, preventive interventions to reduce violence might include training, the organization of work and the design of the workplace.

An analysis of good practice in mental health promotion in European countries (Berkels et al., 2004) suggests that, although approaches vary considerably, projects can be broadly classified according to the level of intervention:

- individual level: for example, improving coping skills to prevent stress and burnout and empowerment to be able to manage transition periods and interpersonal relationships;

- social environment: creating social supportive structures (corporate culture) and developing policies against bullying and moral harassment; and
- working conditions: for example, reducing risk factors, the design of workplaces and the organization of work, including supportive structures for women combining work and child care.

In 1989, EU directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work set a framework for a holistic approach to health at work, considering both mental and physical well-being as part of preventive occupational health and safety. EU legislation on health and safety at work is significant because it directly affects working conditions within all EU countries and influences practice in candidate EU countries. In this context, many individually oriented, organizationally oriented and other context-oriented approaches are available.

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Preventing mental health problems at workplaces in Poland

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Mental well-being at work is an idea that still lacks a proper and clear definition. Many documents reflect the complexity of this concept, which usually views stress and the risk of occupational burnout as the typical results of poor mental working conditions. Some professions are more vulnerable than others. It is true, as the research in many countries shows, that professionals such as lawyers, social workers, teachers or secretaries have a higher risk of depression, and workers in health services and farmers have a higher risk of suicide. One tends to focus on the "dark side of the moon", sometimes forgetting that work could and should be a source of personal growth and satisfaction. Experts working on the European Pact for Mental Health and Well-being (European Commission, 2008) state that the workplace can provide a healthy culture and environment that is psychologically supportive to the workforce. It also helps to promote the social inclusion of people with mental health problems, providing an income allowing them to more fully participate in society (McDaid, 2008).

On the other hand, mental health influences the quality of work performance. Poor mental health, especially depression, results in higher absenteeism rates, lower productivity and problems with making decisions. In some extreme cases, a mental condition could be dangerous for co-workers and/or clients. But more and more often a new issue is being discussed – inefficient work called presenteeism. This phenomenon is frequently caused by mental health problems ignited by poor management, poor leadership, poor job control, lack of social support and many other factors.

Health promotion, if carried out in the workplace according to the rules outlined in the Luxembourg Declaration on Workplace Health Promotion in the European Union (European Network for Workplace Health Promotion, 2007), can be a tool for creating mental well-being, even though the main topic for intervention might be far from mental health issues. This is because, according to the Declaration, the basic rules for workplace health promotion include: improving the organization of work and the working environment, promoting active participation and encouraging personal development, all of which are crucial for good mental health.

Mental health promotion has been present in the activities of the National Centre for Workplace Health Promotion from the time it was founded in the mid-1990s. The Centre is trying to monitor what is going on in the companies in that regard but also to create guidelines and tools to make the development of projects aimed at mental well-being at work more effective and easy to implement. It has prepared a series of step-by-step manuals dedicated to organizing workplace health promotion projects in companies, including one on stress issues developed in 1998 useful for managers and occupational health specialists.

The National Network for Workplace Health Promotion was created to reach companies with that valuable expertise. It works based on regional occupational medicine stations. From the beginning its main goal was to support employers in implementing workplace health promotion projects, including mental health. Since 2002, the formula has been broadened to include all the potential stakeholders in the process of disseminating and implementing workplace health promotion. Local coalitions for workplace health promotion were therefore established in several regions. The general idea is to collect resources and expertise available in the region and to create synergy between the actions of the various actors (employers, trade

unions, local mass media, local health services providers, insurance companies, sanitary inspection, labour inspection, occupational medicine specialists and local authorities). This enables a basic structure of the workplace health promotion project with a set of possible solutions to the specific problems to be developed. From that set, each participating company may choose the activities that are most suitable and needed by the employees but also those that are in accordance with the company policy and possibilities.

This is especially beneficial for the small and medium-sized companies that cannot afford to launch their own projects. The Centre is disseminating such a model of cooperation to make it standard in every region and to encourage coalitions to launch integrated projects on the mental health issues within the local framework for action.

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Managing mental health at BT

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Introduction

BT Group plc has been in business for about 100 years. It is now a truly international communication business in one of the world's most competitive sectors. BT provides communication solutions and services including: networked information technology services; local, national and international telecommunication services; higher-value broadband and Internet products and services; and converged fixed and mobile products and services. BT Group plc has six main lines of business, with more than 100 000 employees operating in 170 countries. BT's workforce is global, diverse and predominantly male (about 75%), and many have long service and are therefore ageing and continue to face changing work demands. All this presents a range of challenges related to health and well-being.

Challenges and business drivers

Organizations are facing several challenges related the health and well-being of their employees. The requirement for lean, customer-focused agile organizations has led to organizational restructuring and downsizing. The increasing use of new technologies provides new opportunities as well as potentially new hazards. Workforce demographics are changing, most notably in terms of age. The proportion of people 50–64 years old in the EU workforce (35%) will be twice that of people younger than 25 years (17%) by 2025. If older workers become unemployed, they take longer to return to work and are more likely to leave the labour force for good. The general population health risk profile has been changing, with increasing numbers of people who are overweight or obese and a rising incidence of certain chronic health conditions such as type 2 diabetes. Non-work-related illnesses, such as depression and respiratory ailments, which are prevalent in the working population, are inadequately recognized and therefore undertreated, with significant effects on work performance.

BT considers that a range of business drivers act in health and well-being, especially in relation to mental health. First and foremost, helping to improve the health and well-being of employees is the right thing to do. It will enhance their engagement with the company and help to position BT in the rapidly evolving health care market. It further establishes BT's corporate social responsibility credentials and reduces the costs of absenteeism and presenteeism. A policy paper (Sainsbury Centre for Mental Health, 2007) estimated the quantifiable costs falling on employers because of mental health problems in the United Kingdom workforce to be £1035 per year per employee. This is equivalent to 3.6% of the national pay bill. Presenteeism is reckoned to be the largest single element of cost. Better management of mental health problems at work clearly has the potential to save costs. There are therefore benefits for people, society and the business.

BT's strategic approach

Health and well-being activities are part of the BT People Strategy, especially theme 5: "Creating a healthy and diverse environment where excellence prospers". The Strategy emphasizes altering attitudes and behaviour, moving people from a dependence to an interdependence mindset in which personal and collective responsibility is the norm. Alongside this, effort is focused more on primary engagement activities – disease prevention and health promotion – than on tertiary resolution.

Primary engagement

To prevent and reduce risks to health and well-being, BT developed Work Fit as a rolling health promotion programme that encourages BT employees to take personal responsibility for their health. The focus is on promoting good health, preventing ill health, minimizing risk, identifying any problems at an early stage and providing support. The Work Fit campaigns to date have covered cardiovascular health, smoking cessation, cancer, diabetes and mental health (Positive Mentality).

Positive Mentality, run in conjunction with the trade unions, the Sainsbury Centre for Mental Health and Mind (a mental health nongovernmental organization) from October 2006 to February 2007, was a large campaign focusing on mental health. The aims were:

- to educate based on evidence and dispel myths;
- to concentrate on common mental health problems;
- to provide practical tools for people and managers;
- to keep mental health mainstream: that is, beware of "experts";
- to address stigma through multi-channel communication;
- to maintain a business focus at all times; and
- to raise awareness, tackle stigma and promote mental well-being.

Content, based on the World Mental Health Day 10 positive steps, was delivered in a programme with 8 modules over 16 weeks delivered through BT's online newspaper.

A three-month follow-up online survey found that, of those who had accessed the material, 68% learned new strategies to promote their mental health, 56% had initiated actions and were maintaining them and 51% of these had noticed positive outcomes as a result. The campaign also encouraged people to seek out other existing materials available through BT. The campaign succeeded due to several factors:

- keeping the key messages consistent and repeating them regularly;
- working with experts and in partnership;
- actively promoting engagement and capitalizing on BT technology to communicate and market;
- keeping it simple to understand and use; and
- monitoring impact and using the lessons learned to improve the next campaign.

Other key areas of focus in relation to promoting good mental health and preventing ill health are: creating good workplaces (good leadership, undertaking health and safety risk assessments, promoting physical activity and healthy eating, break areas, good facilities and good environment) and good jobs (safe, secure, fair pay, fulfilling, developing, accommodating, supporting, control, autonomy, satisfaction and communication); developing excellent leaders and supportive and competent managers; and education and training in mental health and for the job.

Secondary intervention

Secondary intervention is a continual process of maximizing support, building resilience and enhancing coping, identifying and addressing issues early and action planning. Examples of programme at this level include:

- STREAM – BT's online stress risk assessment tool available to BT employees on a voluntary basis with feedback to the individual and line manager for action;
- STRIDE – BT's computer-based training of line managers on stress and how to deal with a STREAM report; and
- a Health and Well-being Passport, designed to help people who have a long-term health problem that could affect their ability to work effectively, either now or in the future, that focuses on what they can do rather than what they cannot, and is agreed while they are at work and in their normal state of health so that it can be implemented quickly if and when they become unwell.

Tertiary resolution

The aim is to provide a stepped-care suite of proportionate interventions for identified mental health and well-being issues. Resources include:

- Open Minds: Head First – a purpose-designed booklet on the management of mental health issues at work available to all BT employees and to line managers;
- Mental Health First Aid training courses – developed for line managers to increase their awareness, build their confidence, enhance their skills and improve signposting in relation to mental health issues;
- guided self-help on the intranet – a range of recommended books taking a cognitive behavioural therapy approach to the self-management of common mental health problems;
- Employee Assistance Service – personal counselling and advice is available via BT's Employee Assistance Programme and for managers and Human Resources via the management consultancy service; and
- cognitive behavioural therapy – trials are underway of cognitive behavioural therapy delivered by telephone and online.

The focus is on maintaining people at work, returning people to work as soon as appropriate or helping people move on with dignity.

Effects of the mental health approach

BT's integrated long-term approach has produced significant results. The sickness absence rate due to mental health problems fell by 30% in four years despite pressured market conditions. Further, almost 80% of people off for more than six months with mental illness were brought back into their own jobs versus 30% five years previously and about 20% nationally.

Conclusion

Employers have a role to play in managing mental health at work. They have access to a large segment of the population who spend significant time at work and can be reached repeatedly

at low cost. Taking action to prevent ill health and promote good health is a reason for business success – not an effect of success.

Recommendations

The following are recommended.

- Incorporate well-being generally and mental health in particular into the business strategy.
- Take an integrated long-term approach.
- Be innovative in health promotion activities.

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Meeting the challenge of integration and empowerment at the workplace

Employment integration: the role of associations of people with mental illness and their families in Spain

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Available research estimates that between 60% and 90% of people with mental illness in Spain are unemployed and that the prevalence of mental disorders among unemployed people is twice the prevalence of employed people (Gómez Beneyto et al., 2007). In particular, a survey on disability in 2003 showed that only 15% of people with mental illness were working at the time or had worked previously (Orihuela Villameriel et al., 2003). Employment obtained was usually temporary and mostly unskilled labour. Of the people surveyed with a disability due to mental illness, 32% said that they are willing to do any kind of work as long as they could have a job.

These are some of the facts revealing the problems and personal and structural discrimination suffered by people with mental illness in their integration and maintenance in employment, which leads to difficulty in enjoying their full citizenship and too often to social exclusion (Mental Health Europe, 2008).

In this context, the Spanish Confederation of Associations of Families and People with Mental Illness (FEAFES), its member associations and other public and private institutions operate various initiatives aimed at addressing some of the main challenges identified:

- quotas for hiring people with disability due to a mental illness are not always respected:
- programmes for employment integration are not sufficient;
- people with mental illness, and especially those with the most severe disorders, benefit far less than people with other types of disabilities from specific measures available for promoting the employment of people with disabilities (Orihuela Villameriel et al., 2003);
- difficulty in making benefits, income and work compatible;
- the stigma attached to mental illness;
- lack of information on the services available and people's rights; and
- lack of participation.

Associations of families and people with mental illness play an important role in planning, delivering, reviewing and supervising mental health activities, as recognized in key documents of WHO and the EU. The Mental Health Declaration for Europe and Mental Health Action Plan for Europe (WHO Regional Office for Europe, 2005a, b), the European Pact for Mental Health and Well-being (European Commission, 2008) and the European Parliament resolution of 19 February 2009 on mental health should be highlighted together with the Strategy for Mental Health of Spain's National Health System (Gómez Beneyto et al., 2007).

According to its mission, which is to improve the quality of life of people with mental illness and their families and advocate their rights and the representation of the movement of associations, FEAFES articulates its action over three axes: advocacy, awareness-raising and providing services.

FEAFES action related to advocacy includes lobbying for including strategically relevant issues in policies, plans and laws at the local, subnational, national and European levels by participating in partnerships, appointments or open consultations. Further, legal advice is understood as a basic service for protecting rights of people with mental illness and their families.

To raise awareness, FEAFES also develops action for fighting stigma targeting the general population through activities such as those around World Mental Health Day and by providing a style guide for journalists. Member organizations, such as FEAFES Castilla y León, also develop specific sensitization campaigns targeting employers.

Many of Spain's associations provide some of the following services and programmes, usually within comprehensive rehabilitation programmes:

- vocational orientation and training;
- work with community environments such as families and friends;
- skills training, such as FSC Inserta, which has programmes funded by the European Social Fund with 304 participants in 2008;
- job search and mediation services, such as the Employment Observatory of Galicia managed by FEAFES Galicia in partnership with the public employment services, with 866 users;
- support in employment (new employment and support for maintaining employment), such as the employment rehabilitation programme of FEAFES Cáceres and the Associations of Families and People with Mental Illness of Alto Vinalopó (AFEPVI) and the joint programme of the Institute on Community Integration (INICO) of the University of Salamanca and Caja Madrid; and
- protected employment: special employment centres and social companies, such as the users' associations of the Association for the Social Inclusion of Mentally Ill People (AEMIS) or families' associations of Associació DAU.

The associations of people with mental illness are therefore working strongly to address various challenges and have shown positive outcomes. As reported by Wallerstein (2006), empowerment has shown effectiveness in improving health outcomes in the mental, organizational, community and policy dimensions. Further empowerment strategies should therefore be explored and implemented to enhance outcomes on employment integration.

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The "IN-VALID-IN" Project: integrating and reintegrating people with disabilities into the labour market

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Project purpose

The purpose of the IN-VALID-IN project was to integrate two key actors in the employment of people with disabilities: people with disabilities and employers.

The project started in 2004 inSlovenia and was successfully completed in 2007. The activities of the development partnership corresponded to the goals and priority tasks of pillar 1a of the EU's EQUAL initiative: employability – to ease access to the labour market for those who are having problems entering and returning to the labour market. The project was conducted by four national partners (the Maribor Regional Chamber of Commerce and Industry of Slovenia, the Maribor Regional Office of the Employment Service of Slovenia, the Regional Organization of Podravje of the Independent Trade Union Association and Ozara Ltd Service and Disability Company) and five transnational partners (Austria, Czech Republic, Ireland, Italy and Poland).

Objectives

The objectives of the development partnership IN-VALID-IN were:

- to establish a stationary and mobile information unit covering the region of Maribor and its surroundings to provide information to employers and individuals;
- to create a base of at least 30 employers and 40 interested people with disabilities with the purpose of promoting at least 5 positive examples of employed people with disabilities;
- to acquire adequate international experience and skills for implementing the responsibilities of a job coach for people with disabilities and to evaluate these experiences;
- to re-evaluate and promote national and international experience in employing people with disabilities through transnational activities within a partnership;
- to evaluate the activity based on key project figures and to appropriately promote the project.

Target groups

The target groups of the development partnership IN-VALID-IN were people with disabilities and employers.

Achieved results

Establishing a stationary and mobile information unit available to people with disabilities and employers

These two information units provide instant advisory service and orientation and facilitate the decisions of the people with disabilities or employers to approach an institution, whereas before this it was uncertain whether they would be able to obtain the needed information, how they would be accepted and how many contacts would be needed to solve a certain problem or difficulty. The two information units provide sufficient information, integrate institutions

and provide access to everyone, regardless of their disability. They are adapted to the needs of disabled people, facilitating access to the labour market and providing other associated mechanisms for promoting the continuity of employment, alleviating social exclusion and encouraging integration in the workplace.

The information units still support the employers in discerning their needs, regardless of whether these needs are related to new legal opportunities, adapting job advertisements to the needs of people with disabilities, creating new posts for people with disabilities or solving difficulties associated with redeployment or acquiring the status of a social enterprise.

Creating a base of employers and interested people with disabilities to promote positive examples
The project assessed the needs of employers and of people with disabilities regarding employment. The research was aimed at:

- determining the basic needs of the employers regarding information about measures, incentives and forms of employment, the legal provisions and the consequences of employing people with disabilities; and
- determining the level of knowledge about this matter, the viewpoints and gathering proposals for improving the situation.

It also created a database of employers and of people with disabilities to find 10 positive examples of employment.

Acquiring international experience and skills for implementing a job coach for people with disabilities
In December 2006, the project group joined the national working group of the Development Centre for Employment Rehabilitation at the Institute for Rehabilitation, charged with developing the knowledge standards of practitioners in the domain of sheltered work with the purpose of creating the professional profile of a job coach.

The profile of a job coach has been developed at the national level and will become, by accreditation, a permanent service of the development partnership IN-VALID-IN.

Re-evaluating and promoting national and international experience in employing people with disabilities through transnational activities
In cooperation with transnational partners, the project group acquired the international experience and knowledge of the professional profile of a job coach and held an international conference and workshop with the purpose of exchanging experiences and promoting examples of good practice.

Evaluating the activity based on key project figures and appropriately promoting the project
The evaluation was performed monthly, and the results and corrections were applied at the meetings of the national partners. An external institution also carried out evaluation at the end of the project.

IN-VALID-IN provides information to employers, to people with disabilities and to the interested general public quickly and in an appropriate manner with the collaboration of the external partners (such as the Slovenian Pension and Disability Insurance Institute and the Association of Social Work Centres) and the national partners (Chamber of Commerce and

Industry and Association of Free Trade Unions of Slovenia). The development partnership IN-VALID-IN Internet forum is providing connections to appropriate sites and contacts related to employing people with disabilities. The information units were designed to operate even after the project ended.

Coordinator and partners

The project coordinator is OZARA Ltd. Service and Disability Company, Slovenia. The transnational partners are:

- Austria: RoomyCompany.at;
- Czech Republic: PENTACOM-labour office-training-vocational rehabilitation-target groups-employers;
- Italy: Fattoria Didattica di Sviluppo e Inclusione Sociale per giovani disabil (FADIESIS);
- Ireland: Carlow EQUAL Employment Programme; and
- Poland: Związkowa Promocja i Ochrona Równouprawnienia Osób Niepełnosprawnych w Zatrud.

Pathways for integration into working life: Integrationsmanagement Bergedorf – office for counselling and job search in a regional network

Heidrun Thiel, Alsterarbeit, Hamburg, Germany

Alsterarbeit offers work and qualification for people with disabilities in every district of Hamburg at 12 different sites. It cooperates with firms to bring people with disabilities into the main labour market. Thus, 220 of 1200 clients work in external structures with appropriate activities for each individual client. Besides the framework of sheltered workshops, alsterarbeit runs two social firms to offer regular employment for people who are almost able to work in the main labour market. Alsterarbeit participates in four regional networks, where people with disabilities, also because of mental illness, can receive independent and non-binding counselling and help in searching for jobs. One of these is the network in Hamburg-Bergedorf.

Ms A.

Ms A. is 43 years old and has found her way back into working life. For the past three years, she has been employed at a supermarket in a suburb of Hamburg. She lives with her daughter and a partner. In the past she had vocational training as a sales assistant. For several years she suffered from anxieties and panic connected to an addiction problem. She got therapeutic treatment and social support from the youth welfare office. During that time she was unemployed. In 2004 and 2005 she received counselling and support from Integrationsmanagement Bergedorf (IMB). The IMB found an internship at the supermarket for three months. After that, the employer was convinced of her competence and decided to give her regular employment, with a grant-subsidized wage at the beginning.

The network office

Ms A. and many others would not be working in the primary labour market without the IMB network office. This means:

- independent consultancy service for people with disabilities – mental or physical – close to their residence, without application forms and entitlements;
- individual assessment, rehabilitation planning and work experience;
- coordinating reference person;
- long-term assistance; and
- cooperation of several institutions in a network.

Partners of the regional network?

In 2003, four institutions agreed to cooperate and to give financial support: the association Bergedorfer Impuls e.V., which aims to create jobs for mentally ill people, the social firm Bergedorfer Impuls gGmbH, alsterarbeit gGmbH, which runs sheltered workshops and offers other work and qualification opportunities for people with disabilities, and the association Der Begleiter e.V., which gives social and therapeutic support to mentally ill people. The IMB network office cooperates with hospitals, public administration, the employment office, the public pension fund and especially with enterprises and other employers to find workplaces for the clients.

Why do these institutions need to cooperate?

Germany's support system is divided into several fields. Institutions offer measures in a few fields to the corresponding group of entitled people.

People who are not able to work more than three hours a day in the primary labour market are offered day-care centres (long-term) and sheltered workshops (long-term).

People who can work for more than three hours a day in the primary labour market are offered:

- the secondary labour market: work opportunities in the non-profit sector for long-term unemployed people (10 months);
- rehabilitation training measures for people with disabilities (10–12 months);
- social firms: regular employment (temporary or permanent); and
- services for job search and placement.

People with mental disorders rarely fit into these categories

Many people with mental disorders have a good school or university education. Sometimes they have many years of professional experience. Many have failed in professional life and now have impaired work performance. Many have been unemployed and discouraged for a long time. They cannot assess their skills and are not aware of the opportunities on the labour market. They do not know where and how to find support, which institution is responsible and how to start and follow up applications.

Individual assistance

The IMB offers:

- introductory counselling and job history;
- assessment and job search assistance;
- conversation groups for exchanging experiences and training communicative skills;
- training concentration and memory;
- testing basic capabilities;
- work experience in enterprises;
- using the Internet café for job research; and
- support for finding therapy places or mobile care services for assisted living.

Places of integration

Many clients have been placed in the primary labour market, such as an industrial metal processing company, retail trade (flowers, food and pet care), physician, dentist, hospital, fitness centre, garden of butterflies, kindergarten, day care and residential home for older people, public administration, public parks and cemeteries.

Conclusion

The existing measures in Germany's support system can provide pathways of integration into the labour market. In the sheltered framework of re-employment, this includes external working places and external vocational training at sheltered workshops and virtual sheltered workshops. In the primary labour market, this includes regular employment, regular wages or salaries at social firms, supported employment in enterprises and a personal budget for work.

People with mental illness should use these services flexibly, with individual assistance and the means of counselling, assessment and individually focused rehabilitation planning and job placement.

Overcoming stigma and discrimination at the workplace

Stigma and discrimination – overcoming the barriers to employment

Bob Grove, Sainsbury Centre for Mental Health, London, United Kingdom

Mental illness is often assumed to be primarily a medical problem, and successfully treating the symptoms is considered the main barrier to resuming normal activities such as returning to work. Research (Thornicroft, 2006) suggests otherwise. A thorough review of the worldwide evidence on discrimination against people with mental illness and large numbers of interviews with people who have experienced it have led Thornicroft to describe the problem as "structural discrimination" and to liken it to "institutional racism" – the term used in the MacPherson (1999) Inquiry to describe the behaviour of the Metropolitan Police towards young black men. Thornicroft (2006) describes a process that, although sometimes made worse by mass-media reporting, in fact pervades daily life and is often experienced in mundane interactions even with friends, family, colleagues, employers and other people. I argue that, for most people, especially those with common mental health problems such as anxiety and depression, the social reaction to the illness is far harder to recover from than the symptoms themselves.

Thus, for return to normal activities, mental ill health should be conceptualized as a social problem with medical aspects rather than the other way around. As such, I agree with Layard (2005) that mental ill health is "Britain's biggest social problem". However, unlike Layard, I do not believe that improved access to psychological therapy – welcome as this is – will inherently improve peoples' ability to remain in work or return to work after sickness absence or job loss. I argue that, unless the behaviour of managers and colleagues and indeed the whole fabric of relationships in the workplace are broadly conducive to helping people resume and maintain normal functioning, the chances of their survival will be greatly reduced, bringing with it the spectre of job loss and disastrous long-term consequences, both for the individual and the United Kingdom (Waddell & Burton, 2006).

Thornicroft (2006) describes stigma as an overarching term that contains three elements: problems of knowledge (ignorance) and problems of attitudes (prejudice) leading to problems of behaviour (discrimination).

His thesis is that simply tackling ignorance and trying to influence attitudes without tackling behaviour is likely to be ineffective. The final section of this chapter suggests some simple ways to change some aspects of workplace behaviour.

Evidence on stigma and discrimination

Stigma and discrimination in the workplace have several dimensions. They are best documented and perhaps most visible in the sheer difficulty people with significant mental health problems experience in getting jobs. Although 70–90% of people with significant mental illness say they would like to work (Rogers et al., 1991; Secker et al., 2001) the numbers in employment are very low – among the lowest of all people with disabilities. Only 9% of people with a probable psychotic disorder are in full-time work, with a further 19% working part time (Meltzer et al., 2002). In 2008, only 22% of those responding to the Healthcare Commission (2008) survey of people using secondary mental health services said

they were in paid work or full-time education. Even those in work appear to be treated worse than their colleagues without disabilities. Among workers with mental illness, the earnings of those who did not perceive stigma were 85% of those of their colleagues without disabilities versus 72% among those who did report stigma (Baldwin & Marcus, 2006).

Discrimination reported in the recruitment process is common in countries worldwide. In one survey in the United States, 61% of the 1301 respondents felt they had sometimes, often or very often been turned down for a job for which they are qualified when it was revealed that they use mental health services (Wahl, 1999). In the United Kingdom, 56% of 411 respondents believed they had definitely or possibly been turned down for a job in the past because of mental health problems (Mental Health Foundation, 2002). In New Zealand, 34% of a sample said that they had been discriminated against while seeking a job (Peterson et al., 2007).

One study in the United Kingdom (Glozier, 1998) set out to test employer treatment of applications by people who acknowledged a history of mental ill health. Vignettes of applicants that were identical except for either having a diagnosis of depression or diabetes were submitted to 200 human resources staff in the United Kingdom. Mention of the depression significantly reduced the chance of recommending employment compared with a history of diabetes (Glozier, 1998). In a government survey in the United Kingdom, fewer than 40% of employers said that they would consider employing a person with a history of mental health problems versus 60% for people with a physical disability and about 80% for long-term unemployed people and lone parents (Department for Work and Pensions, 2001).

Thornicroft's own research with service users highlights the problem of anticipated discrimination. In the International Study of Discrimination and Stigma Outcomes (INDIGO) of global patterns of experienced and anticipated discrimination against people with schizophrenia, 29% experienced negative discrimination in finding a job, 64% experienced negative anticipated discrimination in applying for work training or education and 72% felt the need to conceal their diagnosis (Thornicroft et al., 2009).

Is this caution justified? Surveys of employers indicate that employers not only are most reluctant to recruit people who acknowledge a history of mental health problems but also seem to be in denial about the extent of mental ill health among their own current employees. At any one time, one worker in six experiences depression, anxiety or problems relating to stress (Singleton et al., 2001).

However in a survey of employers by the Shaw Trust (2006) in the United Kingdom, 45% of those who responded believed that none of their current employees will have a mental illness at any point during their working life and 89% believed that they did not have anyone with a diagnosis of mental illness working in their organization. For their views on disclosure, 80% believed that "potential employees should disclose mental health problems prior to recruitment". However, when respondents were asked "Would you employ someone with mental health problems?", only 37% reported that they would (versus 62% for physical disability).

In short, people who have mental health problems face a Catch 22 when applying for jobs. Employers want potential employees to disclose but may not hire them if they do. Employees therefore do not want to disclose due to fear of not being hired or being treated unfairly in the workplace but acknowledge that they may be better able to fulfil the job requirements if they

could ask for the necessary reasonable accommodations. The International Study of Discrimination and Stigma Outcomes in Mental Health (INDIGO) (Thornicroft et al., 2009), however, found that little regret about disclosure was reported when employees feel supported and comfortable in disclosing.

Thus, evidence indicates that:

- stigma and discrimination at work are relatively common and disabling;
- this is associated with lower pay rates, promotion prospects and full-time work rates;
- people with mental health problems experience high levels of anticipated discrimination and thus work avoidance;
- there are low rates of disclosure of current or previous mental illness; and
- employers have low levels of knowledge about mental illness.

Both external (employer) and internal (employee) changes are therefore likely to be necessary to increase levels of work access and retention. Depressingly, however, Thornicroft (2006) found little research evidence on changing employer or employee knowledge, attitudes or behaviour.

In the United Kingdom, there are currently several anti-stigma and discrimination campaigns aimed at changing public knowledge and perceptions. See Me in Scotland and SHIFT and Time to Change in England are based on successful programmes in Australia and New Zealand, and all have workplace elements. However, as Thornicroft (2006) demonstrates, such campaigns seem to have little direct effect on behaviour. An example of a more direct method is lobbying by Rethink, the Employers Forum on Disability and other third-sector organizations to eliminate the discriminatory use of pre-employment questionnaires – widely perceived as used to weed out potentially difficult employees, especially in the public sector. This has some support from among the occupational health professionals who administer these questionnaires, many of whom have long been sceptical of their value.

The business case for change

Another approach may be to look at ways of helping employers to recognize the extent and cost of mental ill health within their own workforces and help them to do something constructive about it. The Sainsbury Centre for Mental Health (2007) has shown that, whether or not employers recognize it, a combination of sickness absence, reduced productivity and staff turnover as a result of mental ill health cost each employer in the United Kingdom slightly more than £1000 per employee per year. The largest part of the cost is in reduced productivity or presenteeism, and the Sainsbury Centre argues, based on case studies from large employers, that relatively simple changes can mitigate up to 30% of these losses.

These enlightened employers have recognized the business case for doing things differently: with mental disorders having such high incidence and prevalence, eliminating employees with mental health conditions from the workforce is impossible. Enlightened employers have therefore concentrated on making an early and helpful response to the first signs of mental ill health, using adjustments that keep people in work while they recover and active rehabilitation for those who do not recover as expected. These principles are enshrined in company-wide policies that recognize that mental ill health is normal and that many members of their workforce will therefore inevitably need help at times. They have programmes to

improve staff knowledge, train managers in what to do and say when employees show signs of distress and provide expert help for those who need it.

An example is the series of Workfit online programmes developed by BT to improve the capacity of the workforce to manage their own health and to signpost employees to the range of help and support the company offers (the mental health part of the programme was called Thinkfit). Another is a brief line manager training course on how to respond to employees and/or colleagues showing signs of mental distress, which is currently being piloted by the Sainsbury Centre with a number of large employers, including Rolls Royce and Royal Mail. This manualized course was devised and run under licence from Beyond Blue – the Australian national anti-depression programme.

These practical steps can profoundly affect the culture because people can ask for help without fearing losing their jobs or their prospects of promotion. South West London & St George's Mental Health Trust, which operates an extensive programme to recruit and support employees with experience of using mental health services, has increased the numbers of new employees prepared to acknowledge a history of mental ill health to 23% in 2008. At BT, 75% of employees who are off work for more than six months return to their old jobs (Wilson, 2007). Such changes begin with changing what people do and thereby change expectations about what should happen. An employer who is managing the mental health of the workforce in this way will be much less fearful of recruiting people who admit to having experienced mental ill health. BT has changed its whole recruitment process to reduce unintended discrimination against people who have had gaps in their employment record due to ill health.

Stigma and discrimination in real life – a story for our times[1]

Alison Brown was in her thirties with two small children. She enjoyed her work in the office of a large firm of solicitors and was good at it. However, after her second pregnancy she was very depressed for quite a while, eventually making it back to work part time.

Coming back to work was hard – colleagues were superficially sympathetic but actually resented the extra workload created by Alison's extended maternity leave. There were a few humorous references to "ladies of leisure", which Alison hated though she smiled and tried to work extra hard to get back into her colleagues' good books.

Her manager was also less than helpful. He was very preoccupied and unthinkingly gave Alison work that required tight deadlines at points when she could not arrange additional child care. Meanwhile, her marriage was under stress. Her husband was also in line for promotion and, although he appreciated Alison's determination to work and to contribute to family income, he also wanted the house to be clean, meals to be on the table and the children not needing his undivided attention when he returned from work.

Alison became very withdrawn at work, bursting into tears for no obvious reason and saying a perfunctory "I'm OK" when colleagues tentatively asked whether anything was wrong. Resentment started to creep in when Alison had not finished work and other colleagues had to do it instead.

[1] This story comes from interviews with clients of a job retention service in Bristol, United Kingdom conducted in 2002 (Thomas et al., 2003). The name has been changed and certain details altered to preserve anonymity.

Eventually Alison snapped and, saying what sounded like "I can't take any more", walked out of the office, leaving colleagues not sure whether they should feel sorry for her, guilty for having pushed her to this point or angry with her for putting them in this position.

The next day her manager received a doctor's certificate for four weeks, saying simply that Alison was unfit for work due to "stress". During the four weeks, no one from work contacted her. Her colleagues thought about it but decided not to say anything in case it made her worse. Alison thought that they were angry with her or else did not care whether she came back or not. She took the pills the doctor gave her, which took the edge off her depression eventually, but did not improve things much at home.

Her husband was alternately overprotective, blaming her work and the general practitioner for her continuing depression, or offering her advice on how he coped with low moods by pulling himself together and playing squash.

Alison went back to her general practitioner after four weeks and, when he had established that she did not feel much better even though the pills were helping a bit, he signed her off for another month.

At work the matter had been passed on to the human resources manager. Feeling under pressure from Alison's manager, who was also passing on the rising discontent among colleagues, the human resources manager sent a letter to Jane asking for a meeting and saying that they wanted a doctor's report. The tone of the letter was formal and used all the right words, but Alison could not help seeing it as a veiled threat. This was confirmed in her mind when she showed it to her husband, who immediately got angry and said she would be better off not working for a firm who treated ill people like that.

Alison agreed to her employer asking for a doctor's report. When it came, it said that Alison was suffering from depression, which was being treated but not when he thought she might be well enough to return to work. The human resources department took legal advice, which was that Alison might be eligible for protection under the Disability Discrimination Act because of her postnatal depression but that her position was marginal and they should follow a formal procedure to establish the likelihood of her returning to work.

When Alison received the letter asking her to attend a meeting with her manager, the human resources manager and a senior partner, her husband went into protective overdrive and said she was not going to face a lynch mob like that and she ought to resign. Jane could not face both her husband's rage and the pressure of what felt like a court hearing with her in the dock and sent in her resignation. Her former colleagues did not send a leaving card.

What could have been done differently?

Things could have been done to change the downward spiral at many points in Alison's journey to unemployment. Had they felt more confident (or been better trained), her manager or colleagues could have picked up on her depression and signposted her to help without making her feel hopelessly inadequate. The firm of solicitors could have had a mental health policy that clearly stated that employees would get the help they needed and perhaps even access to a counselling service. Her general practitioner could have explained to her employer that she would recover and to Alison that she should be thinking about going back to work at least part time to keep her hand in. Her manager and colleagues could have kept in touch –

letting her know that she was still one of the team and that they expected she would come back when she was ready. When she was feeling up to it, her employer could have invited her to consider a gradual return to work and adjusted her hours or working conditions to make that more possible. The employer would also have conveyed to colleagues that it was really important that Alison be given the support and space to get back into her routine and that their efforts to support and cover for her were appreciated. As it was, Alison was left feeling an unwanted failure, her confidence gone and her prospects damaged. Her employer and colleagues, on the other hand, were probably left uncomfortably wondering whether they were to blame, relieved that a problem had gone away and very probably feeling that they would try to avoid employees with any suggestion of mental ill health in the future.

Stigma and discrimination have their roots in this toxic soil of ignorance, fear and guilt. No one intentionally behaved poorly, but Alison's illness had set in motion a chain of events that led to an entirely avoidable breakdown in human relationships, making it impossible for her to return to her old job despite having recovered in the medical sense.

Conclusion

Stigma and discrimination must be tackled at all levels in the workplace and beyond. Good policies and procedures are important, but unless managers and employees are helped to have the skills and confidence to maintain their relationships with the person in distress and to manage mundane interactions in an informed and supportive way, return to work and full productivity may be impossible even when the symptoms of the illness have gone away.

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Overcoming stigma and discrimination at the workplace

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The German Federal Association of Family Caregivers of People with Mental Illness (Familien-Selbsthilfe Psychiatrie BApK e.V.) noticed in 2002 that it started to get more enquiries from companies with employees who supposedly had mental disorders. The executives and colleagues did not know how to deal with these problems and did not know much about mental health problems in general and what the consequences may be at the workplace. It turned out that mental illness was strongly stigmatized in all working processes and that only a few staff members dared to talk about it at work. The companies showed interest in getting support from us.

Dealing with employees with a mental illness requires knowledge and competence. Executives often need support in this special issue. To offer employers the much-needed assistance, the BKK Bundesverband (Germany's national association of company health insurance funds) and the Familien-Selbsthilfe Psychiatrie BApK e.V. initiated a project called "Mentally ill at work. What now?"

The idea was to bring our competence as relatives to the companies and share our knowledge with executives or claims adjusters who work in the health departments of the companies.

Why are relatives of people with mental illness implementing this project? Relatives and the affected people themselves have long-term expert knowledge along all phases of the disease. They are very authentic and they give information from layperson to layperson. So the information is "closer" to the people and may be more easily accepted – perhaps a good means to avoid and reduce the stigma attached to mental illness.

The aims of the project were to provide basic information about mental disorders to companies, remove the taboos connected with mental illness, prevent discrimination, abolish prejudices and give the companies support and security in the contact with employees with mental health problems.

The project had several parts.

First, we started with two hours of information about mental disorders in companies. We found relatives who were interested in the project and who supported us. They had the ability to go in companies and present the information, and they knew from their own experience what executives or colleagues need.

In the mean time, more and more companies required further information, and we developed a one-day in-house seminar with about 17 to 20 participants, mainly executives. The need for more information certainly also relates to the increasing number of employees who have mental problems.

The content of the one-day in-house seminar includes sensitizing people to mental health problems, basic information about the clinical pictures of mental disorders, early signs of mental disorder and consequences for the ability to work and for the work process. Further, we give the companies links for more information or addresses outside the region where they can get further support. More than 1000 employees from a variety of companies have been

trained in seminars throughout the project, and more than 90% of participants said that they were very satisfied with both the content and the set-up of the seminars.

Another building block was the presentation of the project on many conferences of different organizations and organizing a conference with a large employer's organization to destigmatize mental illness at the workplace.

In the course of the project, Familien-Selbsthilfe Psychiatrie BApK e.V. and BKK Bundesverband also created a manual on "Mentally ill at work. What now?" (Bundesverband der Angehörigen psychisch Kranker e.V., 2009) as a further building block. The manual provides companies basic information about mental health problems. Many companies were interested in this manual as a support, and it is still distributed all over Germany, so far about 30 000 copies.

As a last building block of the project, we established a hotline with relatives who can counsel executives, colleagues or mentally ill people if they have questions about mental health problems at work. The hotline is busy three days a week.

Altogether we still are working in the project to overcome the stigma and discrimination at the workplace, and we are very grateful that the BKK Bundesverband made this possible through its support.

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Involving experts by experience: not only for mental health care

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EX-IN

EX-IN stands for experienced involvement. The aim of this programme is to involve people who have personal experience with mental health problems, severe mental illness or addiction disorders in the delivery of services, in the education of health professionals and in the management and governance of health services.

The programme started in 2005 and was funded by the EU through the Leonardo da Vinci programme. In 2006 and 2007, the EX-IN programme focused on training and educating the users of mental health care. A curriculum was developed and is being implemented in seven European countries. These programme now operate under different names in these countries.

In 2009 a new programme started, again funded by the EU, focusing on broadening the concept to experience with poverty. Experts with experience in poverty will be trained to become professionals who will support others living in poverty. The training will be oriented towards finding jobs in all kinds of social services. The new programme is called the Missing Link: Increasing Social Inclusion by Engaging Experts by Experience and is led by an organization in Belgium called De Link.

The EX-IN programme, which is implemented in various European countries, shows that expertise by experience can be enhanced by training and education to such a degree that these experts can fulfil important new functions in mental health care and social support. The knowledge of users is being acknowledged more and more in recent years. Experts by experience form a new profession. New jobs are being created, and they trigger changes in mental health care to become more sensitive to the needs and wishes and experiences of the users.

Roots of EX-IN: the users movement

EX-IN offers a framework and a programme that guarantees qualitative support for the experts by experience. It is built on the knowledge of users and user organizations in mental health care in various European countries. It recognizes three phases in the process of change in the position of service users.

- To improving human rights and patients' rights,: changes were made in the 1960s and 1970s that were necessary because of the deplorable situation in mental hospitals as described by Erving Goffmann (1961).
- Service users' proposals for improving mental health care were negotiated between 1985 and 2000 inspired by the democratic psychiatry of Franco and Franca Bazaglia in Italy.
- Service users took initiatives from 2000 onwards. More or less disappointed by the changes that were implemented in the earlier phases, users became aware that they can do better themselves. *On our own* by Judi Chamberlain (1978) had a big impact. In many countries, a recovery movement arose among service users.

The characteristics of the third phase are an increasing attention for self-help and mutual support in recovery. Service users are taking responsibility for their own health and lifestyles and are not so dependent on the demands of professionals. Service users rely more and more on their own knowledge and expertise.

Expertise by experience

Expertise by experience is defined as personal knowledge about:

- one's own body and mind and your own way of coping with problems
- health systems and professional help and how to cope with them
- society, exclusion, stress and bureaucracy and how to cope with them
- how to deal with each other in interaction and peer support among service users.

The knowledge is gained by special procedures. It relies on personal reflections and on sharing of experiences among service users.

A twin mate

Information technology delivers strong tools for support of personal knowledge and expertise by experience. An example is a twin mate.

A twin mate is a low-threshold digital health domain online. It is a person's alter ego that supports him or her in coping and stimulates the person to find a healthy lifestyle and coaches him or her to stay in control of the situation and to take an active role.

The twin mate is also an intelligent communication platform online communicating data and interests in such a way that the user controls it.

The twin mate offers a health agenda, a data safe and data communicator, a health planner, tailor-made information, a diary and a digital coach. Personal health plans are an integral part of it, as are your electronic patient records. Service users will get more and more control of their health plans. Responsibilities will be redistributed. Health professionals will find themselves much more in supportive roles then in directing decision-making and supervising.

It is called a twin mate because it is a mirror of a person; an Internet coach is an alter ego that helps a person to reflect over the situation, to communicate with others about the situation and to learn from others. The various functions of the twin mate aim for improving expertise by experience, expertise about oneself and about one's situation. It supports people in dealing with their situation coping with the problems and doing it in such a way that their actions are in accordance with what they want and are able to do.

Expertise by experience in relation to mental health and well-being at the workplace

It is easy to imagine that these kinds of tools are becoming more important also at the workplace, as people will increasingly have to rely on personal knowledge in dealing with health problems at the workplace.

In 2005, the programme participants carried out a research project on this kind of knowledge commissioned by the Ministry of Social Affairs and Employment in the Netherlands. The

research questions were about how people with disabilities and chronic illnesses use personal knowledge in getting jobs, keeping jobs, decreasing absence, making careers and improving their well-being at the workplace.

It was found that the personal knowledge of people with a chronic illness or disability about well-being at the workplace encompasses many issues:

- quality of life in relation to work;
- the importance of being an employee for life;
- income, payments from social services and how to address institutions and deal with bureaucracies;
- knowledge about insurance;
- how to search for work;
- reintegration, rehabilitation and recovery;
- company cultures that are inclusive and oriented towards diversity;
- adjustments at the workplace and dealing with disabilities at the workplace;
- taking care that employees with disabilities do not become special employees;
- one's language;
- one's body, mind, behaviour and coping;
- time management;
- energy management;
- sharing experiences with colleagues;
- how to address supervisors and human resources managers;
- personal assistance at the workplace; and
- working as an expert by experience.

Cooperation with health professionals

The resources of personal knowledge about health and healthy situations are enormous, especially among those who have had many health problems and have been forced to handle these problems, both personal and societal, for many years. Addressing, acknowledging and rewarding this knowledge base will be a great challenge. This does not mean that all other scientific and professional knowledge is obsolete.

The implications for professionals are twofold. They have to learn to deal with well-informed and assertive people who are experts about their own life. The role of the professionals will increasingly be to support service users in gaining control.

In addition, they will be confronted with new professionals that are experts by experience. In the workplace and in health care systems connected to companies and industries, new roles and professions will be installed such as peer supporters, recovery workers and inclusion workers. Existing jobs such as human resources officers and social workers will be increasingly filled by experts by experience because they are more effective in performing these jobs. The EX-IN concept will spread in new areas in the same way as at workplaces.

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What can be done? What has to be done? Recommendations for policy-making to encourage mental health at the workplace

Summary

Anja Baumann, WHO Regional Office for Europe

"Diversity" was the keyword of the Conference on Mental Health and Well-being at the Workplace – Protection and Inclusion in Challenging Times. About 130 participants from across Europe discussed a broad range of topics, from the challenges of modern working life to mental well-being and social inclusion, the role of empowerment and pathways to integration, strategies for promoting mental health and preventing mental disorders to overcoming stigma and discrimination at the workplace. The subjective experience of having mental health problems and its effects on families have been shown but also the burden of mental health problems for society. Case examples from various countries provided approaches and solutions to respond to the needs of both employees and employers. The discussants in a lively debate gave recommendations for policy-making to encourage mental health at the workplace – all this against the background of a world in economic downturn.

Paul Schnabel described impressively how the situation on the labour market has deteriorated for those who do not have a mental health problem or a disability in a period of economic downturn. Unemployment in the countries of the WHO European Region has risen rapidly, and even those who previously imagined themselves safe in their positions now risk losing their jobs. Youth unemployment, layoffs of contract and temporary workers and forced early retirement of older workers are being discussed broadly, but the situation of people with mental health problems is given little attention – although people with mental health problems are more vulnerable when the regular workforce is reduced.

Employees with mental health problems pose more problems for employers than people with physical health problems. The diagnosis is usually more difficult and takes longer to establish; the symptoms are often somewhat diffuse and are not always easy to distinguish from problems in and with the work; the problems are often long-lasting; and the risk of relapse is high. Connected with these challenges is the taboo on speaking about the subjective experience of mental health problems and of asking questions about how mental health problems affect work performance. This was the focus of the presentation by Marlies Hommelsen's project Mentally Ill at Work – What Now?, a project of the Familien-Selbsthilfe Psychiatrie BApK e.V. that aims at assisting employers to deal adequately with employees with mental illness.

Gudrun Schliebener said that the stigma attached to mental illness is perceived as the most important barrier in finding and retaining employment for family carers. At the same time, the processes of workplace discrimination and exclusion often lead to long-term absence, job loss and long-term unemployment. Thus, it is imperative to remove the existing prejudice related to mental illness not only among employers but also in society as a whole. Tackling prejudice and discriminatory behaviour against one of the most vulnerable groups in society is ultimately a task and responsibility for each citizen. As Bob Grove made very clear, stigma and discrimination must be tackled at all levels in the workplace and beyond. Certainly governments are responsible for introducing policies and programmes to tackle stigma and

discrimination among the general public and in collaboration with the mass media, but "unless managers and employees are helped to have the skills and confidence to maintain their relationships with the person in distress and to manage mundane interactions in an informed and supportive way, return to work and full productivity may be impossible even when the symptoms of the illness have gone away".

People with mental health problems perceive their returning back to work as one of the most important tasks. Earning money is undoubtedly an important purpose, but the focus for people with severe mental illness is the meaningfulness of activities. Mental health service users stressed at the Conference the importance of encouraging the dialogue between employers and people with mental health problems but also between people with and without experience of mental illness. People who have experienced mental illness can often relatively quickly determine that a person has mental health problems. This indicates an enormous capacity among service users all over Europe who could perform in jobs assisting other service users, such as in coping with mental health problems and stigma and discrimination at the workplace. They could also play an important role in facilitating in the contact between employees with mental health problems and employers.

Early identification and intervention are vital to stop the negative effects of mental health problems at the workplace. Employers recognize this now more than ever and are giving more and more attention to measures to prevent sickness absence. It is also in the employers' interest to provide good working conditions, special leave arrangements, child-care facilities, the ability to work part-time, fitness facilities and measures to relieve stress at work and to combat bullying and harassment. Workplace health promotion is the combined effort of employers, employees and society to improve the health and well-being of people at work. As Karl Kuhn pointed out – referring to the Luxemburg Declaration on Workplace Health Promotion in the European Union developed by the European Network Workplace Health Promotion – this can be achieved by combining improving the organization of work and the working environment, promoting active participation and encouraging personal development. Equally important are strategies and programmes for preventing disease at the individual and organizational levels. The social partners must promote the preventive approach; stakeholders must focus on a healthy working climate and a safe working environment. This requires commitment of the management, inspiring leadership styles, transparency, a healthy work–life balance and training of all stakeholders.

The practice examples of preventing mental disorders presented at the Conference showed two different approaches for implementing a mental health programme in companies. Catherine Kilfedder introduced the Mental Health Programme of the BT Group, which is an integrated part of the global health management programme at BT, designed for 110 000 employees worldwide. It encompasses activities from prevention and intervention to restitution adjusted to the principles of the BT Group. Many smaller or more local companies do not have the capacity and expertise to organize smaller special mental health campaigns. Patrycja Wojtaszczyk presented a concept in which competence centres of the Nofer Institute of Occupational Medicine in Poland provide this kind of structure, experts and knowledge.

Although mental health programmes are already part of health management activities at large global companies, many companies still have no quality standards for these programmes. The qualifications of trainers and choice of activities vary, and not every company is ready for a mental health programme because of fear of stigma. This leads to the question of how to measure the effects of mental health problems and the effects of promoting mental health,

preventing mental disorders and integration programmes can be measured. For example, how can presenteeism be measured? How can stigma at the workplace be measured? The health management departments of companies, organizations of service users and caregivers, health professionals and researchers must develop a transnational standard framework that helps companies in handling the growing number of employees with mental health problems and helping employees remain employed.

All efforts in promoting mental health, preventing mental disorders and combating stigma gain their real value and effectiveness by involving and empowering people with mental health problems and their families. The thinking of health professionals has changed drastically, and the importance of job participation is acknowledged not only by people with mental health problems and their families but also by mental health specialists. Supported employment seems to be more effective than long-term vocational rehabilitation, and the important task is to keep people with mental health problems in their jobs and to lower the high rates of sick leave rather than establishing more sheltered workplaces. Although the empowerment of mental health service users is one of the keys to improving health outcomes at the individual and societal level, empowerment strategies leading to employment integration are not yet sufficiently undertaken. Initiatives such as the employment integration programmes by the Spanish Confederation of Associations of Families and People with Mental Illness described by Maria San Pío and the EX-IN project on experienced involvement in the Netherlands and elsewhere have the potential to be implemented in different countries. The programme in Spain focuses on advocacy, integration and fighting stigma, and the EX-IN project described by Harrie van Haaster provides training and education for mental health service users by experts by experience.

The reports and case examples dealing with pathways to integration in the regular job market showed that, even though countries have different general structures and conditions, the needs of people with mental illness who want to return to the regular job market and possible solutions for integration strategies are rather similar. A major problem is the limited funding and restricted time frame of projects aiming at integration and empowerment. Much energy is required to find niches for funding, and the uncertain project funding situation is an additional burden for people with mental health problems. An individual approach has been considered necessary, as every individual has a different personal history and needs individual support. A task for employers in integrating and improving mental health promotion is therefore to identify and strengthen individual potentials and abilities. Case managers or job coaches who are able to invest time and energy in every single person with mental health problems are needed to facilitate this task. IN-VALID-IN, the integration project in Slovenia presented by Igor Hrast, has been proven to be successful in further developing the concept of job coaches.

National and local health systems often do not explicitly encourage employers to communicate with employees on returning to work. Community approaches such as the German Integrationsmanagement Bergedorf office for counselling and job search presented by Heidrun Thiel are therefore necessary and have proven to be very useful and effective. It should be the aim to establish a community network and support system that strengthens the cooperation between institutions (such as service providers, employers and companies, public authorities and employment agencies) to meet the diverse needs of mental health service users and to coordinate the pathways to multiple responsible public authorities. The success of integration projects relies on good relationships with employers and on good personal networks of case mangers and project coordinators. Communicating successful case histories

is important, both to promote integration and to give people with mental health problems hope and optimism.

Integrating people with mental illness into the regular job market, especially in times of economic downturn, has numerous benefits for employers. It is an advantage for employers to have motivated staff, and social commitment creates a positive image, especially for smaller companies. Finding and evoking individual potential optimizes performance and the use of resources, and integrating people with mental illness promotes social coherence in the community – a gain for employers and society as a whole.

Recommendations and outlook

Wolfgang Gaebel & Wiebke Ahrens, German Alliance for Mental Health, Germany
Anja Baumann & Matt Muijen, WHO Regional Office for Europe

Since the Conference took place in Berlin, there have been various mass-media headlines on mental health at the workplace in different European countries. In Germany, for example, the suicide of the goalkeeper of the national football team who had had depression led to high public awareness on mental health problems. The discussion focused on the fact that high pressure in competitive sports, but also in professional life overall, can lead to mental health problems that may become severe. A high rate of suicide by employees of France Telecom led to a public outcry in France. Public discussion indicated the responsibility of employers to secure healthy working conditions that also take aspects of mental well-being into account. The involvement of France's government in this discussion showed that this question is no longer a matter of individual companies. Action by governments can also be appropriate if not necessary. The mass-media coverage on these events demonstrated that the importance of mental health is no longer exclusively for professional discussion among experts but slowly becomes part of the public debate.

At the time of the Conference in March 2009, the extent of the economic downturn could not be predicted. Nevertheless, experts agreed that it would severely affect the labour market. These predictions have become true to varying degrees depending on the country. For example, Germany's unemployment rate did not rise as much as anticipated by the experts and is now declining (7.1% in April 2010), whereas Spain's rate is already high and rising (19.7% in April 2010). All over Europe, unemployment has risen to the highest rate in more than a decade, with an average unemployment rate in the European Union of 9.7% and 23.3 million people unemployed in April 2010 (Eurostat, 2010). These economic data indicate that the worldwide economic downturn has created insecurity in the job market and thereby for many employees. Although there is reason for optimism and predictions of economic recovery in the coming years, the labour market is not predicted to improve to the same extent.

The public discussion on how the economic crisis is affecting the labour market has mainly focused on unemployment rates. The burden for the employees remaining in work has hardly been recognized. Besides job insecurity, employees have to cope with restructuring measures within companies, increased workload due to layoffs of colleagues, rising stress, higher work intensity and worsening of working conditions overall. The possible effects of the economic downturn have been discussed only in small circles of experts if at all, such as at the Conference on Mental Health and Well-being at the Workplace – Protection and Inclusion in Challenging Times.

High workload, permanent stress, multitasking, job insecurity, working hours hostile to family life and restructuring of working conditions are not phenomena of the current economic downturn. Nevertheless, difficult economic times accelerate these implications of modern working life. The demands of the performance society are not predicted to decline but instead grow in the coming years. Even though few data are available that can actually prove the connection between the growing rates of people with mental health problems and the challenging working conditions, there are indications that they are related. Employers as well as society are therefore advised to meet the challenge and to introduce measures for preventing mental health problems at the workplace. Mental illness has become one of the main reasons for taking sick leave and for early retirement. The effects of this development on

the economic performance of countries can hardly be measured. Experts assume that the costs to society caused by poor mental health are a multiple of the costs for treating mental disorders and rehabilitation covered by the social security sector (Unger & Kleinschmidt, 2007).

For employers, the examples of practice presented at the Conference demonstrated that good practices in meeting the challenges of mental health promotion already exist. The challenge will be to ensure that these examples do not remain exceptions but become standard all over Europe. This has to be realized not only in global enterprises but also in small- and medium-sized businesses. Satisfying this demand requires strengthening awareness in upper management. Decision-makers in companies need to be won to the idea of giving high priority to mental health promotion. In times when public spending on health care programmes is limited, business itself is an important partner in enhancing mental health at the workplace. The argument is that spending money on mental health promotion is worthwhile – not only as an act of humanity but also for economic reasons.

However, mental health promotion is only one aspect of mental health and well-being at the workplace. The subtitle of the Conference refers to another important task: including people with mental health problems. In general, people with mental illness have difficulty in remaining in employment and even more difficulty in finding a new job. This is true not only for times of economic growth but becomes even more relevant when the job market is tight due to economic decline.

Employees with mental health problems often pose some specific challenges to employers. Further, existing prejudices and stigmatization makes tackling the problem even more difficult. The stigma on mental illness leads to negative effects for the employees concerned and for the employers. It is an obstacle to early detection and to successful reintegration. It can be disastrous for the individual but can also adversely affect the working environment (such as even longer periods of absence or additional strain on colleagues). This makes educational programmes on mental health and supporting services for employees and employers even more important.

Case examples presented at the Conference have shown various opportunities for enhancing the inclusion of people with mental illness at the workplace. External financial support, such as by the government, via international programmes or by sponsoring by health services, is essential to run all these programmes. Thus, policy-makers, governments and stakeholders in society at the regional, national and international levels have to accept their responsibilities. Offering people with mental illness the opportunity to be part of the regular working environment has to become the social consensus in society. Realizing this is a great challenge and even more so in times of economic recession, when recovery of the economy, survival of traditional companies and job security even for employees without disabilities is in focus. Nevertheless, raising awareness, advocacy and promoting good practice examples even in challenging times will be the task for people involved in the mental health sector.

At the Conference, various good practice examples were presented by associations of family self-help in psychiatry or in cooperation with people with mental health problems. These examples demonstrated how important the influence of people who have experienced mental illness can be. Experts working in the mental health sector often recognize this more than in business itself or in health promotion. The concept of empowerment will therefore have to be introduced in these areas as well.

The fruitful exchange at the Conference, the opportunity to learn from best practices in other countries and the transnational discussion on challenges and options demonstrated the importance of action at the international level. In the past, WHO has given important impulses on enhancing mental health with the adoption of the Mental Health Declaration for Europe and Mental Health Action Plan for Europe (WHO Regional Office for Europe, 2005a, b). In 2008, the EU countries confirmed the need for action by adopting the European Pact for Mental Health and Well-being (European Commission, 2008). One priority sector identified in the Pact is mental health in workplace settings. This was done because employment is a fundamental component of quality of life and well-being, there is a strong business case for tackling poor mental health at work and the case for action from a government perspective as well as from the employees perspective is strong. In addition, combating stigma and social exclusion has also been identified as another priority theme. The intersectoral importance of this aspect has thereby been recognized.

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The WHO Regional Office for Europe

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Abstract

Mental health problems have become one of the leading causes for absenteeism from work and early retirement all over the European Region. Mental health problems in the workplace have serious effects not only for the individual but also for the productivity and competitiveness of businesses and thus the economy and society as a whole. The current economic recession and its effects on the job market are likely to add to the problems in employment and quality of life experienced by people with mental health problems and their families. There is concern that the global economic downturn will adversely affect public health not only because of job losses but also because of the indirect effect on lifestyles and access to health care.

This publication reflects the presentations given at a WHO Conference on Mental Health and Well-being at the Workplace in March 2009. It suggests ways to respond to how modern working life challenges mental health and well-being, how to overcome barriers to employment for people with mental health problems and opportunities for integration and empowerment given the global economic downturn from the viewpoint of user and family caregiver associations, enterprises, trade unions, politicians and researchers. It is essential reading for employers and policy makers in the European Region and beyond.

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