

# Mental Health in the workplace

## situation analysis

# Germany

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**International  
Labour Office  
Geneva**



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ISBN 92-2-112226-3

*First published 2000*

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Printed in Switzerland

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*The ILO gratefully acknowledges the support of  
Eli Lilly and Company Foundation  
for the Mental health in the workplace project.*

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# CONTENTS

INTRODUCTION i

GLOSSARY iv

## Part 1. MENTAL HEALTH AT THE NATIONAL LEVEL 1

**The socio-economic environment and mental health 1**

**The prevalence of depression 2**

**Defining depression 3**

**Caring for depression 4**

**Mental health and employment 4**

## Part 2. THE ECONOMIC BURDEN OF MENTAL ILLNESS 7

**Background information and data 7**

**Suicide and illnesses allied to depression 7**

**The cost of treating mental illness 8**

## Part 3. POLICY AND THE LEGISLATIVE FRAMEWORK 9

**Discrimination and the right to work: the evolution of the legal framework 10**

The Severely Disabled Persons Act of 1974 11

**Vocational training for people with disabilities 12**

Rehabilitation 13

Work and occupational therapy 14

Corporate occupational training 14

## Part 4. THE ROLE OF GOVERNMENT AND THE SOCIAL PARTNERS 16

**Government 16**

The international framework 16

Policy in Germany 17

**Social partners 17**

**Non-governmental organisations 18**

## Part 5. MANAGING MENTAL HEALTH IN THE WORKPLACE 19

**Health and safety issues 19**

**Corporate health promotion 21**

Success factors of corporate health promotion 22

Corporate health promotion and workplace stress prevention 22

Quality assurance and integrated management systems 23

Corporate health promotion in German companies: case studies 24

REWE Handelsgruppe 24

Volkswagen AG 25

CONCLUSION 26

NOTES 27

BIBLIOGRAPHY 30

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# INTRODUCTION

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**Population:**  
**82.1 million**  
**GDP per capita:**  
**\$22,100 (est. 1998)**  
**Unemployment:**  
**10.6% (est. 1998)**

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**Mental health problems are among the most important contributors to the global burden of disease and disability.**

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**The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.**

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**M**ental health problems are among the most important contributors to the global burden of disease and disability. Of the ten leading causes of disability worldwide, five are psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive-compulsive disorder.<sup>1</sup>

The burden of mental disorders on health and productivity throughout the world has long been profoundly underestimated.<sup>2</sup> The impact of mental health problems in the workplace has serious consequences not only for the individuals whose lives are influenced either directly or indirectly, but also for enterprise productivity. Mental health problems strongly influence employee performance, rates of illnesses, absenteeism, accidents, and staff turnover.

The workplace is an appropriate environment in which to educate and raise individuals' awareness about mental health problems. For example, encouragement to promote good mental health practices, provide tools for recognition and early identification of the symptoms of problems, and establish links with local mental health services for referral and treatment can be offered. The need to demystify the topic and lift the taboos about the presence of mental health problems in the workplace while educating the working population regarding early recognition and treatment will benefit employers in terms of higher productivity and reduction in direct and in-direct costs. However, it must be recognised that some mental health problems need specific clinical care and monitoring, as well as special considerations for the integration or re-integration of the individual into the workforce.

## **Why should the ILO be involved?**

**M**ental illness constitutes one of the world's most critical and social health problems. It affects more human lives and wastes more human resources than any other disabling condition.<sup>3</sup> The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

The ILO's primary goals regarding disability are to prepare and empower people with disabilities to pursue their employment goals and facilitate access to work and job opportunities in open labour markets, while sensitising policy makers, trade unions and employers to these issues. The ILO's mandate on disability issues is specified in the ILO Convention 159 (1983) on vocational rehabilitation and employment. No. 159 defines a disabled person as an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or *mental impairment*. The Convention established the principle of equal treatment and employment for workers with disabilities.

Most recently, the ILO has recognised the need to promote increased investment in human resource development, which can help support employment productivity and growth. This focus pays particular attention to the human resource needs of vulnerable groups, which include individu-

als with mental health problems. As pointed out, employee mental health problems and their impact on an enterprise's productivity and disability costs are a critical human resource issue. Increasingly, employers, employers' organisations and international organisational bodies are recognising that the economic and social costs of mental health problems in the workplace cannot be ignored.

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*In the ILO study, **Mental health in the workplace, situation analyses of Finland, Germany, Poland, the UK and the USA provide in-depth assessments of the impact of mental health concerns in the workplace to determine the scope of the problem in the open labour market.***

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## **The purpose of the research**

With a grant from the **Eli Lilly and Company Foundation**, the ILO conducted in-depth situation analyses in five countries. The five countries selected were Finland, Germany, Poland, UK, and USA. The primary purpose of these situation analyses was to conduct an in-depth assessment of the impact of mental health problems in the workplace in order to determine the scope of the problem in competitive employment. Related to this purpose was also the assessment of the specific ramifications of the impact of mental health problem for employees and enterprises such as workplace productivity, loss of income, health-care and social security costs, access to mental health services and good practices by employers.

An essential objective of these situation analyses is that the information collected and assessed may be used to create further educational materials and assist in designing programmes which can be used by governmental agencies, unions, and employers' organisations for mental health promotion, prevention, and rehabilitation.

The situation analyses were based primarily on a thorough literature review, including documents from government agencies, NGOs, employer and employee organisations, as well as interviews with key informants.

## **The case of Germany**

It has been reported that, in Germany, depression, and in particular major depression is ten times more frequent today than it was 50 years ago. There is also an increasing recognition of the impact of job related stress on the work environment. "Burnout" is viewed as a serious problem, potentially affecting many workers, which is directly related to job stressors. In Germany, the various social partners, i.e., the government, non-governmental organisations, employees' and employers' organisations, and institutions responsible for health and safety in the workplace, have paid great attention to job-related stress and its impact on the work environment. For many years, successful prevention programmes have already been in place in many workplaces. In Germany, the legislative approach to employment of people with disabilities, including those with a mental health disability, is closely associated with social insurance and its emphasis on rehabilitation rather than benefits.

The following situation analysis examines the scope and impact of mental health issues on the German workplace, as well as the role of all social partners in addressing these issues. Selected key agencies, organisations, and institutions were highlighted with illustrations of how important it is for all the social partners to work together to be more effective. Although, the situation analysis is primarily concerned with the impact of mental health on the workplace, and in particular with depression, it is viewed within the context of overall mental health concerns. This is due to the nature of the available information, which does not always distinguish between depression and other mental health concerns, such as work-related stress and burnout.

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The situation analysis examines five major areas: Mental health at the national level, the Economic burden of mental illness, Policy and the legislative framework, the Role of government and the social partners, and Managing mental health in the workplace.

**MENTAL HEALTH AT THE NATIONAL LEVEL** examines the current socio-economic environment and its influence on mental health, definitions, and prevalence of depression and mental health services.

**THE ECONOMIC BURDEN OF MENTAL ILLNESS** discusses the economic implications for treating mental illness.

**POLICY AND THE LEGISLATIVE FRAMEWORK** describes the evolution of the legal framework, identifies relevant laws, and discusses the support and promotion for rehabilitation and vocational training.

**THE ROLE OF GOVERNMENT AND THE SOCIAL PARTNERS** examines the implementation of law and policy by the government, NGOs, and other institutes.

**MANAGING MENTAL HEALTH IN THE WORKPLACE** discusses the importance of a corporate mental health promotion policy and the relationship of health and safety issues to workplace stress and provides examples of corporate workplace health promotion and stress prevention programs.

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# GLOSSARY

The definitions and terms related to mental health are evolving and still subject to much debate. Terms are often used interchangeably, which can be confusing as well as inaccurate. It is therefore useful to attempt to define the vocabulary of mental health and to make distinctions. Specific countries use different terminology to refer to the same issue. In the five situation analyses of mental health in the workplace, the reports have remained faithful to the terminology used by the mental health community in each country. This glossary therefore includes definitions of these nation-specific terms. The following definitions and terminology are based on current usage by such organizations as the WHO and ILO, participating countries in the situational analyses, and the European Union.

This glossary is conceptually oriented and will give the reader the familiarity with the vocabulary of mental health, which is necessary to fully understand the situation analyses.

**MENTAL HEALTH:** Though many elements of mental health may be identifiable, the term is not easy to define. The meaning of being mentally healthy is subject to many interpretations rooted in value judgements, which may vary across cultures. Mental health should not be seen as the absence of illness, but more to do with a form of subjective well-being, when individuals feel that they are coping, fairly in control of their lives, able to face challenges, and take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture.<sup>1</sup>

**MENTAL HEALTH PROBLEMS:** The vast majority of mental health problems are relatively mild, though distressing to the person at the time, and if recognized can be alleviated by support and perhaps some professional help. Work and home life need not be too adversely affected if the appropriate help is obtained.<sup>2</sup> In the situation analyses, the terms mental health problems and mental health difficulties are used interchangeably.

**MENTAL ILLNESS:** Mental illness refers collectively to all diagnosable mental health problems which become "clinical," that is where a degree of professional intervention and treatment is required. Generally, the term refers to more serious problems, rather than, for example, a mild episode of depression or anxiety requiring temporary help.

The major psychotic illnesses, such as endogenous depression, schizophrenia, and manic depressive psychosis, would fall in this category and would be seen less often in the workplace.<sup>3</sup> Mental illness is sometimes referred to as *psychiatric disability*.<sup>4</sup> This term is used primarily in the United States.

**MENTAL DISORDERS:** Mental disorders are health conditions characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Mental disorders are associated with increased mortality rates. The risk of death among individuals with a mental disorder is several times higher than in the population as a whole.<sup>5</sup>

**DEPRESSION:** Depression is an example of a mental disorder largely marked by alterations in mood as well as loss of interest in activities previously enjoyed. It affects more women than men, by a ratio of about 2 to 1. It is projected that up to 340 million people will suffer from depression in the near future. The risk of suicide is high amongst those suffering from depression. Yearly, over 800,000 deaths attributable to suicide are recorded worldwide: The majority of suicides are due to depression.<sup>6</sup>

There is a great deal of information about the different types, causes and treatments of depression. However, it is important to realize that depression is not simple. There are different types and different degrees of each type. There is a high degree of variation among people with depression in terms of symptoms, course of illness, and response to treatment, all indicating the complexity and interacting causes of this illness. The most common form of depression is chronic unipolar depression (clinical depression). This category of depression has been frequently discussed and written about in the popular media in recent years, primarily due to new modalities of treatment.

Other types of depression recognized at this time are:

- Acute Situational Depression
- Dysthymia
- Bipolar Depression (manic depressive disorder)
- Seasonal Affective Disorder (SAD)
- Post Partum Depression
- Depression secondary to other diseases or drugs.

**MENTAL HEALTH PROMOTION:** Mental health promotion is a multidimensional concept that implies the creation of individual, social, and environmental conditions, which enable optimal overall psychological development. It is especially focussed, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes.<sup>7</sup>

**MENTAL HEALTH PREVENTION:** Prevention is based on specific knowledge about causal relationships between an illness and risk factors. Prevention results in measurable outcomes. Within the context of the workplace, prevention is concerned with taking action to reduce or eliminate stressors. *Prevention* and *promotion* are overlapping and related activities. Promotion can be simultaneously preventative and vice versa.<sup>8</sup>

**POST TRAUMATIC STRESS DISORDER:** PTSD or post-traumatic stress disorder can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural disaster such as flood or fire or a man-made disaster such as war, imprisonment, assault, or rape.

**REHABILITATION:** A process aimed at enabling persons with disabilities to regain and maintain their optimal physical, sensory, intellectual, psychiatric, and/ or social functional levels, by providing them with tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/ or restore functions or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.<sup>9</sup>

**STRESS:** Stress is defined as a nonspecific response of the body to any demand made upon it which results in symptoms such as rise in the blood pressure, release of hormones, quickness of breathe, tightening of muscles, perspiration, and increased cardiac activity. Stress is not necessarily negative. Some stress keeps us motivated and alert, while to little stress can create problems. However, too much stress can trigger problems with mental and physical health, particularly over a prolonged period of time.<sup>10</sup>

**JOB STRESS:** Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury. Long - term exposure to job stress has been linked to an increased risk of musculoskeletal disorders, *depression*, and *job burnout*, and may contribute to a range of debilitating diseases, ranging from cardiovascular disease to cancer. Stressful working conditions also may interfere with an employee's ability to work safely, contributing to work injuries and illnesses. In

the workplace of the 1990s, the most highly ranked and frequently reported organisational stressors are potential job loss, technological innovation, change, and ineffective top management. At the work unit level, work overload, poor supervision, and inadequate training are the top-ranking *stressors*.<sup>11</sup>

The following are specific examples that may lead to *job stress*:<sup>12</sup>

**The design of tasks.** Heavy workload, infrequent rests breaks, long work hours and shiftwork; hectic and routine tasks that have little inherent meaning, do not utilize workers' skills and provide little sense of control.

**Management style.** Lack of participation by workers in decision-making, poor communication in the organization, lack of family-friendly policies.

**Interpersonal relationships.** Poor social environment and lack of support or help from coworkers and supervisors.

**Work roles.** Conflicting to uncertain job expectations, too much responsibility, too many "hats to wear."

**Career concerns.** Job insecurity and lack of opportunity for growth, advancement or promotion; rapid changes for which workers are unprepared.

**Environmental conditions.** Unpleasant or dangerous physical conditions such as crowding, noise, air pollution, or ergonomic problems.

**BURNOUT:** This term is used most frequently in Finland to refer to job stressors and the resulting mental health problems that may occur. It is defined as a three-dimensional syndrome, characterized by energy depletion (exhaustion), increased mental distance from one's job (cynicism) and reduced professional efficacy.<sup>13</sup>

**MENTAL STRAIN:** This term is used in the German situational analysis to refer to psychological stress that impacts everybody in all realms of life.

**WORK ABILITY:** Individuals' work ability is based on their, physical, psychological and social capacity and professional competence, the work itself, the work environment, and the work organization. This term is often used in Finland in the world of work.

**JOB INSECURITY:** Job insecurity can be defined as perceived powerlessness to maintain desired continuity in a threatened job situation or as a concern about the future of one's job.<sup>14</sup>

**STIGMA:** Stigma can be defined as a mark of shame, disgrace, or disapproval, which results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm.'<sup>15</sup>

**INTELLECTUAL DISABILITY:** This disability is defined by a person's capacity to learn and by what they can or cannot do for themselves. People with this disability are identified by low scores on intelligence tests and sometimes by their poor social competence.<sup>16</sup> The term mental retardation is also used to refer to a person with an intellectual disability and is the most common term used in the situation analyses.

**DISABILITY MANAGEMENT:** The process of effectively dealing with employees who become disabled is referred to as "disability management." Disability management means using services, people, and materials to (i) minimize the impact and cost of disability to the employer and the employee and (ii) encourage return to work of an employee with disabilities.<sup>17</sup> It should be noted that the term "disability management" is not commonly used, despite the fact that practices understood to be within the scope of disability management processes are now taking place within enterprises of all sizes worldwide.<sup>18</sup>

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# Part 1

## Mental health at the national level

### *The socio-economic environment and mental health*

In Germany, over the past few years the use of the term “stress” has increased significantly. Today, stress seems to be everywhere: at work, in traffic, when shopping, in the family. Feeling “stressed” has a negative connotation and generally means being “overburdened”. But stress is a two-edged sword. It can act as a challenge, which stimulates physical and mental abilities, or it can lead to overload and temporary or even long-term disability conditions.

These statements are particularly applicable to the world of work: Responsibility is, on the one hand, a workplace requirement which develops social and intellectual abilities. On the other hand, under certain circumstances, it can cause anxieties and feelings of being overloaded.

Negative strains can:

- Damage mental and physical health;
- Hinder the preservation and development of intellectual abilities and skills;
- Impair social interactions (family, leisure, and political-cultural activities).

Research has shown that mental and psychosocial strains such as monotony, time pressure, and the conduct of superiors are especially important in the workplace. Since the mid 1980s employees have experienced an increase in stress related to both physical and mental working conditions. This is due mainly to rationalisation and the rapid introduction of technology, which took place in the industrial and service sectors.

Today, entire in-company and inter-company work systems are being redesigned. This includes mechanisation and automation as well as the use of electronic data processing and communication technologies, which involve far-reaching changes in organisations. New activities and workplaces, a greater emphasis on group work, “just-in-time” and “lean production”, and a change in the division of labour due to outsourcing are having a significant impact on stress in the workplace. On the positive side, these changes have led to a reduction in monotony, increased co-operation, greater autonomy and decision-making ability through group work and more highly skilled tasks. However, stress due to time pressure, deadlines, and demands in terms of quality, quantity, and greater flexibility is increasing.

These developments impact organisations in different ways. Suppliers, for instance, are particularly vulnerable to an increase in workplace stress because they have to be on continuous standby and are subject to unpredictable overtime and increased shiftwork.

It is becoming clear that physical stress in the workplace has decreased and mental stress has increased. Social parameters at the end of the 1990s, including global market competition, unemployment, and problems in financing government social welfare benefits, have also increased work stress. Many companies, however, recognise that appreciable gains in productivity are only possible by creating a motivated and committed work-

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**The decline of “traditional” strains in the working domain**  
(Raithel & Lehnert<sup>1</sup>)

Traditional strains		Psychosocial strains	
Machine accidents	-65%	Inappropriate mental load	+40%
Heat, cold, draughts	-37%	In-company personnel turnover	+43%
Appropriate physical load	-40%	Time pressure, stress	+65%
Noise	-47%		

force. The level of work stress will vary according to the economic sector, the economic situation, the level of rationalisation, corporate philosophy, and the objectives of trade unions.

The increased flexibility demanded in the workforce is having a negative effect due to<sup>2</sup>:

- Compression of several jobs into one,
- Result orientation,
- Blurring of the boundaries between work and private life,
- Overload,
- Unpredictability of work requirements,
- Neglect of safety and health protection at work.

### **The prevalence of depression**

**B**urnout and depression are among the most common negative consequences of workplace stress.

There is an increasing amount of discussion regarding the phenomenon of “burnout” as a result of mental stress in the work environment.<sup>3</sup> Burnout is caused by a high concentration of work and pressure to achieve, as well as by a strong personal identification with customers or clients and a high sense of responsibility. Increasingly, in all occupations, issues related to the organisation of work (pressure of time, lack of social support from colleagues, inadequate backing from superiors, little or no feedback and lack of recognition of work performed, including social recognition) are being cited as possible reasons for burnout.

After an initial phase of reduced commitment to work, burnout can lead to emotional reactions which can impact physical and mental health. Depression has been cited as a mental health problem that can be triggered by job burnout.

Depression has been identified in at least 6 % of the population in Germany. Academic opinion continues to hold the view that women become ill twice as often as men. However, studies<sup>4</sup> indicate that women do not have depression more frequently, but that they have a higher relapse rate and are more prone to chronicity. Contrary to popular opinion, the prevalence of depression is not necessarily related to socio-economic status. However, as with other mental illnesses, if depression becomes chronic, it can lead to lower socio-economic status.

Studies state that serious depressive illness is ten times more frequent today than it was 50 ago.<sup>5</sup> Those affected are becoming younger and younger. According to information from the Federal Ministry of Health,<sup>6</sup> use of anti-depressant drugs by those aged between 25 and 30 increased from 0.1% in 1986 to 1.1% in 1989<sup>7</sup>.

Family doctors and mental health professionals are primarily responsible for the timely recognition and adequate treatment of depressive disorders.

**Burnout and depression are among the most common negative consequences of workplace stress.**

However, family doctors diagnose only about 60% of all mental health disorders. The detection rate rises as the severity and clarity of the symptoms increase. The mental health problems which are often not recognized are those which do not have fully developed symptoms of a depressive illness. These mental health problems are the ones for which there are increasingly treatment options which can lower the occurrence of serious depressive illness.

The focus of secondary prevention is on reducing the number and severity of depressive episodes and on reducing the suicide risk. Since it can be assumed that over 50% of depressions are not diagnosed and over 75% are inadequately treated, appropriate care requires an improvement in the knowledge level of general practitioners. Medication can significantly reduce the probability of relapse. This can also be accomplished through psychotherapeutic treatment without medication though with less success. A combination of psychotherapy and appropriate medication appears to be the most effective solution. However, only a small percentage of persons with depression in Germany receive such treatment.<sup>8</sup>

## Defining Depression

Recent efforts have focused on defining depression as an autonomous set of pathological symptoms, rather than feelings of despondency, sadness or despair, which belong to the fundamental phenomenon of human experience.

There is a discrepancy between the “academic view”, which sees depression in the narrow sense, as a condition triggered by a chemical imbalance, and popular science, which tends to propagate a wide-ranging definition of depression which includes conditions due to environmental and social factors.

Popular science, depicts the “mental torment of depression”<sup>9</sup> as caused by problems which get out of control and burden a person’s emotional state. Life as a whole becomes too much to handle, and so uncontrollable stress leads to exhaustion, fatigue and emptiness. In popular medical and practical guides, depression is described as the “disease of the age.” It is attributed, in part, to isolation and various types of stress triggered by work, family, and other environmental and social factors. Pfeiler (1996)<sup>10</sup> points out that when describing the symptoms of depression, these publications only consider depression due to chemical imbalance. Nuber (1993)<sup>11</sup> therefore warns against an excessive use of the term depression. She points out that depressions have been mistakenly identified in cases of despondency, fluctuating moods, or sadness due to loss. “Depressions are an illness, whereas fluctuating moods and sadness are not,”<sup>12</sup> she writes. This highlights a problem which is neglected by most general practitioners and established neurologists<sup>13</sup>, that is the general tendency in German society to scorn acting emotionally. Even sadness is judged negatively. When men in particular give way to their feelings, sadness is quickly regarded as depression requiring treatment. This attitude partly explains the enormous rise in the incidence of depression. This situation analysis reflects a broader approach in understanding and defining depression rather than a narrow academic definition.

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*In popular medical and practical guides, depression is described as the “disease of the age.”*

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## Caring for depression

Mental health care services for people who have depression are provided primarily by general practitioners or physicians and consultants in

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***In general, when symptoms of depression arise, there is easy access to medical help, which is free of charge through the statutory health insurance scheme.***

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neurology, psychiatry, psychotherapy, and pharmacology. Non-medical psychotherapists are also involved in the treatment. The mandatory health insurance agencies will, under certain circumstances, cover the costs of non-medical psychotherapeutic treatment. Socio-psychiatric services, social services and advisory agencies make a major contribution to care and advice. In-patient care involves physicians, nurses, and psychologists, occupational and rehabilitation therapists, and social workers. In addition to specialist psychiatric hospitals, there are psychiatric and psychosomatic departments in general hospitals.

Studies estimate that about 60% of individuals who have had at least one depressive episode in their lives have consulted a physician about it. Surveys show that in neurological practices depression was the main subject in about 9% of consultations.

In general, when symptoms arise, there is easy access to medical help, which is free of charge through the statutory health insurance scheme<sup>14</sup>. Pfeiler (1996), however, points out that there exist major uncertainties with regard to adequate diagnosis, mainly on the part of non-psychiatric general practitioners. This of course also affects the efficiency of the treatment measures. He says, "With nearly half the patients diagnosed as depressive - in accordance with the classification criteria of ICD-9 - there is no depression, and in 87% of the cases the diagnostic classification as psychotic, neurotic and reactive depression is not appropriate."<sup>15</sup> Pfeiler also points out that by far the greater number (75%) of outpatients diagnosed as depressive are not suffering from clinically relevant complaints. "Nevertheless a therapy involving psychopharmaceutical drugs is normally applied; psychosocial factors are medicalised, which may not infrequently mean an iatrogenic chronicification of wellness disorders."<sup>16</sup>

## ***Mental Health and Employment***

Information regarding the employment status of the mentally disabled\* is difficult to obtain. The data does not differentiate between types of disability. The Federal Employment Agency does not provide information about the connection between type of work and type of disability. Other sources do not provide a separate category for disability caused by mental illness. The Federal Statistics Agency, for instance, does not differentiate between paralysis caused by severance of the spinal cord, cerebral disorders, mental illness, and addictive illnesses.

Kleffmann (1996)<sup>17</sup> states that approximately one third of all patients treated in psychiatric clinics are unemployed. All available studies demonstrate that individuals with mental health disabilities have a greater rate of unemployment than the population at large. Moreover a greater proportion of people with mental health disabilities are unemployed in comparison with other types of disabilities.<sup>18</sup>

German Health Reports points out that in comparison with other types of disabilities people with mental health problems often require a longer period of recovery before they can return to work. Particular problems arise for persons with mental health disabilities when they attempt to integrate into the open labour market. It is considerably more difficult to re-integrate

\*In Germany, the term "mentally disabled" ("geistig Behinderte") is used in a legal as well as a popular context to refer to persons with mental health disabilities and persons with intellectual disabilities/mental retardation. (4<sup>th</sup> Report of the Federal Government of Germany on the Situation of Persons with Disabilities and the Development of Rehabilitation. Editor Federal Ministry of Labour and Social Affairs, 1998) Since this report does not address persons with intellectual disabilities, the term "mentally disabled" will not be used but rather the phrase "mental health disabilities."

the severely disabled into working life than those who are not disabled. In all age groups the severely disabled remain unemployed for longer periods and do not have as many job opportunities as their peers who are not disabled.

Because available statistics do not differentiate between types of disability, this report refers to all of the severely disabled.

In Germany, the situation of the severely disabled in the labour market continues to worsen. The number of severely disabled people of working age is increasing and employment opportunities are limited. Consequently, there is a growing unemployment rate among people with disabilities. The gap between supply and demand of jobs for disabled persons is growing<sup>19</sup>. The actual number of disabled workers employed by employers in the private and public sectors who are obliged by law to employ disabled workers has decreased from 4.2% (1993) through 4.0% (1994 and 1995) down to 3,9% (1996). The rate of unemployment among the severely disabled has risen from 14.6% (1993), 15.0% (1994), 15.4% (1995), 16.1% (1996) up to 17.9% (1997).

Health and unemployment are related to one another in many ways. Partly due to company policy regarding hiring and dismissal of staff, people who are not perfectly healthy or whose working capacity is limited are more likely to be unemployed. They run a greater risk of being dismissed, remain unemployed for a longer than average period, and their chances of re-integration into working life are lower.

Job loss and long-term unemployment can lead to behaviour which damages health and can cause or exacerbate mental health problems resulting from the sufferer's relationship to society. The proportion of the unemployed suffering from health problems varied in West Germany between 19% (1985) and 28,7% (1992). In 1997 the figure was 25,3% of the total unemployed. In East Germany, the figure has risen from 10.0% in 1992 to 16.4% in 1997. Within these statistics, the blue-collar sector and the older and long-term unemployed predominate. They are the ones who find it most difficult to reintegrate into the labour market.

Financial disadvantage, and the need to drastically limit expenses or to enter into debt because of unemployment are important causes of psychosocial stress. In the 1930s, inadequate nutrition and poor living conditions had a serious impact on health. Today, in contrast, improved social security provisions prevent the unemployed from experiencing the full effects of poverty. Nevertheless, unemployment does carry the risk of poverty in Germany. If the economic situation of the unemployed continues to deteriorate, the situation which existed in the 1930s could gain new relevance.

The negative effects of unemployment vary according to age and work experience. Those who are unemployed in middle age (generally with dependants) are most vulnerable. Older people are less vulnerable because they take early retirement out of a sense of inevitability and resignation. The young who have never worked are also less vulnerable. However, if they are not given the chance to work, they miss out on opportunities for self-development, such as the transition from school to working life, which are usually beneficial to mental health.

In a society centred around work, employment represents the most important connection with social reality. In addition to providing an independent living, earning money fulfils many other decisive psychological functions such as:

- Provision of social contacts outside the immediate social circle
- Pursuit of common goals
- Acquisition or use of skills
- Fixed time structure

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*In Germany, there is a growing unemployment rate among people with disabilities.*

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- social status and professional prestige.

These psychological functions often can not be fulfilled by other activities.

People may react to unemployment in different ways. Some individuals, for example, have chosen to be unemployed during a transition from one job to another and consequently do not experience as much distress. Others have a dramatic emotional reaction as a result of the accumulation of everyday stresses and because the effects of unemployment are often stronger when other personal crises occur. The German health report for 1998 cites the following factors with regard to the handling of unemployment by the individual:

“The significance of the way work has been experienced up to the time of unemployment is a central factor. As is to be expected, an individual who places a high value on working suffers more from the loss of employment.

Reactions of men and women to unemployment differ particularly when work has a different meaning for each of them. If alternative social roles to work are available, this can lessen the results of job loss on an individual basis. For women, alternatives are more readily available in the traditional social roles of housewife and mother, which encourages some women to enter the “silent reserve” of the labour market. Results of studies from the former East Germany show, however, that the fact that a large proportion of women previously worked and that they were strongly orientated towards their work is responsible for comparable stress levels in women and men in this region.”

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### **According to German Health Reports:**

***“Jobs which have a negative effect on health increase the risk of damage to health in the long term and therefore also the risk of losing the job itself. Unemployed persons who already have problems with health are particularly vulnerable to the stress of unemployment, as this emphasises the effects of other stressful life conditions . It is considerably more difficult for unemployed persons with health problems to return to employment; the period for which they are unemployed is longer on average. In addition, the longer the period of unemployment, the more difficulty the long term unemployed have in finding a job.”<sup>20</sup>***

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# Part 2

## The economic burden of mental illness

### *Background information and data*

In 1993, 2.2% of days lost from work among compulsory members of the statutory health insurance scheme were due to depressive disorders (a total of about 282,000 cases of work incapacity leading to 10.9 million days absence). Women accounted for about twice as many cases of work incapacity as men (1,285 versus 592 cases per 100,000 compulsory members).

According to statistics from local insurance funds (Allgemeine Ortskrankenkassen – AOK) AOK West accounted for more than twice as many cases of work incapacity as AOK East (AOK West: men 748, women 1,670; AOK East: men 314, women 782 cases of work incapacity per 100,000 compulsory members).\*

On average, depression-related work incapacity lasts approximately two and a half times longer than incapacity due to other illnesses. Depressive disorders account for a significant proportion of premature retirements. In 1995 there were 18,629 early retirements (7,146 men, 11,483 women) due to depressive disorders, corresponding to approximately 6.3% of all 297,164 early retirements. The average retirement age was between 50 and 54.

In 1998 the annual average sickness rate for employed compulsory company health fund members was only 4.4 %, the lowest in 30 years, including the old Federal States (4.5%).<sup>1</sup> In 1997, around 81% of absences due to work incapacity could be attributed to six groups of illnesses: muscular and skeletal disorders (29.2%), disorders of the respiratory tracts (16.8%), injuries/poisoning (14.1%), digestive disorders (7.7%), heart and circulation disorders (7.3%) and psychiatric disorders (5.8%). Though there is a downward trend in sick leaves due to the other five illness groups, the figures are up for mental health problems. This is partly due to changes in diagnostic procedures. Though mental health disorders as an illness group remained of secondary importance in the old Federal States through the 1980s, they currently account for 5.9% of all days of illness and occupy sixth place in terms of work incapacity. They are the third most important diagnostic group in hospitals, representing 11% of treatment days.

### *Suicide and illnesses allied to depression*

People with depression are at greater risk of committing suicide. It is estimated in Germany that 3-4% of people with depression commit suicide. In the case of people who are receiving or have received in-patient treatment for major depression, the probability is 15%. In fact, a large proportion of all suicides are attributed to depression.<sup>2</sup>

Although different mental illnesses can coexist in the same person, this situation is often underestimated. More than 60% of all patients are diagnosed with more than one mental illness. In the case of major depression it can be assumed that a personality disorder is present in approximately 18% of cases and addictive illness and anxiety are present in 60-75%. It is

\*AOK West covers insured people in the former West Germany while AOK East covers those in the former East Germany. The socio-economic conditions in the two parts still differ significantly in several aspects even ten years after reunification.

*Though days lost from work due to other major illness groups are declining, an increasing number of sick leaves can be attributed to mental health problems.*

often overlooked that in 10% of cases, patients with psychosomatic or chronic somatic illnesses also suffer from depression. Depressive disorder is present in approximately 15% of non-surgical and surgical hospital cases. This figure rises to 30-35% in the case of patients suffering from neurological disorders.<sup>3</sup>

### **The cost of treating mental illness**

In 1995, approximately 1% of all registered hospital cases were attributed to depressive disorders. The cost of this in-patient treatment is estimated at 2 billion DM per year. Individuals with depression represented 3.3% of the 900,973 rehabilitation treatments paid for by pension insurance.<sup>4</sup>

Incapacity to work leads to absenteeism and ensuing loss of resources. In 1994, 2.32 million working years were lost through absenteeism. Men accounted for 1.28 million or 55.3% of absences caused by illness and women 1.03 million or 44.7%. It is difficult; however, to determine the number of working years lost through depression because the statistics are not differentiated.

In Germany, there is no adequate database for determining exact sickness costs, but some studies provide indications. Both direct and indirect costs of medical treatment, such as production losses due to absenteeism, should be included in calculations. For 1997, based on statistics for employed persons (excluding self-employed) and the gross income from employment, the Federal Institute for Occupational Safety and Health determined an annual volume of 89.5 billion DM in production lost because of absenteeism related to illness. According to this estimate, mental health disorders account for costs of 5.2 billion DM.

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**According to an estimate by the Federal Institute for Occupational Safety and Health, in 1997, mental health disorders accounted for costs of 5.2 billion DM in production lost because of absenteeism.**

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# Part 3

## Policy and the legislative framework

*The German system of social security has a long history. It emphasises social insurance, which protects against illness, accidents at work, unemployment, disability, old age, and death.*

The German system of social security has a long history. It emphasises social insurance, which protects against illness, accidents at work, unemployment, disability, old age, and death. The system is funded primarily through contributions from employees and employers; benefits are either in the form of cash payments or services.

The main features of the German social insurance system are:

- Compulsory insurance: everyone is required to protect him or herself against risk.
- Solidarity: through their work and contributions the working population enables those who can no longer work to benefit from economic development.
- Autonomous administration: volunteer representatives of the insured and of employers co-operate in the management of social insurance.

There are five types of insurance within the system: health, accident, pensions, unemployment, and nursing. Each branch operates independently, but their decision-making process is bound by statutory regulations. Health insurance and accident insurance play an important role in workplace health promotion and protection.

The services offered by health insurance funds are governed by the Fifth Book of the Social Security Code. They mainly provide benefits in kind, meaning that insured persons receive health care services from suppliers who are paid directly by the health insurance funds. Health insurance is covered by the following funds:

- Local sickness funds
- Guilds' insurance funds
- Companies' health insurance funds
- Substitute insurance funds
- Agricultural insurance funds
- Seamen's health insurance fund
- Federal miners' insurance fund

The statutory accident insurance funds insure their members against accidents in the workplace, including occupational diseases. Their primary responsibility is to prevent accidents at work, occupational diseases, and work-related health risks. The benefits they provide are: medical and vocational rehabilitation, injury benefits or temporary allowances, nursing, disability pensions or survivors' pensions, and transportation costs and death benefits.

In Germany, professional and trade associations are the accident insurance carriers. They include industrial associations (for all enterprises in industry and the public service sector, agricultural and horticultural enterprises) and the mariners' association (for all of seafaring and sea-fishery enterprises).

In 1989, under the Act on the Structural Reform of the Health Care System, health promotion became a legal component of health insurance policies. This enabled health insurance funds to develop and finance a

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**Germany's new health care reform initiative requires the health insurance funds to engage in preventing work-related health risk.**

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**Health promotion interventions in the workplace are defined as any activity which contributes to preventing workplace hazards by strengthening factors conducive to health at individual and organisational levels.**

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broad range of workplace health promotion programmes and activities. The big branches of health insurance funds therefore allocated a small part of their research resources to health promotion.

In 1997, the health insurance funds were re-regulated. They could no longer fund community health promotion activities, and their workplace-related activities were restricted to research into possible relationships between hazardous working conditions and work-related diseases. At the same time, the responsibilities of the statutory accident insurance funds in the area of prevention were expanded. These changes resulted from adapting German statutes to the European Framework Directive on Health and Safety (Worker Protection Act 1996), which extended the obligations and responsibilities of employers with regard to health and safety. They strengthened co-operation between health and accident insurance funds.

Following the inauguration of the new German administration in 1998, the German Health Ministry started a new health care reform initiative aimed at containing escalating public health care costs. As part of this initiative the Federal government again revised the legal basis for health promotion investments by health insurance funds. Beginning on January 1, 2000 the health insurance funds were again authorised to develop and finance workplace health promotion, including the organisation of primary prevention and workplace health promotion activities. All activities have to be based on a national quality assurance system established by the health insurance funds and must bring in other key players in public health such as the federal health agency, public health services, public health sciences, and the medical profession.

The new law defines workplace health promotion as a supplementary field of action to health and safety. It requires the health insurance funds to engage in preventing work-related health risks. Total expenditures of the health insurance funds may not exceed 5 Deutschmarks per insured per year for health promotion.

Based on the Worker Protection Act and the extended prevention role of the accident insurance funds, the new strategy to ensure health and safety at work comprises the following elements:

- Hazard and stress analysis (risk assessment)
- Planning of interventions
- Prevention of accidents at work and work-related diseases
- Health and safety at work

Health promotion interventions in the workplace are defined as any activity which contributes to preventing workplace hazards by strengthening factors conducive to health at individual and organisational levels. The German approach reflects the concept of workplace health promotion laid down in the Luxembourg Declaration of the European Network for Workplace Health Promotion, which has been formally adopted by a number of German companies.

### **Discrimination and the right to work: the evolution of the legal framework**

According to German law, “disabled people” are all those who are affected by a functional limitation originating from a physical, mental, or emotional state, which deviates from the norm for a person of that age and is not temporary. This reflects the three stages of the WHO definition of disablement: impairment, disability, handicap.

The right of all people to be treated equally is firmly rooted in the **German Basic Law**, to which the following statement was added in 1994: “No-one

may be disadvantaged because of his disability.” According to the **First Book of the Code of Social Law**, people who are physically, mentally, or emotionally disabled or who are threatened by this type disability have a “social right” to the help they require. The goals of the law, and of the **Act on the Harmonisation of the Services for Rehabilitation** and the **Federal Social Assistance Act**, are as follows:

- To prevent, remove, or improve disability, avoid its worsening, or reduce its effects;
- To secure a place in the community, particularly in working life, for the disabled person, which corresponds to his or her preferences and abilities.

As in all other German laws and regulations, mental health disability is placed on the same level as physical disability. It is not governed by separate laws or treated in a special way. Legislation also exists to promote the inclusion of people with mental health disabilities in gainful employment. The most important laws governing the rights of people with disabilities are:

- The Social Code,
- The Vocational Training Act,
- The Employment Protection Act,
- The Severely Disabled Persons Act 1974.

The objective of all of these laws is to rehabilitate people with disabilities and allow them, as far as possible, to permanently engage in gainful work. Their underlying principle, “rehabilitation before pension,” is laid down in the **Rehabilitation Harmonisation Act**. Rehabilitation is based on a network of medical, educational, occupational, and social measures. Responsibility for rehabilitation is shared by:

- Statutory health insurance,
- Statutory pensions insurance,
- Statutory accident insurance,
- Social welfare agencies, State benefit offices, local benefit offices, the main welfare offices and local welfare offices,
- The Federal Institute for Labour,
- Communities, if none of the former are responsible.

The nature and cause of the disability and the insurance relationship determine which of these institutions is responsible. Despite basic entitlement to equal benefits, the number of rehabilitation initiatives and of institutions charged with enforcing them is so large, that individuals with the same disability sometimes receive different benefits. Though the involvement of so many agencies and institutions allows specific preventive activities and the development of defined policies and services, the co-ordination of services needs to be improved to avoid inconsistency, difficulties in identifying the appropriate agency, and delays in the delivery of services. Some regions and local authorities have appointed a disabled services co-ordinator, but in most cases this is left to independent institutions (NGOs).

## **THE SEVERELY DISABLED PERSONS ACT 1974**

The Severely Disabled Persons Act covers the relationship between employers and severely disabled employees. The Act’s primary function is to protect workers with disabilities and define employers’ responsibilities towards them. Amended in 1986 and 1990, it is the basis of current compulsory employment policy. In the private and public sectors, companies with more than 16 employees must fill 6% of jobs with disabled persons in a way which allows them to be “able to utilise and develop further their knowledge and

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*In all German laws and regulations, mental health disability is placed on the same level as physical disability. It is not governed by separate laws or treated in a special way.*

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*The co-ordination of services and achieving uninterrupted procedures are seen in Germany to be the central problems in trying to achieve effective and cost-effective rehabilitation.”<sup>1</sup>*

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*In the private and public sectors, companies with more than 16 employees must fill 6% of jobs with disabled persons in a way which allows them to be “able to utilise and develop further their knowledge and skills as fully as possible.”*

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***“There is the danger that the disadvantages resulting from formal equality of treatment will give a boost to further exclusion of mentally disabled persons. The legal equality provided by the Severely Disabled Persons Act does not always lead to equal opportunities. For example, the special employment protection often does not become a reality for the mentally disabled. It can only be granted if at least an application for recognition of the disability has been submitted at the time the notice of dismissal is given... In the case of mentally disabled persons (this) ... is often not the case. They waive the right to a disability identity card for fear of being stigmatised.”<sup>4</sup>***

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skills as fully as possible”<sup>2</sup>. The act does, however, allow the employer to substitute a fee and “buy out” of this obligation. In the past, employers have attempted to avoid taking on new staff with disabilities by satisfying the quota through long-standing employees diagnosed as disabled\*.

Under the Severely Disabled Persons Act the disabled employees are entitled to special employment protection. A person with a disability can only be given notice of dismissal with the consent of the main welfare body. This, however, discourages employers from hiring individuals with disabilities because it gives them the false impression that disabled persons have absolute job security.

The act establishes finance grants, which are administered by the main welfare agencies in collaboration with psychosocial services and independent agencies. These grants are intended to ensure that disabled persons are employed in accordance with their skills and knowledge and that they do not lose their social status. The grants are not linked to the severity of the disability. People with mental health disabilities usually do not want to be issued “a disability identity card,” which indicates that they are 30% to 50% disabled and unable to find or retain employment for fear of stigmatisation.

German legislation does not differentiate between physically, mentally, or psychologically disabled people, which can lead to unequal treatment for the mentally and psychologically disabled. Because much of medical, occupational, and social rehabilitation is geared to physical disabilities, it can be counterproductive for the mentally disabled, whose treatment requires a highly integrated team approach.<sup>3</sup> Rehabilitation facilities are usually located a long way from people’s homes, which, in the case of the mentally disabled, often worsens the feeling of social isolation.

### ***Vocational training for people with disabilities***

**I**n Germany, the Federal Institute for Vocational Training recognises about 780 training regulations for disabled persons, relating to approximately 150 occupations. People with disabilities can apply to the agency responsible for specific training for training according to special regulations.

The Vocational Training Act and the Crafts Regulations provide for the modification of training courses set out in the Training Regulations to take into account the needs of disabled trainees. To increase equality of opportunity, the Federal Institute for Vocational Training adopted a recommendation in 1998 for the development of nation-wide special training regulations for disabled persons. The chambers of industry, commerce, and crafts have also passed regional training regulations. The mentally disabled, like the physically disabled, receive the help and services required for their permanent integration into the workplace. However, professional rehabilitation is not implemented as automatically for the mentally disabled as for the physically disabled. Characteristics of mental health disability make targeted rehabilitation more difficult. “It is often not possible to make a safe prediction with regard to the success of the measures; if this is the case it is necessary first to develop prospects for rehabilitation within the framework of specific preparation for work which helps to chart a course from clinical supervision into the real world of work and social life.”<sup>5</sup>

\*In Germany, all people who are legally recognized as being disabled are labelled “schwerbehindert” which translates literally as being “severely disabled”. Within the law, there exist different levels regarding the degree of disability. As the term “severely disabled” creates misunderstandings in international discussion, this report refers to disabled persons meaning all persons having a legally recognized disability and being covered by the Severely Disabled Persons Act.

Training courses which aim to prepare the mentally disabled for work take place in job training centres and in rehabilitation institutions for the mentally ill and disabled. They provide important opportunities for job preparation near the participant's home. While rehabilitation institutions carry out medical treatment and initial preparation for working life, the job training centres, as special institutions for professional rehabilitation, offer practical occupational qualifications as well as psychosocial support. They impart or update professional knowledge and skills and give participants the opportunity to practice or acquire generally expected modes of social behaviour in the workplace or at the training or retraining location. They do this by:

- Strengthening physical, mental and social stability,
- Encouraging motivation,
- Creating the necessary view of reality,
- Preparing for and implementing a realistic choice of job or profession,
- Getting to know and dealing with the disability in the real world of work.

“The courses offered in the job training centres generally last between 12 and 15 months, but three-month courses are also offered. The aim is to find a realistic job perspective, to reintegrate the participants into the general employment market or to make them sufficiently stable to undertake subsequent retraining or training. In some cases the course may lead to the judgement that an individual is not fit for work.”<sup>6</sup> Men and women who are generally at least 18 years old and who have a mental health problem can be accepted into job training centres.

## REHABILITATION

Key components of rehabilitation for mental health disabilities (as with all disabilities) are vocational assessment, training, and follow-up support. This process must be handled flexibly and without rigid time limits. It should always be possible to extend or shorten the measures and to switch between medical and occupational rehabilitation.

“To avoid relapses, waiting times must be minimised and utilised as meaningfully as possible. For mentally disabled persons frequent changes of measures with different reference persons and geographical situations must be avoided. Training measures to prepare for an occupation should pass as smoothly as possibly into vocational training.”<sup>7</sup>

Vocational training of people with mental health disabilities is based on the concept of keeping people “as close to the community and the company as possible”. But studies show “that 40% of adolescents suffering from schizophrenia cannot immediately resume their educational and occupational activity or return to their home environment after inpatient treatment because of the chronic nature of their disorder or marked disturbances within their family.”<sup>8</sup> Training is also based on the principle that one should proceed to a higher level of occupational qualification only after the lower level has been consolidated. “The premature commencement of occupational rehabilitation measures based on unreal wishes without understanding of the illness mostly results in failure.”<sup>9</sup> The purpose of rehabilitation is not only to integrate people with disabilities into the economic and social mainstream of society, but also to prevent further disability. Prevention is integral to any rehabilitative approach. The substance of prevention must be aimed at mitigating risk factors which worsen illness and the ensuing disability.

The choice of occupation for the individual with a mental health disability is determined by the specific dynamics of the illness. Preparation for occu-

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***Prevention is integral to any rehabilitative approach. The substance of prevention must be aimed at mitigating risk factors which worsen illness and the ensuing disability.***

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***Vocational training of people with mental health disabilities is based on the concept of keeping people “as close to the community and the company as possible”.***

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pational and social re-integration should take place in the hospital and should begin as soon as the acute illness processes have receded. Collaboration between the general practitioner, the consultant, the hospital, the vocational adviser, the school, the parents and the rehabilitation facility is essential

“Measures to prepare for an occupation therefore fulfill an important bridging function towards occupational and social reality. On this road the disabled person often needs special assistance to master the anxieties arising (medication, sound relationships, dosed demands, experience of success, recuperation breaks, possibilities of withdrawing).”<sup>10</sup>

## WORK AND OCCUPATIONAL THERAPY

Lengthy periods of illness or hospital stays frequently lead to a loss of elementary mental and social skills. “Patterns of communication and interaction acquired in the illness process and typical for mentally disabled persons have to be broken down and new patterns of communication learned. It should also be considered, however, that for some patients the hospital with its very low-stimulus and low-demand living organisation is an attractive alternative to the anxiety-inducing demands of actual life.”<sup>11</sup>

The crucial consideration in occupational integration is to make vocational training available as soon as the appropriate training programme has been identified.

“The working time must be organised to be as flexible as possible (breaks, possibilities for withdrawing when overtaxed, work plans before and after crises). By means of adapted requirements overload and understretching must be avoided as far as possible.”<sup>12</sup>

Financial support for companies integrating disabled employees into the workplace is available from the Employment Office. Benefits are also available under the Severely Disabled Persons Act.

## CORPORATE OCCUPATIONAL TRAINING

A stable home and flexible training programme are the major prerequisites for the success of corporate occupational training for mentally disabled persons. Companies can access the support of skilled specialists, usually provided through local psychosocial services. Special provisions can be made for people with mental health disabilities for whom the standard examination situations are too emotionally stressful to allow peak performance. And there are special training regulations for disabled persons.

**Workshops for disabled people** cater primarily to people with intellectual disabilities who are not ready for the general employment market. Since the workshops are geared primarily to people with intellectual and physically disabilities, individuals with mental health disabilities often are not performing tasks which match their capabilities. Furthermore, they often feel stigmatized by being juxtapositioned with more visible disabilities

**Transitional companies** ease the transition from a workshop for disabled people to the general employment market. They often include companies operating as much as possible under market conditions. They seek to mitigate the processes of mental and social deterioration brought about by unemployment and long periods of hospitalisation and preparation for reintegration. A major element of these models is that they provide reasonable remuneration appropriate to the work performed.

**Special forms of assistance** are necessary to enable persons with mental health disabilities to enter the world of gainful employment. Socio-psychiatric services, which have been built up over the past few years, seek to involve patient organisations and family to prevent social withdrawal and to restore or maintain qualifications.

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*In Germany, financial support for companies integrating disabled employees into the workplace is available from the Employment Office. Benefits are also available under the Severely Disabled Persons Act.*

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*“Psychosocial services and work assistantships help prepare and stabilise integration. The tasks encompass educational work for companies, intensive advice, support, and assistance with problems in the company and the social environment.”<sup>13</sup>*

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**Self-help initiatives:** The advent of social psychiatry has led to the emergence of numerous self-help organisations and introduced psychotherapeutic approaches into rehabilitation. To be effective, however, they require a supportive situation in the community, workplace, and family, which is not always present.

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# Part 4

## The role of government and the social partners

### Government

Government policy in Germany is to treat all types of disability equally. It attempts to create as much equality of opportunity as possible for disabled people and to reduce disadvantages. It assumes that disabled persons are not passive recipients or objects of help and support. In fact they are responsible citizens and are the experts regarding their disability and how they can best use their abilities to ensure their social and economic integration into society.

Legal regulations, institutions, and services cannot be more than an opportunity and a chance for integration. The disabled person or the person threatened with disability must be motivated to take advantage of them. Advice and help regarding integration must be adapted to the person's level of motivation and must develop it, taking into consideration the rehabilitation measures which are possible in each case.

### THE INTERNATIONAL FRAMEWORK

Questions regarding the rehabilitation and integration of disabled people must be discussed and solved nationally, but they are also the subject of a growing exchange of experience at the international level. Achieving equal opportunity for people with disabilities is becoming a central feature of decisions taken internationally. Ethical questions regarding treatment, particularly of people who are unable to grant permission on their own behalf, are being more frequently discussed.

Resolutions and directives of the European Council of Ministers and the United Nations have influenced German policy and legislation. The European Council of Ministers has played a pioneering role with its 1992 resolution regarding "A coherent policy for the disabled." This sets out a comprehensive concept and direction, relating the demands and developments in the different areas of life and politics to one another and drafting a script for a European policy for disabled persons. The "Framework Provisions for the Creation of Equality of Opportunity for the Disabled" which were passed by the General Assembly of the United Nations are also attracting increasing public attention.

The specifications of the European Council of Ministers and the United Nations influenced the resolutions passed by the executive institutions of the European Union. The European Parliament refers to the framework directives of the United Nations in its 1996 "Resolution on the Rights of the Disabled." The Council of Ministers and the government representatives in the Council refer to the resolution of the European Council of Ministers in their "Resolution on Equality of Opportunity for the Disabled," also of 1996. Both resolutions require that member states achieve equality of opportunity for disabled people and state strongly that any kind of negative discrimination against people with disabilities must be avoided or eliminated.

In order to further strengthen these goals, the European Council of Ministers included the following in the Treaty of Amsterdam in 1997:

- An employment chapter which also applies to the disabled;

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*German government policy assumes that disabled persons are not passive recipients or objects of help and support. In fact they are responsible citizens and are the experts regarding their disability and how they can best use their abilities to ensure their social and economic integration into society.*

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*German policy on disability issues is being influenced by the European Council of Ministers and the United Nations.*

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- The social charter, which did not previously apply to all member states;
- Empowerments in the Treaty on the European Union for Community institutions;
- Fighting discrimination on several grounds including disability;
- With a qualified majority, programmes to establish initiatives to combat social exclusion.

Positive discrimination, such as the obligation to employ disabled persons and the special employment security, which they enjoy, cannot be called into question at the European level. The Treaty of Amsterdam led to a strengthening of social policy at the level of the European Community.

## POLICY IN GERMANY

A 1994 change to the German Basic Law stating that “no-one may be put at a disadvantage because of his or her disability“ had the following effects:

- Efforts towards equal rights for disabled people and their participation in the life of society were confirmed and took an important step forward;
- The presumption that disabled people should be integrated into society became a stronger component of the Constitution of the Federal Republic of Germany;
- The protection of disabled persons against disadvantageous treatment acquired constitutional status.

As a fundamental constitutional right, prohibition of disadvantageous treatment is binding on the legislature, the administration, the judiciary, and the rulings of the courts in the Federation and the Federal States. The Basic Law gives disabled persons the right to demand that unfavourable decisions and measures taken by public authorities not be based on any physical, mental, or emotional disability. This is a right which protects individuals, but does not extend to groups.

Though the Basic Law does not contain specific directives to legislative authorities, the German government considers it fundamentally appropriate to change rulings which are considered by many disabled persons to be discriminatory or disadvantageous, as a supplement to the constitutional law. - In this connection, the relevant associations cite the following as discriminatory:

- § 8 Par. 1 of the German Civil Code, which states that legally incompetent persons are not permitted to establish a permanent residence,
- §§ 104 and 105 of the German Civil Code regarding legal incompetence,
- The obligation of disabled persons to present a psychological report before being granted a driving licence,
- Fire-related regulations which specify that disabled persons may not enter certain premises or may only enter them under certain conditions.

The legislature recognises the necessity for improved co-ordination between existing agencies and instruments and improved co-operation between the institutions responsible for rehabilitation.

## The Social Partners

The social partners agree on the principle of integrating people with disabilities into the economic and social mainstream of society. To protect the interests of taxpayers and of other stakeholders who contribute to the costs of rehabilitation, the Federation of German Employer Associations advocates maximising the efficiency of rehabilitation measures and increas-

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**“No-one may be put at a disadvantage because of his or her disability.”**

**German Basic Law, 1994**

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**The Federation of German Employer Associations advocates maximising the efficiency of rehabilitation measures and increasing the responsibility of disabled persons for their own concerns and care.**

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ing the responsibility of disabled persons for their own concerns and care. The Severely Disabled Persons Act is to be revised to reflect these points.

The Federation of German Employer Associations and the German government are against the draft of a “Council directive on the establishment of a general framework for realising equal treatment in employment and occupations“ presented by the European Commission in the Treaty of Amsterdam. They fear is that if a general anti-discrimination policy similar to that of the USA becomes part of the European social model, protection of the principle of equality in German employment and social law would be limited, and that would impact persons with disabilities.

There are differences of opinion regarding the disabled persons fee which companies can pay when they do not hire the proportion of severely disabled persons mandated by law. The Federation of German Employer Associations pleads: “for a lowering of the currently excessive mandatory employment quota from 6 to 5 % and for deletion of the 5-day additional holiday for the severely disabled, which is no longer necessary in view of the tariff-related and statutory holiday entitlement of around 6 or 4 weeks.”<sup>2</sup> The German Trades Union Confederation, however, calls for better use and increased effectiveness of legal instruments to enforce the duty of employers to hire disabled persons.

## **Non-governmental organisations (NGOs)**

**I**n recent decades, self-help groups and organisations of and for disabled persons have made an essential contribution to social policy and have provided individualised and flexible help and support. In addition, NGOs are responsible for large areas of state-financed professional rehabilitation.

The following is a list of organisations for people with disabilities. It does not claim to be comprehensive:

Aktion Grundgesetz : Kampagne für ein Diskriminierungsverbot  
Aktion Mensch  
Arbeiterwohlfahrt (AWo), Bonn  
Arbeitsgemeinschaft Behinderte in den Medien (ABM) e.V.  
Bundesarbeitsgemeinschaft “Hilfe für Behinderte” (BAGH)  
Club Behinderter und ihrer Freunde (CeBeeF) Frankfurt  
Deutscher Behindertenrat (DBR)  
Deutscher paritätischer Wohlfahrtsverband e.V. (DPWV)  
Deutsche Vereinigung für die Rehabilitation Behinderter e.V. (DVfR)  
Experten helfen Behinderten (EHB)  
Forum Selbstbestimmter Assistenz behinderter Menschen e.V.  
Interessengemeinschaft “Selbstbestimmt Leben” (ISL)  
Kooperationsverbund BBW/BFW : Aus- und Weiterbildung für Behinderte  
Zentrum für selbstbestimmtes Leben behinderter Menschen Mainz e.V. (ZSL)  
Bundesvereinigung Lebenshilfe für Menschen mit geistiger Behinderung (BVLH)

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***“It is necessary in particular to obtain a uniform definition of disability, one which makes clear the relationship between physical damage and its consequences for work and occupation, as well as an improved co-operation and networking between occupational rehabilitation and corporate practice.”<sup>1</sup>***

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***“Self-help organisations are largely involved in planning and decision-making in the extra-parliamentary and parliamentary domains on a municipal, state and federal level, and so decisions are not taken on the disabled, but with the disabled.”<sup>3</sup>***

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# Part 5

## Managing mental health in the workplace

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*“A survey conducted among 30,000 working people in 1991/1992 in Germany shows that for 25-30% of those questioned there are still various environmental burdens or physical strains acting ‘practically all the time’ or at least ‘frequently.’”*

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*In Germany, it is generally acknowledged that comprehensive corporate health protection must take greater account of job stress issues, such as burnout, depression and mobbing.*

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In Germany, improved standards for working conditions has been accompanied by increased criticism of conditions which induce stress and impair health.

“A survey conducted among 30,000 working people in 1991/1992 in Germany shows that for 25-30% of those questioned there are still various environmental burdens or physical strains acting “practically all the time” or at least “frequently.” About every tenth person has to work at night and about every fifth works alternating shifts.

The working individuals questioned mention mental strains in the workplace more frequently than the traditional physical and environmental strains. The proportion of those affected by various mental strains is about 20 – 40%, depending on the type of strain, above that of those who suffer from more traditional strains. Mention is made here very frequently of “high demands on concentration” (62%) and “heavy pressure of deadlines and performance” (55%).”<sup>1</sup>

These survey results reflect the change in the strain structure and the growing importance of mental strains due to changes in workplace values.

“A breakdown according to sectors, occupational groups, occupational qualification, and sex reveals clear differences. High pressure in terms of performance and deadlines is experienced in processing industry by between 50% and 80% of workers, depending on the sector. In the service sector these figures fluctuate between about 40% and 70%.

There are clear differences between East and West Germany, apart from a few individual types of strain. Working people in the East report more frequently about strains. This is especially marked with regard to physical and environmental strains. In the case of mental strains the differences are smaller. Sometimes the impact in this area is even higher in the West. The number of working people affected in the East is also higher with respect to multiple strains. Only 31% of those questioned say they are not subject to any physical or environmental strain (West: 43%).”<sup>2</sup>

### Health and safety issues

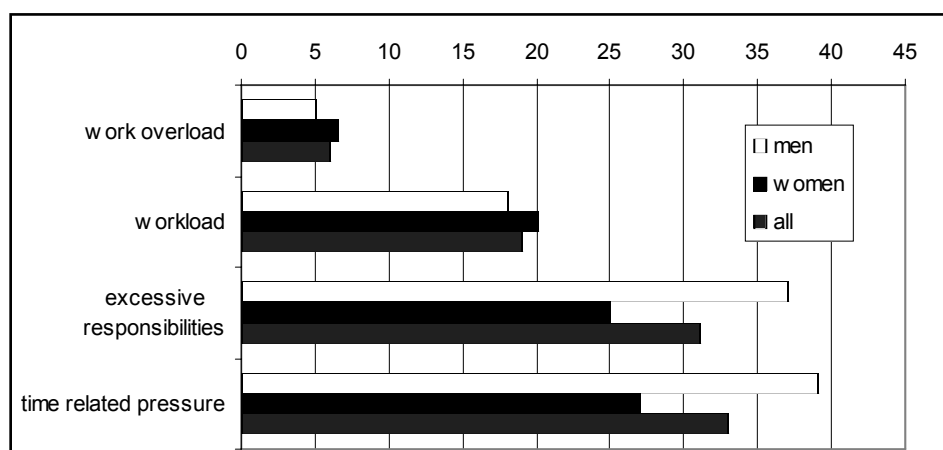
In Germany, it is generally acknowledged that comprehensive corporate health protection must take greater account of job stress issues, such as burnout, depression and mobbing<sup>3</sup>. Mental health stress in the workplace is increasing because of the introduction of new technologies and a growing intensification of work.

For years, individual German trade unions and the German Trades Union Confederation have been concerned about negative psychological influences in the workplace such as stress and mobbing. However, employers’ associations and the Expert Groups for Occupational Safety and Health are only beginning to discuss these issues. Regarding the new Occupational Safety and Health Act and the new code of social law the German Trades Union Confederation<sup>4</sup> states that the additional tasks of occupational physicians include offering advice on mental stress. However, “in practice the implementation of the new legal provisions still faces an unusually large number of difficulties and obstacles. In particular the competent occu-

pational safety and health institutions are often out of their depth with the new, wide-ranging tasks.”<sup>5</sup>

Trade unions repeatedly draw attention to the mental factors related to work at computer terminals and their influence on overall health. The working culture of offices is under growing scrutiny because of the increased pace and concentration which come with modern technology. Dickhausen, the Administrative Director of the German Trade Union Confederation, draws attention to “the resulting mental strains in the workplace, [which] represent a health impairment which must be taken seriously.”<sup>6</sup>

The social partners, like government institutions, the employers’ liability insurance associations, and the health insurance agencies, agree on the necessity of progressive concepts for prevention which aim to reduce psychological and mental stress and which specifically include the promotion of health within companies.



**Mental stressors in the workplace** (Source: [www.ergo-online.de](http://www.ergo-online.de))

A study published in 1997 on the “Design of work requirements with respect to mental health and safe conduct”<sup>7</sup> points out that the restrictive content of work has an adverse effect on the genesis of anxiety-induced stress states, especially among elderly employees. The authors come to the following very important conclusion, however:

“An incorrect and fatal consequence would be to search for “age-appropriate”, simple activities; an approach which is unfortunately still seen as the way to create a humane work design. Especially since the related restrictiveness has precisely the opposite effect of worsening the problem. The results point rather to the need for work design concepts which permit a lifespan-appropriate solution by means of an optional and flexible adaptation of working structures to human resources.”<sup>8</sup>

Though statistical evidence is limited, we know that job stress also influences the rate of workplace accidents. The Federal Institute for Occupational Safety and Health attributed “only” 1% of all fatal accidents in 1993 to physical-mental causes.<sup>9</sup> It is still unclear, however, how many instances of workplace stress are concealed behind the 43% of accidents attributed to behavioural causes.

In the workplace, mental health problems are mainly triggered by overload or underutilisation of capabilities. These work-related influences can lead to a deterioration of existing physical or psychological complaints, to stomach ulcers, heart and circulatory disorders, depressions and addiction. In the early 1980s a study of 840 employees in 10 German industrial companies yielded alarming results<sup>10</sup>: It showed that female workers had worse mental health than male workers did. All employees were subject to job

**In the workplace, mental health problems are mainly triggered by overload or underutilisation of capabilities.**



stress factors, which included job insecurity, blocking of promotional opportunities, deadline pressure, and underutilisation of capabilities.

The study concludes that mental health complaints and absenteeism were both attributable to negative working conditions. The greatest absenteeism came with monotonous, repetitive activities, and the lowest with complex, demanding activities. Mental health complaints occur more frequently with monotonous, repetitive activities than with more highly skilled tasks<sup>11</sup>. Symptoms grow if employees are afraid of losing their job. Other stress factors result from contradictions between occupational expectations and opportunities to realise them, overload or underutilisation, and conflicts with superiors and co-workers.

## Corporate health promotion

Within the framework of a network for corporate health promotion, member states of the European Union and the countries of the European Economic Area have arrived at common definition of corporate health promotion<sup>12</sup>. According to this definition, corporate health promotion encompasses all joint measures taken by employees, employers, and society to improve wellness and health in the workplace. There are three strategies for attaining this objective:<sup>13</sup>

- Improving work organisation and working conditions,
- Promoting active employee participation,
- Reinforcing personal areas of competence.

Over the past few years, interest in corporate health promotion at the national level and in Europe has grown considerably. In 1989, Germany passed the Health Reform Act, which established health promotion and prevention as responsibilities of the statutory health insurance schemes, which then set up appropriate infrastructures.

Corporate health promotion can be approached<sup>14</sup>:

- In the context of behaviour modification and health education in the workplace
- As a component of corporate occupational safety and health;
- As a strategy for reducing sickness-related absenteeism;
- As a combination of health-appropriate work design and health education;
- As a component of organisational development and management systems.

Historically, corporate health promotion began as a series of measures to prevent selected risk factors in the area of heart and circulatory disorders. It was later extended to preventing combined physical and psychological risk factors. A qualitative leap forward came with the combination of measures for health-appropriate work design, education, and the dissemination of information. This was supported by occupational safety and health legislation at the European level and by applying the WHO policy on health promotion to the workplace.

In Germany, the social partners have developed a special understanding of corporate health promotion, especially against the background of enduring public debate about the economic situation and the issue of labour costs. Corporate health promotion is seen as a vehicle for solving the absenteeism problem and reducing the resulting wage costs.

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*According to a definition arrived at by the European Union and the European Economic Area, corporate health promotion encompasses all joint measures taken by employees, employers, and society to improve wellness and health in the workplace.*

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The most recent step in the development of health promotion links it to organisational development and management. Particular attention has been given to linking health promotion to quality systems. A similar approach can be reported in the field of occupational safety and health.

## SUCCESS FACTORS OF CORPORATE HEALTH PROMOTION

Practical experience and scientific evaluation reveal that successful health promotion programmes depend on the following factors:<sup>15</sup>

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**Corporate health promotion is seen as a vehicle for solving the absenteeism problem and reducing the resulting wage costs.**

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- **Participation:** All parties involved, especially employees, must be actively included in all phases of corporate health promotion.
- **Integration:** Corporate health promotion must be taken into account in all major decision-making areas. This includes integrating it into existing management systems.
- **Holism:** Corporate health promotion encompasses both psychosocial and environmental issues. Risk reduction should be linked with the expansion of policies and programmes which include all aspects of occupational health and safety.
- **Project management:** Corporate health promotion measures must be implemented systematically. Ideally, they should be integrated into a process of continuous improvement, be data-supported, and communicated appropriately internally and externally.

## CORPORATE HEALTH PROMOTION AND WORKPLACE STRESS PREVENTION

Preventing stress in the workplace can be addressed through:

- Stress reduction programs;
- Individual advice and team supervision;
- Measures relating to health-appropriate work design and organisational development.

- **Stress reduction programmes**

In Germany, many types of relaxation training procedures have been developed for the workplace. They are targeted at stressed employees in general and human resource managers in particular. Stress reduction programs have been designed which include relaxation procedures, role playing, and behavioural training to increase self-confidence and improve interpersonal skills.

Until the responsibilities of the statutory health insurance schemes changed in 1997, stress reduction was one of their main prevention activities. In Germany, stress reduction programmes have been delivered mainly through evening institutes and independent providers of adult education. For management personnel, providers include management consultancy companies, freelance consultants, and personnel developers. Though there is no empirical data available on the spread and acceptance of these procedures, it can be assumed that they are very much in demand despite changes on the provider side.

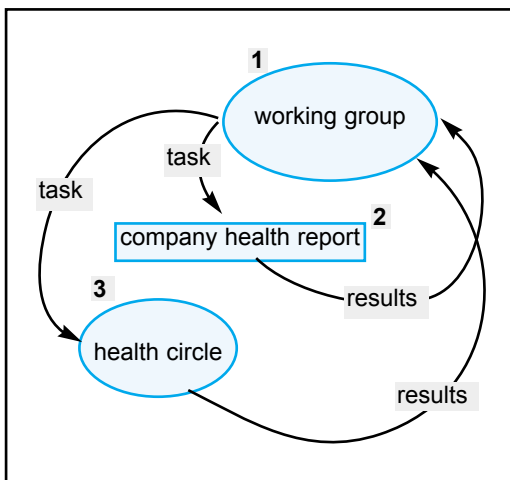
- **Individual advice and team supervision.** Though we cannot give a full description of the models on which these are based, they include all the methods and concepts applied in psychotherapy. It is not possible to identify any empirical details on the spread of these procedures.

- **Health-appropriate work design and organisational development.** There is a specific concept in Germany called the “health circle”. It



serves to identify suggestions on improving working conditions which are detrimental to health so that improvement can begin.

Health circles are ad hoc committees which include employees, superiors and representatives of all other groups and functions involved (company doctor, human resources department, works council, occupational safety etc.). They have meetings of limited duration in which they construct and prioritise a catalogue of identified stresses and suggest ways for addressing them. The findings of the circles are reported back to the working group which uses them as a basis for initiating decisions.



The adjacent figure shows a simplified model of this procedure.

Initially, the framework for implementing the health circle must be energetically championed by people within the company with support from outside experts, if necessary. The procedure begins by setting up a working group in which all stakeholders, including decision-makers, are involved. The working group conducts a needs analysis, modelled on the appraisal reports drawn up by statutory health

insurance agencies in connection with the analysis of sickness-related absenteeism. The analysis helps to pinpoint problems within the company, which should be the starting points for planning measures. Subsequently problem areas, i.e. departments or plants with above-average sickness-related absenteeism, will be identified for the consideration by health circles.

Suggestions from the health circles make it possible to tackle stressful working conditions and provide for health promotion through a continuous process of improvement. The health circle approach has been successful in many Germany companies. The health circle philosophy is consensus-driven and depends on a constructive relationship between the social partners. Evaluation studies on health circles testify to their high level of acceptance. Data on the implementation of their improvement proposals demonstrate their effectiveness.

## QUALITY ASSURANCE AND INTEGRATED MANAGEMENT SYSTEMS

Linking of quality management and corporate health promotion is another step in corporate stress prevention. It is distinguished by the fact that it includes central organisational structures and processes.

Recently, occupational safety and health agencies and the public health sector have initiated a discussion on the connection between corporate health promotion and management systems, particularly quality systems, in Germany and in other European Union countries. Using an approach based on the European Business Excellence Model, Germany has led the European network for corporate health promotion in developing European quality criteria, which served to identify and document successful models in nearly 20 countries.

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**Health circles are vehicles for tackling stressful working conditions and providing for health promotion through a continuous process of improvement. The health circle approach has been successful in many German companies.**

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The European Business Excellence Model, which is the basis for the European Award for Total Quality Management, also served as the basis for the evaluation model for corporate health promotion which Germany developed for its statutory health insurance system. Concurrently, in the context of the discussion on occupational safety and health management systems, members of Germany's occupational safety and health community have produced an important document for the evaluation of these systems which addresses the most relevant issues in corporate health promotion

## **Corporate health promotion in German companies: Case studies**

### **REWE HANDELSGRUPPE**

Branch:	Trading
No. of employees:	210,000 in Europe, 170,000 in Germany
Products/Services:	Food, non-food and services
Locations:	12,000 branches in Europe, 9,500 in Germany
Miscellaneous:	76% women, 60% part-time workers

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***REWE regards the health protection of its employees as a social obligation and an economic necessity.***

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REWE regards the health protection of its employees as a social obligation and an economic necessity. Matters of occupational health and safety are viewed as management tasks and are regularly dealt with in seminars and training courses.

#### **Broad alliance and thorough planning**

At REWE, a national working group on health controls all health-related measures. This group comprises 25-30 members from the REWE companies, its branches and headquarters. They include the head of the social department of the central organisation, the leading occupational safety and health officer, members of works councils, human resources branch managers, representatives of the employers' liability insurance association and the company health insurance fund, as well as external consultants from research institutes and from the Federal Association of Company Health Insurance Funds.

Since 1993 health reports have been prepared every year to help detect any irregularities in the sickness profile of the company. With industrial accident statistics and data from stress analyses, they serve as a basis for planning health promotion.

REWE has participated in several research projects. In the "KOPAG" project on the prevention of work-related illnesses, health risks were surveyed in the warehouse, in sales, at the cash registers, and in the transport sector. The organisation of work improved accordingly. Another project was geared to pooling all activities relating to occupational health and safety and workplace health promotion and integrating them into the company processes.

In order to improve ergonomically work at the cash register, new till stools and tables were developed. Health circles have been set up in work areas where job stress has been identified as a serious factor affecting employee health. Many measures for reducing stress have been introduced through improved workplace design and organisation of work. Employees who frequently transport heavy loads are trained in good posture, and the executive team attends seminars on promoting health through staff leadership.

Thanks to the wide variety of health-related activities, REWE has been able to substantially reduce work stress for its employees. As a result, the working atmosphere and staff satisfaction have improved considerably, leading to greater customer satisfaction.

Over a period of four years, absenteeism due to illness fell by 0.8% to 5.7%, and the number of industrial accidents has almost halved over the last 10 years.

## **VOLKSWAGEN AG**

Branch: Automobile Industry  
No. of employees: 104,000  
Products/Services: Cars  
Locations: 6 plants in Germany, headquarters in Wolfsburg

At Volkswagen AG, the Group Management Board and central works council have set out guidelines on occupational health and safety and health promotion which outline minimum standards world-wide. Guidelines on health management also apply to all domestic factories. Every year, about DM 260 is invested per employee in occupational health and safety and health promotion.

Health management at VW is controlled and co-ordinated by the health department, the occupational health and safety committees of the individual plants and the “health working groups,” if available. The health department, occupational safety department, works council, and company health insurance fund are also represented in these working groups. Discussions on occupational health and safety are held every year.

A comprehensive company health reporting system serves as the basis for planning. The results of risk analyses, occupational medical check-ups, staff surveys, as well as analyses of absenteeism due to illness and incapacity to work are taken into account.

At VW the employees participate in many health related activities such as health groups, ideas management, special workshops, surveys and the “try-out” method.

The company has created a wide variety of programmes to promote health-conscious behaviour among the employees, such as back and posture courses, lifting/carrying, fitness training courses, and relaxation courses. A works agreement on co-operative behaviour in the workplace clearly indicates that the company actively combats bullying, sexual harassment, and racism.

These extensive measures are having an impact and are paying dividends: Physical stress in the workplace has been substantially reduced, through, for example, the elimination of overhead work. Between 1991 and 1998 the health rate rose from 91.6% to 96% while the number of industrial accidents fell from 13.7% to 10.7% per one million hours worked. Targeted occupational health and safety measures have provided financial benefits because certain medical check-ups are no longer necessary. At Wolfsburg works, for example, this has resulted in significant savings. At another factory the number of days lost due to contact dermatitis was reduced by about 1,000 days with a prevention programme called “Skin”. As a result of the introduction of therapeutic measures for 25 alcoholic employees, the number of sick days in this group fell within a year from 1420 to only 351 per year.

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***At Volkswagen AG, extensive health promotion measures are having an impact and are paying dividends: Physical stress in the workplace has been substantially reduced, through, for example, the elimination of overhead work.***

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# CONCLUSION

*In Germany, strain and stress in the workplace are of great concern to the social partners and institutions responsible for workplace health and safety.*

In Germany, both the social partners and the institutions responsible for health and safety in the workplace pay great attention to mental strain and stress in the workplace. Successful prevention programmes have already been in place for many years in this area. This is a response to developments and changes taking place in the world of work and work organisation.

A statistical analysis of the group of disorders known as depression is difficult in Germany. There are no statistical details on mental health disability and type of employment, unemployment or rehabilitation because the Federal Statistics Office makes no distinction between mental/emotional disabilities and paraplegia, cerebral disorders or addictive illnesses. As a result, in Germany, epidemiological information regarding mental illnesses or mental health disabilities is limited.

Care at the workplace, including the prevention of illnesses, and the rehabilitation of disabled persons is addressed through a comprehensive and differentiated social insurance system with branches in unemployment insurance, statutory health insurance, and statutory accident insurance funds. Yet, again, there is no statistical information regarding the number of persons concerned with mental health disabilities.

Studies assume that more than half of all depressive disorders are still not recognised by physicians. An improvement in initial and further training is urgently needed, mainly in the domain of general medical practice. The focal points should be diagnosis and suicide prevention.

Despite growing efforts made over the last decade to research the reasons for the genesis and persistence of depressive disorders, the present state of knowledge is inadequate. To change this it would help to implement targeted promotion of interdisciplinary research approaches, integrating neurobiology, psychophysiology and cognitive psychology. In view of the increased risk that the children of depressive parents will themselves develop a psychiatric disorder during their lifetime, it would be important to know more about illness-inducing or health-promoting family-related factors.<sup>1</sup>

Mental health disorders display high prevalence rates. Although the level of research in psychology provides favourable conditions for the development of suitable prevention measures, there have, to date, only been a limited number of implemented and tested prevention programmes. Moreover, only a few research programmes have addressed the development and evaluation of disorder-specific prevention programmes which can be applied in practice

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3 BMA: Die Lage der Behinderten und die Entwicklung der Rehabilitation, 2000, P. 8

## PART 5

1 ebd. Die Gesundheitsberichterstattung des Bundes, 1999

2 ebd. *ibid.*

After German unification a statutory and economic basis was first created. There are still considerable differences with respect to working conditions. It is considered that, on this basis, there are new challenges and tasks for the rehabilitation and integration of disabled persons, especially the realisation of equivalent living conditions for disabled persons in all parts of Germany.

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## CONCLUSION

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