Assessment and conclusions

The OECD mental health and work policy framework

Mental health is an important driver of labour market outcomes and thus affects economic growth and future development. In OECD countries, mental ill-health is responsible for between one-third and one-half of all long-term sickness and disability among the working-age population. It causes and exacerbates chronic physical illness, pushing up health care costs. And it lowers education outcomes – partly because those who are ill leave school early – so shutting off employment opportunities. Relatively to the mentally healthy, the employment rate of people who suffer from poor mental health is 15-30 percentage points lower and their unemployment rate is twice as high. They are also twice as likely to live in poor households. In the workplace, employees who suffer from mental ill-health tend to underperform and their low productivity is probably the single biggest cost factor, borne to a large extent by employers.

The prevalence of mental ill-health also accounts for it being a heavy economic burden. At any given moment, some 20% of the working-age population suffers from a mental illness, and one person in two will suffer a period of poor mental health during their lifetime. Most people with mental ill-health are affected by mild-to-moderate illness – predominantly mood and anxiety disorders, commonly referred to as "common mental illness".

If labour markets are to function well, it is important that policy makers address the interplay between mental health and work. They are slowly coming to recognise that they have long neglected an issue that is critical to people's well-being and for contributing to sustainable economic growth. The policy changes required are substantial and involve a large number of institutions and stakeholders working towards better co-ordinated policies and service delivery. Reform will therefore require strong political leadership. The consolidated set of social, education, health, and labour market policy responses that are needed to promote better mental health and employment outcomes are the focus of this report.

Rethinking mental health and work policy

In "Mental Health: The New Frontier for Labour Economics", Richard Layard wrote that improving mental health is vital to both economic growth and happiness and "could be the most important single step forwards [economically and socially] in the 21st century" (Layard, 2013). *Making Mental Health Count* (OECD, 2014d) stressed the vast economic and social costs of mental ill-health and high unmet need for appropriate care. *Sick on the Job?* (OECD, 2012) – identified the main challenges posed by the interplay between mental health and work and argued the case for a structural shift in policy.

The objective of this new OECD report, *Fit Mind, Fit Job*, is to identify the key elements of the policy transformation that are required to build a more mentally resilient

workforce and improve the labour market inclusion of people who suffer from mental ill-health. There are three central components to that transformation:

- The first is a shift in **when** to intervene. Mental ill-health is often identified too late. Support and intervention at a time when people have been out of work for several years is often ineffective. Policy should focus on prevention, early identification, and early action.
- The second is a shift in **how** to intervene or **what** to do. Different institutions, especially in the health and employment areas, often operate in isolation in pursuit of their own objectives. And if there is such a dearth of integrated approaches, it is not least because incentives, obligations and procedures are scattered and contradictory.
- The third is a shift in **who** needs to intervene. Currently, the positive influence that front-line actors like teachers, managers, general practitioners and employment counsellors can have on education and labour market outcomes of people with mental ill-health is often poorly harnessed. These mainstream actors are best placed to help people early.

This report discusses why policy must make those changes and how it can achieve them. In doing so, it mainly draws on policy examples from nine OECD countries. The examples are rich in nature and, taken together, provide a promising and inspiring starting point. However, they cannot obscure the fact that there is a significant lack of data, knowledge, and rigorous evaluation of new policies and programmes, both generally and with regard to the policies advocated in this report. But this should not be a justification for inaction: policy makers cannot afford to wait until the evidence base is fuller. They need to act now and, at the same time, invest more in better evaluation of policies and programmes, especially those involving earlier, better integrated intervention which will yield longer-term returns on investment.

The report emphasises the need to take action across a range of policy arenas:

- Education policies to achieve optimal outcomes and robust school-to-work transitions;
- Health policies to deliver accessible treatment, which supports employment as a desirable outcome;
- Workplace policies to ensure high labour productivity and job retention;
- Benefit policies to promote a fast, sustainable return to work.

The policy principles developed in this report provide an integrated framework for guiding action in each country to promoting better mental health and greater labour market inclusion of people with mental illness.

When to intervene: Early identification and action

There is a large body of evidence showing that helping people stay in work is much more effective for sustainable employment than helping them return to a job after an absence. Similarly, the longer people are out of work – due to unemployment, sickness, or both – the more difficult it becomes to bring them back into the labour force and sustainable employment. These findings are even more valid for people who suffer from mental ill-health. Being out of work often has adverse effects on both their health

condition and their workplace relationships (sick leave for mental illness being highly stigmatised), which triggers a vicious circle.

Helping people with mental ill-health back into employment is difficult when they have been out of work for a long period of time and reliant on social assistance or disability benefit. At that stage, their work motivation and self-confidence are so low that easing them back into sustainable employment is costly and fraught with uncertainty. Austrian data, for example, show that people are lost to the labour market once they are seeking to access disability benefit: even those who are denied such a benefit hardly ever walk the employment path again (OECD, 2015a).

The long-term inactive also need help, and every effort should be made to help them early. That thinking, for example, is behind the Swiss Disability Insurance, for example, which seeks to tackle conditions that are likely to result in disability benefit claims later in life. It promotes early notification of problems and offers a special low-threshold provision that focuses particularly on people with common mental illness (OECD, 2014a).

Acting at an early stage in the benefit system

Early action in the benefit system brings to the fore two policy tools critical to helping people back to work quickly and successfully: unemployment benefit and (where it exists) sickness benefit. Few unemployment systems are equipped to deal with mental ill-health despite its high and growing incidence. Indeed, prevalence is growing in many countries – as data from countries like Austria, Australia and the United Kingdom attest. The chief reason is that structural reforms to the disability system in many countries, which seek to restrict access only to those unable to work, have meant that more people with health problems and reduced work capacity are remaining in the unemployment system.

The standard approach taken in most countries' unemployment systems today is to exempt jobseekers with health problems from their participation and job-seeking requirements, and to hope that, and wait until, they return treated and cured. That is not the right approach for most jobseekers who suffer from mental ill-health, because most cannot be "healed" in the traditional sense of the word. Treatment and work reinforce each other: without treatment labour market participation is difficult to sustain and, without work, treatment is much less effective. Unemployment systems should therefore seek to identify jobseekers' underlying mental health problems, the obstacles those problems create to labour market reintegration, and the treatment needed to secure sustainable employment.

Among the countries reviewed by the OECD, Belgium has moved furthest in this direction: in the past years, 12% of the longer-term unemployed in Flanders were submitted to an in-depth screening (OECD, 2013a). In the United Kingdom, the *Employment and Wellbeing Toolkit* was introduced in 2014 to support employment coaches in identifying well-being needs for employment and appropriate interventions to enable job attainment among claimants with mental health problems.

When a front-line actor – e.g. an employment service caseworker – assesses a jobseeker's barriers to finding employment, questions on mental health status are essential. If need be, the jobseeker should be referred for in-depth assessment and targeted support, in addition to any appropriate mainstream employment support. The expectations and participation required of jobseekers with mental health conditions

should be made clear to them in order to encourage or even, in some circumstances, compel them to take up any special services being provided. If mental illness goes unnoticed and unaddressed, the risk of long-term and/or repeat unemployment is high.

Sickness benefit systems should usually be able to respond more quickly than unemployment benefit systems because they are familiar with claimants' health problems but they are often passive payment schemes that deal only with benefit eligibility and not return-to-work management. However, in some OECD countries, such as Sweden and Norway, the sickness benefit system encourages partial sick leave to maintain the workplace connection and foster gradual return-to-work (e.g. OECD, 2013b). To ensure timely return-to-work, sickness benefit policies should have well-established procedures for ensuring regular contact between sick workers and employers though not ignoring issues of confidentiality. In a few countries this is being realised by including the treating doctors and the development of individual return-to-work plans, but even in these cases this policy is not always well implemented and monitored.

Early preventive action in the workplace

Return-to-work plans are critical for employees suffering from mental ill-health. They have to contend not only with their personal problems, but also with workplace difficulties and conflicts that can be solved only if employers and, in particular, line managers get involved. Good management is therefore important. Binding obligations on employers to manage sickness absences and the return-to-work transition properly can help bring it about. Such obligations change the behaviour of both employers and employees, especially if they are backed up with corresponding strong financial incentives, e.g. in the form of sickness benefit reductions and extended periods of employer-paid sick pay. Reforms in the Netherlands and, to a lesser degree, in some other countries go in that direction, despite the challenge of striking a balance between employment protection and employer incentives to strengthen job retention without jeopardising hiring (OECD, 2014b).

The need for better workplace sickness policies is clear in view of the growing share of absences attributable to mental ill-health. More daunting problems still, however, are poor performance and productivity losses due to poor mental health. Data show that many people with common mental illness struggle at work. For example, 69% of the people with moderate mental health complaints report having problems in job performance compared to 26% of the people without mental health complaints. There is a strong business case for addressing the issue, yet employers hold on to poor workplace practices. A first step in the right direction in many countries is the amendment of labour law to include obligatory and far-reaching psychosocial risk prevention. It would be especially effective if complemented with clear guidelines and concrete tools for employers and labour inspection authorities, as in Denmark (OECD, 2013c). In all of the reviewed countries, however, the implementation of psychosocial risk prevention is slow, as traditional issues continue to dominate health and safety policy and the widespread psychosocial issues remain neglected.

Employers therefore need more than general prevention on the one hand and support for managing sick employees' return to work on the other. They also need a strategy for how to deal with underperformance and workplace conflicts caused by or related to mental illness. None of the reviewed countries can yet claim to be particularly advanced in the development of such a strategy, even though some big companies have started to address it. Management and line managers need the right support and training to help

their employees with mental health problems to be able to perform their work. There is a big role in this context for employer and employee representative bodies to help develop guidelines in this area in addition to any public guidelines or action.

Action to ensure a good school-to-work transition

More than one-half of all mental illnesses have their onset in childhood and adolescence. Education systems thus have a key role to play in ensuring good educational outcomes and successful labour market transitions for children with mental health problems. Schools should seek to foster mental health resilience and help students with their social and emotional problems, especially when families cannot provide the necessary support. To avoid stigmatisation of young people struggling with mental health issues, schools should, as far as possible, promote general mental well-being and offer help that is easily available to all students and teachers. Two good examples are the *KidsMatter* and *MindMatters* programmes developed in Australia with the aim of promoting mental health and well-being, preventing problems, and enabling early intervention within schools (OECD, 2015b). *KidsMatter* has been trialled in 101 schools and found to improve general mental health and well-being.

Irregular school attendance can often be a sign of mental illness and eventually turn into early school leaving. Policies should therefore reach out to truants and early school leavers. To guide and monitor such children, some countries have introduced very strong measures. Denmark's municipal *Youth Guidance Centres*, for example, are mandated to intervene very quickly upon truancy to prevent early school leaving (OECD, 2013c). Other countries have put in place freely accessible structures for general health promotion but with a special focus on mental health that teenagers can access easily without being labelled as mentally ill, such as *Youth Clinics* in Sweden which have been able to reach out to 1.3 million young people (OECD, 2013d). These facilities offer a range of support that includes mental health care and counselling from social workers.

Another critical moment is the transition from youth to adulthood and from school to work. A smooth transition to the labour market is important for building the confidence of all young people, particularly those with a mental illness. The move is much more difficult for those with low educational attainment among whom young people with mental ill-health are over-represented. Schools can do more to smooth the transition, for example by early involvement of employment professionals to ensure that strugglers are not lost from sight or left alone too long. In Flanders (Belgium), for example, 85% of all school leavers register with the public employment service, which focuses strongly on young people's first-job experience and monitors mental health issues regularly (OECD, 2013a).

Access to mental health treatment

Early action is also an issue for the health care system. Under-treatment is pervasive in most countries and the length of time between the onset of illness and first treatment tends, sadly, to be extremely long – more than ten years on average, according to some studies. Yet treatment is far more effective in the early stages of illness when people are still generally well integrated into their communities, schools, and jobs. Worryingly, in many OECD countries, it is among young people that rates of under-treatment are highest and waiting times for counselling or therapy are longest. Moreover, some countries have recently reported cuts to mental health services including for young people as a result of overall health spending cuts (in real terms) (OECD, 2014d). Improving access to mental

health care must be a priority. Additionally, the provision of appropriate treatment is a point of concern, especially for people suffering from mild-to-moderate mental ill-health who often are only prescribed medication (such as antidepressants). Improving and expanding the care provided in primary care settings would be an important first step (OECD, 2014d). In that respect, recently taken measures in Australia and the United Kingdom to increase the provision of psychotherapeutic therapies for common mental health problems specifically have proven highly effective, albeit less so for children than for adults (OECD, 2015b; OECD, 2014c). For example, through the United Kingdom's *Increased Access to Psychological Therapies* programme, 1.1 million people with common mental disorders received treatment between 2010 and 2012 with 45% recovery rates.

Who needs to intervene: Involving and empowering mainstream actors

Mental illness was long considered a health issue only and the exclusive responsibility of the health care system. A better understanding of the close links between mental ill-health and educational, social, and employment-related status and outcomes has exposed the narrowness of that perspective. The high prevalence of common mental illness makes it a mainstream issue. People who deal with it daily and directly are best placed to identify problems early, address their impact and implications, and/or initiate early action by mental health care practitioners.

This report identifies four groups of front-line actors as particularly important to the sustainable labour market inclusion of people who suffer from mental ill-health: teachers, line managers, general practitioners (GPs), and employment service caseworkers. Policy should focus on three ways of empowering them:

1. Raise awareness of the problem and their key role in addressing it;
2. Develop their competence in dealing with mental health issues and ability to do the right thing at the right time;
3. Put in place an accessible support structure to which they can refer people with mental health problems – students, workers, patients, jobseekers – for swift and proper professional care.

Raising awareness among front-line actors

Mental health-related problems still go unnoticed for too long. And, when front-line actors eventually notice such problems, they are not always able to adequately address them. The fact is that front-line actors generally lack the knowledge and experience to help people with signs of mental ill-health and often find it difficult to talk about mental health issues. As a result, students, workers and jobseekers with mental health problems run the risk of failing at school, losing their job, or not finding one for a long time. When GPs, for example, write out a sickness certificate, they often do little to help workers with mental ill-health address their work problems and return to work. In the worst case, people end up on long-term benefits, such as disability benefit, just because their problems were never adequately addressed.

Raising awareness among front-line actors of the high prevalence of mental ill-health, and the key role they play in good outcomes for the people concerned is an important first step. Anti-stigma campaigns in many countries have successfully contributed to greater awareness by specifically targeting front-line actors (e.g. workplace campaigns such as *Business in Mind* in Australia and the *Mentally Healthy Workplace Programme* in the United Kingdom). Representative professional bodies (e.g. teachers' unions or general

practitioners' associations) can also play a key part in building awareness, as can employers in their companies and human resource departments. Equally, managerial leadership is needed to helping employment services and line managers understand their role.

Better mental health competence for all actors

Developing mental health competence is the second main policy thrust. Line managers and employment service caseworkers need the proper training to be better able to signal employees and jobseekers struggling in work (or in finding work) due to poor mental health, understand the work and performance implications and impacts of mental ill-health, and know what to do when mental health-related problems with job performance surface. That knowledge will also make it easier for them to judge how much they can expect from a worker or a jobseeker with a mental health condition. Some countries already propose management tools specifically for helping front-line actors to identify critical situations and do the right thing at the right time.

For teachers and, in particular, GPs, changes should be made to their basic training curricula to give them a fuller grasp of mental illness and its impact. Discussions to that effect are on-going in countries such as Austria and the United Kingdom. Some countries – like Australia and Denmark – have recently invested significantly in mental health training courses for GPs. They also fund the mental health care provided by doctors who attend these courses (OECD, 2015b; OECD, 2013c). Training for GPs should be substantive because they are often the first port of call for people with mental health problems and often the only medical professional who ever treat them.

An important part of GP training should be the capacity to deal with work ability, workplace requirements, and sickness certification, especially in the case of mental ill-health. Indeed, more and more OECD countries now require doctors to draw up sickness certificates that include much more information on what a patient is still able to do. Examples are the *fit note*, as opposed to the sick note, that British doctors must fill in and the *work ability record* that Danish GPs are asked to complete in addition to the traditional sick note (OECD, 2014c; OECD, 2013c). Illness-specific sickness certification guidelines, like those developed in Sweden, also follow this purpose (OECD, 2013d).

Access to professional support

The third key element in empowering mainstream actors to deal with mental ill-health is an easily accessible support structure where people with mental health problems – students, workers, patients, jobseekers – get swift and proper professional attention. Schools in some countries have such support structures – e.g. external care teams in the Netherlands and Belgium's student guidance centres (OECD, 2013a; OECD, 2014b). However, they generally cater to young people with more severe mental health problems. Support, and even treatment for people with mild-to-moderate mental ill-health, is more forthcoming from front-line professionals – e.g. Austria's youth coaches and psychology-trained teachers for students with social and emotional difficulties, or Australia's *Youth Connections*, a programme that serves disaffected young people (OECD, 2015a; OECD, 2015b).

Employers and line managers rarely have access to professional support. Some countries, especially in Northern and Western Europe, have strong occupational health systems that support employers and, to some degree, employees. But occupational physicians, too, generally lack mental health knowledge, and very few countries call on

occupational psychologists. In English-speaking countries, employee assistance programmes are common, and bigger companies in all OECD countries are increasingly building their own health units. Although these are all promising approaches, they suffer from low take-up by employees in need and do not exist in small and medium-sized companies (SMEs), where insufficient knowledge and resources preclude any spending on support services. This gap can potentially be filled by a bigger role for work councils and trade unions in those SMEs, in co-operation with the employer, with the support of public resources.

The degree to which employment service caseworkers have access to professional support also varies considerably. The employment services in a few countries (like Sweden) have some psychological expertise available, though not enough for caseworkers to get help quickly (OECD, 2013d). Belgium has a more elaborate support system for severe diagnosed disorders, not for common mental illness (OECD, 2013a). Other countries (like Denmark) call on psychologically-trained caseworkers who work with jobseekers suffering from common mental illness. Because their caseloads are very light they achieve excellent outcomes, but this reaches only a few clients (OECD, 2013c). Greater investment in support from professional practitioners requires making a stronger business case for the high returns for the unemployment system itself.

GPs, too, need quick access to professional support. Referring patients with mental illness to specialists, particularly psychiatrists, in the health care system is not sufficient or always appropriate. Not only do patients in most countries face considerable waiting times but not all need to see a specialist, and specialised care is generally costly. A complementary solution would be to have mental health care providers in primary care practices. Australia and the Netherlands have recently moved to provide funding to enable GPs to hire mental health nurses (OECD, 2015b; OECD, 2014b). In the Netherlands, 62% of the GPs now offer extra support by mental health nurses. In both countries, the move has led to improved access to treatment, better compliance, and closer working relationships with specialised mental health doctors.

How to intervene: achieving well-integrated policies and service delivery

One of the biggest problems in all of the reviewed countries is the mismatch between the needs of the people suffering from mental ill-health and the services that are provided. Many of those with poor mental health require both health *and* employment support. Generally, though, they get only one or the other – and sometimes neither. The mismatch – and shortfall – is worrying in view of the considerable evidence on how mental ill-health can be a barrier to employment and work can be an important element in recovery.

Typically, the mental health and employment sectors operate independently of each other, with different objectives and approaches, and often under different government authorities. Medical services aim to treat people with mental ill-health and improve symptoms and everyday well-being, often with scant regard for employment and workplace issues. Employment services seek to keep employees in work or bring people back into employment through training and activation (e.g. making benefit entitlement conditional on collaborating in return-to-work activities or active job seeking), but usually either fail to address employees' or jobseekers' frequent health issues or wait until they come back "cured" from treatment. This arrangement can meet only some of the needs of people with poor mental health, which leads to patchy social and employment outcomes.

Gradual development of more integrated approaches

Policy across the OECD is slowly responding in different ways through approaches that address employment *and* health needs (Arends et al., 2014). Several countries have been introducing whole-of-government mental health initiatives and action plans, with the emphasis increasingly on retaining and finding employment. The *Australian Ten-Year Roadmap for National Mental Health Reform* and, especially, the *Norwegian National Strategic Plan for Work and Mental Health* are two such instances (OECD, 2015b; OECD, 2013b). These moves in the right direction should be backed up by setting clear targets and measuring to what extent they have been met. The Outcomes Framework of England's National Health Service recently moved a step further towards supporting an integrated approach by using two employment-related outcome targets, on sickness absence rates and employment rates of people with disability and mental ill-health, in addition to a suite of more narrowly drawn "health" indicators. Monitoring of each actor's achievements is necessary to ensure that all actors engage fully with the shift in emphasis.

Some countries have taken a step closer to employment and health service integration. They have developed policies whereby sectors are transparent about the actions they take, share information and knowledge, and have found solutions to address confidentiality issues. Two examples are the systematic communication between the mental health sector and the public employment service in the Netherlands and between social security and the public employment service in Austria (OECD, 2014b; OECD, 2015a), both initiatives relevant for people with more severe mental illness at risk of becoming long-term unemployed or inactive.

Sweden has gone even further by making services from different stakeholders more coherent through financial co-ordination: resources of the social insurance authority, the public employment service and the municipal welfare sector are pooled in order to provide more integrated vocational rehabilitation services (OECD, 2013d). Switzerland has been trying something similar through *inter-institutional co-operation* though with much more diversity in approaches across the country (OECD, 2014a).

Policy makers in some countries have sought to provide the right services to clients through partnerships between different sectors, with one institution acting as a case manager co-ordinating the services they provide. One good example is a programme developed by the Flemish employment service in co-operation with the mental health and welfare sectors. It brings together a job coach from the employment service (who is also the case co-ordinator), a health coach from the mental health sector, and an empowerment coach from welfare (OECD, 2013a). A further example is Denmark's new vocational rehabilitation model designed to prevent disability benefit claims. It is co-ordinated by the municipal job centre and involves health services, social services, and the education sector (OECD, 2013c).

Promising examples of fully integrated service delivery

A few countries are in fact moving further towards delivering truly integrated mental health and employment (or education) services alongside each other. They come in two forms:

1. More integrated services delivered *within* a sector through the provision of employment support in the health system and health care in the employment system;
2. Services delivered by a *new entity* specialised in integrated service provision.

Good examples of integrated services within a sector are to be found in the health sector. *Individual Placement and Support* (IPS) for people with severe mental ill-health is the most widespread approach. This model uses an evidence-based fidelity scale to measure the level of implementation or the degree of adherence to the characteristics of the intervention. A key element of the model is the on-going support for both the employer and the employee to ensure on-the-job learning and prevent drop-out although sustaining employment remains the biggest challenge.

Another example of how mental health service providers cross sector boundaries to support people with common mental illness is the employment advisor working alongside a psychological therapy provider in the UK's *Improving Access to Psychological Therapy* initiative (OECD, 2014c). A pilot study of this initiative showed that through the support provided by the employment advisors, 63% of the patients on sick leave were able to return to work.

A good example of a new entity that provides integrated services is the Australian *headspace* programme. It delivers such services largely free of charge to 12-to-25 year-olds, mostly through self-referral, and often reaches young people with non-diagnosed mental illness – a recent evaluation of the programme participants showed that 17% had a sub-threshold mental health condition (OECD, 2015b).

Policy makers could develop all these approaches alongside each other in order to work towards better labour market outcomes for people with mental ill-health. Critical to success are: i) the alignment of policy objectives and financial incentives; ii) rigorous implementation; and iii) on-going evaluation. The first is particularly important for efforts to deliver simultaneous client-oriented support from different institutions and professionals across different sectors.

Aligning objectives and incentives

In principle, aligning sector-specific policy objectives should be evident because both the health and employment sectors aim to improve individuals' ability to function in society. That goal can be furthered by ensuring that all professionals properly understand the mutual links between mental health and employment and how actions in one impact and spill over into the other.

However, stakeholders and professionals also need better rewards and financial incentives if they are to push for and participate in integrated service delivery. There is too much focus in the health system on rewarding repeat use of health services, and too little on rewarding successful addressing of mental health needs, including through increased employment. Similarly, public employment services while trying to address client needs to succeed in work reintegration need more funding and better incentives for addressing their clients' mental health issues. Financial co-ordination and the pooling of resources between sectors go some way to addressing that problem.

Clearer obligations and guidelines are also desirable on when and how to use and invest in integrated service delivery. To the extent possible, rules and regulations should be binding on all stakeholders, as voluntary service integration cannot deliver high take-up and can therefore be detrimental to better outcomes on a macro level.

Good implementation and evaluation

Current policy initiatives often suffer from discrepancies between lofty ambition and modest efforts of implementation. Whole-of-government strategies, for example, aim to

set the agenda for better policy across governments but often fail to clearly set out what each stakeholder should do to achieve the policy objectives. And implementation cannot be left to the discretion of stakeholders only. Strong leadership at both the political and the managerial level is necessary to change practices and foster understanding of the need for integrated services at all levels of an organisation and of the consequences of failing to deliver them. Roles need to be clearly assigned and newly implemented practices monitored continuously.

Policy evaluation, too, needs to be improved. Policy makers need better data and better knowledge on social, health and employment outcomes to decide which policies to continue and which new ones to trial. The stakeholders involved also need continuous feedback to assure improvement in the way policies and services are delivered. Rigorous evaluation of new intervention programmes or services requires methodologically sound (pilot) studies, ideally including a comparison group and random allocation, systematic data collection and – particularly important – the measurement of longer-term labour market outcomes for people with mental ill-health.

Future directions for better integrated services

Some people seek help through the health care system and others through the employment system. This should not matter. It should be the responsibility of each sector to deliver integrated services in line with client needs, which in turn requires a much better understanding in all sectors of the needs of clients with a mental illness. More integrated provision of services *within* each sector – e.g. through employment advice in the mental health system and psychological expertise in employment services – appears to be the easiest and most cost-effective approach because it requires less harmonisation of the objectives and incentives of the professionals involved.

Integrated mental health and employment services can improve labour market outcomes for people with mental ill-health if implemented rigorously. However, some of the gains will be realised in sectors other than those where investment has been made, and not every sector will see its costs reduced – or not, at least, to the same degree or in the short run. It is important to state the business case for each sector (e.g. the health and social protection systems), for each entity within a sector (e.g. the unemployment and disability systems) and for the economy as a whole.

Moving towards better policy: The OECD mental health and work policy framework

Strengthening mental health and work policy in order to improve the labour market and social outcomes of people with mental ill-health and generally bolster mental health resilience needs concerted action in a range of policy fields. Action has to be synchronized across them, following the same objectives and using the same policy framework.

Helping young people through mental health awareness and education policies

Develop mental health competence among teachers and education authorities:

- Include mental health competence in the teacher-training curriculum;
- Invest in preventive mental health programmes in schools (coping skills, emotional learning, etc.);
- Assure an adequate number of professionals with psychological training in schools.

Assure students' timely access to co-ordinated support for mental ill-health:

- Ensure waiting times are short in the mental health care sector for children and adolescents;
- Have in place a support structure linked to schools and other youth services that offers integrated services free of charge to all young people and has a special focus on common mental illness.

Invest in the prevention of early school leaving and support for school leavers, with mental health problems:

- Provide a solid evidence base on the link between school leaving and mental ill-health;
- Monitor early school leaving, watch for signs of mental health problems among early school leavers and provide support in all such cases.

Provide effective support for the transition from school to work:

- Ensure proper higher education and work transitions for people with common mental illness through career advice and access to treatment;
- Involve the PES as early as possible, e.g. by requiring all school leavers to register with the local PES office, build PES capacity to deal with youth with mental health issues and reinforce the links between schools and the PES;
- Prevent young people with mental health issues from becoming permanently dependant on disability benefit through effective and well-resourced multidisciplinary rehabilitation.

Towards an employment-oriented mental health care system

Assure timely access to recommended effective treatment of mental health problems:

- Increase the mental health system's capacity through a shift away from expensive specialist care and greater mental health treatment capacity for common mental ill-health in primary care;
- Investigate the use of on-line psychological therapies with solid treatment compliance.

Provide training and supports to GPs to treat mental illness:

- Expand the GP curriculum to include mental health training;
- Remunerate GPs for talking therapy time with their patients with mental health problems;
- Provide funding to GPs to incorporate mental health nurses and psychologists in their practices.

Improve incentives and tools for GPs to address work and sickness issues:

- Modify absence certification practices to focus on ability to work ("fit notes");
- Develop illness-specific guidelines for GPs on sickness certification and return-to-work practices;
- Provide funding for employment specialists who support GPs in their practices.

Strengthen the employment focus of the mental health system:

- Introduce employment outcomes in the quality and outcome frameworks of the mental health system;
- Integrate employment support into the treatment plan for people with common mental illness;
- Develop supported employment programmes for people with common mental ill-health.

Moving towards better policy: The OECD mental health and work policy framework (*cont.*)

Better workplace policies and employer-support mechanisms and incentives

Enforce legislation for psychosocial risk prevention:

- Specify employer obligations in regard to psychosocial risk assessment and risk prevention;
- Provide tools and supports to enable employers to adjust the psychosocial work environment;
- Shift the resources of labour inspectorates and occupational health services (where they exist) as necessary to adequately reflect the incidence and impact of psychosocial health issues.

Improve (line) managers' response to workers' mental health issues:

- Provide mental health training for (line) managers and co-workers;
- Offer toolkits to line managers on how best to deal with a worker's mental health problem;
- Develop mental health knowledge in HR departments to support and monitor line managers;
- Promote employee mental health screening and paying for short-term intervention.

Design an effective return-to-work management process:

- Establish publicly funded fit-for-work counselling services with mental health competence to help sick-listed workers at an early stage;
- Promote a gradual return to work, which is also a means of helping to rebuild full work capacity;
- Strengthen the role of occupational physicians and occupational psychologists.

Strengthen incentives and obligations for employers to prevent and address sick leave:

- Increase employer responsibility for return-to-work planning for sick employees;
- Promote meetings between employers, employees with mental ill-health and treating doctors;
- Extend the sick-pay obligation as an incentive to prevent absences and support return-to-work.

Making benefits and employment services fit for claimants with mental ill-health

Prevent disability benefit claims for mental illness:

- Focus on early intervention and identification of people in need of support, with medical and vocational rehabilitation measures targeted at people suffering from mental ill-health;
- Better recognise the work capacity of people with mental illness and limit disability benefit to people permanently unable to work.

Identify and support jobseekers with mental health problems:

- Use adequate tools to identify jobseekers' mental health problems and the resulting labour market barriers;
- Implement clear guidelines for caseworkers on what to do when mental health problems surface;
- Ensure access to mainstream or special services for jobseekers with poor mental health, while avoiding exemptions from participation requirements as much as possible;
- Adjust the performance management process of the employment service to secure sufficient attention to jobseekers suffering from mental ill-health.

Invest in mental health competence for all benefit actors:

- Provide mental health training for caseworkers, welfare counsellors, and social workers;
- Put in place an easily accessible psychological coaching capacity in employment services and welfare offices.

Develop integrated health and work services in the employment sector:

- Pool resources with health authorities or purchase services from the health sector in order to deliver integrated multidisciplinary rehabilitation services;
- Develop programmes targeted at jobseekers and welfare clients with common mental illness which combine psychological advice with job-placement services or work experience programmes.

REFERENCES

Arends, I., N. Baer, V. Miranda, C. Prinz and S. Singh (2014), "Mental Health and Work: Achieving Well-Integrated Policies and Service Delivery", *OECD Social, Employment and Migration Working Papers No. 161*, OECD Publishing, Paris, http://dx/doi/org/10.1787/5jxsvvn6pq6g-en.

Layard, R. (2013), "Mental Health: The New Frontier for Labour Economics", *IZA Journal of Labor Policy*, Vol. 2:2.

OECD (forthcoming 2015a), *Mental Health and Work: Austria*, OECD Publishing, Paris.

OECD (forthcoming 2015b), *Mental Health and Work: Australia*, OECD Publishing, Paris.OECD (2014a), *Mental Health and Work: Switzerland*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204973-en.

OECD (2014b), *Mental Health and Work: Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264223301-en.

OECD (2014c), *Mental Health and Work: United Kingdom*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204997-en.

OECD (2014d), *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, OECD Publishing, Paris, http://dx/doi/org/10.1787/9789264208445-en.

OECD (2013a), *Mental Health and Work: Belgium*, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264187566-en.

OECD (2013b), *Mental Health and Work: Norway*, OECD Publishing, Paris, http://dx/doi/org/10.1787/9789264178984-en.

OECD (2013c), *Mental Health and Work: Denmark*, OECD Publishing, Paris, http://dx/doi/org/10.1787/9789264188631-en.

OECD (2013d), *Mental Health and Work: Sweden,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264188730-en.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.