Chapter 2

Ensuring educational attainment and school-to-work transition for young people with mental ill-health

Childhood and adolescence are crucial periods for promoting good mental health. Every second mental illness has its onset before the age of 14. Those suffering from mental ill-health are more likely to leave school early with poorer education outcomes and consequently have greater difficulty accessing the labour market. Education systems have a key role to play in identifying and supporting children with mental health issues at an early stage. Policies to prevent early school leaving and enable smooth transitions from school to work are essential if young people's education outcomes and adult working lives are not to be adversely affected.

Policy conclusions:

- *Develop mental health competencies among teachers and education authorities.*
- *Ensure timely access to co-ordinated support for students suffering from mental ill-health.*
- *Invest in the prevention of early school leaving and early action for school leavers.*
- *Provide effective support for the transition from school to work.*

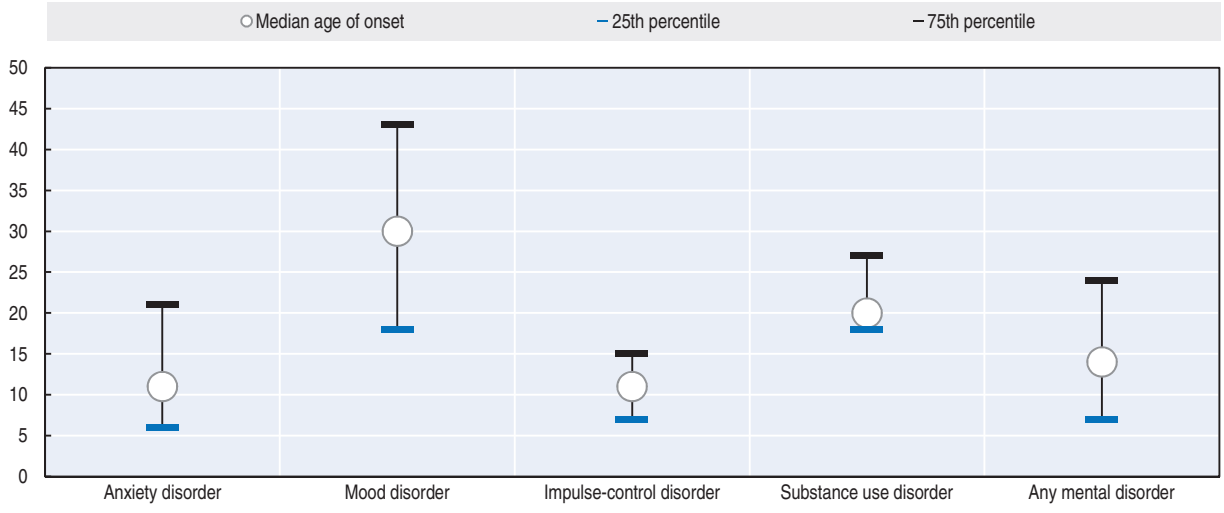
Preparing people affected by mental ill-health for the labour market has to start early, long before they actually start looking for work. The foundations for employment opportunities in adult life are, to a great extent, laid during childhood, adolescence and early adulthood through good education. The educational attainments of young people with mental health problems are often poor, and many do not finish school at all. Getting off to such a disadvantaged start considerably heightens the risk of poor work outcomes like unemployment and work disability in later life.

The education system is the ideal setting for investing in ways to prevent adverse outcomes related to poor mental health, as 50% of all mental illnesses begin before the age of 14. Only mood disorders tend to start later in life (Figure 2.1). As affected people do not generally seek treatment for, on average, twelve years after the onset of their illness (Kessler and Wang, 2008), few young people come into contact with mental health care services. Strong support within the education system is therefore crucial.

Enabling young people with mental health complaints to attain high levels of education and prepare for a successful labour market career requires: i) mental health literacy among teachers and students; ii) timely access to co-ordinated, multidisciplinary support; iii) prevention and early action when students leave school early; and iv) effective support for the transition from school to work.

Figure 2.1. **Most mental illness has its onset in childhood or adolescence**

Median age of the onset of mental illness in the United States, 2001-03



Source: OECD compilation based on Kessler, R. et al. (2005), "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication", *Archives of General Psychiatry*, No. 62, pp. 593-603.

StatLink http://dx.doi.org/10.1787/888933184060

Mental health literacy and training for teachers and students

The few epidemiological studies on mental illness among young people show that the prevalence of diagnosed mental disorders is the same as or slightly higher than among adults. Between 20% and 30% of all young people experience a mental disorder at any given time with lifetime prevalence by age 20 sometimes reaching 50% (Merikangas

et al., 2010; Ormel et al., 2014; Philip et al., 2014). Importantly, prevalence is particularly high among disadvantaged young people, i.e. those with little schooling (OECD, 2012).

Disadvantages early in life have long-term implications

Negative childhood experiences greatly affect mental health in adult life (Figure 2.2, Panel A). Indeed, most people who experience a mental disorder in adulthood have had mental health problems in childhood or adolescence already (Kim-Cohen et al., 2003). For the most prevalent mental illness among young people, anxiety disorder, the median age of onset is as low as 8-11 years of age (Kessler et al., 2005).

Young people with mental ill-health are more likely to show poor educational attainment and leave school earlier than their healthy peers (McLeod and Fettes, 2007; Veldman et al., 2014). Consequently, they are often to be found among those who are not in education, employment or training (NEETs) (OECD, 2013d). The share of early school leavers (17%) and NEETs (13%) is high in many OECD countries (Figure 2.2, Panel B) – and there is strong evidence that those groups face significant labour market disadvantages. Data for Austria, for example, reveal that many early school leavers and, especially, NEETs remain inactive for very long periods (Figure 2.2, Panel C).

Teachers play a crucial role in providing the support that can prevent negative educational outcomes. Generally, however, they are not trained to spot signs of mental illness. They find it particularly hard to detect internalising symptoms (e.g. anxiety and depressed moods) as opposed to such visible symptoms as disruptive or aggressive behaviour and disobedience. Nor do they have the means or the time to provide the extra support needed.

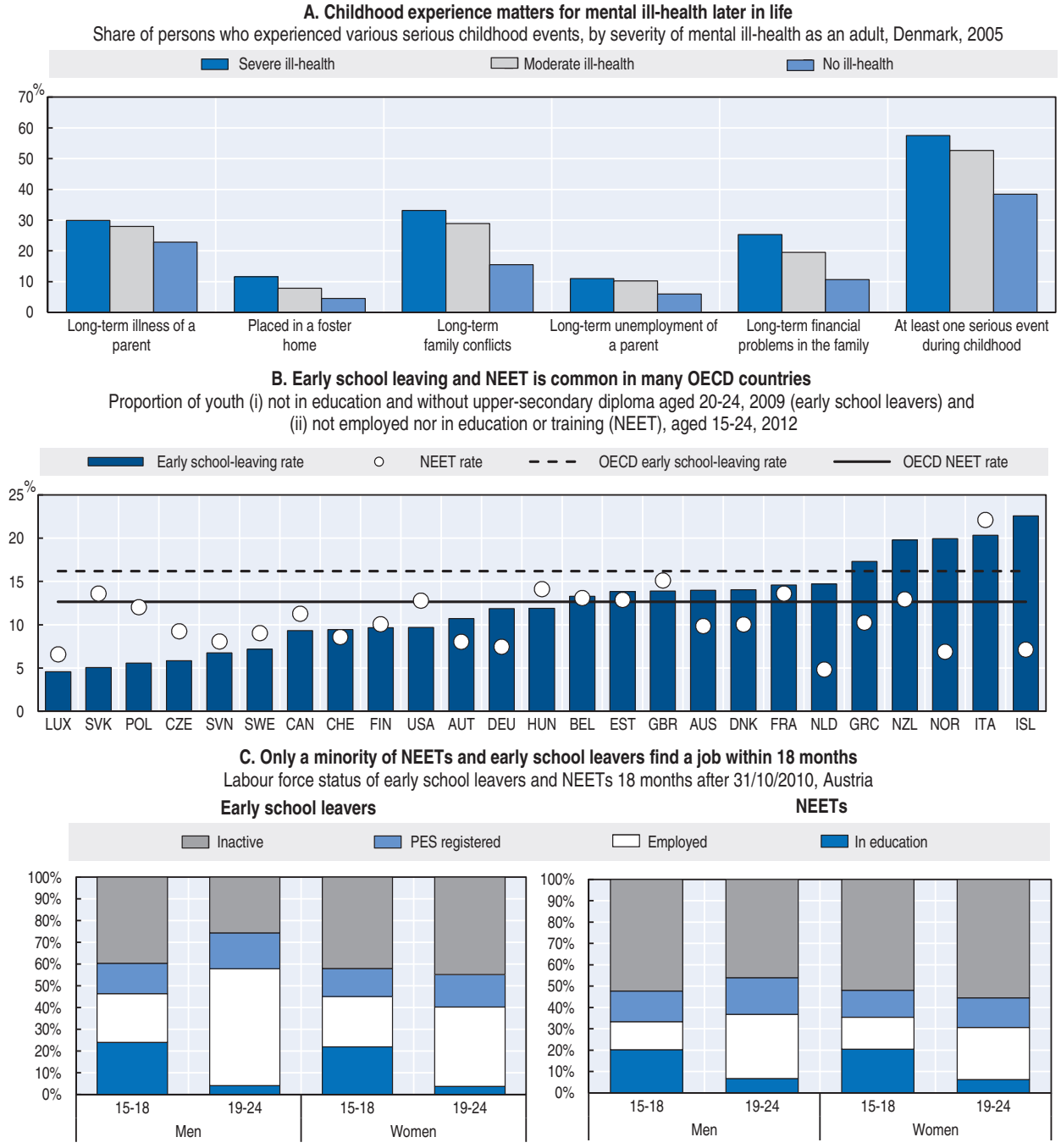
Yet school provides an ideal setting for building mental health resilience and easing the stigma that weighs so heavily on mental illness. As many students will either experience some form of mental ill-health themselves or know a peer with such problems, greater mental health literacy among school-goers could help strengthen support for and inclusion of young people with mental health problems.

Developing general mental health competencies in the school system

Although many countries have developed preventive mental health programmes, only a few have rolled them out in their schools on a national scale. In Norway, the *Mental Health in Schools* co-operative project, which ran from 2004 to 2011, comprised mental health training directed specifically at teachers and their students. They were designed to improve mental health literacy, so enabling teachers to better identify mental health problems and understand and support their students (Factsheet 2.1).

Similarly, the Australian Government funds two programmes to promote mental health: *KidsMatter* for use in primary schools and *MindMatters* for secondary establishments (Factsheet 2.2). Both take a "whole-school" approach. They provide training in fostering mental health and use a structured approach to help schools identify their strengths and weaknesses with regard to mental health promotion.

Figure 2.2. **Young people at risk need more attention earlier to prevent poor outcomes later**



NEET: Neither in employment nor in education or training.

Note: OECD total includes all 34 member countries. "Inactive" refers to all persons who are not classified as employed or unemployed.

Source: Panel A: National Health Interview Survey, 2005; Panel B: *OECD Education Database*; Panel C – Statistik Austria, Bildungsmonitoring, www.statistik.at/web_de/statistiken/bildung_und_kultur/bildungsbezogenes_erwerbskarrierenmonitoring_biber/index.html.

StatLink http://dx.doi.org/10.1787/888933184079

KidsMatter and *MindMatters* also seek to stimulate collaboration between teachers, parents, students and the wider school community and guide schools in choosing the right course of action in four areas: i) positive school community; ii) student skills for resilience; iii) parents and families; and iv) support for students experiencing mental health difficulties (Wyn et al., 2000; MindMatters, 2014).

School-based mental health promotion programmes are difficult to evaluate rigorously, but studies have shown that they can be effective in sharpening teachers' and students' ability to spot mental health problems and in improving both students' mental health and educational performance (Slee et al., 2009; Langeveld et al., 2011; Weare and Nind, 2011; Skre et al., 2013). Qualitative research suggests that programmes are appreciated by schools and teachers and that they can change a school's culture in getting it to communicate openly about mental ill-health (Slee et al., 2009).

However, schools seldom implement full-scale mental health programmes. One alternative would be for the educational authorities to choose any particularly effective components of such programmes and incorporate them into the general teaching curriculum. To date, there appear to be no instances of compulsory training for teachers in how to spot mental ill-health or teach resilience skills. This is a missed opportunity given that the positive effects of mental health promotion programmes could carry over effectively into general teaching practices.

Key messages

The prevention of poor mental health and related schooling problems does not receive proper attention in the education sector. School-based mental health promotion programmes are not used widely, even though they foster a non-stigmatising school climate and help develop emotional skills, such as resilience and coping, among both students and teachers. Such programmes contribute to better mental health and school performance in the short term, which suggests that it would be worthwhile to invest in large-scale longitudinal studies to investigate whether they will also pay off in the long run through the greater participation in the labour market of young people with mental ill-health.

There are two core conclusions for improving mental health literacy among teachers and students:

- Invest in preventive mental health programmes in schools to develop resilience, coping skills and emotional learning more generally.
- Incorporate mental health competence training in the teacher-training curriculum.

Timely access to support for young people with mental ill-health is critical

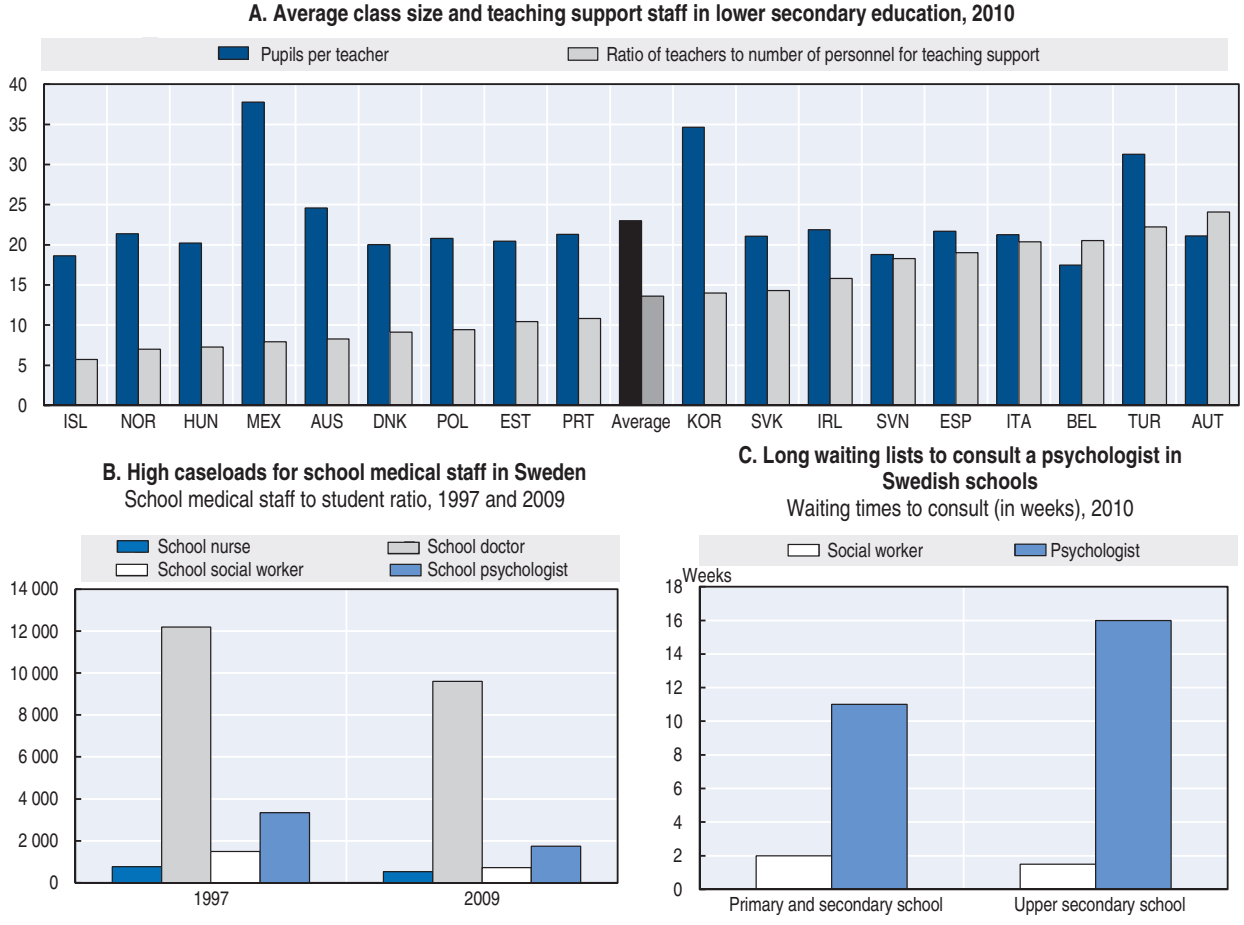
Providing timely treatment and support to young people with poor mental health is challenging. Treatment rates are at their lowest and waiting lists at their longest among young people, many of whom are reluctant to seek professional help (OECD, 2012). General preventive health checks for school-aged children are a widespread practice, but they are so broad in range and last such a short time that they are unlikely to spot any signs of incipient mental illness. School doctors, like general practitioners, lack mental health expertise.

School-based mental health support is insufficient

In many of the countries reviewed by the OECD, schools have developed in-house mental health services as a primary form of support. In some cases, teachers are trained to take up part-time roles as student advisors or student counsellors (OECD, 2015; OECD, 2014b), while in other cases school social workers, educationalists and psychologists form internal care teams, as in Belgium (Factsheet 2.3). The greatest advantage of school-based services is their low entry threshold, which enables teachers to refer students to them and students to access them at an early stage.

However, school-based mental health services generally have limited capacity. As shown in Figure 2.3 (Panel A), levels of teaching support staff in schools are low, resulting in heavy caseloads and long waiting lists. In Sweden, for example, school psychologists are responsible for around 2 000 students and waiting times of 16 weeks have been reported (Figure 2.3, Panels B and C). Similarly, in the Netherlands, the average caseload of a social worker in vocational education is 2 600 students (OECD, 2014b).

Figure 2.3. **Access to professional support in schools is limited in most countries**



Note: Data for Belgium refer to Flanders only.

Source: Panel A: OECD (2010), *Creating Effective Teaching and Learning Environments: First Results from TALIS,* OECD Publishing, Paris; Panel B: Administrative data provided by Ministry of Education; and Panel C: Socialstyrelsen paper, Survey on Children's Health in School.

StatLink http://dx.doi.org/10.1787/888933184081

Further strain on the capacity to provide timely support comes from the lack of collaboration between schools and primary, specialised, and community mental health care services. When poor mental health deteriorates and problems transcend the school environment (and are family-related, for example), schools need to be able to refer to and work closely with other services. Yet, establishing collaborative networks to support young people has proven problematic. To look at the example of Sweden again, only 25% of schools work with other youth services (OECD, 2013d).

One reason for such poor collaboration is that it is neither compulsory nor backed by financial incentives. Another factor is that many of the reviewed countries have different youth services all operating independently, which makes it hard for parents, children, and schools to pick their way through to the most suitable care provider (OECD, 2014b).

Low threshold services and collaborative networks as policy response

To provide more timely, better co-ordinated treatment for young people with poor mental health, some countries have put in place multidisciplinary services outside schools. They have low thresholds so that young people can access them easily. Two different models can be distinguished: one has a preventive, general health approach and is open to all, while the other is geared to students who have been identified with mental health problems and accessed through school referrals.

Examples of preventive, open-to-all external services are Sweden's *Youth Clinics* (Factsheet 2.4) and the *headspace* centres in Australia (Factsheet 2.5), both of which are government funded. Although they are low-threshold, general-purpose services, they do have a special focus on promoting mental health, as reflected in their staff composition – psychologists, social workers, and health care professionals like general practitioners (GPs). Not only do they provide information and advice on mental health, they offer treatment to young people with mental health problems and, in the event of referrals, their multidisciplinary teams can call upon their close connections with a range of other health care services. The *headspace* centres in Australia go one step further in that they also provide vocational support and collaborate closely with public employment services as a matter of course.

Examples of the model that uses referrals from schools are the *Student Guidance Centres* in Flanders, Belgium (Factsheet 2.6), and the *Care and Advice Teams* in the Netherlands (Factsheet 2.7). Their core focus is the provision of individual, multidisciplinary support for students with behavioural, emotional, and/or social problems. Students' problems are discussed in multidisciplinary teams that bring together GPs, psychologists, social workers, and educationalists. The Dutch structure also includes school representatives. Treatment is part of the support that the Belgian and Dutch centres provide. Another strength lies in co-ordinating health care through referral to other providers and in informing and guiding schools, parents and teachers through the health and community care system.

Both models have their strengths. With their preventive, general approach, the *Youth Clinics* and *headspace* avoid labelling young people who come to them with a "problem" and in this way avoid immediate medicalisation of mental health issues. Accordingly, they are very low-threshold and anyone can make use of their facilities. The open-to-all approach increases the chances of encountering young people with the first signs or sub-threshold symptoms of non-diagnosed mental ill-health. Close connection with the school system is the major strength of the referral-based *Student Guidance Centres* and *Care and Advice Teams*. These ensure that children identified by schools as having social,

emotional or behavioural problems or needs, can be referred swiftly for support, guidance, and suitable care.

Restricted capacity hampers the proper implementation of both kinds of care. The Flemish *Student Guidance Centres* have difficulty coping with the growing demand, while the Dutch *Care and Advice Teams* are able to cater for only 1% of the primary and 4% of the secondary school populations. Those figures are very low given that 20-30% of young people experience mental ill-health. In practice only those with severe problems receive support. What's more, close collaboration between multidisciplinary teams and specialised mental health care professionals is rendered useless in case of long waiting lists for psychologists and psychiatrists.

The reviewed countries have not yet responded to the shortages of mental health staff in schools or to the insufficient capacity of child and adolescent mental health care systems as a whole. Governmental influence does not reach far into schools in a number of countries where schools enjoy considerable degrees of autonomy. Nevertheless, where schools do receive state funding, governments could consider earmarking a certain amount for investment in school-based mental health support.

Key messages

Although in-school mental health services are common in OECD countries, they lack the capacity to provide timely support to all students in need. To ensure that young people – even those with mild-to-moderate mental health problems – receive attention, the public provision of freely accessible general health care services with a focus on mental health would be a valuable addition in many countries. There is a need for multidisciplinary facilities that bring together front-line social assistance, general and mental health services, and employment support. These actors should work closely with schools and specialised professionals in a coherent, co-ordinated manner.

The following strategies would go some way to ensuring that young people have timely access to support and treatment:

- Increase the number of psychologically-trained professionals available in schools.
- Ensure waiting times are short in the mental health care sector for children and adolescents.
- Set up a special support structure (possibly a special agency) linked to schools and other youth services. It should offer integrated services free of charge to all young people with a focus on common mental illnesses.

Preventing early school leaving

Young people who leave school early with no qualifications have low job prospects. In the Netherlands, for example, they have been found to be twice as likely to be unemployed than those who complete school (OECD, 2014b). There is also a much higher probability that they will have to rely on financial assistance such as social security benefits (OECD, 2013d).

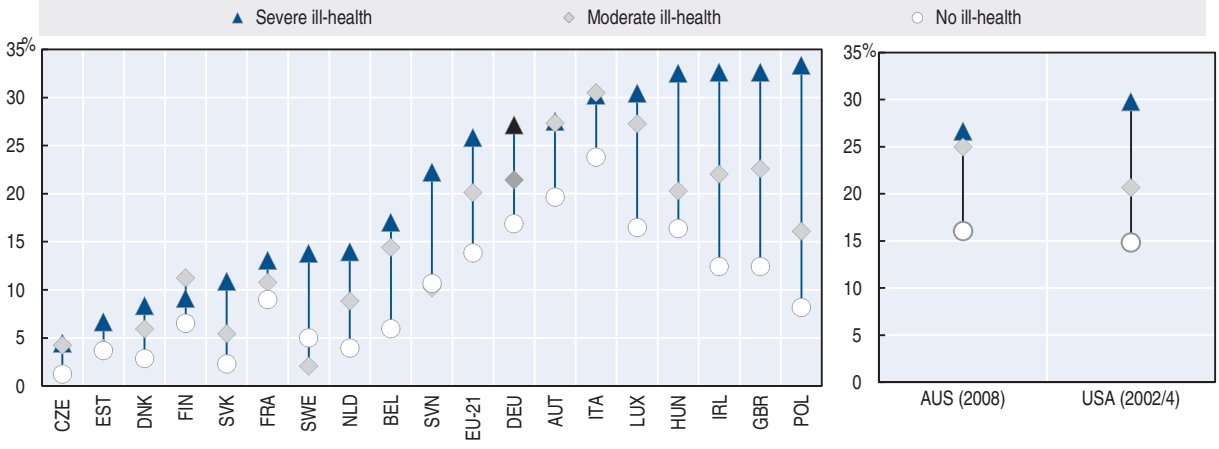
Early school leaving is more frequent among young people with mental ill-health

Leaving school early is more prevalent among young people who have moderate to severe mental health problems. Among young people with no mental health issues an average of 14% leave school early, compared to 20% among those who suffer from moderate mental illness and 26% among those with severe mental illness (Figure 2.4, Panel A). The EU 2020 Strategy for Education and Training has set a target for reducing the percentage of early school leavers to 10%; meeting that target will be especially challenging when it comes to young people who suffer from mental ill-health. The problem, however, is not restricted to the EU area. In Australia and the United States, too, there are high numbers of early school leavers among young people with poor mental health (Figure 2.4, Panel B).

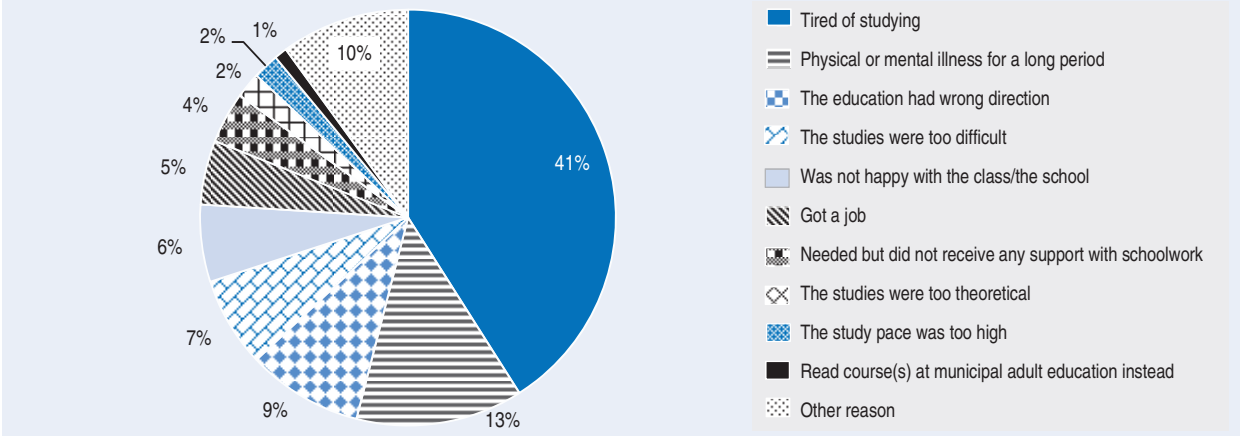
Figure 2.4. **Leaving school early lowers educational attainment and job prospects**

A. Youth with mental ill-health are more likely to stop education early
Share of people who stopped full-time education before age 15, by severity of mental ill-health, 2010

B. Youth with mental ill-health more often leave school without a diploma
High school non-completion rate among youth aged 20 by degree of mental ill-health at age 18



C. Poor health is an important reason for early school leaving
Beginners at upper secondary school who have not completed their studies by reasons for study drop out, Sweden, 2000



Source: Panel A: OECD compilation based on Eurobarometer 2010; Panel B: OECD estimates based on Youth in Focus (Australia) and the National Longitudinal Survey of Youth 1997 (United States); and Panel C: Statistics Sweden.

StatLink http://dx.doi.org/10.1787/888933184091

Unique data from Sweden on reasons for leaving school early show that poor health is an important factor for many school leavers (Figure 2.4, Panel C). The inference is that mainstream policy to curb early school leaving needs to go beyond motivational issues and address how (mental) health problems hamper school attendance among young drop-outs. This is also supported by the finding that young people who visit mental health services more frequently have been found to be more than two times more likely to leave school early five years later (Homlong et al., 2013).

Good policy on early school leaving, but no focus on the role of mental ill-health

Many of the reviewed countries have taken measures to improve support for early school leavers and help them either go back to school or transition into work. Three approaches can be distinguished (although they are sometimes implemented in combination):

1. Rising the compulsory school attendance age.
2. Organising a central register for early school leaving.
3. Setting up special centres for the case management of early school leavers.

Rising the compulsory attendance age is one strategy to curb early school leaving. It makes schools and parents responsible for ensuring that the children attend school for longer, so increasing their chances of securing qualifications. School leaving ages differ from country to country – 16 years of age in Norway and Sweden, for example, and 18 in Belgium. In the Netherlands, children can leave school at 16 years of age, by when it is hoped that they will at least have obtained a secondary vocational qualification and go on to higher vocational education. However, in recognition of the high numbers of early school leavers – particularly among pupils in vocational education – the government introduced a "qualification obligation", whereby pupils have to stay on at school until they are 18 unless they obtain a basic qualification (OECD, 2014b).

To be able to act fast to curb early school leaving, a good registration system is fundamental. Several countries have put in place central registers to identify and track potential early school leavers. Registration may be centralised at different levels; e.g. municipally, as in Denmark, or nationally, as in the Netherlands. In both cases, schools must report students who have been absent from school for a certain number of hours or days, e.g. after 16 hours in four consecutive weeks in the Netherlands and after 20 half-days in Flanders, Belgium. In countries which do not have central registers, or where there is no obligation to report absent children (e.g. Sweden and Australia), they are easily lost from sight.

A central registration system for tracking early leaving may also serve to monitor schools on their rates of early school leavers. That is the practice in the Netherlands where schools are financially rewarded for lowering early leaving rates to certain levels. They are required to invest the money in further initiatives for the prevention of early school leaving (OECD, 2014b).

Several countries use a case management approach for students who leave school without qualification. The regional *Register and Co-ordination Centres* in the Netherlands (Factsheet 2.8), Australia's *Youth Connections* programme (Factsheet 2.9), and Austria's *Youth Coaches* (Factsheet 2.10) are all designed to help pupils who have left school or risk doing so to resume schooling or transition swiftly to higher or

vocational education and employment. In the Netherlands and Australia, the centres have close links with other service providers, e.g. those that offer employment support.

A more prevention-oriented approach to early school leaving comes in the shape of Denmark's municipal *Youth Guidance Services* (Factsheet 2.11). Guidance counsellors follow all students and develop educational plans with them and their parents. They monitor students' transitions from lower secondary to upper secondary education and, should they fail to attend school, counsellors would get in touch very quickly and – if necessary – refer them to other support services.

Key messages

Notwithstanding the fine initiatives to tackle early school leaving, the high share of young people with mental ill-health among early school leavers is an issue that remains unaddressed. Most countries do not record reasons for early school leaving and consequently have no overall idea of how many early leavers struggle with mental ill-health. Countries that operate the case management approach should train case managers to identify and address mental health problems among early school leavers. They would thus be able to factor mental health issues into their return-to-school efforts. They could also initiate mental health treatment and support to prevent long-term absence from school.

To prevent early school leaving and enable quick action when it happens, countries should:

- Develop a central registry system for early school leaving (where this does not exist).
- Have a strong system in place for the case management of early school leavers, with particular emphasis on school leavers with mental illness.
- Build an evidence base on the link between school leaving and mental ill-health.

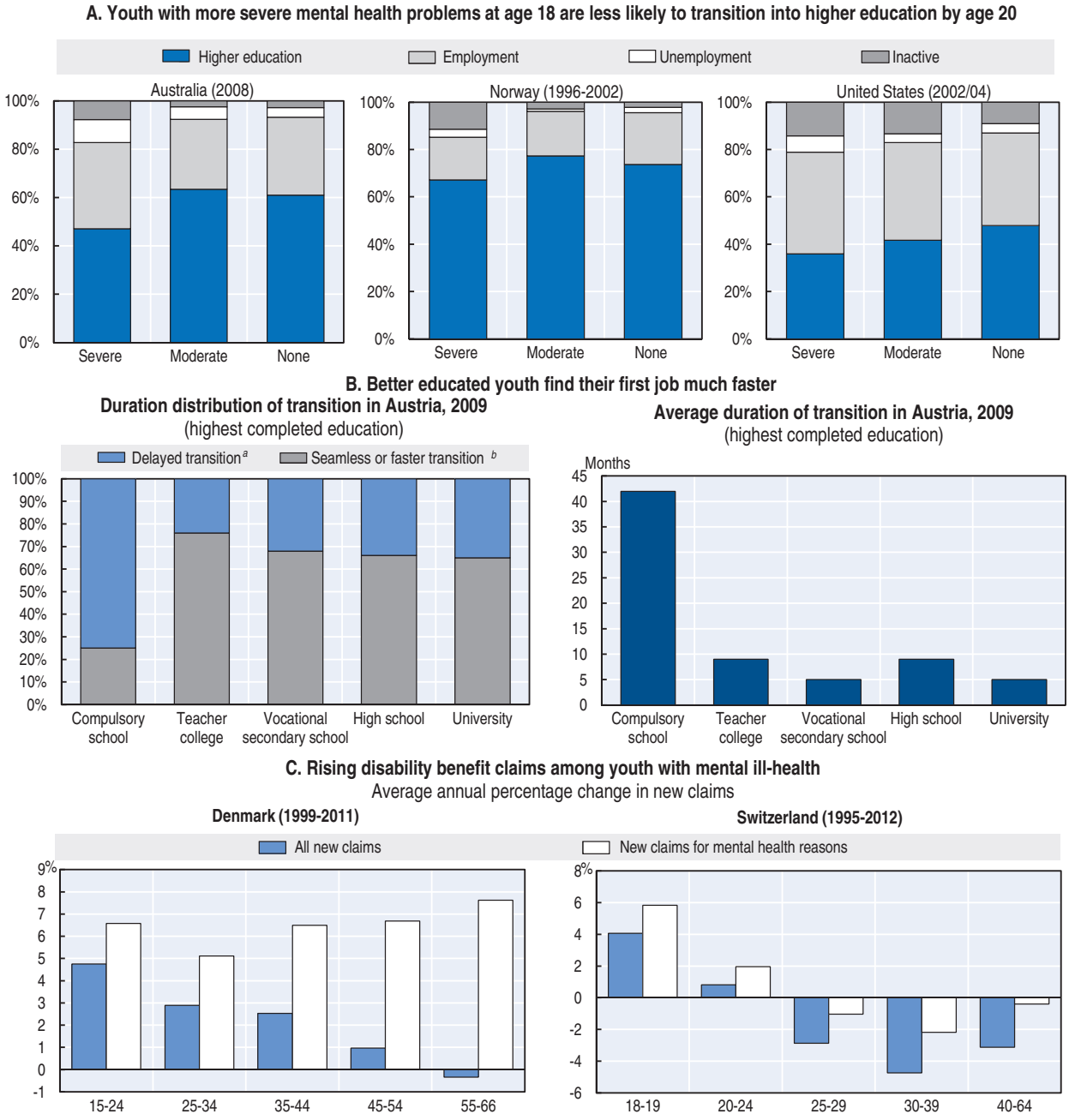
Effective support for the transition from school to work

Youth unemployment rates that are much higher than for the rest of the population and the disproportionate effect on young people of the massive jobs crisis of recent years underscore how difficult the transition from school to work has become (OECD, 2014c).

The transition to work is difficult for disadvantaged youth

Jobless rates among young people who suffer from poor mental health are worse than those of their mentally healthy peers. Longitudinal data from some countries paint an even gloomier picture: fewer such young people go on to higher education, which makes their chances of a successful transition into work even slimmer (Figure 2.5, Panel A). Young people with low educational attainment are at a great disadvantage when seeking their first job. Recent data for Austria confirm that young people who have merely completed compulsory schooling (nine years in Austria) take much longer to find work. They spend an average of 40 months job hunting, compared to ten months for those who complete high school and five months for those who go to university or a vocational school (Figure 2.5, Panel B). And, as young people with mental ill-health are overrepresented among pupils who leave school when compulsory schooling comes to an end, there is every chance that their first job experience will be disappointing – which will further contribute to falling self-esteem.

Figure 2.5. **The transition to higher education and employment is more difficult for young people who suffer from mental ill-health**



a. Persons between 15 and 34 years of age who have already completed their training and are living in private households.

b. Transition duration education/profession of more than three months (excluding persons who reported during the transition Präsenz-/Zivildienst as main activity).

Source: Panel A: OECD estimates based on Youth in Focus (Australia), Young HUNT (Norway), and the National Longitudinal Survey of Youth 1997 (United States); Panel B: Statistik Austria, LFS 2009 ad hoc module "Eintritt junger Menschen in den Arbeitsmarkt" (taken from Nationaler Bildungsbericht Österreich 2012, Band 1); and Panel C: OECD questionnaire on mental health.

StatLink http://dx.doi.org/10.1787/888933184104

In the past one or two decades, many OECD countries have seen a sharp rise in the number of young people aged 15 to 24 filing new disability benefit claims with a mental disorder. The increase has been much faster than in other age groups (Figure 2.5, Panel C), even in countries where disability benefit reform has led to a decline in new claims in all other age brackets (OECD, 2012). Swedish data also point to a close link between youth unemployment and disability claims: regions with higher youth jobless rates also show higher disability recipiency rates (OECD, 2013d).

Support for job seeking and work experience comes too late

In response to very high (and rising) unemployment rates among the young, countries have invested in activation programmes steered by the public employment service (PES). Under Sweden's *Youth Job Guarantee Scheme* (OECD, 2013d), for example, or the *Apprenticeship Guarantee* in Austria (OECD, 2015), unemployed young people who are registered at the local job centre attend programmes, often lasting several months, where they receive intensive job-search support or get their first work experience through apprenticeship arrangements. Denmark has also started to up-skill young registered jobseekers with no upper secondary education by enrolling them in mandatory education programmes (OECD, 2013c). Sweden has put in place special so-called *Navigator Centres* for unemployed young people who are estranged from the labour market because of mental ill-health, for example, or because they have never worked. The centres provide education, health care, and employment support and work closely with industry (Factsheet 2.12).

Most countries, however, have little inkling of the greater vulnerability of unemployed young people who suffer from poor mental health. The upshot is that they fail to address mental ill-health at all or consider it grounds for ineligibility for job support. Such stances are deeply damaging. While work can help improve poor mental health, the distance from the labour market widens the longer unemployment lasts, and unemployment grows worse (Strandh et al., 2014; OECD, 2013c; OECD, 2012; Mroz and Savage, 2006).

Despite the good intentions behind PES-administered youth activation programmes, there are two important shortcomings. First, rolling out such programmes is a reactive approach – i.e. taking action only after the fact, once young people have become unemployed. Governments should seek to bolster labour market integration programmes through earlier career support in mainstream education. However, job coaches in secondary or higher education are uncommon in the countries reviewed by the OECD. And although they are more common in special and vocational education, they have no training in spotting mental ill-health or addressing any of the attendant issues that may arise during first-time work experience (OECD, 2014a; OECD, 2014b). That such knowledge would be highly valuable is stressed by results from a Survey on Mental Wellbeing in Higher Education in the United Kingdom, showing that 80% of 56 higher education institutions reported a significant increase in the number of students approaching student services because of mental health needs (Royal College of Psychiatrists, 2011).

Second, only those young people who manage to sign on at their local employment offices may benefit from the activation programmes. So far, none of the reviewed countries has experimented with requiring school leavers to register with the PES so as to monitor those who have trouble finding work. Only in Belgium, where 85% of all school leavers sign on, is it common practice (OECD, 2013a).

Many OECD countries are also struggling with the rising numbers of disability benefit claims of young people, mostly on the grounds of mental ill-health. To prevent allowances being granted too early in life, a number of countries have tightened access to

permanent disability benefit and instead pay temporary benefits. They have become a popular alternative. In Austria, for example, almost all allowances paid to young people are temporary at the outset (OECD, 2015). However, such a change of tack is not enough in itself, because countries do little to reactivate people who are on temporary benefit. And eventually temporary entitlements are almost always made permanent.

What's more, in countries like Sweden and Norway, the focus on temporary payments in recent years has prompted a rise in new claims from young people – again mostly on the grounds of mental disorder. The reason is that temporary disability benefits have lowered the threshold for new claims (OECD, 2013b; OECD, 2013d).

It has proven to be very difficult to activate young people who are about to claim disability benefit and to strike the right balance between more rigorous requirements and better support. Recent reforms in Denmark (see Factsheet 5.3) and Austria (see Factsheet 5.4) have sought to strengthen activation by restricting entitlements to disability benefit and offering a more comprehensive and interdisciplinary rehabilitation and integration approach instead. Such changes apply particularly to young people, as initial outcomes in Denmark confirm. It remains to be seen, however, whether the new rehabilitation models are effective and if reforms can help young people enter or stay in employment.

A promising initiative for helping young people suffering from psychotic disorders into employment is Australia's *Orygen* Youth Health, a psychosocial recovery programme. It was adapted from Individual Placement and Support (IPS), a scheme originally developed for adults. As with IPS, an employment advisor works alongside the clinical team to support returns to school, training or employment (Factsheet 2.13). Although *Orygen* focuses chiefly on young people with psychotic illness and has not yet been as widely evaluated and implemented as adult IPS, it is a promising example of integrated health, education, and employment support. Developing similar programmes for registered young jobseekers who suffer from mild-to-moderate mental ill-health is an avenue worth exploring.

Today, support for young people with poor mental health seeking to make the school-to-work transition is substandard. It often comes too late – namely, after young people have left school – and only if they voluntarily register with the PES. And the longer they are out of work, the slimmer their chances of joining the labour market.

Key messages

Disability benefit claims usually spell the end of career prospects. Action to assist school-to-work transitions needs to start when students are still in education – be they in mainstream or special-needs establishments – and should be the work of job coaches with understanding of mental health. Given the high lifetime costs of being unable to enter the labour market, investing in strong support for the school-to-work transition is likely to pay off handsomely.

The following steps could help make support for the school-to-work transition effective:

- Improve early detection of mental ill-health in order to help those with mental health problems make the transition to higher education or work, e.g. with the support of specialised job coaches in secondary and vocational education.
- Involve the PES as early as possible, e.g. by requiring school leavers to register with the local employment office and guaranteeing training for young people who fail to find work.
- Use multidisciplinary rehabilitation to curb young people's disability benefit claims.

REFERENCES

Homlong, L., E. Rosvold and O. Haavet (2013), "Can Use of Healthcare Services Among 15-16 Year-olds Predict an Increased Level of High School Dropout? A Longitudinal Community Study", *BMJ Open*.

Kessler, R. and P. Wang (2008), "The Descriptive Epidemiology of Commonly Occurring Mental Disorders in the United States", *Annual Review of Public Health*, Vol. 29, pp. 115-129.

Kessler, R. et al. (2005), "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication", *Archives of General Psychiatry*, No. 62, pp. 593-603.

Kim-Cohen, J. et al. (2003), "Prior Juvenile Diagnoses in Adults with Mental Disorder: Developmental Follow-Back of a Prospective-Longitudinal Cohort", *Archives of General Psychiatry*, Vol. 60, pp. 709-717.

Langeveld, J. et al. (2011), "Teachers' Awareness for Psychotic Symptoms in Secondary School: The Effects of an Early Detection Programme and Information Campaign", *Early Intervention in Psychiatry*, Vol. 5, pp. 115-121.

McLeod, J. and D. Fettes (2007), "Trajectories of Failure: The Educational Careers of Children with Mental Health Problems", *American Journal of Sociology*, Vol. 113, No. 3, pp. 653-701.

Merikangas, K. et al. (2010), "Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplemente (NCS-A)", *Journal of American Academic Child and Adolescent Psychiatry*, Vol. 49, No. 10, pp. 980-989.

MindMatters (2014), "Background, Framework and Rationale: MindMatters Redevelopment", www.mindmatters.edu.au/docs/default-source/fact-sheets/mindmatters---background-framework-and-rationale.pdf?sfvrsn=12.

Mroz, T. and T. Savage (2006), "The Long-term Effects of Youth Unemployment", *Journal of Human Resources*, Vol. 41, No. 2, pp. 259-293.

OECD (forthcoming 2015), *Mental Health and Work: Austria*, 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), *Employment Outlook 2014*, OECD Publishing, Paris, www.oecd.org/employment/oecdemploymentoutlook.htm.

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.

OECD (2010), *Creating Effective Teaching and Learning Environments: First Results from TALIS*, OECD Publishing, Paris. http://dx/doi/org/10.1787/9789264068780-en.

Ormel, J. et al. (2014), "Mental Health in Dutch Adolescents: A TRAILS Report on Prevalence, Severity, Age of Onset, Continuity and Co-morbidity of DSM Disorders", *Psychological Medicine*, Epub ahead of print.

Philip, J. et al. (2014), "The Mental Health in Austrian Teenagers (MHAT) Study: Preliminary Results from a Pilot Study", *Neuropsychiatrie*, Epub ahead of print.

Royal College of Psychiatrists (2011), "Mental Health of Students in Higher Education", *College Report No. CR166*, Royal College of Psychiatrists, London.

Skre, I. et al. (2013), "A School Intervention for Mental Health Literacy in Adolescents: Effects of a Non-randomized Cluster Controlled Trial", *BMC Public Health*, Vol. 13, No. 873, pp. 1-15.

Slee, P. et al. (2009), *KidsMatter Primary Evaluation Final Report,* Centre for Analysis of Education Futures, Flinders University of South Australia, Bedford Park.

Strandh, M. et al. (2014), "Unemployment and Mental Health Scarring During the Life Course", *European Journal of Public Health*, Vol. 24, No. 3, pp. 440-445.

Veldman, K. et al. (2014), "Mental Health Problems and Educational Attainment in Adolescence: 9-year Follow-up of the TRAILS Study", *PLoS One*, Vol. 9, No. 7, pp. 1-7.

Weare, K. and M. Nind (2011), "Mental Health Promotion and Problem Prevention in Schools: What Does the Evidence Say?", *Health Promotion International*, Vol. 26, No. S1, pp. i29-169.

Wyn, J. et al. (2000), "MindMatters, A Whole-school Approach Promoting Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, Vol. 34, pp. 594-601.

FACTSHEETS 2.1 TO 2.13

Factsheet 2.1
Norway: Improving the mental health literacy of teachers and students

Context

Teachers play a crucial role in recognising mental ill-health among students and taking action accordingly. Breaking the stigma that attaches to students affected by mental ill-health can help secure them social support and inclusion. It is important to improve the mental health literacy of both students and teachers to prevent negative educational outcomes.

Programme

In Norway, the Mental Health in Schools co-operative project, which ran from 2004 to 2011, provided different mental health training programmes directed at teachers and students. The project, part of the government's strategic plan for mental health, aimed to raise awareness of mental health conditions, increase available support, and foster confidence in the effects of treatment.

Specifically, six different mental health programmes were run, all with the goal of fostering knowledge on how students can safeguard their own mental health, where they can get help, and how they can provide support for each other. One programme specifically focused on teachers to increase their i) understanding of mental health, ii) competency in dealing with students suffering from mental ill-health and iii) knowledge of models of co-operation between schools and health and social services. The ambition was to create a more open atmosphere conducive to discussing emotional problems in schools.

Outcomes

A non-randomised controlled study evaluated the effects of one of the mental health programmes – Mental Health for Everyone. The programme focused on teaching young people about mental health and helped students to express their feelings and become more aware of their own and others' mental health. It showed that mental health literacy improved significantly more among students who attended the programme than among those who did not. They recognised symptom profiles better and held less prejudices. A study evaluating information campaigns in Norway for increasing teachers' ability to spot the early signs of psychosis revealed that those who were reached by the campaign had more confidence in the effectiveness of psychosis treatment and were better able to identify psychosis. Such information campaigns could be a basis for closer collaboration between the education and the mental health care systems.

There has been no investigation of whether training for teachers in identifying a broad range of signs of poor mental health has been successful. It is crucial that its scope should not be confined to identifying students with more easily recognisable problems, such as defiant behaviour, hyperactivity, or conduct disorders. It should encompass less visible, less disruptive mental health problems such as anxiety and depression.

Further reading

Langeveld, J. et al. (2011), "Teachers' Awareness for Psychotic Symptoms in Secondary School: The Effects of an Early Detection Programme and Information Campaign", *Early Intervention in Psychiatry*, Vol. 5, pp. 115-121.

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

Skre, I. et al. (2013), "A School Intervention for Mental Health Literacy in Adolescents: Effects of a Non-randomized cluster Controlled Trial", *BMC Public Health*, Vol. 13, No. 873, pp. 1-15.

Factsheet 2.2
Australia: KidsMatter and MindMatters – Promoting mental health programmes in schools

Context

Young people who suffer from mental ill-health run a higher risk of attaining low levels of education and leaving school early than their healthy peers. Promoting mental health programmes in schools can improve mental health literacy among teachers and students and prevent early school leaving.

Programme

The Australian Government funds two mental health promotion programmes in schools: KidsMatter for primary schools and MindMatters for secondary schools.

KidsMatter aims to encourage partnerships between the education sector, early childhood professionals, the health system, and local communities in order to optimise children's mental health and well-being and to intervene early in children's lives where necessary. MindMatters builds on the mental health promotion, prevention, and early intervention frameworks developed for KidsMatter, but has been adapted to secondary schools contexts and adolescent development. Aligning MindMatters with KidsMatter through a consistent framework can support the large number of schools with both primary and secondary intakes.

Both programmes provide training in promoting mental health and help schools to identify their strengths and weaknesses in that regard. To that end, the programmes foster collaboration between teachers, parents, students, and the wider school community. They guide schools in choosing an available intervention programme in four major areas: i) positive school community; ii) student skills for resilience; iii) parents and families (*e.g.* information support and good communication); and iv) support for students experiencing mental ill-health.

Outcomes

A pilot phase of KidsMatter was trialled in 101 schools across Australia during 2007-8. A comprehensive evaluation (albeit without a comparison group) found a general improvement in students' mental health and well-being – greater optimism, coping skills and mental health difficulties – and in teachers' knowledge of mental health and ability to support their students. No robust measurement has yet been taken of how the MindMatters programme improves mental health literacy, implements interventions, or achieves mental health outcomes. Nor is it known how many secondary schools have integrated the programme into the curriculum. In 2011, the Commonwealth Department of Health and Ageing commenced work with the Principals Australia Institute on how to consistently and continuously measure the outcomes of KidsMatter and MindMatters.

Further reading

Graetz, B. et al. (2008), "KidsMatter: A Population Health Model to Support Student Mental Health and Well-being in Primary Schools", *International Journal of Mental Health Promotion*, Vol. 10, pp. 13-20.

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

Slee, P. et al. (2009), *KidsMatter Primary Evaluation Final Report*, Centre for Analysis of Education Futures, Flinders University of South Australia, Bedford Park.

Factsheet 2.3
Belgium: Internal care structure in schools

Context

Childhood and adolescence are crucial times for promoting good mental health and preventing mental illness. Organising school-based mental health services with a central role for the teacher as primary actor is one promising way of addressing the issue.

Programme

Flanders has a scheme, *interne leerlingenbegeleiding* (internal care structure), that operates within schools. Each school receives funding that allows it to relieve teachers of part of their teaching duties or to hire specialised staff (a psychologist, pedagogue, medical professional, or social worker) so that they can provide extra care for pupils in need. These teachers are called "care teachers". All primary schools are obliged to conduct a three-level care policy with some teachers co-ordinating action at the school level, some coaching and supporting their co-workers, and others guiding students. However, should the need arise, care teachers are allowed to fill in at other levels than the one to which they are assigned. In some schools, the care teacher engages primarily in one-to-one interventions (e.g. encouraging pupils to talk about their problems at school or at home). In other schools, the care teacher focuses more on group-based approaches (e.g. bullying prevention programmes), or devising new policies (e.g. healthy school schemes).

Outcomes

A recent evaluation shows that the internal care policy with the teacher as primary actor has become widely accepted in primary education in Flanders thanks to a range of policy initiatives and increased spending from the Flemish Government. Primary schools have, on average, the full-time equivalent of 0.6 care teacher, with the 25% largest schools employing between 0.75 and 1 full-time care teacher. In addition, schools with at least 10% of their pupils (25% in secondary education) in a risk group (e.g. foreign language spoken at home, poorly educated mother, or household in receipt of a school subsidy) receive additional resources equivalent to one to two full-time teachers. The same study points out, however, that secondary schools typically have a much less well developed internal care structure as the issue has received much less attention and resources from the government.

Further reading

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

Struyf, E. et al. (2012), "Zorgbeleid in het Gewoon Basisonderwijs en Secundair Onderwijs in Vlaanderen: Kenmerken, Predictoren en Samenhang met Taakopvatting, en Handelingsbekwaamheid van Leerkrachten" [Care policy in primary and secondary education in Flanders: Characteristics, predictors and congruence of tasks, and competency of teachers], Onderzoek in opdracht van de Vlaamse Minister van Onderwijs en Vorming in het kader van het onderwijskundig beleids- en praktijkgericht wetenschappelijk onderzoek (OBPWO 09.05), Brussels.

Factsheet 2.4
Sweden: Youth clinics help young people with multiple problems

Context

Many young people with mental health problems do not receive the right support, if any at all, because they have no dealings with the relevant public services. Those who are not in education or employment are a prime example as they have typically lost touch with either the education or the employment system. Making sure that they receive support is a daunting challenge.

Programme

Youth clinics are an easily accessible, free public service for young people up to 20 years of age. Young people can make contact voluntarily through the clinics' open house policy. The clinics play an important role in general health promotion because of their close contact with a large proportion of the teenage population. They are run jointly by municipalities and regions, providing services to young people with multiple problems, particularly mental health problems. Municipalities or regional councils fund the clinics, either separately or jointly. Although there are some differences in the way that municipalities organise their youth clinics, the general focus is the same.

All youth clinics have at least one midwife, a general practitioner, a social worker and a psychologist. Their main activities include prevention and treatment services for young people with i) psychological and social problems and ii) sexuality issues (*e.g.* unwanted pregnancies and sexually transmitted infections). Workers in youth clinics actively work to identify early signs of mental illness and deal with concerns related to adolescents' social development. Depending on the severity of the illness, psychological treatment measures can take the form of short or long therapies that focus on crisis care, support, and/or patients' lack of insight. The work of the various professionals involved consists of individual conversations, investigation, treatment, and group activities. Outreach activities are also essential part of the clinics' work. They include study visits to school classes and informing schools about the available health services.

Outcomes

Around 1.3 million young people have registered with youth clinics since their inception in 2002. There is no evidence available on the effectiveness of the programme. However, it has strengths that are recognised as important to designing services for young people. First, the service mix within a single youth-friendly setting addresses young people's low use of and engagement in traditional primary and specialist (mental) health care. Second, integrating mental health programmes and services into general youth and welfare programmes could be a way forward, notably in low-resource settings. The third distinct strength is that youth health programmes are less stigmatising when multiple youth-friendly services are provided under one roof and are thus better able to reach out to young people with common mental illnesses.

Further reading

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

Patel, V. et al. (2007), "Mental Health of Young People: A Global Public-Health Challenge", *The Lancet*, No. 369, pp. 1302-1313.

Factsheet 2.5
Australia: Headspace – Providing services for young people with mental ill-health

Context

Mental health problems are extremely frequent during the transition from childhood to adulthood – they occur even more often than later in life. Yet young people are less likely than any other groups to seek professional help for mental ill-health. Reasons include lack of awareness and poor service accessibility.

Programme

Headspace addresses the mismatch between the need for and supply of mental health services among young people between 12 and 25 years old. As at December 2014, there were 70 headspace centres across Australia, a number that will be scaled up to 100 by 2016. They bring together a range of professionals from psychologists, social workers, alcohol and drug workers, to GPs, career counsellors, vocational workers and youth workers. Headspace centres are accessible, youth-friendly, integrated service hubs that provide evidence-based interventions and support to young people with mental health and well-being needs. Each centre offers medical and vocational services as part of the aim to provide holistic and integrated support.

Headspace's access threshold is very low: anyone can walk in. The centres are thus ideally placed to reach young people with non-diagnosed common mental illness. Services are provided largely free of charge with high confidentiality. Headspace works together with and refers to other services, such as government-funded employment schemes and the Department for Social Services (which assesses eligibility for income support and refers claimants to employment services). Headspace also has a support programme for secondary schools affected by suicide.

Outcomes

A recent study into the characteristics of headspace clients, between January and June 2013 (across all 55 centres open during this time), showed that the majority had problems with how they felt – most often sad, depressed and/or anxious. Over half presented very high levels of psychological distress. About 15% came with no mental disorder, 17% with a sub-threshold condition, about 40% with mild to moderate mental illness, close to 20% with a full-threshold diagnosis, and 6% with a serious, on-going mental disorder.

Almost 50% attended school and 20% were in higher education – figures that demonstrate headspace's potential as a programme for preventing early school leaving among young people with mental health issues. That one-third not engaged in education, training or employment indicates the vulnerability of youngsters with mental health problems. No details are known so far about the types of services used most frequently or the sustainability of interventions.

Further reading

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

Rickwood, D., N. Van Dyke and N. Telford (2013), "Innovation in Youth Mental Health Services in Australia: Common Characteristics Across the First Headspace Centres", *Early Intervention in Psychiatry*, Epub ahead of print, http://dx.doi.org/10.1111/eip.12071.

Rickwood, D. et al. (2014), "Headspace – Australia's Innovation in Youth Mental Health: Who Are the Clients and Why Are They Presenting?", *Medical Journal of Australia*, Vol. 200, No. 2, pp. 108-111.

Factsheet 2.6
Belgium: Student guidance centres

Context

With the average age of onset of mental disorders being 14 years old, the education system has an important role to play in early identification of mental ill-health. Providing individual, multidisciplinary support for students with behavioural problems can contribute to the timely, co-ordinated treatment of young people with mental health problems.

Programme

In Flanders, student guidance centres (Centra voor Leerlingenbegeleiding – CLBs) assist schools in four core domains – learning strategies, educational career planning, psychosocial functioning, and preventive health care. The centres work with multidisciplinary teams consisting of psychologists (typically directors of centres), doctors, nurses, social workers, and educationalists. The CLBs also perform regular medical check-ups and are structurally linked to both the Flemish Department for Education and the Flemish Department for Welfare, Public Health and Family.

They operate on the principle of universal surveillance for all students on the one hand and, on the other, provide individual, multidisciplinary, and intensive counselling to students with greater needs. The work of the centres is mainly demand-driven and they intervene after a request from a student, parent or school. However, they also play a key role in the prevention of early school leaving and access to special and integrated education.

Besides giving information, support and guidance, the centres typically have a clear overview of the external services to which they can refer people if they cannot resolve issues themselves.

Outcomes

All schools are required to work with a student guidance centre, with each CLB caseworkers responsible for about 400 students on average. Yet practices vary greatly across centres and they do not always have enough staff to meet all their tasks. There is growing demand from schools, parents and students for support from the CLB centres, in particular with respect to psychosocial problems. Long waiting lists for external services, especially in the mental health sector, have increased the workload for CLB caseworkers as they support the students until they get specialised care. Due to lack of time, centres tend to undertake little prevention or early detection.

Further reading

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

Vermaut, H. et al. (2009), "Het CLB-Decreet: Tussen Wens en Realisatie", Evaluatie Acht Jaar na de Invoering van het CLB-Decreet, Hoger Instituut voor de Arbeid, Katholieke Universiteit Leuven.

Factsheet 2.7
Netherlands: Regional care and advice teams for young people at school

Context

Early identification and co-ordinated treatment of students with mental ill-health is important for supporting those with psychosocial problems. The education system has a key role to play.

Programme

In the Netherlands, schools are part of regional care and advice teams (ZAT) that support students with psychosocial and/or behavioural problems. The teams include other youth care specialists such as paediatricians, social workers, psychologists, educationalists, education officers, and the police. There are separate teams for primary, secondary and vocational education.

The ZATs' main tasks are to i) conduct interdisciplinary problem analysis of the cases that come before them; ii) further explore the problems of students or families; iii) co-ordinate the support services necessary for a specific case; iv) advise school representatives; v) provide support to students and/or families; vi) refer to external support; vii) prevent early school leaving (mainly in vocational school care and advice teams).

Outcomes

Almost all secondary and vocational schools, but only 67% of primary establishments, take part in ZATs. Teams are confronted with high caseloads: 8 200 students in primary education and 721 and 3 200 in secondary and vocational education, respectively. Of the total primary school population, about 1% of all pupils are discussed in an academic year, while in secondary education the figure is 4%. (No statistics are available for vocational establishments.) The inference is that a large group of students with problems is being missed, as national data have shown that about 20% of Dutch young people experience mental health problems. Consequently, the ZAT teams support those who suffer from more severe psychosocial problems.

Each year, schools evaluate the ZAT teams. Overall, they rate them well for expertise, teamwork, clear administration and reporting of agreements, speed of response and effective problem management. In primary and secondary education, teams have been criticised for the lack of preventive programmes and the limited scale on which support programmes are provided. Teams in primary education do not work closely enough with local youth care providers. In secondary education, problems are encountered with feedback from the teams to students, parents and teachers. And in vocational education, timely referral of students to the ZAT teams and to other external parties has been found wanting.

Further reading

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

Steenhoven, P. van der and D. van Veen (2012), "Monitor deelnemerszorg en ZAT's in het middelbaar beroepsonderwijs 2011", Nederlands Jeugdinstituut, Utrecht.

Steenhoven, P. van der and D. van Veen (2011a), "Monitor ZAT's, zorgteams en leerlingenzorg in het primair onderwijs 2010", Nederlands Jeugdinstituut, Utrecht.

Steenhoven, P. van der and D. van Veen (2011b), "Monitor leerlingenzorg en ZAT's in het voortgezet onderwijs 2010", Nederlands Jeugdinstituut, Utrecht.

Factsheet 2.8
Netherlands: Preventing early school leaving

Context

Young people with mental health problems are a risk group that is particularly prone to early school leaving (ESL), which seriously reduces their levels of educational attainment and labour market prospects. Policies to prevent early school leaving and offer timely support to young people who have dropped out are essential, therefore.

Programme

Since 2007, the Netherlands has introduced several measures to curb ESL. All young people in education receive an "education number" to facilitate the tracking of ESL. In line with this move, a national digital School Absenteeism Desk has been put in place. Schools report to the desk absenteeism (defined as missing 16 hours within four consecutive school weeks) and ESL (defined as leaving school before having acquired a basic qualification). Since 2009, it has been compulsory for all schools to report absenteeism and ESL to the desk.

A nationwide programme to address ESL, called "Aanval op schooluitval", has also been initiated. Its chief goals are: i) scrutinise more closely the transition from pre-vocational secondary education to vocational education; ii) take more and better action at school (schools receive financial rewards for lowering ESL percentages to certain levels); iii) cater better to pupils who would rather "work with their hands"; iv) support career orientation and study choices more effectively; v) offer more attractive syllabi, that include sports and culture, to keep youth in school; vi) agree with employers basic qualification requirements for early school leavers aged 18 to 23.

The Netherlands has also set up 39 regional registration and co-ordination centres to further tackle ESL in collaboration with schools and municipalities. Students under the age of 23 who leave school without a basic qualification fall under the responsibility of the centres. They seek to guide students back into education, possibly in combination with work, in order to obtain a basic qualification. If education is no longer a feasible option, the centres help their wards find a sustainable job (often working with employment services).

Outcomes

A clear downward trend has been observed in the number of new early school leavers per school year since the measures to tackle ESL were implemented. The number almost halved from over 50 000 in school year 2005-06 to around 28 000 in 2012-13, which is 2.1% of the total school population (the statistics are preliminary). The bulk early leavers (79%) come from vocational education, 18% from secondary education, and the remaining 3% from adult education.

Further reading

OCW (2011), "Schooluitval voorkomen in Nederland: Speerpunten huidige aanpak en doorkijk naar vervolgbeleid; resultaat schooljaar 2009-2010 (voorlopige cijfers)" [Preventing school dropout in the Netherlands: Priorities of the current approach and perspective on follow-up policy; Result for school year 2009-10 preliminary numbers], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

OCW (2013), "Aanpak voortijdig schoolverlaten" [Approach to early school leaving], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

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

Factsheet 2.9
Australia: Youth connections – reconnecting disengaged young people with education, training and employment

Context

Young people who suffer from mental ill-health, diagnosed or not, are at a higher risk of disengaging from education and, consequently, facing poor labour market prospects. Special centres for case management can improve support for early school leavers and help them return to school or otherwise make the transition to work.

Programme

Youth Connections was a safety net scheme for young people who had disengaged from education, or were at risk of doing so. It provided individually-tailored case management to help them re-connect with education or training and build resilience, skills and attributes that promote positive life choices and well-being.

The programme had three components: i) individual support services; ii) outreach and re-engagement activities to track young people who have dropped out of education; and iii) activities targeted at strengthening services in the region to identify and respond more effectively to young people at risk of disengagement. Case management included mentoring, advocacy and referral to other service providers. The most common barriers addressed were low self-esteem, low literacy, and numeracy and behavioural problems.

Providers were funded by the federal government, complemented by state programmes. The amount of funding depended on the size and nature of each service region. Though the agreements between the federal and state governments ended in 2013, the Australian Government continued funding Youth Connections until the end of 2014.

Outcomes

The service was delivered in 113 service regions by 67 organisations and provided support services to more than 87 870 young people. 26 079 (29%) of these young people had suspected or diagnosed mental health issues. During the life of the programme, approximately 54 150 young people receiving support commenced education, re-engaged in education or strengthened their education engagement, approximately another 40 740 improved educational performance, attendance or behaviour and 4 490 engaged in employment (Youth Connections participants could achieve multiple outcomes).

A survey among case management providers suggests that Youth Connections is effective in establishing a long-term effect through lasting re-connection: six months after completing the programme, 93% of participants were in education, training, or employment. A significant proportion experienced improved psychological outcomes. The main reasons for not achieving outcomes are a failure to engage when initially contacted and withdrawals during the programme.

The main success factors included the very low caseload of 25-30 adolescents, the flexibility of the service, and links to others services. The majority of staff working with the young people had Youth Work or Social Work qualifications and were trained to recognise mental health problems and provide crisis intervention.

Further reading

Dandolopartners (2014), Final Evaluation of the National Partnership on Youth Attainment and Transitions, Dandelopartners, Melbourne.

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

Factsheet 2.10
Austria: Youth coaching – Helping pupils stay in the education system

Context

Young people with multiple problems, which may include mental health issues, are at a high risk of leaving the education system without a qualification. Premature drop-out permanently affects their labour market prospects and calls for early intervention.

Programme

The aim of the Youth Coaching programme is to help young people stay in the education system as long as possible and to re-engage those who are neither employed nor in education or training (NEET). The three target groups are young people in their ninth school year (the last year of compulsory education) typically in the 15-16 age group; NEETs under the age of 19; and young people with a disability or special educational needs under 25 years old. Those eligible typically display a combination of individual conditions and social disadvantages and thus at a high risk of failing to complete school. Young people at risk access the programme chiefly through teachers who identify them (for those in their last school year) and through agencies like the employment service.

Youth Coaching is a graded three-step process. Step one is a three-hour initial consultation, including educational counselling and resulting in a mutually-agreed target. Step two comprises eight hours of counselling, during which students are required to take the initial agreement further and, if necessary, consult external experts such as social workers. Step three involves 30 hours of individual case management, in which youth coaches set out goals for implementing the target agreement and conclude with a clearance report. In this process, youth coaches refer their clients to services like debt or counselling and, if necessary, organise psychological therapy. The entire process may be spread out over no more than one year. An important element of the programme is the involvement of both parents and teachers and a strong focus on students' resources.

Outcomes

In its trial phase, Youth Coaching applied primarily to pupils in the ninth school year. They are easily reached through their class teachers although access procedures to the programme differ widely between regions and are in most cases highly non-transparent. For other target groups, better outreach methods will be needed, such as close collaboration with other actors (e.g. youth workers).

Of those who have gone through the whole programme so far (only 7% have dropped out), 85% achieved outcomes in line with target agreements. In total, 30% ended up in step-3 case management, though for the NEET group the proportion is expected to be much higher – raising significant issues of funding due to the large current caseload of some 100 students per caseworker.

Finally, there appears to be little conflict with other mental health care professionals (such as social workers, school psychologists and advisory teachers for children with mental and behavioural problems). Youth coaches actually seem to function like hubs for carers.

Further reading

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

Steiner, M. et al. (2013), "Evaluierung Jugendcoaching-Endbericht", Studie im Auftrag des Bundesministeriums für Arbeit, Soziales und Konsumentenschutz, Vienna.

Factsheet 2.11
Denmark: Municipal youth guidance centres

Context

Young people who suffer from mental ill-health are greatly at risk of leaving school early, which dims their labour market prospects. Early action to ensure a smooth transition from lower- to upper-secondary education and from upper-secondary education to work is needed.

Programme

Municipal Youth Guidance Centres are responsible for i) counselling young people up to the age of 25 in their critical transition from lower- to upper-secondary education, and ii) following up on those who drop out of upper-secondary education.

Guidance counsellors are responsible for preparing education plans for all pupils for the time after they complete lower-secondary school. Planning involves counsellors meeting pupils and parents and building on pupils' school records, which provide information on their achievements, interests, expectations for the future, and how they wish to develop.

Planning starts several years before the end of compulsory schooling. Youth guidance counselors assess the pupil's academic, social and personal competences in the 8th grade. Children assessed as not having the competenes needed to be ready for further education must participate in an individually adapted, focused education and guidance programme in grade 8 and 9 in co-operation between the school and the guidance centre. The goal is that the pupil becomes ready to receive an upper secondary education by the end of grade 9 or 10.

The transition process between lower and upper secondary education is monitored and pupils 15 to 17 years old who fail to turn up for upper secondary education after compulsory school are monitored to prevent early school leaving. In the event of a pupil's non-attendance, the guidance counsellor has to get in touch with his or her parents within five days of being notified by the school and initiate action within 30 days. Counsellors are not allowed to provide any treatment or therapy but they can identify problems and refer pupils or parents to specialists – a social worker in case of severe social problems in the family, for example, or a psychologist in the event of mental illness.

The centres co-operate closely with the educational institutions and the municipal job centre, for which young people in general and 18-19 year-olds in particular are also a target group (all young people can get guidance from the job centre for labour market questions and employment options). The guidance centres have acces to a database with a full overview of the education and training of each person under age 25 within the municipality who has not finished upper secondary education. This enables a quicker identification of vulnerable youth.

Outcomes

There are 53 centres in Denmark with around 1 000 counsellors covering the 98 municipalities. The Ministry of Education has developed guidelines for a quality assurance system to be set up by each centre including figures regarding the scope, results and effects of the guidance provided, and a procedure for evaluating the services provided through user and employee surveys. Centres are also required to publish objectives, methods, planned activities and performance on the Internet.

Further reading

Euroguidance Denmark (2014), *Guidance in Education – The Educational Guidance System in Denmark*, Danish Agency for Higher Education, Copenhagen.

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

Factsheet 2.12
Sweden: Navigator centres for young unemployed people

Context

High unemployment among young people who suffer from poor mental health is a problem in many OECD countries. Several have therefore invested in public employment service youth activation programmes. Ensuring co-ordinated and interdisciplinary support for young unemployed people is crucial to integrating them into the labour market.

Programme

During 2005-07, the Swedish National Board for Youth Affairs piloted eleven municipal navigator centres with a common "single-door" to provide support for young people. The navigator centres are a good model of co-ordinated employment, educational and health support for young people between 16 and 25 years of age facing high entry barriers to the labour market. The navigator centres focus their attention on individuals who are harder to motivate than those usually encountered by the employment service. They include young people who suffer, or have suffered, from social phobias, depression, or the effects of drug abuse. Many are on social assistance benefit and have never been integrated into the labour market.

The navigator centres provide services mainly through a one-stop shop formula that range from curriculum vitae writing skills, educational and vocational counselling, and motivational interviewing to preventive health care. Young people may also be referred to mental health professionals in the county where the centre is located. Or, centres themselves may deliver support depending on the nature of the young person's disorder and how the centre is organised. If referrals are made through municipal employment units, the public employment services, or the Social Insurance Agency, young people are required to take up the support provision that is offered to them.

Outcomes

Evaluations of the navigator centres across the country are not available. But evidence from the pilot phase suggests that out of the 2 000 young people who have so far been placed in a navigator centre, between 45% and 70% have moved on to education, employment, or work experience. Qualitative evidence suggests that navigator centres are a good way of filling the gap left by the employment service, social services and the local education committees between which young people are shuttled. Ensuring that all municipalities offer navigator-centre-type services would ease access to both employment and health support. Alternatively, navigator centres could be turned into a national initiative subject to a rigorous evaluation of the programme.

Further reading

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

Factsheet 2.13
Australia: Orygen youth health – Embedding employment services in a clinical setting

Context

Health services tend to have little employment focus or expertise and are also generally poorly connected with employment agencies and job brokers. Yet the vocational services provided in parallel to health services have been shown not only to help people into employment but also to improve health and well-being outcomes.

Programme

Orygen Youth Health is a state-funded hospital-based youth mental health service. It runs an experimental psychosocial recovery programme, which is in fact Individual Placement and Support (IPS) adapted to young people. This means that employment counsellors are directly employed by the health service and provide support in attaining educational goals or finding and maintaining employment in line with the IPS model.

Orygen focuses on three disorder groups: first-episode psychoses, mood disorders, and personality disorders. However, Orygen does not wait until people have been assigned a disability tag and has a strong focus on indicated prevention when the first signs of mental illness arise. Referrals may thus also come from schools, families and the community.

Returning to school, training or employment are common goals for young people attending the Psychosocial Recovery Programme. Young people can work on their job interview skills, update their resume, explore their skills and identify training they might want to pursue. A Group Programme may be offered as a first step in vocational recovery providing structure and routine and opportunities to participate in meaningful activities with others. Qualified teachers are available on site to support young people in staying at, or returning to, school. Vocational group programmes such as catering and horticulture are offered and co-facilitated by clinicians and teachers. Those ready to enter work have access to employment consultants from outside agencies and the consultants employed at Orygen.

Outcomes

The effectiveness of the IPS service for young people with first-episode psychosis is currently being evaluated in a randomised controlled trial. First – unpublished – results are positive: the integrated service is more effective than health intervention alone (85% of subjects moved into education or employment compared to 29% in the control group which received the usual clinical case management care, some of which have a vocational orientation). Factors that contribute to the success of Orygen's employment counsellors include the low caseload of around 20 clients and the focus on prevention and early intervention (before clients are caught in inactivity).

Funding employment specialists remains an issue for integrated services of this type. It requires convincing people that the employment specialist is of more value than an additional clinician. A further worry is that capacity is insufficient for offering such service to everyone in the region, e.g. there are 2 500 referrals every year but resources only for 700-800 clients.

Further reading

Killackey, E. et al. (2013), "A Randomized Controlled Trial of Vocational Intervention for Young People with First-episode Psychosis: Method", *Perspectives in Early Intervention*, Vol. 7, No. 3, pp. 329-337.

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