Chapter 5

Improving benefit systems and employment services for jobseekers with mental ill-health

The ability of benefit systems to identify clients' mental illness is crucial to helping them back into the labour market quickly and sustainably. Mental ill-health is highly prevalent not only among disability benefit recipients, but also among unemployment and social assistance recipients. Across OECD countries, between one-third and one-half of all benefit recipients suffer from mental ill-health. Activation policies can assure fast return to work for those people and prevent high caseloads in the disability benefit scheme.

Policy conclusions:

- *Prevent disability benefit claims with mental ill-health.*
- *Identify and support jobseekers with mental health problems.*
- *Invest in mental health competence for all benefit actors.*
- *Develop integrated health and work services in the employment sector.*

When people are about to lose or have just lost their job, benefit systems and employment services become critical. Benefits secure income and employment services deploy activation strategies to help people back into the labour market. This chapter discusses how the two – referred to here as the "employment sector" – can make a difference to people suffering from mental ill-health.

Across the OECD, mental ill-health has become the main driver of new disability benefit claims (OECD, 2010; OECD, 2012). However, mental ill-health is also highly prevalent among beneficiaries of all other types of income-replacement benefits. And causality runs in both directions: people with mental ill-health are at a higher risk of job loss and inactivity, while unemployment and (involuntary) non-employment themselves worsen people's mental health.

Population survey data suggest that across the OECD, between one-third and one-half of all benefit recipients suffer from poor mental health (Figure 5.1), with some cross-country variation. The share is highest among long-term sick, long-term unemployed and long-term inactive people who also frequently suffer from severe mental disorders. The share of people affected by mild-to-moderate mental ill-health is very much the same in most countries, regardless of the benefits they claim.

Time is a critical factor in helping people go back to work after economic or health-driven absence, job loss, and inactivity. The longer people are away from their job and from work in general, the less likely they are ever to return (OECD, 2010). That pattern is particularly true of people who suffer from mental illness, which is often chronic or recurrent. For them, work can be a key factor in recovering their well-being and self-esteem (OECD, 2012).

Sickness absence and unemployment are critical times. Activation policy must respond accordingly to ensure that people with a mental health condition return to work fast and durably and to prevent disability benefit claims. To those ends, systems should focus on identifying the mental health problems of their clients and developing the means to address the barriers arising therefrom.

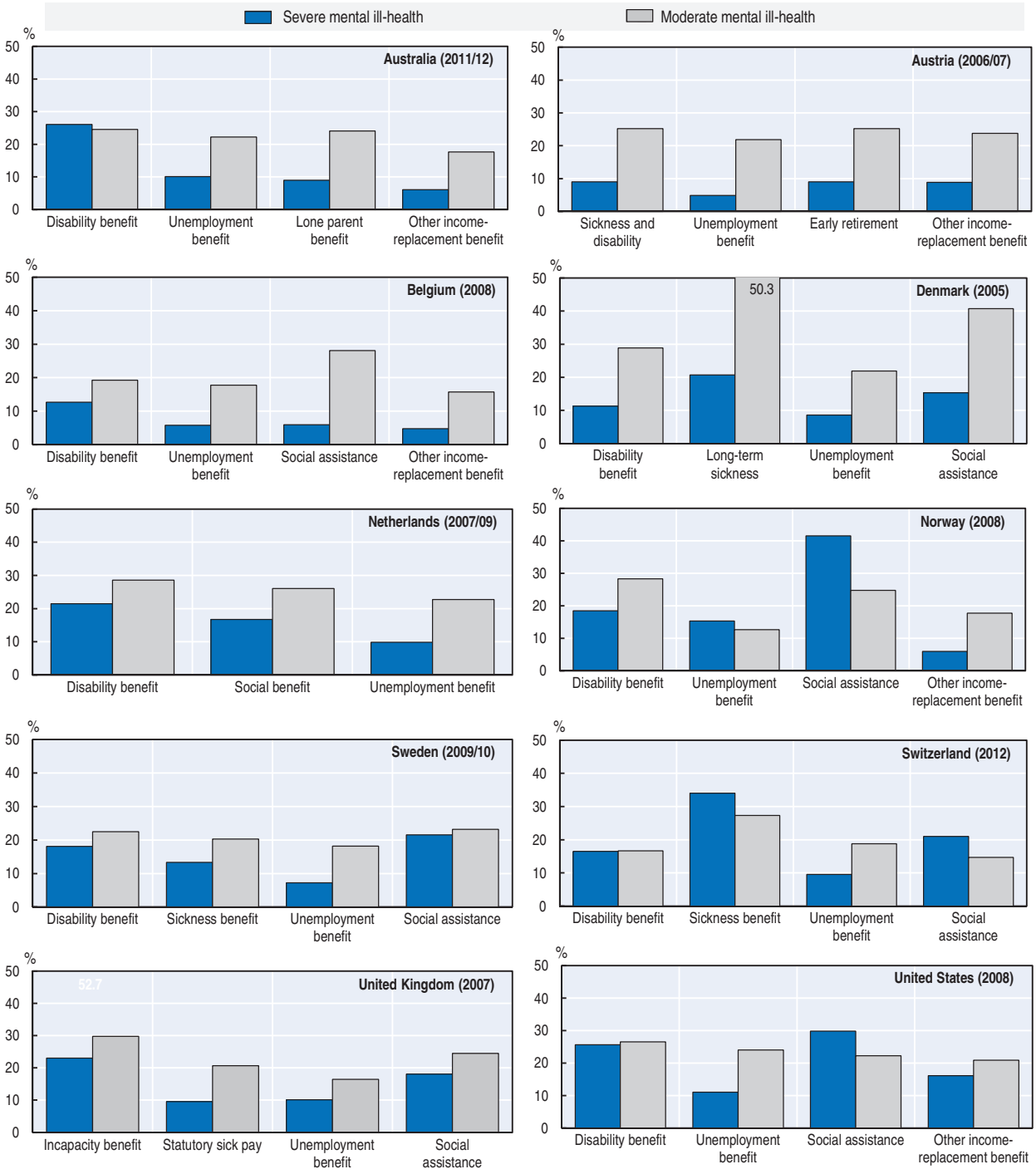
This chapter discusses those barriers while focusing particularly on:

- Disability schemes that are better adapted to the peculiarities of mental ill-health,
- Early identification and action in the unemployment system,
- General understanding of mental health in benefit systems,
- More closely integrated health- and work-related services and interventions.

Adapting disability benefit schemes to claimants with mental ill-health

Mental ill-health accounts for the bulk of new disability benefit claims. Although the trend is universal and structural, it is not irreversible and has a range of causes. First, greater awareness of mental ill-health has led to shifts in diagnosed causes of the incapacity to work. It is more frequently identified as the root cause of work problems among people with co-morbid physical and mental illness. Second, work has become psychologically more demanding. As a result it is now more difficult to remain in work with a mental health problem. Third, the assessment tools and support measures used in disability systems are often inadequate when it comes to mental ill-health. Fourth, poor knowledge of mental ill-health tends to lead to underestimates of the capacity to work of people with mental illness reflected, for example, in fewer benefit denials, more frequent grants of full rather than partial benefits and less benefit outflows. The inference is that structural reform in some countries has succeeded in curbing all kinds of benefit claims except those for mental illness (OECD, 2012).

Figure 5.1. **The prevalence of mental ill-health is high on all working-age benefits**



Note: Austria refers to the age group 50-64 only, the unemployment benefit in the Netherlands refers to unemployed people and data for the United Kingdom cover all persons with a mental disorder.

Source: National health surveys. Australia: National Health Survey 2011/12; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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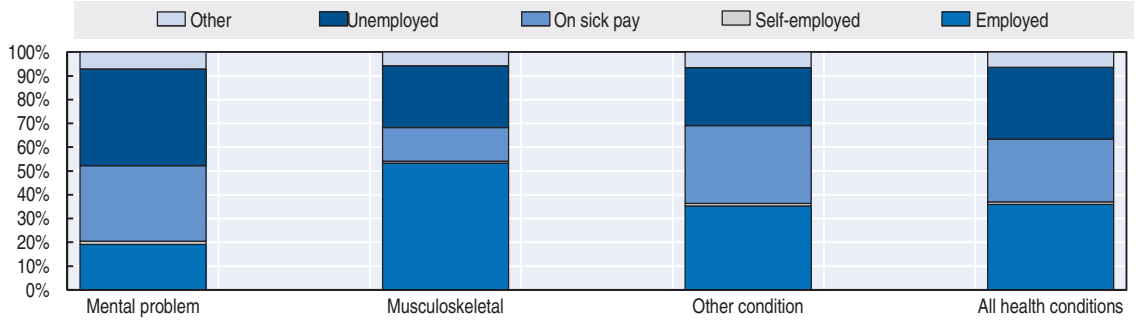
Claimants with mental disorders are furthest removed from the labour market

The greater recognition of mental ill-health in disability benefit claims affords a fine opportunity for addressing the issue appropriately. Claimants with mental ill-health are different from most of those who suffer from physical complaints. The reason lies in the very nature of mental illness – its onset comes at an early age, it is persistent and chronic, it has high recurrence rates, and is frequently comorbid. The consequence is a much greater labour market distance, with frequent periods of unemployment and inactivity (Figure 5.2, Panel A). Most benefit applications for reasons of mental ill-health come from claimants going through long-term unemployment or long-term sickness. Few are from people with job contracts. In other words, the people with mental ill-health are already at a considerable distance from the labour market even before they enter the benefit system (Figure 5.2, Panel B).

Figure 5.2. **The large labour market distance of disability benefit claimants**

A. Proportion employed and not employed in the five years prior to a disability benefit claim, by health condition, Denmark, 2009

B. Distribution of new disability benefit claims by status before the benefit claim and health condition, Austria, 2012



Note: "Inactive" refers to all persons who are not classified as employed or unemployed.

Source: Panel A: Data provided by the National Social Appeals Board; and Panel B: Austrian Ministry of Labour, Social Affairs and Consumer Protection, www.sozialministerium.

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Strengthening the labour market focus of the disability system for mental ill-health

Disability benefit systems have to respond to the recent changes. Many OECD countries have successfully implemented structural reform to tackle the general increase in benefit claims over the past decades (OECD, 2010). But reforms have not been able to stop the rise in claims due to mental ill-health. Effective disability reform components have yet to be adapted to respond to the needs of claimants with mental ill-health.

Successful structural reform often includes one or more of the following measures: i) earlier intervention and faster decisions to curb disability claims; ii) better incentives to make work pay and stronger obligations on employers and public authorities to make disregard for health issues more costly; and iii) restricting disability benefits to only those who are fully and permanently unable to work.

Towards earlier action

Early identification and quicker intervention is particularly important for people with mental ill-health. The Swedish Work Introduction Programme is an intensive three-month scheme to reconnect people on long-term sick leave with the labour market. It involves psychologists and job coaches who motivate them, give them work experience, and provide them with counselling. Yet even schemes of its kind have limited impact when they are offered too late: in the Swedish case, only after someone has been sick for 914 days (OECD, 2013c).

Switzerland acts earliest in identifying health-related work problems: the disability insurance system gets involved, lending employers advice and support, while people still have a job. Intervening so far upstream is essential in that workers with mental ill-health are much better able to hold on to a job than to go back to one. Switzerland has also introduced new low-threshold measures for workers at risk of developing problems – particularly mental health ones – that could make them eligible for disability benefit (Factsheet 5.1).

Several other countries have also introduced policies to ensure earlier intervention when health problems surface, mostly through sickness benefit (see earlier chapters of the report). Nordic countries in particular focus strongly on partial sick leave as a means of speeding up gradual returns to work and pre-empting later disability benefit claims (OECD, 2013a).

Towards stronger incentives

The thinking behind such approaches is promising. But implementation often lags behind regulation because countries are poor at defining what is required of the different actors, monitoring existing obligations, and enforcing sanctions for non-compliance. The best way to make employers and employees meet stiffer obligations is by matching them with financial incentives. The Netherlands has gone furthest in this regard, making it attractive for workers with health problems to use their (partial) work capability in the job market and costly for employers not co-operate in seeking quick returns to work for sick employees (see Factsheet 4.7).

Also important are the roles and responsibilities of the bodies that administer benefits. Several countries – e.g. Austria, Denmark and Switzerland – have introduced and gradually tightened a rehabilitation-before-benefit principle which requires benefit bodies

to explore all rehabilitation avenues before granting disability benefit (OECD, 2013b; OECD, 2014; OECD 2015). Again, however, implementation has proven challenging.

Denmark, for its part, has made considerable effort to strengthen incentives for the government departments and local authorities that administer benefits so that they deliver better services. It has put in place an online database to facilitate the benchmarking of the processes used and outcomes achieved by all municipal job centres. It also seeks to stimulate and steer their action by varying its rates of funding. The government thus requires municipal authorities to foot much of the bill for long-term benefit payments, but offers them strong incentives through reimbursement of the costs to provide rehabilitation and other labour market services (Factsheet 5.2). These are promising mainstream measures, but they can be effective for groups like people with mental ill-health only if they factor in their particularities.

Towards better assessments

Work capacity assessment is a critical factor in reforming the disability system. Many OECD countries are shifting towards identifying capacity and ability rather than incapacity and disability. Although it is a necessary structural change, acceptance is limited. Countries which spend relatively little on rehabilitation and reintegration services for people with disability face particular challenges when reforming assessment. In the United Kingdom, for example, the government has repeatedly had to adjust its new *Work Capability Assessment* in response to the many successful appeals against assessments and criticisms of the way in which people struggling with mental health issues have been deemed fit to work.

Reassessments of the capability to work are even more politically controversial. Most reforms apply to new disability claims only, leaving the rights of those already on benefit unchanged (Prinz and Tompson, 2009). Recently, however, more countries have started to apply new, more stringent criteria to recent benefit claimants, with the Netherlands and United Kingdom going so far as to reassess almost their entire caseloads of entitlements. Such policies can be helpful in bringing people with mental health problems into the labour market if they are matched with appropriate reintegration support.

Restricting the disability benefit entitlements of people who are still partially able to work has cut new benefit claims in some countries, e.g. Australia and Switzerland. Again, though, the policy's success depends on the extent to which other benefit schemes, particularly unemployment, can step in and properly serve the needs of those with partial work capacity due to mental health problems.

Very recent developments in some countries show the direction in which policy will have to move. Both Denmark and Austria have significantly restricted access to disability benefit, replacing it by schemes that are far more geared to bring people back into the labour market. In Denmark, the number of benefit claims dropped by almost half in 2013. The denied claimants are now undergoing new multidisciplinary, case-managed rehabilitation courses that the country's municipalities have developed (Factsheet 5.3). In Austria, many people will no longer be entitled to disability benefit. Instead, they will have to rely on either rehabilitation benefit (administered by the health insurance system) or retraining allowances, which are the responsibility of the labour market service (Factsheet 5.4). The impact of such reforms will depend on how they are implemented and the quality and adequacy of the rehabilitation and retraining that is provided.

Key messages

Countries struggle to make their disability benefit schemes more labour market-oriented. Although activation policies have proven effective for most groups of unemployed and inactive people, they have not had the same success with people with a disability, particularly those with mental health complaints (OECD, 2010; Martin, 2014). The main reason for this limited effectiveness is the poor timing of measures. Comprehensive programmes which kick in only after people have been away from the labour market for years are often ineffective. By then they have long given up on employment. Another challenge is striking the right balance between entitlements and responsibilities and implementing reciprocal obligations for claimants, workers, employers, and the health, employment and social security agencies and the employment service providers.

Effective measures to control the disability benefit claims of people grappling with mental ill-health include:

- Focusing on the early identification of people in need of support and intervening early with medical and vocational rehabilitation measures that target those with mental illness.
- Better recognising the work capability of those with mental illness and limiting disability benefits to all those who are *permanently* unable to work.
- Spelling out fair, clear reciprocal responsibilities and financial incentives for benefit administration bodies and employment service providers.

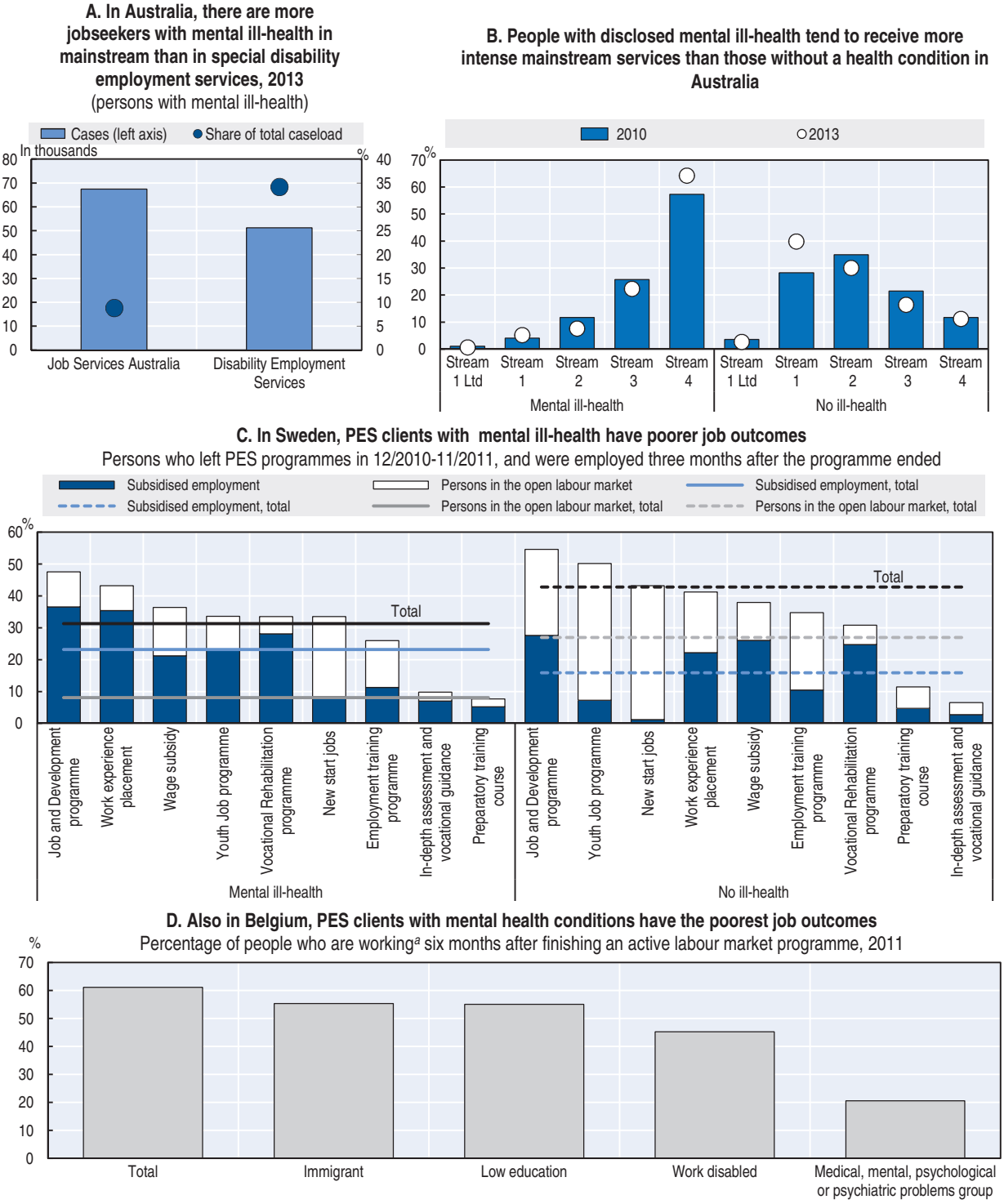
Identifying and supporting unemployed people with mental health problems

The strengthening of the activation agenda over the past two decades has prompted the public employment services (PESs) in many countries to focus on work-ready jobseekers and contributed to pushing people with health problems onto disability benefit. Recent structural reforms to disability benefit systems have tried to rectify that mistake by also activating jobseekers with poor physical and mental health. As a result, PES clienteles have changed. It is thought, for example, that the United Kingdom's employment service providers (who are private) will cater chiefly to groups of hard-to-place jobseekers and that 78% of all clients will have some current or previous connection to the disability system (Heap, 2012). This fact has yet to be understood by mainstream service providers.

Jobseekers with mental illness attend employment programmes but have poor outcomes

Statistics on the prevalence of mental ill-health among jobseekers in mainstream employment services are scarce, as PES and unemployment systems in most countries do no measure health. However, some do have information on numbers of jobseekers with diagnosed disabilities. Australia is an interesting case because it operates two parallel systems of job-seeking services: one for those with a disability and a mainstream one for the rest. Yet most people with identified mental disorders are in mainstream employment services (Figure 5.3, Panel A), where they are more likely to be found in streams 3 or 4, which provide high-intensity support, than in streams 1 and 2 (Figure 5.3, Panel B). Were all people with common mental illnesses to be identified in job-seeking statistics, the message would be even clearer: poor mental health is a key issue in employment services.

Figure 5.3. **Programme participation and employment outcomes for participants with mental ill-health**



a. Employment includes sheltered employment and employment care.

Source: Panel A: Australia Department of Employment ESAt data; Panel B: OECD estimates based on administrative data from the Australian Department of Social Services; Panel C: the Swedish Public Employment Service; and Panel D: the Flemish Public Employment and Vocational Training Service.

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PES clients with mental health conditions also have poorer job outcomes. In Sweden, three months after programme termination, only about 8% had moved into the open labour market and 23% into subsidised employment in 2010 and 2011. The figures for other PES clients were 27% and 16%, respectively (Figure 5.3, Panel C). In Belgium, six months after completing an employment scheme, 60% of all PES clients had found a job, in contrast to only 20% of those with recognised "medical, mental, psychological and psychiatric" problems (Figure 5.3, Panel D).

Identifying jobseekers' mental ill-health in the unemployment benefit system

Activation schemes start with an intake phase, where jobseekers are profiled to assign them to the appropriate target group. Yet only rarely is their mental health assessed – a wasted opportunity for early action. That being said, a few countries, such as Norway and Australia, do gather some health information during intake. Australia's *Jobseeker Classification Instrument* is a good example of a tool that efficiently matches client needs to services and refers them to in-depth assessment if necessary (Factsheet 5.5). In its current form, it cannot systematically spot labour market barriers related to mental ill-health, although it could easily be expanded to that effect.

Maybe the strongest focus on mental health in the intake phase is in Flanders, the Flemish-speaking part of Belgium. Jobseekers are systematically screened for reintegration barriers, which include mental health issues. Whenever problems are suspected, an interview can be requested and a referral can be made to an in-house psychologist or an external centre specialised in multidisciplinary screening (Factsheet 5.6). The PES in Belgium takes a special interest in screening jobseekers for health barriers because unemployment benefit is payable for an unlimited duration. There is thus a strong money-saving incentive for providing extra support to people who struggle with mental ill-health and run a high risk of long-term unemployment.

There are several ways to screen for mental ill-health in jobseeker populations. One is through validated instruments (Liwowsky et al., 2009) either for all clients or only when a caseworker suspects a problem. In that event, caseworkers should have clear guidelines on when to use the instrument, what to do when a mental health issue arises, and how to handle confidentiality. Another approach is to send clients to a psychologist for in-depth clinical screening or interviews.

The trend towards the computerisation of PESs in many of the countries reviewed by the OECD clears the way for mental health screening during initial registration and intake procedures. The Dutch PES's new *Work Explorer* too, for example, has great potential. It is a fully digitalised support system that can identify barriers to work – including those related to mental ill-health (Factsheet 5.7). Early digital screening also opens up new opportunities for the provision of web-based mental health therapy.

Many of the reviewed countries use PES performance management processes to support groups who are particularly exposed to long-term unemployment. The Danish Ministry of Employment, for example, sets three targets every year that municipal jobcentres have to meet. They may include a certain employment level or an improved placement rate for a particular group of jobseekers. Such a priority group could be jobseekers with mental health problems.

Earlier intervention for jobseekers with mental ill-health

The identification of jobseekers' poor mental health is meaningful only in combination with appropriate follow-up procedures and services, such as regular meetings with caseworkers. In this respect, Sweden's *Job Coach Programme* is a good illustration. A coach works closely with the jobseeker and the new employer, focusing strongly on the work environment (Factsheet 5.8).

A PES provision of follow-up services for registered jobseekers with health problems is essential to preventing them from slipping into reliance on disability benefit and suffering from long delays in employment support. Often such claimants will be sent back and forth between different agencies, losing their employability and motivation and becoming more prone to long-term unemployment. Shifts between benefit schemes are costly and unproductive for society and the person concerned.

Austria has sought to address the issue through a scheme called *Health Road* under which its unemployment and disability benefit systems share information to get agreed early assessments of claimants' work capacity. Knowing that a disability benefit application has no chance of success, the PES has a much stronger incentive for assisting the client (Factsheet 5.9). Another interesting approach to addressing both incentives and co-operation between benefit systems is the Swiss *Inter-Institutional Co-operation* scheme. It builds on information sharing and case management to achieve better outcomes for clients with complex problems and prevent them from being shuttled between institutions (Factsheet 5.10).

Key messages

It is important to spot mental ill-health and any labour market barriers as early as possible – ideally, on a jobseeker's first contact with the employment service, or soon after. Where a problem is identified or suspected, there should be a swift referral for counselling. The aim is, if necessary, to provide psychological support, advise the patient to seek help from the health care system and develop an adequate reintegration strategy with the PES caseworker.

Helping jobseekers with mental health conditions should be achieved by:

- Using adequate tools to identify mental health problems and how they compromise labour market access. Problems should be identified at the first interview with the job service or very soon after.
- Implementing clear guidelines for caseworkers on what to do when problems arise.
- Putting in place a strong follow-up process with frequent interviews with caseworkers and ensuring access to mainstream or special services for jobseekers with mental illness.
- Avoiding, as far as possible, exemptions from job-search and participation requirements.
- Making adjustments to the employment service's performance management process so that jobseekers who suffer from mental ill-health get proper attention.

Develop mental health competencies and support in the employment sector

To enable unemployment benefit systems, public employment services, and local welfare offices to cater to their clients' mental health needs, changes are required to: i) develop the mental health competencies of those institutions and ii) help people access adequate mental health support.

Research has shown that, typically, none of the systems address highly prevalent mental illness. German data found that among the older long-term unemployed who struggle with poor mental health only 10% had received adequate treatment and most no treatment at all (Bühler et al., 2013). Similarly, Norwegian data suggest that one-third of claimants who receive disability benefit for mental illness have never been treated in any way (Øverland et al., 2007).

Addressing mental health needs early on through better mental health awareness and competence by employment services is a key factor in preventing long-term unemployment and permanent inactivity. In Austria, it has been found that anyone who once tried to claim a disability benefit, even unsuccessfully, hardly ever joins the labour market again (Fuchs, 2013).

Mental health training and guidelines for caseworkers

The reviewed countries have developed a range of strategies to develop mental health competence in their employment services and local welfare offices. Sweden is a case in point. Country-wide the PES has about 330 psychologists, 200 occupational therapists and 30 psychotherapists providing specialist support. Yet the high caseload they face is a considerable strain on their ability to provide adequate support. Significant investment will be needed to develop this into a fully functional support structure.

PES caseworkers need training and guidelines to enable them to work with jobseekers suffering from mental ill-health and to identify situations which call for specialised employment or mental health interventions. In that regard, the University of Leipzig has devised a scheme for tackling high levels of under-treatment. It combines one-day mental health training for PES caseworkers with the provision of psychosocial coaching. Coaching involves an initial diagnostic interview, advice on treatment, mental health first aid and short-term therapy (Pfeil et al., 2013). The university's scheme has helped to significantly improve both treatment rates and overall motivation.

Another possibility is to work with specialised employment service providers that have mental health expertise. The return-to-work programme of the Danish Mental Health Foundation (a private non-profit provider) is a good example. Psychologically trained caseworkers work with low caseloads of no more than 10-20 jobseekers, which allows close contact with and better outcomes for clients all of whom suffer from common mental illness (Factsheet 5.11).

The Swedish national social insurance system, which administers sickness and disability benefit, meets treatment needs by purchasing care from the health sector for clients at risk of long-term absence. Treatment consists mostly, but not only, of short-term cognitive behavioural therapy that lasts between 8 and 20 sessions. This approach, known as the *Rehabilitation Guarantee,* has been effective for clients who still have links with their employer. Those who do not, however, require additional support (Factsheet 5.12).

Key messages

Across the OECD, mental health competencies and psychological expertise in the employment sector are still underdeveloped and not commensurate with the high prevalence of mental illness among jobseekers and welfare clients. The sector will come under extra strain as a result of recent policy changes in many countries that will increase the number of clients with partially reduced work capability in mainstream employment services. Better mental health competencies have to be developed to make early identification and quick intervention possible in all systems. Efforts in that direction should come, first and foremost, in the unemployment system because better job retention and reintegration at this early stage can prevent people with poor mental health from slipping into welfare and disability.

Improving the mental health competencies in the employment sector is facilitated by the provision of:

- Mental health training for caseworkers in the PES, welfare counsellors and social workers.
- An available, quickly accessible, psychological coaching capacity in employment services and local welfare offices.

Integrated work and health action to activate jobseekers with mental ill-health

Employment and health needs are rarely addressed together. Even where jobseekers' mental health issues are recognised, the approach of employment services in most reviewed countries is usually to exempt them from job-search and availability requirements, expect – but not request – them to seek treatment, and hope that they return fit and healthy to seek work. Exemptions are granted on the basis of a medical certificate or, at least initially, the caseworker's judgement.

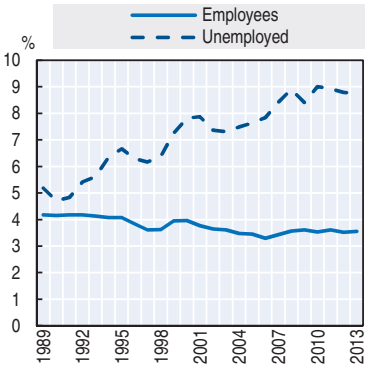
Ignoring health often accounts for failed labour market reintegration

The passive approach of employment services in the event of ill-health – be it mental or physical – emerges clearly in comparisons between outcomes for sick people who are unemployed and those who have a job. In Austria, for example, the incidence of sickness among unemployed people is more than double that of their employed peers, a disparity that has gradually widened during the past 20 years (Figure 5.4, Panel A). Long spells of sickness absence are more frequent among jobseekers. Swedish data on unemployed people returning from long-term sickness further confirm that those who struggle with mental ill-health have the lowest chance of finding work (Figure 5.4, Panel B).

Data for the Netherlands are particularly illuminating because the entire system hinges on strongly enforced employer obligations. People who do not have an employer responsible for their swift return to work – i.e. unemployed people and temporary workers whose contract has ended – receive much less support in resuming work. Publicly funded support can compensate only partially (Figure 5.4, Panel C). The lack of employer support may account in part for work resumption rates among the sick unemployed being much lower: two years after a long-term (nine-month) sick leave, only about one in four unemployed people had found a job in 2012, compared to more than 80% of their peers who were in work when they fell ill (Figure 5.4, Panel D). Support for the sick unemployed obviously falls short of their health and employment needs.

Figure 5.4. **Longer sickness durations and poorer labour market outcomes for sick unemployed people**

A. Sickness absence rate of Austrian employed and unemployed workers



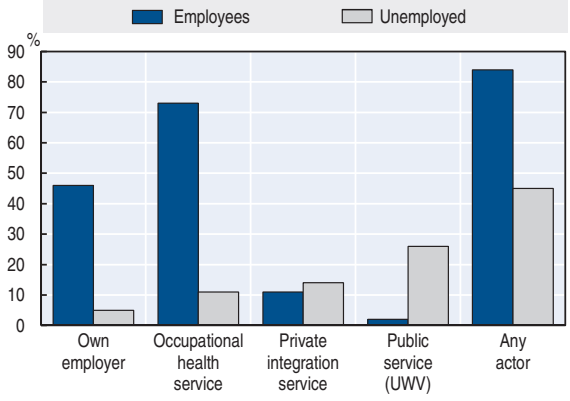
B. Unemployed sick in Sweden move back into employment less often

Share of individuals ending a sickness spell during 2011, by destination (percentage)

	Starting new sickness spell		Registered with employment service		Into disability		Other (mostly into employment)	
	Mental ill-health	Other illness	Mental ill-health	Other illness	Mental ill-health	Other illness	Mental ill-health	Other illness
Employed	17.8	16.9	3.5	1.8	1.1	0.7	77.6	80.6
Unemployed	19.4	19.9	4.4	2.8	4.8	2.3	71.5	75.0

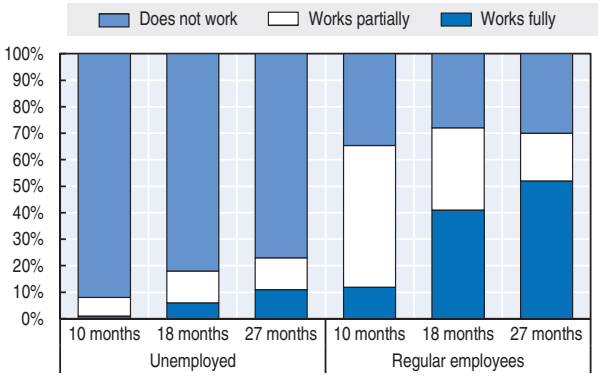
C. In the Netherlands, sick unemployed people receive less reintegration support than sick employees...

Supporting actors in the work resumption process, 2012



D. ...and they resume work less often

Work resumption after 10, 18 and 27 months by the unemployed and employees on long-term (9 months) sick leave



Note: In Panel C several answers are possible; the bars do not sum up to 100%.

Source: Panel A: WIFO-update based on Leoni, T. (2010), "Differences in Sick Leave Between Employed and Unemployed Workers", *WIFO Working Paper No. 372/2010*; Panel B: Swedish Social Insurance Agency data used in Van der Burg, C. et al. (2013); Panel C: Weg naar de WIA: Langdurig zieken 2012 [Road to the WIA: Long-term sick 2012], AStri Beleidsonderzoek en -advies, Leiden; and Panel D: de Jong, P. et al. (2010), "Nederland is niet meer ziek: Van WAO-debakel naar WIA mirakel" [The Netherlands is no longer sick: From WAO-debacle to WIA-miracle], APE/AStri Beleidsonderzoek en –advies.

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Developing integrated health and work services in the employment sector

A PES can address clients' health needs either by co-ordinating its services with the health care system or providing integrated services itself. One approach is to pool resources with other sectors to facilitate provision in line with clients' multiple needs. Sweden has taken that line of action to good effect through local associations that co-ordinate funding from the national employment service, the regional health authority, municipal welfare offices, and the national social insurance system (Factsheet 5.13). The multidisciplinary rehabilitation services thus cater for long-term sick or unemployed people.

The new Danish rehabilitation model (described above) steers many potential claimants away from disability benefit. It takes an integrated approach to rehabilitation that brings together labour market services, health care, social services, and education. All municipal job centres are required to develop such arrangements, with each sector covering its own costs (see Factsheet 5.3).

In most other OECD countries, municipalities take charge only of welfare clients among whom the prevalence of mental ill-health and multiple problems is particularly high. In five big Dutch municipalities a new pilot project, *Fit-4-Work*, is being run for welfare recipients whose many psychological and social problems have removed them from the labour market. The scheme is co-funded by the national employment service and local social and mental health offices. Key features include psychological treatment and quick job placement with follow-up coaching in the workplace (Factsheet 5.14).

Belgium (Flanders) uses a similar approach in which the Flemish PES funds a special programme developed in co-operation with the mental health and welfare sectors. It is designed for jobseekers with severe psychological and psychiatric problems and is run through an institution that specialises in combining care and employment support. Three coaches bring their expertise to bear: a job coach (who is also the overall co-ordinator), a health coach, and an empowerment coach from the welfare sector (Factsheet 5.15). The scheme could be expanded to reach many more of the large number of people with common mental health problems.

It has been widely observed across the OECD that integrated services originate in work to help people with severe mental ill-health, which also explains why they typically started in the health care sector. In the United Kingdom, a new pilot got underway in mid-2014 to test the effectiveness of interventions based on the principles of Individual Placement and Support (IPS) for people with mild-to-moderate mental ill-health (Van Stolk et al., 2014). The pilot programme – *Individual Placement and Support in Improving Access to Psychological Therapies*, or IPS in IAPT – is funded by the health and employment sectors and run in different versions in different areas of England, linking up partly with existing health services and partly with regular employment intervention providers. Initial outcomes will not be available until late 2015 (Factsheet 5.16).

Key messages

Evidence from across OECD countries suggests that they struggle to deliver co-ordinated, integrated health and employment services because of the lack of coherent incentives, obligations and guidelines for stakeholders and participating professionals (Arends et al., 2014). Integrating services requires a PES to address clients' health and employment needs at the same time, be it through internal mental health expertise or new structures that provide integrated services.

Ways to develop integrated health and work services in the employment sector include:

- Pooling resources with, or purchasing services from, the health sector in order to deliver a multidisciplinary, integrated rehabilitation provision.
- Developing programmes targeted at jobseekers and welfare clients with common mental illness. Such programmes should combine psychological counselling with job-placement services or work experience programmes.

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FACTSHEETS 5.1 to 5.16

Factsheet 5.1
Switzerland: Early intervention by invalidity insurance

Context

Different OECD countries have introduced structural reforms to tackle the steep increase in disability benefit caseloads in recent decades. Countries are moving away from merely compensating work disability towards activating claimants to return them to the world of work.

Programme

The increase in invalidity claimants since the 1990s led to several revisions of the Swiss Invalidity Insurance Act. The 5th revision, in 2008, switched the strong focus on invalidity benefit to the ability to work. The reform reinforced the emphasis on vocational rehabilitation, added a new focus on job retention, and implemented a paradigm shift in the invalidity insurance's focus to early identification and activation of potential claimants. The main measures introduced by the reform and primarily targeting claimants with a mental illness were:

- Early identification through early notification of problems to invalidity insurance, by the employer, employee, the treating doctor, or any other stakeholder.
- A set of early intervention measures to secure job retention or to help claimants find a new job. Measures included: i) workplace adaptations; ii) educational courses; iii) active job placement; iv) vocational counselling; v) social-vocational rehabilitation; and vi) activation. These measures require an assessment and binding rehabilitation plan.
- Substantial wage subsidies for employers hiring a claimant. Subsidies may be paid for half a year at up to 100% of the salary if the claimant has not regained full work capacity. Moreover, if a hired claimant is again absent through sickness, any increase in the employer's premium to sickness benefit insurance is reimbursed.

Outcomes

A recent evaluation of the effects of new and early intervention measures showed that, before the reform, 40% of all claimants were back in employment roughly 18 months after initial contact with the cantonal invalidity office. After the reform, the rate rose slightly to 44%. Claimants who were employed when they first contacted the cantonal invalidity insurance office had a much higher employment rate 18 months afterwards than unemployed claimants, both before and after the reform. Of those employed at the time of uptake, 55% were employed 18 months later compared to 30% among initially unemployed claimants. It has to be seen whether early intervention will deliver a more significant improvement of the employment outcome in the future (the first evaluation came at a rather early stage).

Further reading

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Factsheet 5.2
Denmark: Incentives for municipalities through variable funding rates

Context

Without the right incentives, benefit and employment services can be reluctant to actively help claimants back into work. Financial incentives, together with systematic monitoring and benchmarking, can be effective mechanisms for strengthening the activation policies of benefit and employment departments.

Programme

The Danish benefit system has differential reimbursement rates that vary according to state and municipal budgets (responsible for benefit and employment services) and the type of benefit or intervention that claimants receive. The main idea behind this stimulus scheme is to give incentives to municipalities for offering measures that help a person back into the labour market and prevent long-term benefit pay-outs. Accordingly, the state reimburses 65% of the costs of rehabilitation and wage subsidies, but only 35% of disability benefit costs, 30% of the costs of social assistance and unemployment exceeding eight weeks, and none of the costs of sickness benefit payments that exceed one year. Reimbursement rates are also set at 0% whenever insufficient documentation is provided or active measures are unduly delayed.

At the same time, the government moved towards stronger, more systematic monitoring and benchmarking of claimants' benefit and employment outcomes, so giving poorer-performing municipal job centres the opportunity to learn from good practices. The work of job centres is measured more stringently against a comprehensive benchmarking tool that monitors the use of programmes for different clients (Jobindsats) and another tool that measures the cost-effectiveness of those programmes (Effektivindsats). Jobindsats data are available online to everyone and allow comparisons by municipal job centre or employment region.

Outcomes

There is little information available on the impact that the differential reimbursement rates and municipal practices have on different groups of clients, including those who suffer from mental ill-health. While the stimulus scheme has significant potential, it has also been shown to allow "tactical" behaviour – i.e. providing too few services to clients with complex mental health and social problems. There is also a great risk that municipalities' reactions to the differential reimbursement scheme are driven by short- rather than long-term considerations.

In general, benchmarking and "naming and shaming" are considered more appropriate and administratively more efficient than sanctions. With no information being collected on the mental health problems of job centre clients (or health problems more generally), none of the monitoring mechanisms target mental disorders. Additional municipal targets with regard to jobseekers with a mental disorder, however, would be possible – and could lead to a more systematic, transparent approach to that group. Sufficiently accurate instruments which enable the early detection of mental health issues are available.

Further reading

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

Factsheet 5.3
Denmark: Integrated rehabilitation services to prevent disability claims

Context

When people start claiming disability benefit they are at risk of permanent inactivity. That trend is especially problematic for young people with little work experience, as it shunts them away from the labour market altogether. Early vocational rehabilitation that integrates health and employment support can help to bring people with health problems into jobs.

Programme

In response to the large and growing number of young adults under the age of 25 moving to claim disability benefit (in most cases due to mental ill-health), the Danish Government has made a major reform to the disability scheme. The intention is to largely abolish disability benefit for the under-40s (unless they are totally unable to work), replacing it with a new rehabilitation model whose chief features are that:

- The health sector, labour market institutions, social services and the education sector are involved, with responsibility lying with the municipal job centre.
- An interdisciplinary rehabilitation team is established in every municipality to ensure the integrated approach will work in practice.
- The rehabilitation team discusses needs, makes recommendations, and co-ordinates actions, although decisions are taken jointly by every institution towards an agreed goal.
- It lasts for up to five years depending on the client's needs.
- It involves a co-ordinator, whose role is to co-ordinate action and steer clients through the system.
- During rehabilitation, people continue to receive whatever benefit they are on or, if not entitled to any, a minimum income at the social assistance level.

The new model aims to ensure treatment where necessary, with work seen as part of the solution. It is focused neither on assessing the degree of illness (the health sector view) nor the work capability (the job centre view), but on integrating those approaches.

Outcomes

The success of the reform will depend on the way it is implemented. The new approach is promising, although it is too early to tell how well it will work in practice and what its longer-term outcomes might be. Initial data for 2013 suggest there is a chance that the reform may achieve at least some of its aims – it has already more than halved the number of new disability benefit allowances. Those people no longer entitled to disability benefit (especially young people and those with mental illness) are now engaged in the new rehabilitation process. It is too early to tell whether they will be reintegrated into the labour market in a sustainable manner.

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Factsheet 5.4
Austria: Focus on rehabilitation and retraining to prevent disability

Context

Limiting disability benefits to people permanently unable to work can be a solution to large, steep increases in the disability benefit caseload. Mental illness is often not permanent, though often chronic and recurrent. Temporary disability benefits have shown little positive impact for people with mental ill-health. A much stronger focus on retraining and rehabilitation instead of granting a temporary disability benefit could be a way forward.

Programme

In late 2012, the Austrian Government agreed on a comprehensive reform to reduce the number of disability benefit claims by improving the labour market integration of people with chronic health problems or disabilities, but who had the capacity to work. Only people permanently unable to work, can now access disability benefit. For those who are no longer entitled, two new benefits were introduced – rehabilitation and retraining benefit.

People who are temporarily too sick to work and in need of treatment will now be entitled to rehabilitation benefit. They had previously to apply for a temporary disability benefit which was in reality a dead end and will now be abolished. Health insurance pays the rehabilitation benefit. Although it is not a temporary benefit, the health status of recipients will be reassessed regularly (at least once a year). The amount is identical to sickness benefit – normally 60% of the last wage.

People who are fit enough to work but unable to exercise their profession will now be entitled to a retraining benefit (a special unemployment benefit with a 22% top-up) and receive retraining in a comparable profession.

Moreover, people on either rehabilitation or retraining benefit are legally entitled to medical rehabilitation if it is necessary to their reinstatement in the workplace.

Outcomes

The new rules, applicable since January 2014, will be phased in gradually and apply to everyone who was under 50 years old at the time they came into force. The expectation is that between 2014 and 2018, around 15 000 people will receive retraining benefit and some 23 000 rehabilitation benefit. It is estimated that the cuts in disability benefit spending will yield savings in the order of EUR 700 million by 2018. Initially, however, data for the first months of the first year suggest that the real figure could be much lower.

In the coming 15 years, the changes will gradually be extended to the entire working-age population. One downside, however, is that the reform will apply only to blue- and white-collar workers: civil servants, farmers, and the self-employed (who all have their own pension and disability benefit systems) are not included. This remains an important policy gap, particularly as farmers and civil servants have comparatively easier access to disability benefits.

Further reading

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

Factsheet 5.5
Australia: Unemployment profiling tool ensures quick referral

Context

Mental illness is often a considerable barrier to labour market re-entry for the unemployed. When the public employment service identifies poor mental health early, it can help improve jobseeker activation and prevent long-term unemployment and disability benefit dependence. So far, however, most OECD employment support schemes do not assess the jobseekers' mental health status upon intake.

Programme

In Australia, the Job Seeker Classification Instrument (JSCI) is the primary profiling tool used for determining clients' labour market disadvantages and quickly referring them to an employment service or for more in-depth assessment. JSCI interviews are conducted during face-to-face or telephone interviews after jobseeker have registered for income support. It seeks to determine a person's labour market disadvantage and connect them quickly to an appropriate employment service. More importantly, for people with mental ill-health, diagnosed or not, the JSCI is the earliest opportunity in the system for identifying and assessing the impact of their health condition on their past and future participation in the labour market.

Outcomes

While the profiling tool could determine a client's labour market disadvantage more accurately, the actual identification of mental ill-health is not self-evident. The instrument does not seem to work well for people with mild-to-moderate mental illness, as the JSCI question relating to mental health is voluntary. If their condition is undiagnosed and/or they do not disclose their condition in the JSCI interview, then it is unlikely they will be quickly referred for a more intensive assessment conducted by an allied health professional. As a consequence, the person's underlying barrier to labour market reintegration can long go unidentified. And even if jobseekers disclose their mental health issues, it will only have a relatively small impact on the JSCI score measuring their level of disadvantage. Consequently, there is lots of room for improving a profiling tool that in principal has considerable potential.

Further reading

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Factsheet 5.6
Belgium: Assessing mental health problems at intake

Context

It is important that the public employment service identifies mental ill-health early if it is to prevent long-term unemployment and disability benefit dependence. Systematically assessing jobseekers for reintegration barriers can improve the employment outcomes of those who have mental health problems.

Programme

Since 2010, jobseekers estranged from the labour market are systematically assessed by the Flemish Public Employment Service (VDAB) for problems that hinder their re-employment. Such assessment used to take place within the first six months of unemployment, but not necessarily when jobseekers enrolled. The target group includes people with reduced psychological stability and those who are unable to deal with stress. Upon intake, caseworkers use an assessment form to map jobseekers' possibilities and inabilities. The caseworkers look out for employment-specific competencies and qualifications, job-search behaviour, social and communication skills, disabilities, secondary conditions (e.g. mobility, childcare, and the inactivity trap), and health problems. After the caseworker has completed the assessment form and proposed a follow-up programme, a VDAB psychologist has to approve the application.

The aim of the assessment is to quickly detect multiple problems in order to prevent long-term unemployment and offer the jobseeker a tailor-made activation programme. Assessment can be requested at any time during unemployment if there is any sign of a problem. When a caseworker believes there is a more severe mental health problem, he or she refers the client for diagnosis to a VDAB psychologist or an external employment research centre specialised in in-depth multidisciplinary screening.

Outcomes

In the first half of 2014, 7 676 jobseekers were registered for an assessment by the VDAB. Of those 8% were referred for in-depth multidisciplinary screening. After following an activation programme, 35% were ready to work on the regular labour market. The rest need additional support and care.

Supervisors of the activation programmes are satisfied with the quality of the screening reports they receive from caseworkers. The reports contain sufficient information on jobseeker' possibilities and inabilities. The assessment form is more easily accessible than its predecessor and leaves plenty of scope for (qualitative) information sharing through the use of empty text boxes that jobseekers fill in. However, supervisors believe the screening process could be improved by adding objective facts about jobseekers (e.g. internships, previous employer references), in addition to self-assessment.

Further reading

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

Factsheet 5.7
Netherlands: Digital support for people on unemployment benefit

Context

Public employment services do not always have the resources to provide their clients with personal support. Computerising support services – including evidence-based e-mental health programmes such as online cognitive behavioural therapy – could be fruitful.

Programme

Since 2013, the Dutch Employee Insurance Agency (UWV) has been using a digitalised system to support its clients. During the first three months of unemployment, all contact with UWV goes through the Internet: benefit administration, job search and applications, and online workshops and training. After three months, UWV conducts an evaluation to see whether or not the unemployment benefit recipient is eligible for intensive support.

In the future, eligibility for intensive support will be assessed through the use of a digital questionnaire, called "Work Explorer", which determines a jobseeker's chances of resuming work within a year. The outcome of the questionnaire will determine whether or not the jobseeker is entitled to intensive support as well as the kind of support that is necessary to increase his or her chances of finding a job. The questionnaire consists of a list of 20 questions on hard factors (e.g. age, job tenure and knowledge of the Dutch language) and soft factors like jobseekers' personal takes on their chances of resuming work, perception of their health, active job search behaviour, and physical and psychological work capability. Work Explorer's questions are drawn from an extensive review of the literature and an econometric analysis designed to select those with the highest predictive power.

Outcomes

UWV is still developing its digital support system on the basis of national and international experience in e-services in the health sector combined with strategies from the behavioural sciences to influence the behaviour and motivation of jobseekers. To jobseekers with mental health problems it would be particularly relevant if UWV would consider the inclusion of Internet-administered cognitive behavioural therapy for depression and anxiety as part of its support provision.

Further reading

Andrews, G. et al. (2010), "Computer Therapy for Anxiety and Depressive Disorders is Effective, Acceptable and Practical Care: A Meta-analysis", *PlOS One*, Vol. 5, No 10, e13196.

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Factsheet 5.8
Sweden: Job coaches for people moving in and out of employment

Context

Although employers could help considerably improve the employment levels of people with mental ill-health, they often lack knowledge of mental health issues. They need better tools to identify critical situations. Co-operation between the public employment service (PES) and employers could help to retain sick workers.

Programme

In 2012, the Swedish PES initiated a pilot project in collaboration with the Work Environment Authority. Known as the Job Coach Programme, the pilot was designed to enhance co-operation with employers by enlisting job coaches with special workplace-related competencies to: i) offer support to employers in understanding psychosocial issues in the workplace; ii) smooth the return to work for jobseekers who have been out of the workplace for long periods; and iii) help employers retain jobseekers who resume work.

The main target groups of the programme are the long-term unemployed and people with records of disrupted employment and PES programme participation. Although sickness benefit recipients and people with mental ill-health are not targeted explicitly, many of them match the target groups.

The job coach can be a psychologist, social worker, or a workplace specialist with a minimum experience of one year in the psychosocial side of work. The programme lasts for three months during which time the employer, the jobseeker, and the PES have a minimum of four meetings. In the first meeting, the job coach meets solely with the jobseeker to understand his or her needs and what prevents the return to work. The second meeting brings in the employer and seeks to draft an initial plan for securing entry into the workplace. The last two meetings are used to evaluate the plan and action of employers and to develop recommendations for further improvement.

Outcomes

So far, there is no evidence available as to the success of the programme. Evidence from other labour market programmes targeted at harder-to-place client groups shows that co-operation of the kind in the Job Coach Programme can facilitate job retention and early returns to work.

Further reading

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

Factsheet 5.9
Austria: Health road to improve the unemployment-disability interface

Context

Unemployed people who suffer from mental ill-health are often sent back and forth between different agencies. They gradually lose their employability and motivation and become increasingly at risk of long-term unemployment. If the unemployment and disability benefit systems shared information, they could prevent long delays in support provision.

Programme

The Gesundheitsstraße, or Health Road, is a project that Austria first launched as pilots in some regions in 2009 before recently rolling it out nationwide. Health Road seeks to replace multiple assessments by putting in place a central assessment authority which can take decisions that are binding both on the disability benefit agency (PVA) and the public employment service (PES). If a PES caseworker has doubts about a client's ability to take up employment, he or she can be referred for an early assessment at the PVA to determine whether or not he or she is able to work or at least benefit from rehabilitation. The PVA also needs to clarify whether the client should stay with the PES or be handed over to the PVA. In this way, the PES gains some insight into PVA know-how at an earlier stage. If the client refuses the PVA assessment, his or her unemployment benefit is suspended.

Administratively, the new assessment authority is based in the PVA but the costs of early assessments are covered by the PES (because at this stage the client is a customer of the PES). If assessed as "able to work", the client will be served by the PES. If not, an application for a disability benefit is recommended – but eligibility will be tested more carefully. Although the assessment has to include a decision on the person's ability to work, it should also go into further detail about reasonable job requirements and, where applicable, recommend medical and/or vocational rehabilitation.

Outcomes

The advantages of the new approach include: an acceleration of the work ability assessment process (the medical report has to be prepared within three weeks and is valid for six months); no more contradictory assessments; greater legal certainty since decisions are binding on both agencies; more transparency for the client and agencies; considerable savings; and earlier rehabilitation and better reintegration chances.

From the evaluation period to late 2011, more than 5 000 clients were assessed (85% within one month). Of those, 22% were deemed temporarily unable to work. About 40% of all clients had mental health problems and their chance of being assessed as temporarily unable to work was higher – 35%. However, one year after the assessments very few clients were working, even among those assessed as able to do so, which points to the importance of rehabilitation measures for clients with mental health problems. Qualitative interviews also showed that clients following the Health Road generally believed they could work and were more interested in the support provided than those who applied directly for disability benefit.

Further reading

Hausegger, T., C. Reidl and C. Scharinger (2012), "Begleitende Evaluierung der Gesundheitsstraße", Endbericht, Prospect Research & Solution [Report for the Federal Ministry of Labour, Social Affairs and Consumer Protection], Vienna.

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

Factsheet 5.10
Switzerland: Interinstitutional co-operation to improve work outcomes

Context

Clients with complex problems, often involving mental health, tend to be shifted around between different social protection systems. They face service gaps and service duplication as well as poor labour market outcomes. The situation is neither efficient nor cost-effective and demands greater inter-institutional co-operation.

Programme

Inter-institutional co-operation (IIZ) was launched in Switzerland in the early 2000s. IIZ's objectives include bringing clients with complex needs to the right institution faster; improving co-operation across institutions to increase clients' chances of reintegrating into employment; clarifying funding responsibilities for complex cases; and identifying and addressing (mental) health problems which hinder fast labour market reintegration.

A recent inventory of existing IIZ initiatives identified four major types of IIZ: i) multilateral co-operation concentrated on the integration of the young and young adults; ii) bilateral co-operation between two institutions, most frequently unemployment insurance and local social welfare; iii) multilateral co-operation for people with complex problems, generally involving case management; and iv) structural co-operation, which includes, for example, training provided jointly by two or more institutions.

IIZ MAMAC, a special project launched in 2006, aimed at making IIZ work better through: i) joint assessments of a person's work capacity that is binding on all institutions involved; ii) reintegration measures jointly agreed by all IIZ partners; and iii) making one institution responsible for managing a particular case throughout the entire process. IIZ MAMAC clients had to fulfil two criteria: i) suffer from health problems and face social difficulties but have been enrolled for less than six months with identified reintegration potential, and ii) be clients of at least three institutions (typically cantonal disability insurance, cantonal unemployment insurance, and municipal social assistance).

Outcomes

Evaluating the effect of IIZ is difficult because it is a highly decentralised initiative – with most forms of co-operation taking place on a regional and often local level – and a process that is constantly expanding. The only evaluation available concerns IIZ MAMAC. The project was well received by clients and adopted in most cantons, but has neither improved labour market outcomes nor reduced costs. Insufficient financial incentives to engage and the voluntary nature of IIZ explain to a considerable degree why implementation was very slow. Anecdotal evidence suggests that, despite all efforts to expand co-operation, it takes maybe half a year on average for a client to be referred to an IIZ team. People then typically stay between one and one-and-a-half years in co-operative schemes, during which time their employability gradually increases. Between one-third and one-half of clients might eventually find a job, which might not be sustainable, however. IIZ still reaches too few people and comes too late in most cases, thereby losing impact significantly. Meanwhile, the focus of all the institutions involved continues to be on their own cost containment rather than service efficiency and effectiveness for society as a whole.

Further reading

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

SECO (2004), Handbuch zur Interinstitutionellen Zusammenarbeit (IIZ), SECO, Bern.

Factsheet 5.11
Denmark: Return-to-work with caseworkers trained in psychology

Context

Employment services deal with many clients who suffer from mild-to-moderate mental ill-health. They need support in addressing their mental health, workplace, and employment issues. Since employment services are rarely in a position to offer them much face-to-face time, specialist providers take over.

Programme

The return-to-work programme of the Danish Mental Health Foundation (a non-profit organisation) targets clients with mild-to-moderate mental health conditions who have considerable labour market experience but have been on sick leave for at least six months. Because the programme deems motivation essential, clients must agree to interventions and be ready to be helped. Client commitment is determined in a preparatory meeting with the municipal job centre, which makes all referrals. Any client judged not to be job ready will be refused.

Interventions are structured, educating clients on their mental illness while tackling workplace issues and providing short-term treatment through cognitive behavioural therapy. After initial clarification, intervention typically last 19 weeks: 6 weeks of (group) courses to help understand the illness and teach coping mechanisms, followed by 13 weeks of trial employment or apprenticeships of a few hours per week.

Interventions are essentially specialised casework with a particularly low caseload (of between 10 and 20 clients) and are run by people specialised in working with clients suffering from mild-to-moderate mental ill-health. Most counsellors are psychologists who talk to clients as recovery counsellors, not therapists. The counsellor's focus in the weekly one-to-one meetings with a client is on education and employment, not the client's personality. Talking about resuming work (often in a new workplace), psychological counselling and helping to access mental health treatment are key aspects of the meetings.

Outcomes

The Foundation only acts in the Greater Copenhagen area (representing a population of approximately 1.5 million people), and solely as a knowledge, research, education and coaching centre for civil servants at the municipal job centers who run the programme.

There is no evaluation of the programme available. Anecdotal evidence suggests that most clients end up in employment, but there is no longer-term follow-up. Immediate outcomes after the 19-week interventions are as follows: 34% are ready to move into education or employment; 42% start treatment with a psychologist or a psychiatrist; and 24% stop the course or move onto benefits.

Further reading

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

Danish speakers may want to have a look at www.psykiatrifonden.dk/.

Factsheet 5.12
Sweden: Ensuring psychological treatment for people on sick leave

Context

It is important to intervene quickly when employees are absent from work for reasons of mental ill-health. Both the health and the employment sector have major roles to play in averting long-term sickness, but they often undertake their policies in isolation. Collaboration could provide people with poor mental health with the multiple supports they need.

Programme

In 2008, the Swedish Ministry of Health and Social Affairs introduced its Rehabilitation Guarantee for people on sick leave or at risk of longer-term leave as a result of long-standing psychological problems such as anxiety, depression or stress. Through the scheme, county councils may receive direct payment from the Social Insurance Agency (which grants and pays sickness and disability benefits) for each medical intervention. The Rehabilitation Guarantee offers rehabilitation measures in the form of cognitive behavioural therapy (CBT) and interpersonal psychotherapy for relatively short periods (typically between 8 and 20 sessions). Those working with CBT must be qualified, and assessment and treatment can take place either individually or in groups.

Outcomes

Evaluation studies show mixed outcomes. On the one hand, the Rehabilitation Guarantee reduces the risk of absence among employees who are still at work compared to those who have not benefitted from it. On the other hand, no positive effect on sickness absence has been found among people who undergo interventions under the scheme while on sick leave without a valid job contract. They do, however, show improvements in self-reported health. While the programme is still in its early stages of delivery, important lessons can be learnt. For instance, one major challenge the Rehabilitation Guarantee is managing are the high drop-out rates before the end of treatment. A need for stronger incentives may be inferred to encourage people to take up, comply with, and complete courses of treatment. The lack of expertise in CBT was another problem that undermined the effectiveness of the programme.

Further reading

Karolinska Institutet (2011), "En nationell utvärdering av rehabiliteringsgarantins effekter på sjukfrånvaro och hälsa, Slutrapport del I", Stockholm.

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

Factsheet 5.13
Sweden: Delta – Financial co-ordination to provide integrated services

Context

Medical and vocational rehabilitation requires the involvement of different policy sectors. The alignment and integration of health policies is still particularly weak in most countries. As a result, rehabilitation may be hampered by different and even contradicting priorities, poor communication, and inadequate joint planning leading to longer sickness absences and poor return-to-work outcomes.

Programme

DELTA is a local Swedish association that ensures financial co-ordination between the national employment service, the regional health authority, the municipal social service, and the national social insurance department. The four institutions supply the funding for DELTA. Established first in 1997 as a pilot project, it aims to improve cross-sector, inter-professional, and inter-organisational collaboration in order to meet rehabilitation needs in the working-age population more efficiently. Such needs are related mainly to mental ill-health, musculoskeletal disorders, complex social problems, or long-term work incapacity. The funds are pooled into a joint budget, which is allocated to the different rehabilitation services provided by the association.

Most of the activities under the aegis of DELTA operate with the objective of early, co-ordinated rehabilitation and may be divided into three main areas: i) social and medical activities included in treatment plans to shorten patient treatment, ii) occupational activities to speed up return-to-work, and iii) preventive activities that seek to avert sickness absence and social exclusion. These activities are carried out by multidisciplinary teams, consisting of professionals from the different sectors and institutions involved – e.g. physicians, nurses, physiotherapists, psychologists, economists, lawyers, and social workers. The teams are supervised by co-ordinators appointed by the association.

Outcomes

A number of evaluations have shown that DELTA has led to improved job-finding outcomes. Eight out of ten formerly unemployed people were able to maintain gainful employment, while two out of three were no longer sick-listed. Users also perceive services as well integrated and adapted to their needs. However, little is known about actual co-operation. One drawback of financial co-ordination is that it remains solely voluntary. It does not guarantee sustained collaboration in the long run or effective follow-up of individuals who need the greatest support. Improvements to programmes such as DELTA can also be made by involving employers in facilitating returns to work.

Further reading

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Wollberg, P. (2006), *Integrated Service in Rehabilitation – On Co-ordination of Organisation and Financing*, Host Country Report, Peer Review and Assessment in Social Inclusion, European Commission.

Factsheet 5.14
Netherlands: Integrated Fit-4-Work services for municipal clients

Context

Mental ill-health is common among social assistance recipients, although they are not necessarily identified as having such a condition. Better identification of mental health problems and co-operation with the mental health sector would help provide recipients with appropriate support in returning to the labour market.

Programme

To better co-ordinate services across sectors for clients with multiple psychosocial problems, the Dutch employee insurance agency (UWV) and the social and mental health services of five large municipalities started a pilot project in 2013 called Fit-4-Work. The project's goal is to activate benefit recipients whose multiple psychosocial problems have disconnected them from the labour market and to help at least 50% of them find sustainable employment (longer than one year).

Fit-4-Work has seven component parts: i) diagnosis of the problem; ii) discussion in a multi-disciplinary team that brings together the social services, UWV, and the mental health sector; iii) integral service packages that include psychological treatment (without waiting time) and social interventions (such as debt relief, social activation and participation, and housing services); iv) care continuity; v) a fast problem-solving approach; vi) quick job placement; and vii) coaching for the client and employer during and after the placement.

Outcomes

Fit-4-Work is built on national and international experience in multidisciplinary integration approaches, including the ExIT project in Rotterdam and the WeCare project in New York. An evaluation of the ExIT approach showed a 40% outflow to work compared with 13% in a control group that followed a regular trajectory.

The pilot project is financed by the stakeholders and subsidised by the government. However, an *ex ante* cost-benefit analysis shows that the benefits should outweigh the costs for all stakeholders within four years. Actual reintegration is the work of a private provider (selected through a tender process), which is paid 75% of the budget after a client has held a job for more than one year. The remaining 25% is paid if at least 50% of the participants are still in employment after four years.

Further reading

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Factsheet 5.15
Belgium: Activation team for jobseekers with mental health problems

Context

Efficient co-operation between public employment services and the mental health sector is crucial for reintegrating jobseekers with mental health problems into the workplace. The employment sector can address clients' health needs by co-ordinating its services with the health sector or providing integrated services within the sector. One way is to run a centre specialised in combining care and employment support.

Programme

In 2009, the Flemish Public Employment Service (VDAB) in Belgium developed a project in co-operation with the mental health and welfare sectors designed for jobseekers with severe medical, mental, psychological, or psychiatric problems. Under the scheme, they follow intensive activation programmes that combine care and employment support provided by a specialised non-profit centre (GTB). Recipients of disability benefits and social welfare were recently also allowed into the programmes. All services are financed by the Flemish Government and free of charge for jobseekers.

The activation team consists of three players: 1) a job coach; 2) a health coach; and 3) an empowerment coach. VDAB pays a fixed amount to each coach and requires them to work closely together in activation guidance and to meet on a regular basis.

The job coach – employed by GTB – puts in place an individual action plan together with the jobseeker and introduces him or her to the health coach and the empowerment coach who are responsible for identifying the right services in the health sector and welfare sector respectively. During the entire process, the job coach makes sure that the activation guidance keeps its focus firmly on work.

The health coach – typically a psychologist working in a centre for mental health – focuses on the health problems and provides rehabilitation and training in, for instance, self-confidence, coping with stress, assertiveness, and self-image. Individual or group therapies are provided in-house or by partner providers.

The empowerment coach from the welfare sector focuses on economic, psychosocial and social impediments and deals with issues such as mobility, personal budgeting, and housing (also either on an individual or group basis).

Outcomes

Co-operation between the three sectors delivers tailored services to long-term jobseekers who have grown remote from the labour market. Co-operation with a psychologist, the focus on case management, and the multidisciplinary team meetings are the major strengths of the programme.

In 2011, some 12% of the long-term unemployed in Flanders underwent in-depth multidisciplinary screening. Between 2007 and 2012, 11% of participants in the activation guidance programme found a job in the regular labour market and no longer receive unemployment benefits. Another 5.5% moved into sheltered employment and 2.8% into other forms of employment outside the regular labour market.

Further reading

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

Factsheet 5.16
United Kingdom: Individual placement and support for common mental illness

Context

Integrated health and employment services for people with common mental illnesses are scarce. On the contrary, for people with severe mental illnesses evidence-based approaches exist with a strong focus (among other things) on fast job placement, integrated health intervention and post-placement follow-up. The evidence base on the cost and potential of such an approach for people with common mental illnesses is lacking.

Programme

Individual Placement and Support (IPS) for people with severe disability (and in particular, severe mental illness) works with a strict fidelity model and has a strong evidence base. England's National Health Service is now the first to test the potential of IPS for a much larger target group, i.e. people with common mental illnesses. The hope being that it will be less costly per person and therefore equally cost-effective for this group.

This pilot will test whether treatment within the Individual Access to Psychological Therapy (IAPT) programme together with employment support based on the IPS model, improves labour market outcomes compared to:

- Usual Jobcentre support (i.e. usual support by the employment sector)
- Usual IAPT support (i.e. usual support by the health sector).

The target group for the new pilot are disability benefit claimants (i.e. claimants of UK's Employment and Support Allowance) with common mental health problems.

Outcomes

The pilot began in June 2014 and runs across four Jobcentre districts. First outcomes will become available in mid-2015.

Further reading

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