Chapter 5

Making more of the potential of the Swiss mental health care system

This chapter assesses the performance of the mental health care system in Switzerland in providing adequate treatment to persons with mental disorders. While very comprehensive, there is potential to reach even more of those needing treatment. Therefore, the chapter looks at the role and collaboration of different mental health care providers and the potential for further improvements. The contributions of psychiatric services and physicians in private practice to facilitate job retention and re-integration are assessed, and barriers as well as possibilities to engage more actively in health-related work problems are discussed.

Although most mental illnesses have a good potential for improvement over time if treated quickly and effectively, these illnesses usually begin very early in the life course and can be persistent or subject to frequent relapses. Moreover, mental ill-health often has a negative impact on social skills, personality and work-related anxiety, and leads to stigma both inside and outside of the workplace. Job retention and re-integration of workers with mental health problems may only be solved by integrated interventions addressing the medical condition and adequately intervening in emotionally complex situations in the workplace. Adequate treatment is, therefore, necessary in any policy strategy aiming to raise the labour market participation of people with a mental disorder, but, as discussed in Chapter 2, it must also be connected to workplace interventions.

While there are many generalist and specialist mental health care providers in Switzerland, and while the Swiss health care system ranks highly regarding the satisfaction of users, there are challenges around linking general and specialist health care with employment issues and with rehabilitation and employment services. The large resources available in the Swiss health care system enable differentiated and good medical and psychological services but the diversity of these services also involves the risk of fragmented activities and concepts. These challenges are addressed below.

Characteristics of the mental health care system

Some structural characteristics of a mental health care system may have consequences not only on illness recovery but also on the employment situation of the patient, including for example whether the treatment facility is close to the patient's place of residence, facilitating contacts between employers and mental health care, or whether services are offered in a non-stigmatised environment (e.g. in general hospitals), facilitating access to treatment, or whether outpatient services and interdisciplinary day clinics are available, facilitating the return-to-work process.

Switzerland, generally, has a well-performing health system with a broad range of accessible services, universal health insurance coverage, and high levels of patient satisfaction (OECD, 2011; Sturny and Camenzind, 2011). At the same time, health expenditures in Switzerland in 2009 ranked among the highest within OECD countries both as a percentage of GDP (11.4%) and on a per capita basis (5 000 USD PPP; OECD, 2011).

In 2010 total costs for health care services covered by mandatory health insurance amounted to CHF 32 billion (EUR 28 billion). CHF 21 billion were contributed by health insurance and CHF 11 billion by the confederation, the cantons and the municipalities. CHF 30 billion (94%)

went into somatic health care and only CHF 2 billion (6%) into specialised mental health care. Of the latter, 56% went into inpatient psychiatric care, 14% into ambulatory and day care services, and 30% into private practices.

A large array of mental health services

First, in 2010 around 6 000 general practitioners (GPs) treated some five million patients. An estimated one-quarter to one-third of these patients had a (co-morbid) mental disorder (e.g. WHO/Wonca, 2008; Goldberg and Lecrubier, 1995). The same magnitude (around 35%) was found in a survey of 2 330 GP patients in the canton of Bern (Amsler et al., 2010). Generally, nearly 80% of the Swiss population sees a doctor (a GP or a specialist) at least once during a year. This rate rises to more than 90% in people suffering from an enduring mental health problem (Sturny and Schuler, 2011). The more people feel stressed, the more they seek medical treatment (Schuler and Burla, 2012). However, in most cases, people with a mental disorder do not seek treatment for their mental health problem but for a physical health condition, and mostly their mental health problem remains undetected and/or untreated. Nevertheless, 36% of all psychiatric diagnoses are done by GPs and another 2.5% by specialised somatic physicians in private practice. All other mental psychiatric diagnoses are done by psychiatrists.

Second, also in 2010 around 2 900 psychiatrists in private practice treated 330 000 patients (Schuler and Burla, 2012). Their caseload (115 patients per psychiatrist on average) is much lower than the caseload of the average GP (830 patients). While the number of treated patients in GP practices has increased by around 4% between 2006 and 2010, the increase in psychiatric practices was much higher at more than 18%. Compared with GPs, psychiatrists treat especially often patients with schizophrenic, neurotic and personality disorders. Psychiatrists can be accessed directly by patients within the mandatory health insurance, without GP referral. Some psychiatrists work together with psychotherapists, to whom they can delegate patients – enabling patients to be reimbursed for the costs by their health insurance (generally, the compulsory health insurance only covers the costs of psychotherapy provided by psychiatrists). Altogether, in 2010 around 4 000 psychotherapists provided treatment to clients with mental health problems; around one-third of the psychotherapies are paid out of pocket by patients.

Third, there are many outpatient psychiatric institutions in Switzerland (ambulatory care, day hospitals). According to Moreau-Gruet and Lavignasse (2009), there are around 500 units in 60 institutions with each unit treating between 11 and 65 patients per 1 000 population, depending on the canton. Altogether, an estimated number of around 175 000 cases are

treated by outpatient psychiatric services (Schuler and Burla, 2012; Moreau-Gruet and Lavignasse, 2009). The most treated mental health conditions in these services are neurotic, affective and substance abuse disorders.

Fourth, around 60 000 patients (around 80 000 cases) in 2009 were in inpatient treatment, around three-quarters of them in a psychiatric clinic and one-quarter in a general hospital. While the rate of hospitalised patients has not increased between 2002 and 2009 the *case rate* has, i.e. the same patients were re-hospitalised more often (Kuhl and Herdt, 2007). The main diagnoses in inpatient treatment are substance use disorders (in men), affective disorders (in women) and neurotic disorders. Treatment can take place in a psychiatric clinic or a specialised unit in a general hospital. There are also a lot of hospitalisations of patients with co-morbid mental and physical disorders in general hospitals. A somatic hospitalisation may provide the occasion to identify co-morbid mental disorders. Hospital doctors often perceive mental health problems in their patients. In a survey of patients of medical clinics of two general hospitals, doctors reported "relevant" mental disorders (which need treatment) in around 25% of the patients (Cahn and Baer, 2003). However, this early identification seldom leads to a referral to a specialist after discharge from the hospital.

GPs recognise mental disorders but treatment and referrals are scarce

The gap between the high rate of patients with a mental disorder and the low treatment rate in GP practices is not only due to a low recognition rate. In a Swiss survey of GPs about patients with depressive disorders, GPs reported 3.2 treated cases of depression per 1 000 patients. However, GPs estimated that around one in three of their patients have a depression, when including milder forms (Schuler and Burla, 2012). Because milder forms of depression can translate into more severe ones if untreated, there would be a potential if GPs intervened more often. A main problem still is that only 5-10% of people with a mental disorder discloses their illness to their GP and asks for treatment (Linden et al., 1996). Most substance use disorders on the contrary are treated by GPs, who are responsible for nearly 60% of all diagnoses for alcohol abuse disorders and for 70% of all other substance abuse diagnoses.

Only a minority of patients diagnosed with a mental disorder in a private practice is referred to a psychiatrist. For example, this occurs for only 20% of patients with a depressive disorder (Schuler and Burla, 2012). Referral from GPs to psychiatrists is influenced by different factors, e.g. patient preferences, whether GPs perceive treatment as their own duty and whether they see themselves as competent, whether there is good collaboration with psychiatrists at the local level, whether they are accessible without

excessively long waiting times, and whether the GP can expect the patient to be referred back to him or her (Spiessl and Cording, 2000).

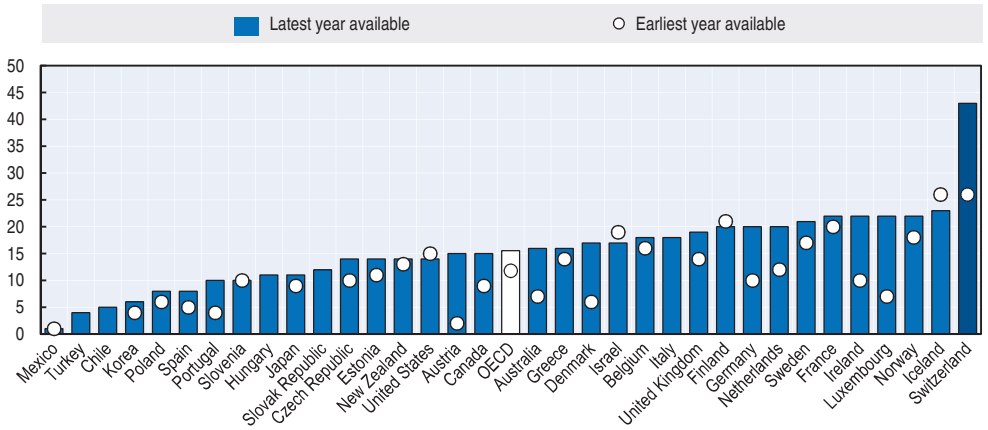
In a Swiss survey of around 550 patients in private practice (Cahn and Baer, 2003), GPs reported that 19% of their patients have a mental disorder which should be treated, and another 9% have a minor mental health problem. According to the GPs, only in the case of 15% of patients with a need for psychiatric treatment was a specialist involved, which equals 3% of the total number of patients in general practices. This very low number may indicate that there are some problems with the referral to psychiatrists.

High density of psychiatrists and psychotherapists in practice

An outstanding characteristic and potential of the Swiss mental health care system is the large number of psychiatrists in private practice (Figure 5.1). With almost 45 psychiatrists in private practice per 100 000 population Switzerland has three times more specialists than the OECD average. The high rate of psychiatrists per population suggests that psychiatrists in private practice are partly functioning as a first-line primary care service for people with a mental disorder.

Figure 5.1. **Extremely high rate of psychiatrists in Switzerland**

Density of psychiatrists per 100 000 population in OECD countries, earliest and latest years available



Note: The OECD average is an unweighted average.

Source: OECD Health Care Quality Indicators Data 2011, http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC.

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Despite a large supply, however, access to psychiatric services remains an issue. A recent Swiss study simulating clinical symptoms of an acute

depression and an acute psychotic disorder concluded that making an appointment with a psychiatrist is difficult, far more so than making an appointment with a GP (Bridler et al., 2012). Establishing a personal contact with a GP was possible in 95% of all cases, but only in around 50% of cases with psychiatrists. On average, seven phone calls were necessary to make an appointment with a psychiatrist, which was only possible with 30% of all of the contacted psychiatrists. The other psychiatrists were not reachable or not accepting new patients. The average waiting time for an appointment with a psychiatrist for an acute problem was around six days.

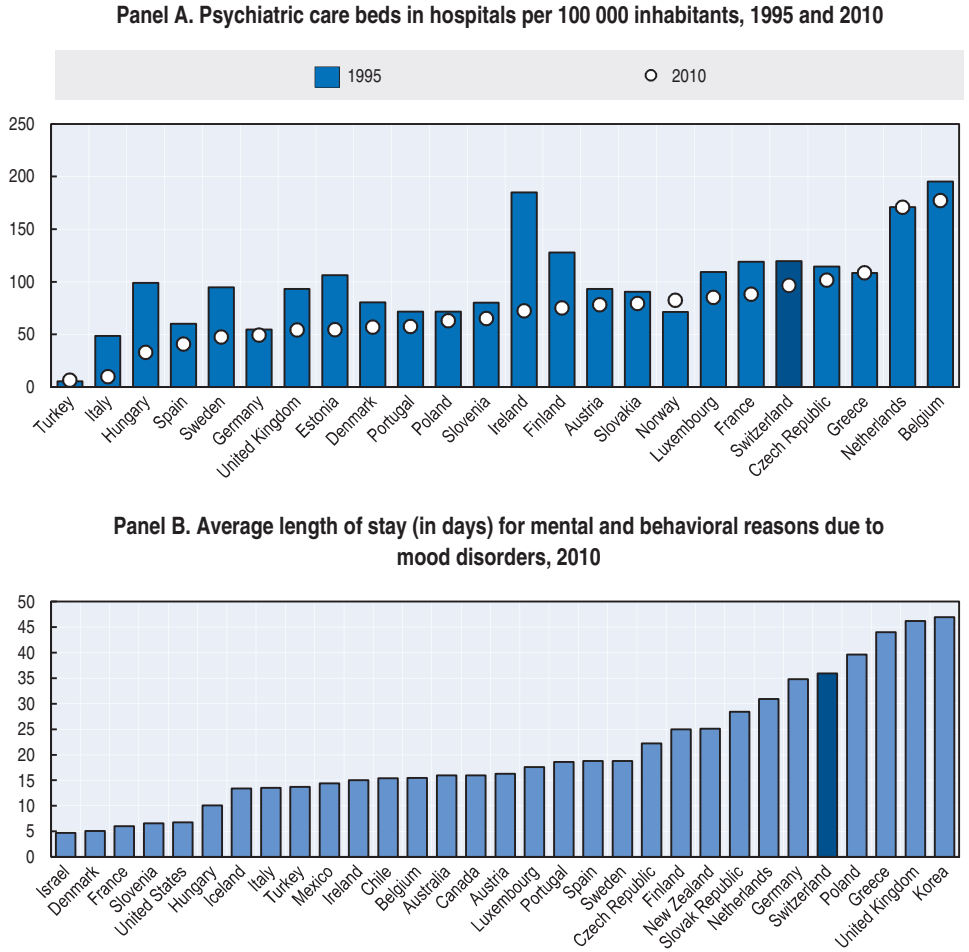
Another bottleneck for accessing psychiatric services is the long treatment duration in psychiatrist practices. A survey of psychiatrists in the canton of Bern (Amsler et al., 2010) showed that the treatment duration is around 60 months (i.e. the duration of the already realised treatment combined with the expected future treatment duration). Long treatment durations reduce access for new patients.

Switzerland also has a large number of psychotherapists, some 4000 across the country. Data about the number of psychotherapies provided, however, are not available and the overall contribution of psychotherapists to mental health care is therefore not measurable. Psychotherapists are currently not on an equal footing with psychiatrists regarding their health insurance status, i.e. the services they offer are not a part of the catalogue of services covered by mandatory health insurance. Only if a psychiatrist delegates a psychotherapy treatment to a psychotherapist is it remunerated by mandatory health insurance. A law about psychological professions has been put into force in 2013 which not only regulates the criteria and conditions to work as a psychologist in different areas but also clarifies the possibility of psychotherapists providing treatment at the expense of mandatory health insurance.

High inpatient resources make the system costly

Despite the high number of psychiatrists in private practice, Switzerland has the fifth highest rate of psychiatric beds and the fourth longest inpatient stay in the OECD in 2010. There are around 100 psychiatric inpatient beds per 100 000 population (Figure 5.2, Panel A) providing treatment over a relatively long duration, around 30 days on average over all mental illnesses and 35 days for mood disorders (Figure 5.2, Panel B). In contrast to many other countries, the bed rate per population has only moderately fallen since 1995. Longer hospitalisation does not necessarily improve outcomes; on the contrary, there is some evidence that shorter inpatient stays relate to better rehabilitative outcomes (e.g. with respect to independent living; Nordentoft et al., 2010).

Figure 5.2. **Very high inpatient mental health resources in Switzerland**



Source: For Panel A, New Cronos, Eurostat, http://epp.eurostat.ec.europa.eu. Panel B, OECD Health Care Quality Indicators Data 2011, http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_PROC.

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Switzerland is also different from many other OECD countries in that inpatient psychiatric treatment is usually detached from general hospitals and concentrated in separated public or private psychiatric clinics, often far away from the patients' workplaces. This may hinder people to seek treatment due to the fear of stigmatisation. It is easier to seek treatment in a general hospital in town than in a psychiatric clinic outside of the city, and

to disclose a stay in a general hospital than in a psychiatric clinic. Moreover, mental disorders are often co-morbid with physical disorders, suggesting that specialised treatment in general hospitals also providing somatic treatment would be more efficient.

Large differences between cantons in the use of inpatient care

Hospitalisation rates for mental disorders in Switzerland are in the range of one to four admissions per 1 000 of the population. Rates are high and increasing for substance-use and affective disorders, which are responsible for every second inpatient admission (Figure 5.3, Panel A). Rates for schizophrenia and neurotic disorders have remained stable.

The overall hospitalisation rates for mental disorders vary considerably across cantons, from around 20 admissions per 1 000 population in the cantons of Geneva and Basel-City to seven admissions in the rural cantons of Nidwalden or Schwyz in 2010 (Figure 5.3, Panel B). It is highly unlikely that these differences are fully explained by differences in illness incidence between cantons. It is more probable that differences are supply-driven and relate to different mental health care traditions, different quality of outpatient mental health care and rehabilitative care, and differences in access to care. In the past decade, hospitalisation rates have increased in 19 of 26 cantons. The average duration of hospitalisation also varies across cantons (Figure 5.3, Panel C).

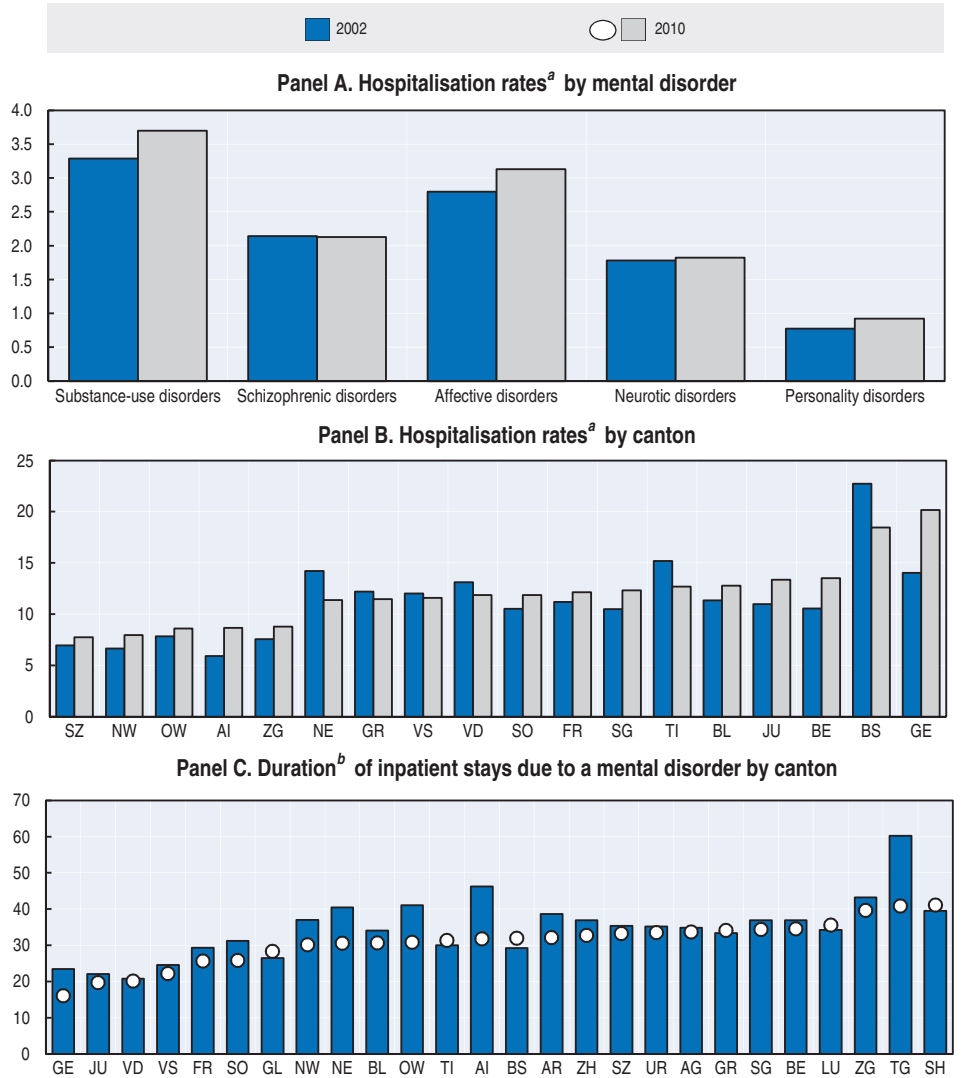
Readmissions in turn are relatively rare

Long treatment duration does not necessarily lead to significantly better improvement of symptoms. Lauber et al. (2006) analysed Swiss inpatient data and showed that the optimum inpatient length of stay for mood disorders is between 15 and 30 days. After this period symptoms do not improve any more but stay stable. The average length of inpatient stays for mood disorders in Switzerland of 35 days (Figure 5.3) suggests that a substantial proportion of patients with mood disorders stay in a psychiatric clinic for too long.

The long duration of inpatient treatments in Switzerland may have additional negative consequences on the employment situation of those undergoing treatment, first, because there is a long absence from the workplace among those who are still employed, and, second, because long inpatient treatments may increase avoidant behaviour (i.e. avoiding to return to the workplace out of fears of failure or conflict, etc.).

Figure 5.3. **Hospitalisation rates for mental disorders are generally rising but rates and durations vary considerably between cantons**

Rates per 1 000 population, persons aged 15-64



a. Hospitalisation rates are defined as the rate of hospitalisations in a psychiatric clinic or in a psychiatric unit of a general hospital within a year, per 1 000 population in a canton.

b. The duration refers to the average length of stay in a hospital in each canton.

Source: Medical Statistics of the Hospitals 2010, Swiss Health Observatory, Obsan, Federal Office of Statistics.

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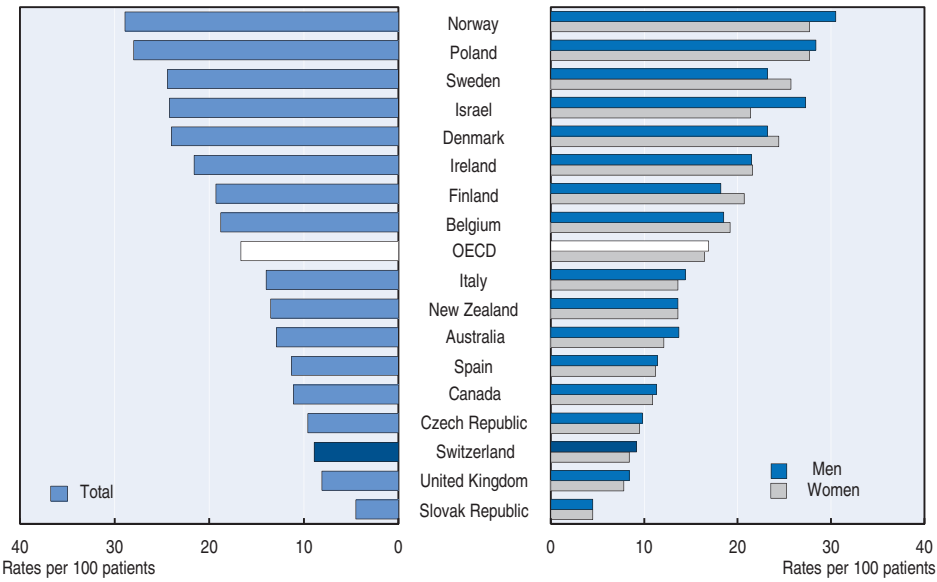
On the other hand, readmissions of discharged psychiatric inpatients are rare in Switzerland, thereby supporting job retention among such patients. Less than 10% of schizophrenic inpatients are re-admitted within 30 days (Figure 5.4). This is around one-third of the rate in countries such as Norway, Sweden or Denmark, for example, which have a much shorter length of stay, and about the same as in the United Kingdom where inpatient stays are even longer than in Switzerland. However, there is evidence that length of inpatient stay and readmission are not necessarily related (see e.g. Hodgson et al., 2001), suggesting that it may be possible to reduce the duration of hospitalisation without risking to increase readmission rates.

Figure 5.4. **Few inpatient re-admissions in Switzerland**

Schizophrenia re-admissions to the same hospital, 2009 (or nearest year)



Source: OECD Health Care Quality Indicators, 2011, http://dotstat.oecd.org/Index.aspx?DataSetCode=HCQI_STAND.

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An important factor for readmission is the quality of after-care in the community (Zhang et al., 2011). Thus, readmissions rates have to be valued against the background of the whole mental health care system. In Switzerland, the low readmission rate might be related to a well-functioning system of after-care in the community, including the high rate of psychiatrists in private practice.

While around 18% of patients are admitted to a psychiatric clinic due to their own or their relatives' initiative, and around 75% are admitted by GPs, after-care is mostly provided by private psychiatrists (around 40%) or an outpatient psychiatric institution (around 22%). The share of GPs treating patients discharged from a psychiatric clinic is around 13%. This implies that psychiatric clinics often initiate treatment or re-allocate patients from general to specialised care (i.e. from GPs to psychiatrist). But, in the other direction, psychiatrists do not refer substantial numbers of their patients to psychiatric clinics. This suggests that psychiatric outpatient treatment is effective in the sense that it prevents inpatient hospitalisations and that there might be further potential to scale back in-patient care by providing accessible specialist care without necessarily reducing the quality of care.

However, treatment availability in private psychiatrist practices also varies considerably across cantons with a high concentration of practices in a few urban cantons, e.g. more than one psychiatrist per 1 000 population in Basel-City and 0.67 per 1 000 in Geneva, and a much lower density in rural areas, as e.g. the canton of Uri with one psychiatrist per 30 000 population. In the latter regions, mental health care is therefore provided by GPs to a much larger degree.

The potential of day care is not fully used

Day hospitals for patients with acute mental health conditions, who are often still in employment, have a high rehabilitative potential (BAG, 2004; Cahn and Baer, 2003). Usually, personnel working in day clinics are interdisciplinary involving psychiatrists, psychologists, social workers, nurses and social pedagogues, and the needs of the patients are mostly at the interface between illness recovery and social or vocational re-integration. Furthermore, treatment duration in day hospitals is often around 3-6 months, allowing for a sound assessment of working problems and support needs, for executing training elements, and for preparing vocational re-integration, for example by initiating work trials or supporting job-seeking. Moreover, psychiatric day clinics cause significantly lower costs than full inpatient care (between one-third to one-half) while treatment outcomes are comparable, or, with respect to quality of life and social outcomes, probably better (Marshall et al., 2011).

However, unlike some well-researched day care facilities in the United States which have been transformed successfully into supported employment services (Becker et al., 2001), day care facilities in Switzerland do not target vocational integration. The programmes of day clinics in Switzerland mainly consist of therapeutic treatment and there are no employment specialists working in such day clinics. Hence, where available,

Swiss day clinics may be a good alternative to full inpatient care, but they do not use their potential with respect to social integration and employment.

Funding mechanisms favour inpatient care

The main reason for the high number of inpatient facilities in Switzerland – despite widely accepted guidelines by the Conference of the Cantonal Health Directors (GDK) to strengthen ambulatory and day care – lies in funding mechanisms favouring inpatient care (GDK, 2008). While outpatient mental health care, including day hospitals, is exclusively financed by health insurance (on a fee-for-service basis), around 50% of the costs of inpatient care are financed by the cantons, provided a hospital is on the cantonal hospital list. This considerable co-financing gives inpatient care much more financial freedom, and it provides strong incentives for health insurance to finance inpatient care. The cantons should have an interest in scaling down inpatient care but political barriers seem to blockade this.

High inpatient spending makes the system unnecessarily expensive. Moreover, from an employment perspective, these financial incentives and funding arrangements run counter to the more employment-friendly approach of outpatient services which: first, treat a clientele more often still in employment; second, usually treat patients with a better rehabilitative prognosis; and, third, are potentially more effective in supporting people to stay at work than more remote inpatient care.

Employed people prefer outpatient treatment

There is some evidence that patients still employed prefer outpatient crisis services over inpatient services. In a comparison of patients in need of crisis intervention, the degree of social integration in general and the employment situation of the patient in particular were shown to be critical for the choice of treatment (Krowatschek et al., 2012). Employment status and marital status are the most important factors differentiating inpatient from outpatient treatment – independent of the degree of functional impairment.

While inpatient care is effective in terms of symptom reduction, with comparatively low readmission rates in Switzerland, it is questionable whether inpatient hospitalisation serves the treated population well with respect to employment: around one-third of the inpatients partly employed at admission to the psychiatric clinic are unemployed when discharged (Baer and Cahn, 2008). Although this figure has to be interpreted with caution, it suggests that inpatient psychiatry is not the best approach to secure jobs.

Under-treatment is substantial – despite enormous resources

Despite large resources in specialised mental health care as well as in health care more generally, under-treatment remains considerable and is an important concern in Switzerland, as in other countries (Schuler and Burla, 2012). According to the Health Survey 2007, 5.3% of the population was in professional treatment due to a mental health problem in the past 12 months – mostly treatment by a psychiatrist (39%), a psychotherapist (34%) or a GP (21%). The treatment rate in 2007 was around one percentage point higher than in the first Health Survey in 1997 but still very low compared to the prevalence of mental disorders in the population, even if only every second person concerned would be in need of treatment. Rüesch et al. (2013) come to a similar conclusion. Around 480 000 people aged 14 and over are treated by specialised mental health care per year (data mainly from 2009); this corresponds to 7% of the population. Probably, the rate of treated persons who register for the disability insurance is significantly higher. However, the question remains how adequately these claimants have been treated. The generally moderate treatment prevalence also applies to employed people suffering from depressive symptoms (Baer et al., 2013). According to the Health Survey, only 9% of workers with mild depressive symptoms and 27% of those with moderate to severe depressive symptoms were in medical depression treatment in 2007 (mostly with a psychiatrist). In view of the prognostic importance of early treatment in order to stay in employment (see e.g. van der Feltz-Cornelis, 2010) the magnitude of under-treatment of both mild and severe depressive conditions in workers is worrying.

With respect to the screening of a Major Depressive Disorder (MDD) fulfilling the diagnostic criteria of DSM-IV, the same data show that 65-70% of those with at least one MDD episode in the past 12 months were not in treatment during this period (Schuler and Burla, 2012; Rüesch et al., 2013). Along with the discussion above, this suggests that, on the one hand, people who seek psychiatric or psychological care receive intensive and enduring treatment, while, on the other hand, the majority of the population with treatment needs is not reached by the mental health care system. This raises the question whether more collaborative models with psychiatrists consulting GPs might not only improve patients' functioning (van der Feltz-Cornelis, 2010) but also treatment take-up in patients with mental health problems.

Organisation and responsibilities of mental health care

Overall, a stronger employment focus is needed in treatment concepts of mental health care, including the development of employment-related quality indicators of care and bringing employment issues into the further

education of psychiatrists. However, the question arises at which political layer this should be done. In Switzerland, the confederation, the cantons and the municipalities are involved in legislation and provision of (mental) health care (OECD, 2011). The confederation has a legislative and supervisory role but it has no direct influence on mental health care structures or concepts. This results in a lack of a coherent steering competence. However, the authorities for medical education would be able to implement a more employment-oriented approach.

Rather weak steering at the national level

Recently, the parliament decided not to implement a proposed law on prevention and health promotion which would have given the confederation, i.e. the Federal Office of Public Health (FOPH), more means to intervene in health care. Employment-related issues of people with mental health problems are entirely left to the social insurance system, as reflected in the revisions of the disability insurance (IV) over the past nine years.

In 2013, the government decided on 12 priorities in health policy to be put in place in the coming seven years ("Health 2020" report). In order to tackle the expected increase in chronic non-communicable diseases due to changes in population structure, health behaviour and working life (e.g. higher expectations on workers) and the rise in related costs for health provision and social security, health policy should strengthen its focus on early identification of health-related problems in the workplace. A main focus should be given to people with mental disorders. The report criticises the health system for being too focused on acute inpatient care, neglecting prevention and early intervention, and for not being well co-ordinated.

In order to compensate for the lack of mechanisms to steer mental health care, the Federal Offices of Public Health, Economic Affairs and Social Insurances, together with the Conference of the Cantonal Health Directors (GDK) and the Swiss Foundation for Health Promotion, established a network for mental health. This network should function as an information platform for knowledge transfer and bring the different stakeholders from different government layers as well as different professional fields (mental health, primary care, prevention, health promotion) together. However, this network has no executive power for direct action. The network is also a consequence of earlier initiatives to establish a shared and coherent health policy, e.g. the "project for a national health policy" which started around ten years ago, but which has never been fully implemented. Within that project, recommendations for a national mental health policy and for mental health care were elaborated which initiated similar activities by the GDK, e.g. guidelines for cantonal mental health care planning (GDK, 2008). The

new network is a new attempt to bring different actors together but an information platform cannot compensate the lack of steering in a field which involves several actors with differing interests.

The FOPH also supported the implementation of the so-called "Alliances against depression" in ten cantons in the past ten years. These alliances aim to: educate GPs in identification and treatment of depressive disorders; raise the awareness of the population; educate other key persons (teachers, nurses, police officers, journalists etc.); and support people with depression and their relatives. While the alliances had some effect on public awareness, there is no evidence so far that the education objective has been achieved.

While the FOPH has no direct influence on health care provision, it is responsible for education, licensing and further education of mental health professionals. This responsibility might be a starting point for seeking to improve the mental health care system in terms of making it more responsive to the link to work problems and job retention of patients. By developing the evidence base of mental health problems at work, including evidence-based support concepts, and by integrating this evidence into the curriculum of physician training and further education of psychiatrists, the FOPH could have a considerable impact.

The cantons plan and provide mental health care

A very important layer in health care are the cantons which provide – and partly finance – inpatient health care services as well as services for people with disabilities, and are responsible for health care provision (inpatient and outpatient), prevention and health promotion. This results in Switzerland having 26 different mental health care systems, giving the GDK substantial importance in the planning of the future mental health care system.

The GDK has initiated the development of guidelines for psychiatric service planning (GDK, 2008), however, the guidelines do not consider employment issues or rehabilitative support needs at all. Nevertheless, the GDK has stated that mental health care is oriented too much on inpatient care and that the duration of hospitalisations should be reduced. According to the GDK, inpatient care takes up too large resources which might be used in a more effective way by expanding outpatient care.

Definitions and criteria vary across sectors

The interface between mental health care, rehabilitation services and social insurance is highly fragmented. An example of the fragmentation is the assessment for disability benefit eligibility by the cantonal IV offices

and the assessment of service needs of people with disability, a responsibility of the cantonal departments of education. In case someone is awarded a disability benefit and wants to work afterwards, the canton's education department is responsible for assessing the health-related needs for assistance, e.g. a place in a sheltered workshop, a supported housing facility, etc.

Due to a recent shift in the financial responsibility for people with disability from the confederation to the cantons, all cantons had to develop a concept for the care of this group. Most cantons are in the process of changing their funding system from object-financing (of rehabilitative institutions) to subject-financing (of people with disability). Consequently, the cantons have been elaborating new instruments over the past few years to assess the support needs of people with a disability.

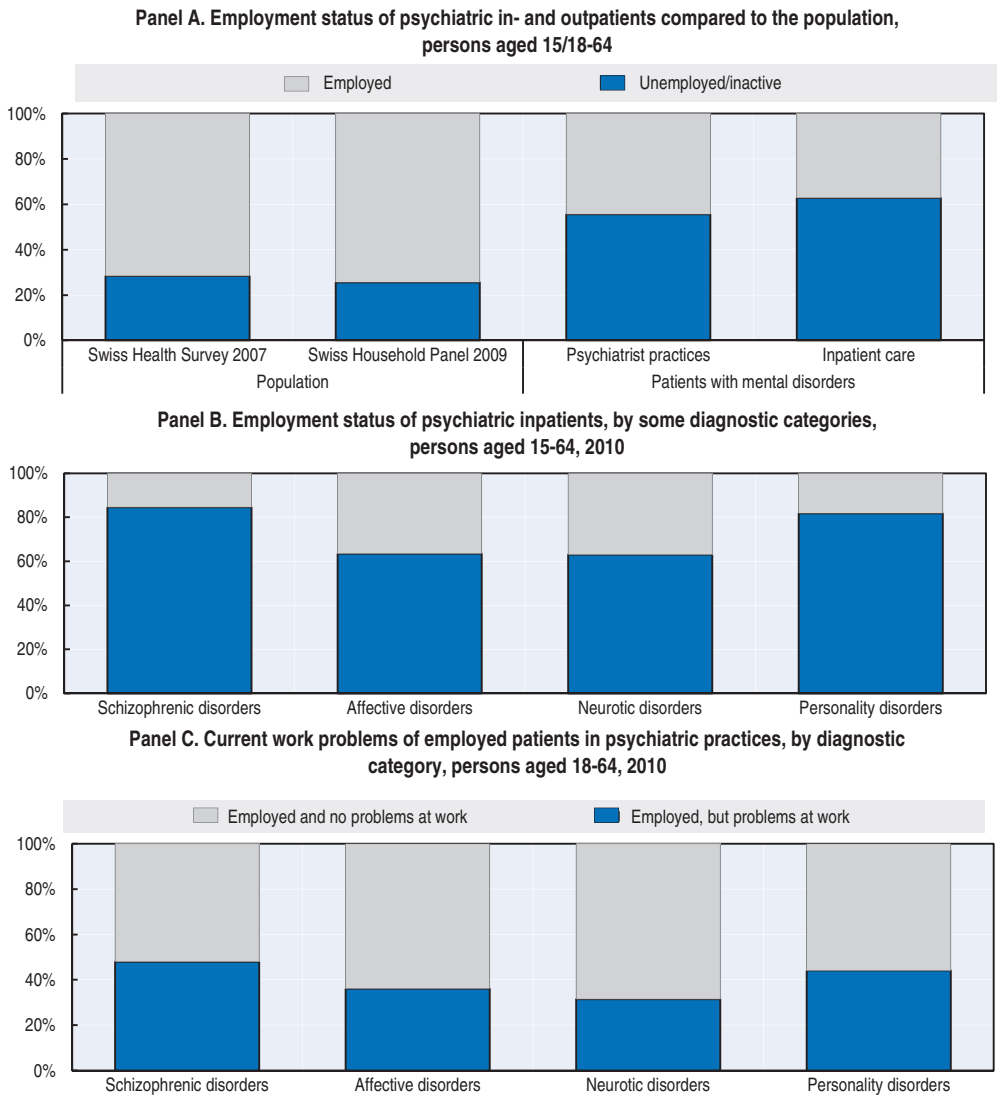
These new cantonal assessment instruments have been developed without co-ordination with the IV-offices, which – due to their responsibility for the assessment of a disability benefit entitlement – are well aware of the degree of impairment of a beneficiary, and, moreover, without any involvement of physicians or psychiatrists. The medical situation is given not much importance for the assessment of the rehabilitative needs of the person with disability.

Employment has a large impact on treatment outcomes

The employment situation of a patient is one of the most important determinants for the probability, the length and the outcome of inpatient admission (Kuhl and Herdt, 2007; Baer et al., 2013). Figure 5.5 (Panel A) shows that patients in psychiatrist practices and in clinics are seldom employed (around 40%), and those with schizophrenic or personality disorders are especially disadvantaged (Panel B). Both of the latter disorders usually have an early onset in childhood or young adulthood and may be very disabling due to cognitive deficits (schizophrenia) or interpersonal problems (personality disorders). For outpatients who are still employed, the picture is similar: those with schizophrenia or personality disorders have more workplace problems than those with affective or neurotic disorders (Panel C).

There is some evidence suggesting that the employment status of psychiatric patients has possibly an independent effect on treatment duration and recovery. Outpatients who are employed also have much shorter treatment durations than unemployed or inactive patients – independent of their illness severity (Figure 5.6, Panel A). Generally, the more severe the health condition is at treatment start, the longer the treatment and the larger the treatment effect, i.e. the improvement of symptoms. But, between patients with the same illness severity (assessed by the treating psychiatrist), the employment status makes a large difference.

Figure 5.5. **Unemployment is generally high in psychiatric patients, but diagnosis-specific differences are substantial**



Note: Substance-use disorders are missing due to n < 10 in this calculation

Source: Panels A and B, Baer, N. et al. (2013), "Depressionen in der Schweizer Bevölkerung", Schweizerisches Gesundheitsobservatorium; Panel C, OECD based on Amsler, F. et al. (2010), "Schlussbericht zur Evaluation der institutionellen ambulanten und teilstationären Psychiatrieversorgung des Kantons Bern unter besonderer Berücksichtigung der Pilotprojekte".

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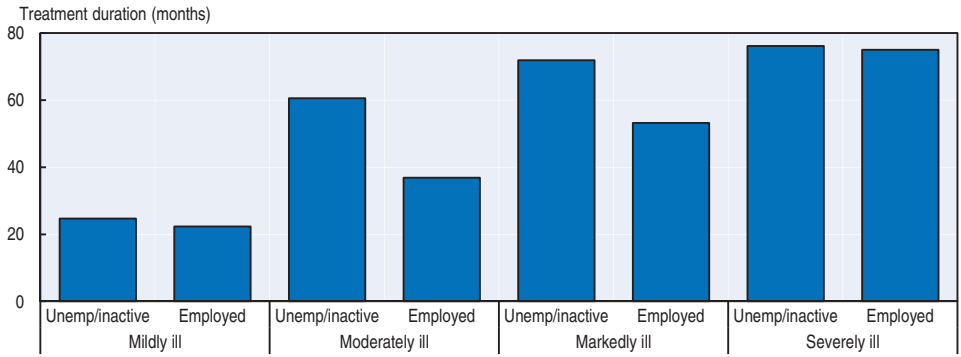
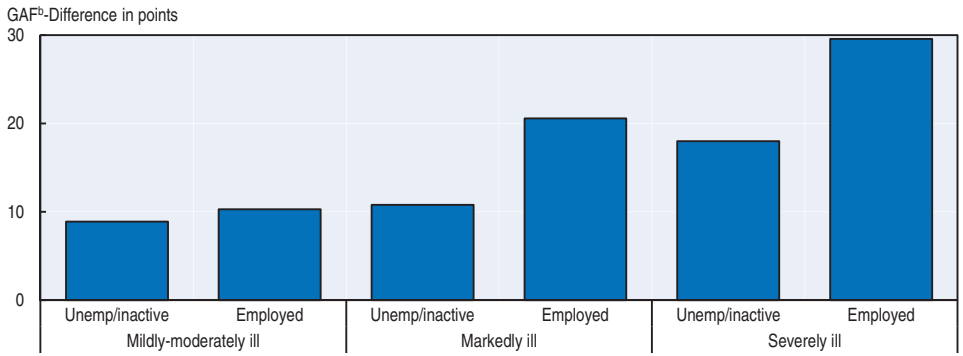
Figure 5.6. **Employed outpatients are treated shorter and recover better, independent from their illness severity**

Panel A. Treatment duration[a] of patients in private psychiatric practice, by illness-severity and employment status, persons aged 18-64, 2009



Panel B. Improvement of functioning since the beginning of treatment, by illness-severity and employment status



Note: Prevalence distribution: Mild-moderately ill (18%), markedly ill (51%), severely ill (31%).

a. "Treatment duration" is the sum of the months already in treatment and the expected number of months patients will stay in treatment in the future; it may comprise several treatment episodes.

b. The Global Assessment of Functioning Scale-GAF (DSM IV-TR) is a rating instrument for professionals to describe illness-severity and disability on a range from 0 (most severe) to 100 (no symptoms, superior functioning); the "GAF-Difference" means the difference in points on the GAF-scale between the current state and the state at the beginning of treatment

Source: Baer, N. et al. (2013), "Depressionen in der Schweizer Bevölkerung", Schweizerisches Gesundheitsobservatorium; calculations based on a survey of private psychiatrists in the canton of Bern [Amsler, F. et al. (2010), "Schlussbericht zur Evaluation der institutionellen ambulanten und teilstationären Psychiatrieversorgung des Kantons Bern unter besonderer Berücksichtigung der Pilotprojekte"].

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While the total treatment duration, i.e. the past and potential future duration, and the treatment outcome in private psychiatrist practices does not vary in mildly-ill patients with respect to their employment status, employment makes a huge difference for moderately and markedly-ill patients. The treatment duration of employed patients with a moderate mental disorder is more than 20 months shorter compared to the unemployed, and for markedly-ill it is more than 15 months shorter. Moreover, most employed patients make more progress in their recovery process than unemployed or inactive patients (Figure 5.6, Panel B). The same result has been shown for inpatients (OECD, 2012). This result has also been found by earlier research about the predictors of inpatient length of stay in Swiss psychiatric clinics, calculating regression models with the same hospitalisation data (Meyer et al., 1998).

While there may be different explanations for the strong relation between employment status, treatment duration and treatment outcome (e.g. that the measure of "illness-severity" may be limited due to its focus on an acute status), such results point to the importance of promoting job retention and quick moves back into work for those not employed.

Mental health care is not yet prepared for treating work problems

Although cantonal mental health care service plans in Switzerland are based on principles developed by social psychiatry emphasising the significance of social factors for the development, manifestation and outcome of mental disorders (GDK, 2008), mental health care structures are not systematically related to employers or vocational rehabilitation. Furthermore, there are neither principles nor tools for interventions for patients with health-related difficulties at work (Cahn and Baer, 2003).

With respect to patients who are unemployed or inactive but want to gain competitive employment, some psychiatric clinics have developed services based on the model of supported employment, e.g. in the psychiatric university clinics of Zurich (Burns et al., 2007), Bern (Hoffmann et al., 2012) or Lausanne. However, although these services have gained some popularity within mental health care, they i) do not serve a large population; ii) are often not well integrated into routine mental health care, and iii) often do not lead to financial independence from disability benefits. Most supported employment services are not provided by mental health care but by vocational rehabilitation institutions or sheltered workshops which have expanded their services over the past years. There is no systematic co-operation between these employment services and psychiatric institutions

and shared principles, e.g. on how best to assess work problems, plan rehabilitation and support job retention or re-integration are lacking. The psychiatric knowledge about functioning and deficits is not used in work-related services, and vice-versa.

There are several circumstances contributing to this fragmentation. First, rehabilitation professionals usually have a pedagogical background and often distance themselves from medicine in general and diagnosis in particular – in favour of emphasising the rehabilitation potential. Second, GPs and psychiatrists are not well trained in translating psychopathology into functional limitations, and underestimate how important their knowledge about symptoms would be for the assessment of work problems and the planning of rehabilitative interventions. Third, due to different funding arrangements and oversight by different authorities, there are no congruent quality indicators in place to ensure that psychiatric services focus on employment issues, or that employment services bother about the consequences of a mental disorder for work functioning.

The problem of insufficient information on functioning in doctors' reports was found repeatedly (e.g. Ebner et al., 2012). In the meantime, formal recommendations for physicians have been elaborated on how to assess disability e.g. emphasising the significance of a functional assessment and the underlying personality of the claimant. This seems to be a promising step, although it remains to be seen whether this approach delivers.

Beyond medical examination, psychiatrists usually do not seek contact with employers in case their patients are at risk of losing their job or having work problems (Baer et al., 2013). While around 40% of employed patients in private practice have problems at work (Figure 5.6, Panel C), psychiatrists seldom have a direct contact to the employer, only partly because patients do not want such a contact However, psychiatrists do have regular contacts with sheltered employment institutions. This suggests that psychiatrists care about the work situation of their patients, but only for those with severe disability and within a sheltered work framework. This raises the question as to whether psychiatrists feel ill-equipped to communicate with line managers and human resources professionals.

Physicians may be reluctant to give work-related information to the employer to secure the trust in their therapeutic relationship with their patient. However, work-related mental health issues are often not directly related to a specific workplace. It would be sufficient for psychiatrists to translate the predominant symptoms of the mental disorder (e.g. a lack of impulse-control in straining interpersonal situations) into a functional context (e.g. needing more individual work and reduced teamwork) and to let the employers translate this information into their specific work context.

Conclusion

Altogether, Switzerland has a well-functioning and differentiated mental health care system providing a broad range of generalist and specialist outpatient and inpatient services. Readmission rates of discharged inpatients are low compared to other OECD countries. A characteristic of the Swiss mental health care system is the high rate of psychiatrists in private practice; by far the highest in the OECD. Additionally, there are many psychotherapists and psychiatric institutions providing outpatient care.

However, this rich supply of mental health care services comes at a relatively high price: Switzerland invests a lot of financial resources into health care in general and especially into psychiatric hospitals. Mental health care traditionally has a strong inpatient focus with a high number of inpatient beds in psychiatric clinics and a long duration of inpatient hospitalisations, both significantly above the average of OECD countries.

While mental health care seems to be very effective in reducing symptoms, it lacks any links with the employment sphere thereby not doing justice to the strong positive impact employment can have in the recovery process and contributing little to securing existing employment. There are specific on-going problems and potentials which should be addressed in the future.

Integrate fragmented responsibilities

Many actors are responsible for mental health care in Switzerland, including the Federal Office of Public Health (FOPH), the cantons and the health insurance. Because mental health care also concerns patients with social and rehabilitation needs, the communities and the Federal Social Insurance Office (FSIO) are also involved. This fragmentation of legal and financial responsibilities hinders a coherent steering of the mental health care system. No entity is responsible for the interface between work and mental health. There are several efforts to compensate this fragmentation but more could be done in this regard.

- The FOPH should strengthen its steering competence by introducing mandatory employment-related modules in the education, licensing and further education of physicians in general and psychiatrists in particular. The Swiss institute for training and education which has the responsibility for the content of medical education and training should implement such a focus, together with the professional organisations of physicians and the academy of medical science.

- The FOPH should develop employment-related quality indicators for mental health professions.
- The FOPH, the GDK, the FSIO and the psychiatrists' and psychotherapists' associations should develop shared principles for effective health interventions to ensure job retention and re-integration, in co-operation with the employers' associations.

Strengthen the focus on employment issues

Although the working situation is crucial for the pace of illness recovery, mental health care providers do not see the employment situation of their patients as a high-priority problem.

- The FOPH and the GDK should develop employment-related guidelines for mental-health treatment, together with psychiatrists and GPs.
- Institutional inpatient and outpatient mental health care providers should develop support structures for employers in order to prevent longer absenteeism, job loss and disability.
- The development of formal guidelines for functional assessments by psychiatrists, recently initiated by the FSIO, should be broadened to also include work-related guidelines in general, including the handling of medical confidentiality and sickness-absence certification as well as the collaboration with employers and cantonal disability offices.
- Psychiatric clinics should be encouraged to develop an early screening of possible work problems and employment-related support needs of their newly-admitted inpatients.
- Cantons, health insurances and mental health care providers should develop criteria for inpatient and outpatient admission, with the aim to increase the relevance of day hospitals and outpatient care at the expense of unnecessary inpatient treatment.
- Psychiatric day hospitals should be encouraged to recruit employment specialists and to develop vocational rehabilitation measures within their treatment concepts.

Reduce under-treatment and inadequate treatment

Despite very high resources in specialised mental health care, treatment rates are not much higher in Switzerland than in other countries with much lower spending on mental health care. Psychiatrists treat a relatively low

number of selected patients over a long time; GPs treat only a small share of those patients who they are identifying as mentally-ill; and psychotherapists cannot treat enough patients due to structural funding problems.

- Cantons and health insurances should strengthen financial incentives to promote collaboration between GPs and psychiatrists in order to increase treatment up-take and treatment adequacy.
- GPs' and psychiatrists' associations should develop rules for mutual referrals between primary and speciality services.
- Health insurances, psychiatrists' associations and the FOPH should develop recommendations about typical and adequate treatment durations.
- The financing of psychotherapy should be simplified, and therapy be refunded under the mandatory health insurance scheme.

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