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MENTAL HEALTH, DISABILITY AND WORK

ISSUES FOR DISCUSSION

Organisation for Economic Co-operation and Development
Directorate for Employment, Labour and Social Affairs

www.oecd.org/els/disability

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ISSUES FOR DISCUSSION

INTRODUCTION

Policymakers across the OECD are currently trying to minimise the job losses from the recent downturn and to prepare the ground for when the demand for labour will start to grow again. For the latter, governments have to continue pushing forward with structural reform to ensure the best use of future labour potential especially among disadvantaged groups. In this regard, there is a growing need to improve labour market participation for people with mental health conditions and disability. This is crucial to achieve both higher economic growth and greater social cohesion in society given the relation between health, employment and productivity. OECD's thematic review *Sickness, Disability and Work: Breaking the Barriers* shows that the employment rate of people with disability is low; typically 40% below the average rate in the population.[1] Most strikingly, on average only one in four individuals reporting a *mental health condition* is employed (Annex 1)[2]; and of those with a severe mental illness, up to 90% are not economically active.[3]

Not only are employment rates of people with disability low, but they have even fallen in many cases. Instead, most OECD countries have experienced a substantial rise in the number of disability beneficiaries over the past two decades. The profile of disability beneficiaries is also changing drastically, with mental health conditions increasingly taking precedence over other causes. Today, 30-45% of all new disability benefit claims are attributed to mental ill-health (Annex 1)[4] which does not even reflect the true extent of mental ill-health among beneficiaries. There are additional numbers of people who receive benefits for a physical disability but also suffer from mental disability and people who develop mental health problems as a secondary condition following an initial claim for disability benefits.

Mental illness is a particularly frequent diagnosed cause for disability benefit claims among young adults, who in many countries increasingly enter the disability benefit system without any significant time spent in the workforce and stay on benefits for their lifetime. Rising unemployment and higher job insecurity due to the current economic downturn could potentially increase the risk of more and more

1. OECD (2009). *Sickness, disability and work: Keeping on track in the economic downturn*. Background Paper. High-Level Forum, Stockholm, 14-15 May 2009.

2. OECD analysis of the European Labor Force Survey (2002).

3. Harnois G. and P. Gabriel (2000), *Mental Health and Work: Impact, Issues and Good Practice*s. Geneva: World Health Organization and International Labor Organisation. Employment rates for individuals with mild depression and anxiety disorders are higher but still very low, see Lelliot P., S. Tulloch, J. Boardman, S. Harvey, M. Henderson and M. Knapp (2008), "Mental Health and Work. Commissioned by the cross government Health Work and Well-being Programme", Royal College of Psychiatrists, London.

4. OECD analysis of data supplied by national authorities.

people of all ages experiencing mental health problems, thereby reducing their employment prospects and further increasing the likelihood of people claiming disability benefits.

Employment can improve social integration and quality of life, and reduce the likelihood of impoverishment and the often associated worsening of the illness.[5,6] Several surveys by advocacy groups in OECD countries indicate that most individuals with mental illness want to work.[7,8] The barriers to work are diverse, ranging from stigma and discrimination to fear of losing benefits; from poor access to services to a changing workplace that is increasingly intolerant of variations in employee productivity. The barriers to employment for individuals with a mental health disorder can be more complex and more subtle than those faced by individuals with a physical health problem. The episodic nature of the disorders and other unique features of mental health-related disability, pose possibly greater system and policy challenges.

Clearly the systems responsible for supporting individuals with a mental health-related disability in OECD countries – in particular, the education, health care, and disability benefits systems – are failing to create adequate services and supports, and incentives, that make it possible and beneficial (both to employees and employers) for individuals with a mental illness to find work, remain at work, or return to their jobs after an episode of illness. Whereas the systems in place often work well to support employment and avoid inactivity of individuals with physical disability, they have not been designed nor adequately adapted to face the unique challenges of mental health-related disability. One of the reasons for these system failures is the lack of information to better understand the complex issues of mental ill-health and evidence upon which to base informed policy decisions.

Although mental health-related disability poses one of the greatest new social and labour market policy challenges in OECD countries, relatively little is known about the underlying causes of this phenomenon or what the appropriate responses may be. Is the prevalence of mental illness in the population actually increasing, or did many cases previously go undetected or undiagnosed? Is the changing workplace environment contributing to trends in mental health-related disability? To what extent is the increasing share of mental health-related disability an "artefact" of policy and system design? Which mental disorders are driving the increase in disability benefit recipients? Are claims increasing for serious mental illnesses or more common disorders, such as mild depression and anxiety? Why are youth in OECD countries increasingly moving into the disability benefit system without ever entering the workforce or remaining for a sustained period? What steps can be taken by all of the actors to better integrate individuals with a mental health-related disability into the labour market?

With the current state of knowledge, only very general policy conclusions can be drawn. Several countries have made or are making progress to raise awareness of mental health and mental ill-health among caseworkers, decision takers, general practitioners, employers, occupational health experts and wider society. This will help to ensure that mental health problems feature more prominently in disability policy considerations. More specific policy conclusions, however, can only be developed with deeper knowledge and understanding of the issues surrounding mental ill-health, disability and the labour market.

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5. Waddell G, and K. Burton (2006), *Is Work Good for Your Health and Wellbeing*?, The Stationery Office, London.

6. Harnois G. and P. Gabriel (2000).

7. Mental Health Foundation (2002), *Out of Work: A Survey of the Experiences of People with Mental Health Problems within the Workplace*, Mental Health Foundation, London.

8. National Alliance for the Mentally Ill (NAMI) (2000), *Facts About Mental Illness*.

The purpose of this document is to identify key issues and questions to be discussed at the launch meeting for the new OECD project *Mental Health, Disability and Work*.[9] This project follows up on the finding of the thematic review *Sickness, Disability and Work: Breaking the Barriers* that probably the biggest new challenge to disability benefit systems in OECD countries is the rising incidence of disabilities related to mental health problems. The new project aims to generate information and evidence to guide better and more integrated social, labour, and possibly health, policies to increase labour market participation of individuals with mental health-related disabilities in OECD countries.

The launch meeting at OECD headquarters in Paris, April 26-28, 2010 is intended to bring together policymakers, researchers, and other experts who can contribute state-of-the-art evidence and experience to frame the issues surrounding increasing labour market inclusion for individuals with a mental health-related disability. The agenda of the meeting is designed to first provide an overview and common understanding of the conceptual issues underlying mental illness, and the implications and trends related to the disability benefit system and the labour market in OECD countries. The overview is followed by four thematic sessions that examine key systems and actors in depth – the workplace, the education system, the health care system, and the disability benefits system. The final session aims to identify cross-cutting issues and how to move forward in an integrated way. The remainder of this document summarizes key issues and possible questions for discussion in the five thematic sessions of the meeting, and the concluding session.

9. The full name of the new OECD project is "Disability and Work: The Challenges for Labour Market Inclusion of People with Mental Health Problems".

THEME 1: MENTAL HEALTH, MENTAL ILLNESS AND TRENDS IN MENTAL HEALTH-RELATED DISABILITY

There is a range of terms and definitions used to discuss mental health issues with different and partly overlapping meanings. *Mental health* has been defined by the World Health Organization as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[10] *Mental disorders* are mental health problems severe enough to reach the threshold of a diagnosis within the internationally-agreed psychiatric classification systems. *Mental ill-health* (or mental illness) is a broader concept and comprises both mental disorders and mild or moderate mental health problems, such as depression or anxiety that do not reach the threshold of a diagnosis (see Annex 2 for more detail). Mental disorders, which are by definition more disabling, tend to affect only a small proportion of the adult population, 5% or less, while depression and anxiety are generally somewhat less disabling but are found in 10-20% of the adult population at any one time.

A mental disorder is defined on the basis of the symptoms, the severity and duration. There is enormous heterogeneity and diversity across types of mental disorders, further complicated by high rates of co-occurring disorders, including chronic physical illnesses and substance abuse disorders. A disorder becomes a *mental disability* when the mental disorder interferes with the performance of one or more major life activities, such as the ability to live independently, work, attend school, or manage basic activities of daily living.[11] Diagnosis alone is insufficient to understand the consequences of a mental illness and the way it will develop. The severity and duration of a mental health problem are often more important determinants of current and future disability, and the extent of disability can vary significantly across individuals who have the same diagnosis. With increasing level of disability, it can be expected that the prevalence in the population will decrease, while the likelihood of work incapacity and a disability benefit award will increase.

Objectives of the Sessions under Theme 1
• Provide a general understanding of the nature of mental ill-health and how it is both different from, and related to, physical disability; • Define key terms that characterize different types of mental health problems, and discuss international trends in prevalence; • Identify trends in OECD countries related to mental ill-health and the disability benefit system using the experience of Norway; • Present examples of the connection between mental health problems and the labour market with a focus on the case of Sweden.

10. World Health Organization (2007), *Mental Health: Strengthening Mental Health Promotion*. Fact Sheet No. 220, *www.who.int/mediacentre/factsheets/fs220/en/*.

11. Jans L., S. Stoddard and L. Kraus (2004), *Chartbook on Mental Health and Disability in the United States: An InfoUse Report*. US Department of Education, National Institute on Disability and Rehabilitation Research, Washington, DC.

Session 1.1 will focus on building a common understanding of the characteristics of different types of mental disorders and examining epidemiological trends. For policy purposes, it may be useful to identify markers along the increasing level of mental disability where individuals face different challenges, benefit from different treatment approaches, and require different policy responses. This session will aim to establish a consensus on policy-relevant working definitions of mental ill-health and mental disability.

Session 1.2 presents evidence from Norway, based on a series of studies which link clinical and social security data sets, on issues such as under-recognition of mental health conditions which through under-treatment and under-utilization of adequate employment supports may be leading to more disability benefit claims. It then explores evidence from Sweden on how the availability of health services and employment supports for people with common mental health disorders can influence the prevalence of mental illness in the workplace and their participation in the labour market.

Questions for Discussion
• How can the definitions and characterization of mental illness be used to distinguish target groups for policy interventions to increase labor market participation? • What factors are contributing to the observed increase in mental disability as a share of all disability benefit claims? • To what extent are changes in labour market conditions and the current jobs crisis contributing to poor employment opportunities of people with mental ill-health?

THEME 2: MENTAL HEALTH IN THE WORKPLACE

Because mental health problems have become increasingly recognized as one of the leading causes for absenteeism from work and early retirement throughout OECD countries, maintaining good mental health at the workplace has become critical not only for government policy, but also for the productivity and competitiveness of private businesses. The workplace plays a dual role in the mental health of employees – it can be a source of stress due to the culture, organization and demands of the workplace; or it can be a source of support and contribute to overall mental well-being and the recovery process from mental illness.

Work conditions and the labour market have changed considerably over the past decades. The key elements in these changes are increased automation and the rapid implementation of ICT. Workers are faced with an array of new organisational processes and new challenges – including less stable and more temporary employment and increased workloads. These changes in the work environment, as well as the greater job insecurity created by the global economic crisis, may be contributing to increased workplace stress – even though evidence on this matter is inconclusive. Job stress has been linked to a wide range of adverse effects on mental and physical health. Furthermore, the new workplace environment demands greater social competencies and communication skills, and deficiency related to these competences is a common element of mental health problems. This is likely to put individuals experiencing or at risk of a mental health problem at a disadvantage in the modern workplace.

For employers, there are potentially substantial costs associated with mental health problems arising from absenteeism, reduced productivity while at work, providing cover for absent staff, the impact on the productivity and morale of peers, and the training and recruitment of new staff.[12] In spite of these significant consequences, however, employers often have a poor understanding of mental health problems and what they can do to promote good mental health in the workplace, including early intervention and support when mental health problems do arise.[13] Employees with mental health problems, in turn, face particular challenges in the workplace, including the potential consequences of disclosing or not disclosing their condition, stigma and discrimination.[14]

The role of the workplace is possibly most critical for individuals with more moderate to mild mental health problems. A negative workplace environment could tip them into being unable to work; or the workplace could contribute to keeping them healthy and supported enough to continue working.

12. Kessler R. C., H. S. Akiskal and M. Ames *et al*. (2006), "Prevalence and Effects of Mood Disorders on Work Performance in a Nationally Representative Sample of U.S. Workers", *Am J Psychiatry* 163(9) pp. 1561-1568.

13. Shaw Trust (2006), *Mental Health: The Last Workplace Taboo,* Shaw Trust, London.

14. Wheat K. (2010), "Mental Illness and the Workplace: Conceal or Reveal?", *Journal of the Royal Society of Medicine*. 103(3), pp. 83-86.

Objectives of the Sessions under Theme 2
• Identify changes in the workplace environment that may play a role in mental health-related absenteeism and disability; • Debate the role that the information technology evolution and increased communication requirements may be playing in the changing workplace environment; • Discuss the role and responsibilities of employers related to mental health in the workplace; • Present the perspectives of employer and employee organisations on the key challenges in the workplace related to mental health problems.

In Session 2.1, results of research on psychosocial risk factors for job-strain exposure will be presented. There is consistent evidence that certain aspects of workplace stress, such as high psychological demands, low control over work tasks, effort-reward imbalance, and high job insecurity, are predictors for common mental disorders.[15] The consequences of job-strain exposure on mental health will be examined using the example of France. Also in this session, Norway's long-standing experience in defining responsibilities of the employer for mental health in the workplace will be discussed.

In Session 2.2, the experiences of employers and employees with mental health in the workplace will be discussed to complement the research findings with a more personal perspective. These experiences will be contributed by BIAC (the Business and Industry Advisory Committee to the OECD) and TUAC (the Trade Union Advisory Committee to the OECD). The social partners play a key role in shaping the work environment and in addressing workplace problems not addressed sufficiently otherwise.

Questions for Discussion
• What impact have the changes in the workplace environment had on the mental health of employees? • Will the current economic downturn increase the prevalence of mental ill-health among employees and the unemployed? • How can job-related stress be measured and monitored? • What workplace risk factors translate job-related stress into mental ill-health for some but not for other workers, and how can these risk factors be identified in advance?

15. Stansfeld S. and B. Candy (2006), "Psychosocial Work Environment and Mental Health--A Meta-Analytic Review", *Scandanavian Journal of Work and Occupational Health*. 32(6), pp. 443-62.

THEME 3: PREVENTION AND EARLY INTERVENTION AMONG YOUTH

A large number of OECD countries are facing a sharp rise in numbers of young people under age 25 and sometimes younger (e.g. as young as 18-19 years in some countries) accessing disability benefits. These people have typically never worked or only for a very short period, and they often will remain on benefits and excluded from the labour market for their entire lives. Most of these young people suffer from mental health problems. This raises important questions about prevention and early intervention for mental health problems during the early phases of life.

Up to 50 percent of mental disorders have their onset during adolescence,[16] so childhood is an important time to promote healthy development and prevent mental disorders. Both biological factors and adverse psychosocial experiences during childhood influence child and youth mental health. Factors such as exposure to violence and mental health and substance-abuse problems of caregivers place children at risk of developing emotional and behavioural problems in childhood and mental disorders in early adulthood. In turn, children at risk are much more likely than others to drop out of the education system. Students with a mental health disorder have the lowest rates of secondary school completion, which translates into poor chances of finding stable employment after leaving school.[17]

Because schools are the most universal natural setting for delivering services to children and can be a normalizing experience for at-risk children, the education system is a major focus of the effort to improve children's mental health services. At-risk children can be identified in the early grades of school, and effective interventions exist.[18] Supporting youth with mental health disorders to complete school and their transition to career-advancing employment is a critical step in averting the path of lifelong underemployment or exclusion from the labour market.

Objectives of the Sessions under Theme 3
• Describe the nature, risk factors and causes of mental health problems among children, and present some epidemiological trends; • Discuss the role of education in promoting mental health and how the education system can support prevention, assessment, and intervention to address children's emotional and behavioural problems; • Discuss the issues of school-to-work transition for youth with mental health problems; • Provide an overview of the services and supports that are available or would be needed to assist youth in the transition from education to work and the linkages required across sectors.

16. Kessler R. C., P. Berglund, O. Demler *et al*. (2005), „Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication", *Archives of General Psychiatry* No. 62, pp. 593–768.

17. Cook J. (2006), "Employment Barriers for Persons with Psychiatric Disabilities: Update of a Report for the President's Commission", *Psychiatric Services* 57, pp. 1391-1405.

18. Weist M,, J. Lowie, L. Flaherty and D. Pruitt (2001), "Collaboration Among the Education, Mental Health, and Public Health System to Promote Youth Mental Health", *Psychiatric Services* 52, pp. 1348-1351.

Session 3.1 will discuss the risk factors among children and youth that are associated with a greater likelihood of childhood emotional and behavioral disorders and future mental health problems, as well as the causes and prevalence of mental health disorders among children and youth. The session also will provide an example of a national initiative in the U.K. to deliver multi-tiered therapeutic and holistic interventions for children with mental health problems through the school system, the *Targeted Mental Health in Schools* programme targeted at children aged 5 to 13 and their families.

Session 3.2 will discuss the main risks facing youth with mental health problems as they transit to adulthood and from school to work. This period is a time of particular risk for the development or exacerbation of mental health problems in young adults. Two key problems in the transition phase are, first, a high risk of failure to complete secondary school and, secondly, service use drop off.[19] This is followed by a review of experience in European countries that identifies obstacles, facilitating factors and successful approaches for the transition from education to employment.

Questions for Discussion
• How can the trajectory of different disorders with onset in childhood be influenced? • How could the school system prevent drop-outs of children at risk and those with mental health problems? • What are the most effective services and supports to assist youth with mental health problems in their transition to work? • What role should labour market institutions have in the transition phase?

19. Gralinski-Bakker J. H., S. Hauser, R. Billings, and J. Allen (2005), "Transitioning to Adulthood for Young Adults with Mental Health Issues", *Network on Transitions to Adulthood Policy Brief*, Issue 21. MacArthur Foundation, Network on Transitions to Adulthood, University of Pennsylvania, Department of Sociology.

THEME 4: HEALTH SYSTEM RESPONSES TO MENTAL ILLNESS

The health system can potentially play an important role in supporting individuals with a mental disorder to obtain or retain employment in multiple ways. Through a combination of specialty mental health services and primary care, the health system provides the mental health services and supports that may be necessary for individuals with a mental disorder to manage their symptoms and engage successfully in the workforce. The health system also has a fundamental role in providing assessments that determine whether individuals are eligible to enter the disability benefits system. Finally, health care providers may serve as a referral point to link individuals with mental disorders to vocational rehabilitation services and other supports to return to work.

The health care systems in many OECD countries have not, however, made sufficient progress to meet the needs of individuals with mental health problems, and in particular to provide adequate support for achieving their employment goals. Although effective treatments are available for most mental health conditions that make it possible for an individual to enter the labour market, problems with access and utilization are pervasive. Under-treatment for mental disorders is even widespread among those individuals receiving disability benefits for a mental health problem.[20] When individuals do access mental health services, employment typically is not one of the explicit objectives of health care providers in treating mental health problems.

The dual role of the health system in treating illnesses and gate-keeping benefit eligibility is inherently contradictory. Health practitioners are expected to act as gatekeepers for the return-to-work process, while they generally rather see their role as advocates for the patient.[21] Taking a short-term view of the needs of the patient, practitioners may be more likely to extend sick leave and time in the disability benefit system. Over the longer term, however, much evidence points to the benefits to mental health of returning to work. The health care system will need to take less of a disease focus and recognize the positive impact on outcomes for people with a mental disability returning to work.

Objectives of the Sessions under Theme 4
• Provide a general understanding of how different mental health systems are organized, and how the organization and incentives are related to employment objectives; • Discuss how the objectives and incentives of the mental health care system can be better aligned with the disability benefit system; • Present evidence on the cost-effectiveness of different approaches to treating both serious mental illnesses and common mental disorders; • Discuss key barriers to accessing effective mental health services, considering both demand-side and supply-side issues.

20. Overland S., N. Glozier, S. Krokstad and A. Mykletun (2007), "Undertreatment before the Award of a Disability Pension for Mental Illness: the HUNT Study", *Psychiatric Services*, No. 58, pp. 1479-1482.

21. Pransky G., J. Katz, K. Benjamin and J. Himmelstein (2002), „**I**mproving the Physician Role in Evaluating Work Ability and Managing Disability: A Survey of Primary Care Practitioners", *Disability & Rehabilitation* 24(16), pp. 867- 74.

Session 4.1 will discuss what the health system can do to attenuate mental disability, and how to intervene early and target conditions that are most likely to lead to disability later. The session also will discuss the incentives and values that are inherent in different mental health systems that affect whether, how, and which mental health services are utilized. This can have important impacts on the likelihood of the individual retaining a job or returning to work after an episode of mental illness. The potential lack of coordination and mismatch in objectives between the health care system and disability benefits system also will be examined in more detail.

Session 4.2 will provide an overview of mental health services and supports that are known to be effective in treating mental health conditions, and barriers to accessing effective treatment. This will be discussed drawing on evidence from Australia on national reforms, with a focus on demand-side versus supply-side barriers to accessing mental health services. This is followed by a presentation on the experience of the German pension insurance system, which requires any individual on sick leave for more than four weeks to undergo intensive inpatient treatment. Evidence will be presented on the impact and cost-effectiveness of this approach on the prognosis of individuals with a mental disability, including returning to work.

Questions for Discussion
• What changes in the health care system are needed to incorporate and support employment goals? • How can health care providers support individuals with mental disability in their return to work? • What are the key challenges in overcoming under-treatment among people with common mental health conditions? • How can medical rehabilitation be a bridge between health treatment and employment?

THEME 5: THE ROLE OF THE DISABILITY BENEFITS SYSTEM

Disability benefits are the last resort for people with chronic health problems or disability who are unable to work. Disability benefit systems have a number of features and components aimed to avoid the granting of benefits and to support people applying for benefits in retaining employment or improving employability so to increase their chances of finding employment. By and large, these system features and components – many of which were introduced more than fifty years ago – were not designed for mental ill-health and do not appear to be working well for the nature and characteristics of these problems. Two elements of disability benefit systems stand out, because they need particular attention and adaptation to the special challenges of mental health problems: work-capacity assessment and vocational rehabilitation.

One of the biggest challenges for disability benefit systems is to determine eligibility, *i.e.* to distinguish those who are unable to work and therefore deserving a benefit payment from those who are able to work. Systems in most OECD countries use work-capacity assessments of different sorts to distinguish those groups and establish benefit eligibility. The enormous diversity and heterogeneity of disability is a big challenge in this regard, requiring flexibility in approach which is only partially accounted for in existing systems. Work-capacity assessments and benefit payment rules in most OECD countries are not adequate for the often episodic nature of mental disorders, or for the co-morbidity of mental and physical illness. For instance, employment potential is often estimated on an evaluation of a person's medical impairment; this approach is not appropriate for the nature of most types of mental disability. Numerous studies suggest a weak relationship between measures of mental health diagnosis or symptoms and employment outcomes.[22]

Vocational rehabilitation is a process to support individuals with reduced work capacity due to illness or disability to access, maintain or return to employment. Interventions focus on diminishing the limitations and restrictions identified during the assessment, such as increasing fitness, work conditioning, ameliorating anxiety or depression, building confidence, and training in the management of stress.[23] Interventions as part of vocational rehabilitation may involve counselling, job coaching, workplace modification, workplace supervision or support, and case management.[24] Access to vocational rehabilitation and support services is particularly low among individuals with a mental health-related disability. Given their desire to work, together with low labour force participation, it is a serious concern that many people with mental illness receive few or no employment services.[25]

22. MacDonald-Wilson K., E. S. Rogers, and W. A. Anthony (2001), "Unique Issues in Assessing Work Function Among Individuals with Psychiatric Disabilities", *Journal of Occupational Rehabilitation* 11(3), pp. 217-232.

23. Chamberlain M. A., V. F. Moser, K. S. Ekholm, R. J. O'Connor, M. Herceg and J. Ekholm (2009), "Vocational Rehabilitation: an Educational Review", *Journal of Rehabilitation Medicine* 41, pp. 856-869.

24. Chamberlain *et al*. (2009).

25. Cook 2005.

Objectives of the Sessions under Theme 5
• Identify unique challenges of mental disability that require modification of policies and approaches in the disability benefit system; • Discuss the limitations of work-capacity assessment tools in the application to assessment of mental disability; • Identify possible reasons behind the low utilization of vocational rehabilitation services among individuals with mental disability. • Analyze successful examples of vocational rehabilitation services targeted to or adapted for the unique challenges of mental disability and examine the evidence of their impact.

Session 5.1 will discuss the challenges of adapting work-capacity assessment tools to the particular needs of mental disability, using the examples of the UK and Sweden. The UK has updated its assessment tool multiple times over the past 15 years, partly (but not only) in an attempt to better meet the unique needs of mental disability assessment. Sweden has chosen to address the accuracy and limits of work-capacity assessment in general as well as the borderline between capacity and incapacity before changing its assessment tool, and is now facing strong challenges in its attempts to implement a new and better system.

In Session 5.2, specific examples of successful vocational rehabilitation approaches for mental disability will be discussed based on research from a vocational rehabilitation clinic in Canada[26,27,28] and experience in Denmark. Findings from Canada suggest that the approach and services aimed at helping people with muscular-skeletal disabilities can, with some adaptation, be transferred successfully to those with mental health problems. Danish research, focusing on interventions for the long-term sick, finds that integrated education and workplace measures have the biggest potential in increasing the likelihood and speed with which people return to employment.

Questions for Discussion
• What are the main challenges for disability benefit systems in relation to episodic conditions? • How can the disability assessment tools better capture work capacity and labour market potential of individuals with mental ill-health? • What are the key challenges in expanding vocational rehabilitation services and increasing their take-up among individuals with mental health problems? • Is it useful to introduce vocational rehabilitation at an early stage also for people with mental illness?

26. Durand, M. J., N. Vézina, R. Baril, P. Loisel, M. C. Richard and S. Ngomo (2009), "Margin of Manœuvre Indicators in the Workplace during the Rehabilitation Process: A Qualitative Analysis", *Journal of Occupational Rehabilitation*, 19(2), pp. 194-202.

27. Briand, C., M. J. Durand, L. St-Arnaud and M. Corbière (2008), "How Well do Return-to-Work Interventions for Musculoskeletal Conditions Address the Multicausality of Work Disability?", *Journal of Occupational Rehabiltation*, 18(2), pp. 207-217.

28. Briand, C., M. J. Durand, L. St-Arnaud and M. Corbière (2007), "Work and Mental Health: Learning from Return-to-Work Rehabilitation Programs Designed for Workers with Musculoskeletal Disorders", *International Journal of Law and Psychiatry*, 30, pp. 444-457.

SUMMING-UP AND REMAINING CHALLENGES

The purpose of this final session is to summarise the findings from the thematic sessions and to provide a set of conclusions. The session also addresses some of the remaining challenges for policymakers, in particular how to integrate approaches and services that often operate in isolation, and align objectives and incentives of the different systems that serve individuals with mental disability.

There is broad agreement that under-employment or exclusion of individuals from the labour market due to mental ill-health results in significant economic costs for individuals, employers and the state. All stakeholders would benefit from the provision of integrated and effective supports and minimising system failures that hinder the provision of appropriate services.

For example, integrating mental health services within the education system has positive impacts on educational attainment and other outcomes for children with mental health problems.[29] To give another example, the integration of clinical and vocational services is associated with improved employment outcomes.[30] In addition, challenges remain in ensuring access to effective services and supports especially for people with mild and moderate mental health problems which make up the large majority of the target group, and to provide services in a cost-effective way.

Objectives of this Session
• Summarize the barriers and potential solutions to increasing inclusion in the labour force of individuals with mental health-related disability and how they may differ from issues facing individuals with a physical disability; • Summarize the conclusions that can be drawn from the previous sessions, the challenges that remain, and how to move forward in an integrated way to improve labour market participation for individuals with a mental health-related disability.

Three different summaries and conclusions will be shared. First, the barriers facing employees, employers and other actors such as mental health and rehabilitation professionals will be addressed. These include stigmatising beliefs, lack of knowledge on how to create a supportive work environment and fragmentation of support systems. Examples will be given from a study in Switzerland based on in-depth analysis of disability benefit recipients.[31]

Second, evidence will be presented on successful integrated interventions to assist individuals with *severe* mental illness through "Individual Placement and Support" (also known as supported employment),

29. UK Department for Children, Schools and Families (2008).

30. Cook, J. C., A. F. Lehman, R. Drake *et al*. (2005), "Integration of Psychiatric and Vocational Services: A Multisite Randomized, Controlled Trial of Supported Employment", *American Journal of Psychiatry* 162, pp. 1948–1956.

31. Baer, N, U. Frick and T. Fasel (2009), Dossieranalyse der Invalidisierungen aus psychischen Gründen. Beiträge zur Sozialen Sicherheit. Bundesamt für Sozialversicherungen, Bern.

the aim of which is to place people into the open labour market with intensive help from a job coach for an unlimited period. This approach combines a number of elements equally critical for improving labour market outcomes of people with common mental health problems.

The session will close with the perspective of a mental health non-governmental organization committed to the promotion of mental health and the prevention of mental disorders, drawing on a range of issues already addressed throughout the meeting and ending with some examples of good practice.

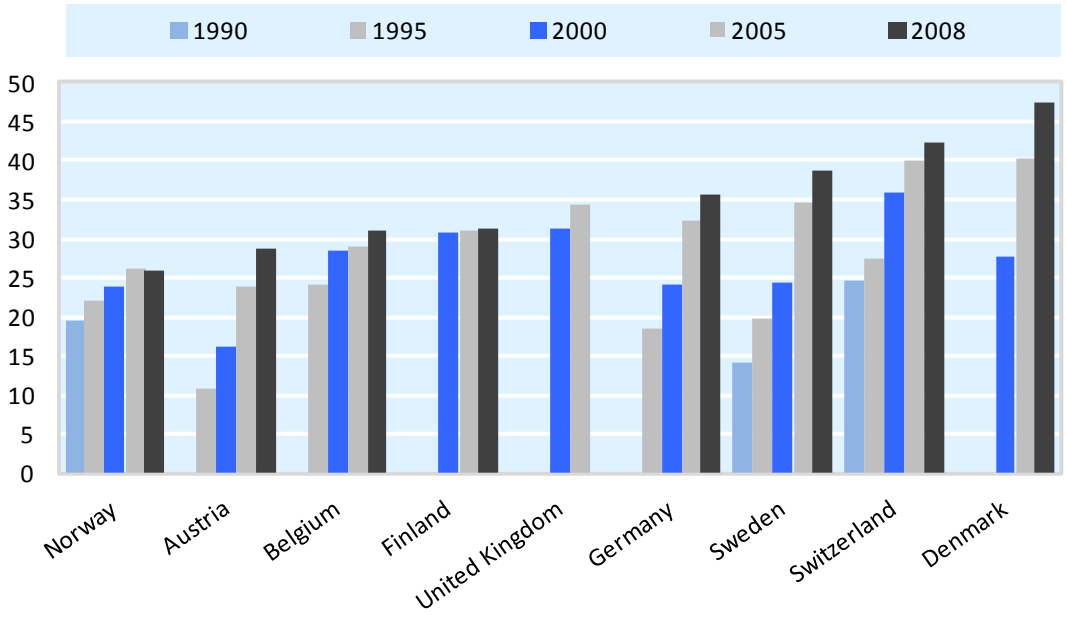
Questions for Discussion
• How to progress with reducing stigma and discrimination against individuals with a mental health problem in the workplace and society at large? • How can people with mental health problems become a target group for employment services? • How can intensive and costly approaches such as supported employment be adapted for more common mental health conditions? • What are the first steps in addressing system fragmentation? • What are the key challenges in reforming and delivering policy changes for this target group?

ANNEX 1: SUPPORTING FACTS ON BENEFIT RECIPIENCY AND EMPLOYMENT

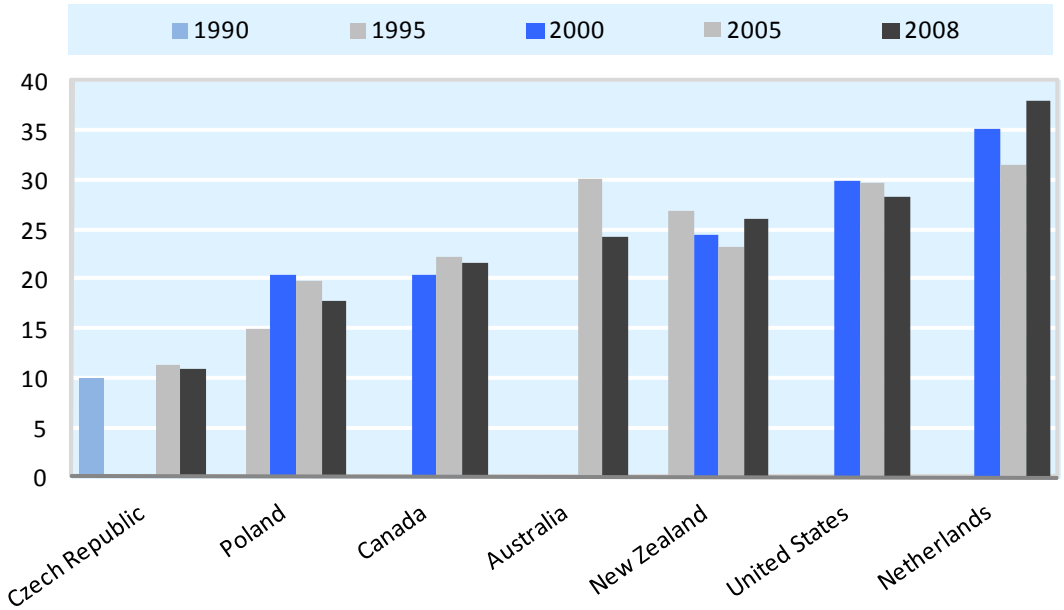
Figure A1.1. **Around one-third of the annual number of new disability benefit grants is attributable to mental health conditions and there is a trend increase in most OECD countries**

Percentage of new disability grants due to mental ill-health, 1990-2008

Panel A. Increasing trends in mental health inflows



Panel B. Varying trends in mental health inflows



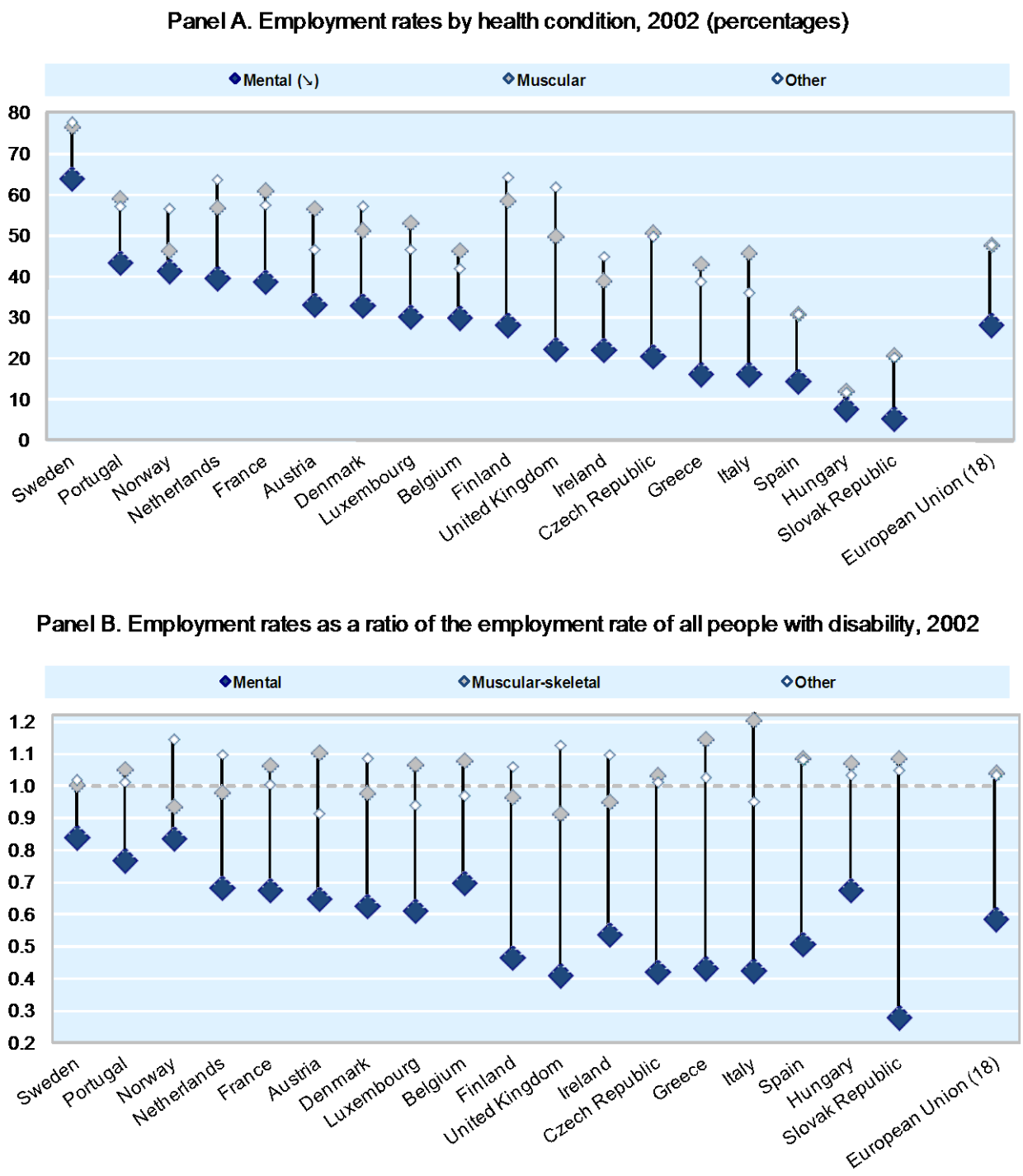
Source: Administrative data supplied by national authorities.

Figure A1.2. **The health conditions causing new disability benefit grants vary by age and grants due to mental ill-health are particularly frequent among young adults aged 20-34 years**

Percentage of new disability grants by health condition, around 1995 and 2008

Source: Administrative data supplied by national authorities.

Figure A1.3. **Employment rates of people with mental health conditions are particularly low**



Source: European Labour Force Survey (2002), Ad-hoc module on employment of people with disability.

ANNEX 2: DEFINITION AND PREVALENCE OF MENTAL HEALTH CONDITIONS[32]

Mental health and mental disorders: definitions and assessment

There are several dimensions to mental health, which can be described in different ways. Positive mental health relates to wellbeing and the ability to cope with adversity. Mental ill-health falls into two categories: (1) **psychological distress**, or symptoms such as depression or anxiety that do not reach the threshold of a diagnosis within the psychiatric classification systems; and (2) **mental disorders**, which do reach the threshold of a diagnosis according to the classification systems. Mental ill-health is not restricted to mental disorders. Many chronic physical conditions (e.g. asthma, diabetes, musculoskeletal diseases and coronary diseases) have strong behavioural components affecting the course and outcomes that are responsive to behavioural treatments.

Psychiatric diagnosis classification systems

Mental disorders are classified by two main classification systems-- the International Statistical Classification of Diseases and Related Health Problems (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These classification systems require certain explicit criteria to be met in order to warrant a diagnosis. Criteria may include minimum number of symptoms from a given list within a defined time frame, and marked distress or impairment in several life domains. Since the aetiology for most mental disorders is unknown, current classification systems are not, for the most part, theoretical. ICD-10 and DSM-IV both use a descriptive approach—the definitions of disorders are limited to descriptions of their clinical features, or easily identifiable behaviour signs or symptoms.

Diagnosing and evaluating mental health and mental disorders pose unique challenges, because:

- Clinicians have to rely largely on *subjective* information from the affected person; objective measures, such as laboratory tests, are usually not available.
- Due to poor reliability of earlier psychiatric diagnoses, some of the diagnostic criteria in the classification systems have been changed over the years, and such changes take time to be implemented in clinical practice.
- Routinely collected statistics, such as the cause of death or the reasons for hospital discharge, do not fully reflect the majority of mental health problems, so there is under-recognition of the actual number of individuals identified with, and treated for, mental disorders.
- Not every diagnosis of a mental disorder entails treatment, or treatment may be refused. Therefore, prevalence of mental disorders may be underestimated.
- Diagnosis of mental disorders is based on the individual reaching a threshold of diagnostic criteria, but individuals only slightly below the threshold are still at risk for higher morbidity. Classifying individuals in discrete groups obscures the reality that psychopathological symptoms are dimensional and range from none to severe.

32. Adapted from Jacobi, F. (2007), "Mental Health Problems in the Working-Age Population across the OECD area". Unpublished OECD Background Document, OECD Publications, Paris.

The most relevant mental disorders

- *Mood disorders*. The primary symptom of mood disorders is a disturbance in mood that goes beyond normal mood swings in terms of intensity, duration and quality. The main categories of mood disorders are major depressive disorder, dysthymia and bipolar disorders. Major depressive disorder is characterized by sadness and/or loss of interest in the person's normal interests, as well as at least four other specified symptoms for two weeks or more. Dysthymia is characterized by a longer time period but fewer symptoms. Bipolar disorder involves episodes of mania (continuously heightened, exaggerated, or irritable mood that is out of the ordinary for at least one week) and episodes of depression.

- *Anxiety disorders*. The primary focus of anxiety disorders is abnormal or inappropriate anxiety, characterized by excessive psycho-physiological reactions (e.g. panic attacks) and/or excessive avoidance and safety behaviour (phobias). The main categories of anxiety disorders are panic disorder, agoraphobia, social phobia, specific phobias, and generalized anxiety disorder. DSM-IV also includes obsessive-compulsive disorder and post-traumatic stress disorder.

- *Substance-abuse disorders*. Psychotropic substances are natural, chemically processed, or synthetic substances that have an effect on the central nervous system and influence perception, thinking, mood and behaviour. Substance abuse refers to a pattern of substance use leading to significantly impaired functioning, such as failure to fulfil major obligations at work, school or home. Substance dependence is defined as a maladaptive pattern of substance use leading to significant impairment or distress, with three or more additional symptoms within a 12-month period, such as tolerance (experiencing less effect with the same dosage), withdrawal (unpleasant physical symptoms after a period of abstinence), or loss of self-control (frequent use of the substance in larger amounts or over a longer period than intended).

- *Somatoform disorders*. Somatoform disorders are characterized by physical symptoms for which no adequate medical explanation has been found. The complaints are serious enough to cause significant emotional distress and impairment of functioning. Diagnosis of a somatoform disorder implies that psychological factors are a large contributor to the symptom's onset, severity and duration.

- *Psychotic disorders*. Psychotic disorders affect a variety of aspects of behaviour, thinking and emotion, and can cause the most severe functional impairment. Characteristic symptoms include delusions (fixed false beliefs) and hallucinations (sensory perceptual distortions, such as seeing, hearing, smelling, feeling or tasting sensations that do not exist outside the individual's perception). Schizophrenia is the most prominent psychotic diagnosis and is characterized by disturbances in thought, perception, affect, behaviour, and communication that last longer than six months, and two or more additional symptoms –delusions, hallucinations, incoherent speech, disorganization of thoughts, severely disorganized or catatonic behaviour, loss of emotionality, reduced speech, or lack of volition.

Prevalence of Mental Disorders in OECD Countries

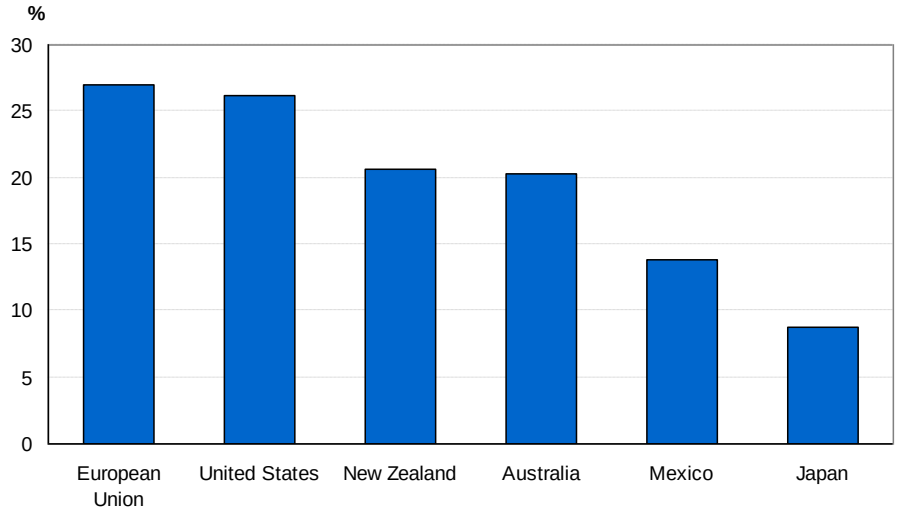
Due to wide variability in the definition and aggregation of mental disorders in population surveys, the prevalence of mental disorders is extremely difficult to estimate, and even more difficult to compare across countries. For example, in Germany the 12-month prevalence rate varies from 25-40% depending on whether pain disorder and nicotine dependence are included.

This section provides an overview of the estimated 12-month prevalence of mental disorders in OECD countries. Given the limitations in interpreting and comparing the reported data, the objective is to provide a starting point for understanding the orders of magnitude of the prevalence of mental disorders and discussing a standardized approach to compiling such data for social and labour policy purposes.

Prevalence is defined as the percentage of the population that meets the full criteria for one of more mental disorder within the past year. The prevalence of mental disorders in OECD countries is estimated from a review of population-based, nationally representative epidemiological studies that were conducted after 1990, involved an established clinical interview, included a range of specific mental disorders, and included a sample of the working-age population (age 18-65). Twenty-seven studies were identified that met the inclusion criteria. Figure A2.1 shows estimates of 12-month prevalence of any mental disorder for several OECD countries and the European Union.

Figure A2.1. **12-month prevalence estimates for mental disorders in OECD countries**

Any mental disorder (DSM-IV scale), percentages



The figures are only partially comparable due to differences in included (sub-) diagnoses and applied diagnostic algorithms.

Source: Australian National Survey on Mental Health and Well-Being 1997; Canadian Community Health Survey 2002; WHO-WMH Japan Survey 2002-2003; National Survey on Psychiatric Epidemiology Mexico 2001-2002; New Zealand Mental Health Survey 2003-2004; American National Co-morbidity Survey Replication 2001-2003: and for the European Union: Aggregation of 27 studies conducted in the EU from 1990 to 2001, published in Wittchen, H.-U. and F. Jacobi (2005), "Size and Burden of Mental Disorders in Europe – A Critical Review and Appraisal of 27 Studies", *European Neuropsychopharmacology*, 15(4).

Table A2.1 shows estimates of 12-month prevalence of selected mental disorders for most of the 30 OECD member countries. Anxiety and mood disorders were the most common disorders in all studies, but the prevalence estimates for all disorders vary significantly across countries. Cultural and methodological factors, as well as different diagnostic algorithms, are likely to contribute to these differences. The low prevalence rates in Japan compared with other OECD countries are consistent with previous research showing low prevalence of mental disorders in Asian countries.[33]

33. WHO World Mental Health Consortium (2004), "Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization—World Mental Health Survey", *Journal of American Medical Association* 291(21), pp. 2581-2590.

Psychotic and somatoform disorders have not been studied s often as mood and substance abuse disorders. Prevalence estimates that are available for OECD countries show a range of 0.2-2% for psychotic disorders, and 1.1-11% for somatoform disorders. The large variations in the estimates are unlikely to be related to variations in true underlying prevalence and are indicative of the problems measuring the prevalence of mental disorders. For schizophrenia, the most prominent psychotic disorder, studies suggest a relatively stable 12-month prevalence of 0.5%, and a lifetime prevalence of 1%.[34]

Table A2.1. **12-month prevalence of selected mental disorders in the OECD area**

Percentages

	Australia	Canada	European Union*	Japan	Mexico	New Zealand	United States
Alcohol dependence	4.1	2.6	2.4	0.4	1.8	1.3	1.3
Illicit substance dependence	2.0	0.8	0.5	0.1	0.1	1.2	0.4
Major depression	6.3	7.3	6.9	2.9	1.5	5.7	6.7
Bipolar disorder	n.a.	2.4[1]	0.9	0.1	2.0	2.2	2.6
Any anxiety disorder	5.6	n.c.	n.c.	4.8	8.1	14.8	18.1[2]
Any panic disorder	1.1	1.5	1.8	0.5	1.1	1.7	2.7
Agoraphobia	0.5	n.a.	1.3	0.3	1.7	0.6	0.8
Social phobia	1.3	3.0	2.3	0.8	2.3	5.1	6.8
Generalised anxiety disorder	2.6	n.a.	1.7	1.2	0.7	2.0	3.1
Any specific phobia	n.a.	n.a.	6.4	2.7	4.0	7.3	8.7
Obsessive-compulsive disorder	0.7	n.a.	0.7	n.a.	n.a.	0.6	1.0

* Aggregated figures (median; see Wittchen and Jacobi, 2005). n.a. Not assessed. n.c. Not calculable.

1. Lifetime prevalence. 2. Includes separation anxiety disorder.

Source: See Figure A2.1.

Mental Disorders, Disability and Treatment

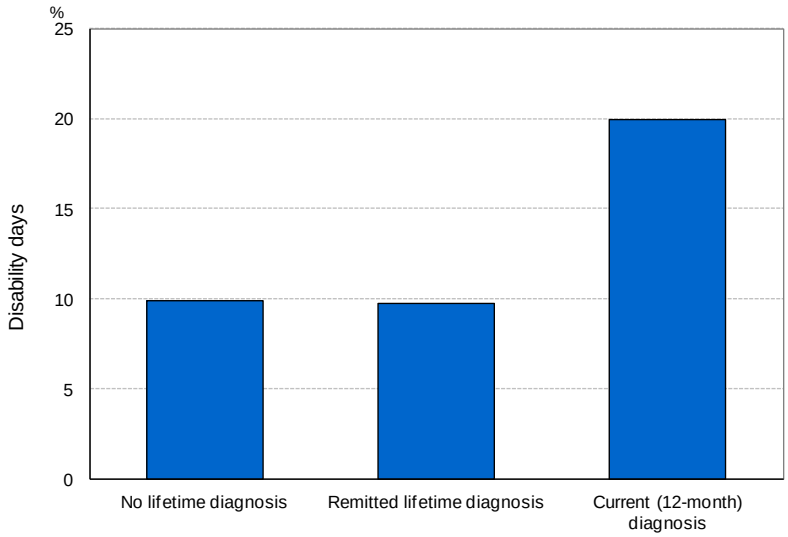
Mental disorders are by definition conditions producing significant impairments in social role functioning. The associated impairments can be reflected in professional/occupational functioning, such as reduced productivity, sick leave and disability days. Figure A2.2 shows estimates from a community study in Germany of disability days, defined as too sick to carry out usual activities.[35] Disability days are compared for individuals with no lifetime diagnosis of a mental disorder, remitted lifetime diagnosis (having a lifetime diagnosis without meeting diagnostic criteria in the last year), and a current diagnosis (within the past 12 months). Individuals with a current diagnosis reported twice as many disability days as those with no diagnosis or with a previous diagnosis but not currently meeting diagnostic criteria. These results suggest that achieving remission with successful treatment may reduce disability days and may also contribute to continued successful participation in the labour force.

34. Rossler, W, H. J. Salize, J. van Os and A. Riecher-Rossler (2005), "Size and Burden of Schizophrenia and Psychotic Disorders", *European Neuropsychopharmacology* 15(4), pp. 399-409.

35. Jacobi, F, K. Klose and H. U. Wittchen (2004), Psychische Storungen in der deutschen Allgemeinbevolkerung: Inanspruchnahme von Gesundheitsleistungen und Ausfaltage. *Bundesgesundheitsblatt* 47:736-744. [Mental disorders in the community: health care utilization and disability days].

Figure A2.2. **Mental disorders and disability days within past 12 months**

Percentages



Source: Jacobi, F., K. Klose and H.-U. Wittchen (2004), "Psychische Störungen in der deutschen Allgemeinbevölkerung: Inanspruchnahme von Gesundheitsleistungen und Ausfalltage", *Bundesgesundheitsblatt, 47*, pp. 736-744. [Mental disorders in the German population: healthcare utilization and disability days].

Although mental disorders can cause significant disability, most mental disorders still go untreated or are treated after considerable delay. Numerous studies show an average of only about 40% of individuals with a mental disorder receiving any mental health care. In the European Study of Epidemiology of Mental Disorders (ESEMeD), reported 12-month treatment contact ranges from 8% for alcohol abuse or dependence to 37% for mood disorders (Table A2.2). Of those individuals who receive any treatment, most (19.5 to 37.9%) receive only drug treatment.

Table A2.2. **Type of treatment received by the users of formal healthcare services**

According to 12 month disorder; ESEMeD data

	Any consultation,[1] %	Proportions among respondents with any consultation			
		Only drug treatment, %	Only psychological treatment, %	Drug and psychological treatment, %	None, %
Any disorder	25.7	34.0	18.3	26.5	21.2
Any mood disorder	36.5	37.9	13.8	33.1	15.1
Any anxiety disorder	26.1	30.8	19.6	26.5	23.2
Any alcohol disorder	8.3	19.5	34	31.7	14.9
Only one disorder	19.6	34.3	19.4	17.2	29.1
More than one disorder	40.0	33.5	17	37.3	12.1

1. Proportions with consultation of any type of formal health services in the previous 12 months.

Source: Adapted from ESEMeD/MHEDEA 2000 Investigators (2004), "Use of Mental Health Services in Europe: Results from the European Study of the Epidemiology of Mental Disorders Project", *Acta Psychiatrica Scandinavica* 109 (Suppl. 1).