

Assessment and recommendations

Mental ill-health poses a key labour market and social policy challenge. The total estimated costs of mental ill-health for society are large, reaching 3.3% of GDP in the Netherlands, and are mainly the result of indirect costs through lost employment and reduced performance and productivity rather than direct health care costs. Sickness absence among workers with mental health problems is a big problem in the Netherlands. The percentage of people with moderate or severe mental health problems who are absent from work is 30-50% higher in the Netherlands than in other OECD countries. People with mental health problems frequently end up on disability, unemployment or social assistance benefits, and their share has been rising over time. In 2012, 7.9% of the working-age population received a disability benefit, of which one-third on the grounds of mental ill-health. Among unemployment and social assistance beneficiaries, approximately 30% and 40% report mental disorders, respectively. Finally, people suffering from mental health problems are less likely to be found in employment and face an unemployment rate double the rate of their healthy peers. Nevertheless, the employment rate of people with mental ill-health is higher in the Netherlands than in many other OECD countries, in part because of the widespread use of part-time employment.

The Netherlands has a dynamic, evidence-based reform climate

The importance of mental well-being for good work outcomes is well engrained at most policy levels in the Netherlands. The government and social partners frequently invest in research projects and policy analyses in the area of work and mental health, providing good starting points for policy improvement. Several large reforms have been implemented over the years to improve labour market inclusion of people with health problems. In particular, the employer incentives to invest in sickness management (they have a two-year responsibility for sick pay at 70-100% of the salary) are stronger in the Netherlands than in any other OECD country and have created ideal conditions for a support system for workers with mental health problems, provided they have an ongoing work contract. In 2015, a major reform will follow which decentralises responsibilities to the municipalities for co-ordinating and financing support services for three groups: i) youth;

ii) social assistance and social work beneficiaries; and iii) young disabled people with remaining work capacity. With this reform, the government hopes that support for these groups will be provided in a more integrated way, through co-operation with the education, (mental) health care and employment support sector, and closer to home.

Notwithstanding the positive climate to invest in improving work outcomes for people with mental health problems, many challenges remain. To start, the strong financial incentives for employers to address sickness absence among their employees did not result in comparable investments in preventive interventions for mental health risks to minimise sickness absence at the first place. Second, sickness management for those without an employer (including unemployed people and workers whose contract has ended) has only partially been addressed. As a result, many of these people end up on disability benefits or social assistance. Third, in all areas, the education sector, the mental health care sector and the social benefit sector – the primary focus is on people with severe mental disorders, while a much larger group exists with mild-to-moderate mental disorders. This group is often neglected or underserved, while early intervention could help to prevent deterioration of problems and the need for specialised and costly support. Fourth, probably most problematic for realising effective support for workers with a mental health problem is the strong separation of mental health care and employment support in the Netherlands. Finally, the major benefits from the decentralisation process are expected through the delivery of integrated services and a better alignment of policies across sectors. However, this process takes time, and the significant budget cuts coming with this change may hamper the implementation and success of the reform.

Improve school services and address the school-to-work transition

The onset of most mental disorders is during adolescence and often comes with impairments in several life domains, which can severely impact education and, subsequently, work outcomes. The Dutch school system provides a good support structure for pupils struggling with social-emotional, behavioural and/or learning problems through care teams present at most schools and external care and advice teams at the regional level available to the majority of schools. However, these teams are confronted with high caseloads and insufficient resources, resulting in an exclusive focus on children and youth with more severe problems and a lack of preventive activities. Furthermore, connections with other services in the youth care system (e.g. youth mental health care and youth care centres at the provincial level) are largely absent, which is characteristic for the whole youth care system with its scattered services. Proper co-ordination of youth care is essential to ensure that each child needing support receives timely

and adequate care. The planned devolution of youth care to the municipalities by 2015 should help in realising co-ordinated services; however, whether this policy change will be able to deliver will have to be monitored closely.

Policies are also lacking to support the transition from school to work for youth with mild-to-moderate mental health problems despite their high risk of exclusion in a weak labour market with growing youth unemployment. Support in the school-to-work transition should start early in the school career, for example through courses on social and employee skills in secondary education, and job coaching should be offered both in vocational and higher education.

Increase preventive actions and re-install occupational health knowledge at the workplace

In the Netherlands, employers have strong financial incentives in principle to invest in sickness management and the law requires them to undertake a risk assessment on occupational health and safety issues, including psychosocial risks at work. Nevertheless, only little support is provided to workers with mental health problems due to a number of reasons, including: i) insufficient knowledge among employers about the cost of mental ill-health and how to deal with it; ii) continued stigma towards mental ill-health; and iii) limited use of guidelines among occupational physicians (OPs) and return-to-work case managers. In addition, financial incentives have created a narrow focus on a fast return to work to reduce direct sickness absence costs, while little attention is being paid to prevention, at-work performance and sustainable reintegration. Early action is needed to avoid that work-related problems translate into reduced mental well-being and subsequent sickness absence and potentially labour market exit.

A growing concern is the increased freedom for employers in how to organise sickness management, including reintegration support. Whereas in the past, OPs were the primary professionals guiding workers back to work, nowadays employers can choose any kind of return-to-work case manager (including a supervisor or a human resource manager). This has resulted in scaling down the role of OPs and, consequently, a loss of specialised knowledge within companies on occupational health and reintegration issues. To provide adequate sickness management to workers with mental health problems, occupational mental health knowledge at the workplace needs to be strengthened, for example through the development of a competency profile for the return-to-work case manager. This profile should include expertise on mental health problems and the interplay between work-related factors and mental health.

Address mental ill-health among people who are out of work

Workers who no longer have an employer rely on the public employment service (UWV) for support and benefit payment; either an unemployment benefit for a duration depending on their employment history or a public sickness or disability benefit in case of illness. People who are not (or no longer) eligible for UWV benefits and have insufficient financial means for daily living, can receive social assistance from their municipality. Mental ill-health presents a major challenge for each of these public benefit systems as one-third or more of the beneficiaries have a mental disorder. Also, the share of people with a mental disorder has increased over time in all benefit systems.

The Dutch benefit systems have a strong focus on obligations and financial incentives for their beneficiaries to actively look for a job and work according to their remaining capacity in case of illness. Yet, employment support for people with mental ill-health by UWV and municipalities remains limited, and incentives are missing to improve services. The lack of appropriate case management support is a major concern for people with mental ill-health as they often have multiple problems which are interlinked and need to be tackled collaboratively by the employment, mental health and social sectors. Multidisciplinary support is to some extent provided by private reintegration offices contracted by UWV or the municipalities, but such support is available to only a small number of clients and available support has been further declining in recent years as a result of budget cuts.

The recent and upcoming reforms of UWV and the decentralisation of responsibilities to the municipalities should be closely monitored and evaluated to measure the impact on employment outcomes of unemployed and disabled people with mental health problems. The reforms provide opportunities to better address mental ill-health among these groups. First, the digitalisation of UWV support services for jobseekers could potentially become a powerful tool to identify mental health problems early on and provide web-based therapies in combination with face-to-face support. Second, it could be more efficient and effective for municipalities than for UWV to develop integrated support in collaboration with the education, mental health and care sectors for its clients, which is one of the drivers behind the latest reform. Yet, re-organising existing structures and services takes time and the simultaneous reduction in resources will drastically impact the support municipalities will be able to give to their clients.

Tackle the strong separation between the health care system and the employment sector

Mental health care and employment support are strongly separated in the Netherlands, mainly due to different financing systems. Health care is covered by personal health insurance while employment support is the employer's financial responsibility or the government's for those out of work. Due to this separation, mental health care providers are not required and not encouraged to focus on work in the treatment process. At the same time, employers and occupational physicians do not co-ordinate their services with mental health care providers and GPs (the same can be said about UWV and the municipalities). Collaboration is also impeded because: i) medical information cannot be shared without the patient's consent; and ii) referrals to an occupational physician require the consent of the employer.

The Netherlands is among the very few OECD countries with professional guidelines for GPs, mental health care providers and occupational physicians on how to guide workers on sickness absence due to mild-to-moderate mental disorders. These guidelines include information on the roles of the different professionals. However, not all professionals are familiar with the guidelines and they are not well followed in practice. Use of the guidelines and collaboration between the professionals needs to be further stimulated to ensure a shared understanding that work (and returning to work) contributes to mental health and appropriate, integrated action upon this.

Summary of the main OECD recommendations for the Netherlands

Key policy challenges	Policy recommendations
<p>1. School services are under-resourced and insufficiently focus on prevention and moderate mental health problems.</p>	<ul style="list-style-type: none"> • Ensure full coverage of internal and external care teams for all education levels. • Implement preventive programmes in schools focusing on coping skills, emotional learning and resilience. • Install job coaches in secondary, vocational and higher education to support youths with mild-to-moderate problems in their transition into the labour market. • Improve the competence of teachers to identify and deal with mental health problems.
<p>2. The well-developed occupational health system is not used in an optimal way.</p>	<ul style="list-style-type: none"> • Ensure better labour law compliance related to psychosocial risk prevention. • Provide workers with the opportunity for preventive consultations with their occupational health services. • Create a professional profile for the return-to-work case manager, which should include knowledge on the interaction between work and mental health.
<p>3. Activation policy by UWV for people with mental ill-health is insufficient.</p>	<ul style="list-style-type: none"> • Develop measures to identify jobseekers with psychosocial problems even before they fall sick and offer appropriate support in co-operation with the health sector. • Oblige early intervention by UWV through the development of a work plan within eight weeks of sickness absence regardless of health status and work capacity. • Improve sickness and disability management through job coaching, active recruitment into jobs and co-operation with the mental health sector. • Introduce financial incentives for UWV to improve their activation policy.

Summary of the main OECD recommendations for the Netherlands (cont.)

Key policy challenges	Policy recommendations
<p>4. Municipalities are confronted with an increase in caseload combined with a significant decrease in budgets.</p>	<ul style="list-style-type: none"> • Monitor municipal efforts by benchmarking outcomes in a transparent database. • Encourage sharing of best practices between municipalities, in particular regarding integrated support across sectors. • Scale up municipal resources if necessary as savings at the municipal level might affect other systems, such as the disability system and the mental health care sector.
<p>5. The mental health care system does not incorporate employment in the treatment process.</p>	<ul style="list-style-type: none"> • Include indicators on employment outcomes in the mental health care quality framework. • Incorporate workplace knowledge in GP practices either by training the assistant mental health care specialist (i.e. the POH-GGZ) or by providing funding for an employment specialist. • Improve collaboration and mutual referrals between OPs and treating doctors through a better use of the existing guidelines for each profession.